National Health Insurance and The Strategy for Change

VICENTE NAVARRO

This paper sounds a note of caution that regardless of the type of national health insurance program Congress will approve from among the proposals now before it, the present defects in the organization of health services in the United States may be strengthened rather than alleviated. Consequently, the reorganization and redistribution of health resources required to secure the availability of care for the greatest possible number may be hindered rather than stimulated. Strategies for change based upon a "market" and "incentives" ideology, such as those implicit in the current proposals for national health insurance (as well as those in Health Maintenance Organization proposals), will necessarily be limited in their reorganizational and redistributive effects, inasmuch as they leave untouched the locus of economic and political power in the health sector; it is argued that this very locus of power precipitated the much-quoted "medical care crisis."

In order to achieve the necessary reorganization and redistribution of resources in the health sector, the author believes that the locus of power must shift from the private to the public sector, permitting the levels of federal, state, and local government to formulate a mechanism for national and regional health planning in which public agencies would be the ones primarily responsible for planning, regulating, and controlling (but not necessarily owning) the distribution of human and physical resources within the health sector. In the light of this recommendation, the present structure for national and regional planning in the United States is described and appraised.

Introduction

In the United States, a great debate in the political arena is under way on the desirability of some form of national health insurance which would cover most of the population for at least large medical expenditures. From very ambitious and comprehensive insurance programs to less demanding, categorical ones, a wide range of opportunities and alternatives exists from which, at least in theory, the public will ultimately choose (Congress of the United States of America, 1971). Much as this debate may be needed, and much as some comprehensive form of insurance may indeed be required, there is the risk that whatever type of national health insurance the

Congress of the United States will pass, it may be presented as a panacea, and the solution to what is usually referred to as the "crisis of the nonsystem of the American health services."

Implicit in this point of view is the assumption that the type and source of financing determine the type and nature of the organization of medical care (Saward and Greenlick, 1972). However, the experience of those countries with national health insurance shows this assumption to be unwarranted. On the contrary, their experiences would seem to indicate that although national health insurance may be a necessary step toward the provision of full health care coverage for the entire population, it is by itself not sufficient to stimulate or determine the type of organization of health services that is required to make this commitment possible. Actually, in most of these countries experience has shown that the insurance system will adapt itself to the organization of medical care and not vice versa. And when national health insurance programs were adopted, they have not inevitably led to changes in the types of medical practice in the delivery system[1] but instead have frequently strengthened the existing patterns and types of delivery. In those instances, the insurance mechanism may have acted more as a consolidating force than as a stimulant for change in the organization of medical care. And changes within the insurance scheme in these countries have not primarily been aimed at stimulating changes in the delivery of care, but mostly at adapting the system of funding to the needs of the already existing delivery system or at simplifying the administration of the health insurance system. An example of this latter possibility is the seven-kronor reform that took place recently in Sweden, which changed the system of payment of physicians from a fee for service to a salary mechanism. This change was motivated primarily by the desire of the administrators of the delivery system for a simpler billing mechanism, and it was the administrative requirements of the delivery system that determined a change in the insurance system and not vice versa. Thus, the change in the payment plan of the insurance system was not primarily intended to change the organization of medical care.

Actually, where the evolution of the insurance system from voluntary to compulsory coverage (as in most countries with na-

[1]The term, health or medical care delivery system, refers to the collection of human, physical, and institutional resources that interact and interrelate in the provision of medical and hospital services.

tional health insurance) has caused an expansion of demand for services, this development has often made the weaknesses of the medical care system more apparent. The "new visibility" of the problems of delivery, or the maximization of those already present, may have determined a further public demand for changes in the system of delivery of care. But these changes have then occurred not necessarily through the insurance mechanism (using the insurance as a leverage) but separately. An example of this situation is Finland, where the increased demand for ambulatory care due to the introduction of national health insurance in 1964 revealed great weaknesses in the delivery of that type of care; public demand for changes in the organization of care resulted in a new public law in 1972 aimed at reorganizing the health care system (Purola *et al.*, 1973). In such cases the insurance program has been a prelude to (but not a leverage for) intensive modifications. In other instances, however, modifications have not, or not as yet, followed the inauguration of insurance programs, e.g., the Medicare program in the United States. Indeed, in the light of this program, which used an insurance philosophy, it can be postulated that Medicare has left unchanged (and some may say reinforced and strengthened) the prevalent system of providing medical care in the United States.

The large number of possible effects of a national health insurance on the delivery system would strengthen the argument that national health insurance *per se* is a mere billing mechanism that may or may not stimulate change in the system of delivery of care. Actually, it is my observation that the possibilities of insurance programs as leverage for change in the practice and organization of care have been somewhat overemphasized in the medical care literature, without much support by empirical evidence. On the contrary, it seems that there is more quantitative evidence in this and other countries of the reverse—of the use of insurance programs as leverage against instead of for change in the power structure[2] underlying the delivery system. This situation has led some to postulate that the insurance programs are actually the response of the holders of the locus of power in the delivery system to avoid its socialization, a strategy eloquently summarized in a line from Giuseppe de Lampedusa's *The Leopard* (1960): "If we want things to stay as

[2]Power structure here refers to the distribution of influence and control among competing groups in the elements of decision making.

they are, things will have to change. . . ." According to that interpretation, insurance (first voluntary and later compulsory) is the response of those groups at the locus of power in the delivery system to avoid the collapse of the health delivery system for lack of purchasing power of the majority of the population. This point has been discussed by Rimlinger (1971), and a similar critique of the insurance mechanism as a system of payment for health services has been made by Lichtman (1971).

Two Systems: Insurance and Medical Care

Part of the confusion in considering national health insurance as the solution for the medical care "crisis" arises from an apparently insufficient understanding of the concept of insurance. As indicated before, the insurance system is, primarily, a billing system whereby insurance contributions from employers, employees, and the state are collected to reimburse the providers, as components of the delivery system, for their services. However, these two systems, the delivery system involved with the organization of health care, and the insurance system charged with part of the funding, are separate. For one, in all countries with national health insurance, the delivery system is administered by different administration(s) than the insurance program. In Sweden, for instance, the medical care delivery system is administered by the county authorities, who, under the general supervision and regulation of the National Board of Health (the equivalent of the U. S. Department of Health, Education, and Welfare), plan, administer, and own the facilities and services in the personal health services sector. The insurance system, on the other hand, is run by local (county) insurance boards and, in terms of policy and administration, is dependent on the National Social Insurance Board (somewhat equivalent to the U. S. Social Security Administration) and entirely independent of the county authorities. The latter is national in scope (the standards of administration of the local insurance funds are fairly uniform across the country), while the former is local and varies, within certain national guidelines, from county to county.

In summary then, in Sweden, as in most Western European countries, the planning, regulation, and administration of the delivery of personal health services are in the hands of different agencies than those which administer health insurance. Thus, the failure to

distinguish between insurance and organization and the confusion stemming from considering the insurance mechanism as the determinant of the type of organization of medical care have led to the erroneous assumption that a centrally financed national health insurance would create a monolithic national medical care organization. Actually, Sweden has a system of centrally financed and locally administered insurance, and, at the same time, great variety (too much according to some) in the organization of health care delivery, with services that are owned, planned, administered, and partially funded by the local authorities. And in view of the Swedish and most Western European experiences, it is entirely possible that the proposed national health insurance schemes in the United States could be centrally financed and regulated, yet locally administered, and still have as much variety and diversity in the organization of health services as the public would tolerate. It is interesting to note in this regard that most of the present political debate assumes that variety in the delivery of health services is preferable to uniformity. The main rationale for this value judgment is another assumption, i.e., that variety also means more choice. It is noteworthy, however, that little evidence has been adduced for or against this assumption, and it is entirely possible that the opposite may be true, and that uniformity may be a prerequisite for choice. Actually, a large number of observers of the United Kingdom and the United States would agree with Brotherston's (1972) statement that the average citizen in the United Kingdom has more freedom of choice of medical and hospital care within the supposedly uniform National Health Service than in the supposedly varied American health services. Indeed, empirical evidence would seem to show that a certain degree of uniformity is required to guarantee choice (Brotherston, 1972).

If the Swedish and other European experiences are relevant to the United States, it would seem that, parallel to the political and professional attention presently being paid to national health insurance, concern should likewise center on the development of the planning, regulating, and administration systems which are indispensable for a restructuring of health services in this country. Actually, if the crisis in the American "nonsystem" is mainly due, not to problems of financing, but, as I would postulate, to problems of organization, then there should be a concomitant concern by the promoters of national health insurance with organizing the health

services system and with the process of its national and regional planning, regulation, and administration.

The Strategy for Change: The "Market" Ideology and Its Incentive Strategy

Actually, the growing awareness that the insurance programs in the United States may not solve the "medical care crisis" explains the recent arrival of Health Maintenance Organization (HMO) proposals on the political scene. In these proposals, it is assumed that money, supposedly from a national insurance scheme, would be channeled via the consumer and by some type of prepaid funding to certain types of practice, e.g., group practice. A basic assumption of this strategy for change is that the supply side, the delivery system, can be stimulated and changed from the demand side, with the distribution of resources to be regulated and guided primarily through the "invisible hand of the market forces." The main emphasis in this view is on modification of existing structures by a *system of incentives,* with heavy reliance on the *initiative of the private sector* instead of state (government) control, for the improvement of the delivery system, reflecting, as Harold Laski noted (quoted in Seidman, 1970:205), that

> most Americans have a sense of deep discomfort when they are asked to support the state. . . . They tend to feel that what is done by a government institution is bound to be less well done than if it were undertaken by individuals, whether alone or in the form of private corporations.

In the HMO and similar programs, accordingly, the money is spent in the private sector; it is assumed that the correction of and changes in demand (mainly through its increase in previously underconsuming populations) will stimulate changes in the supply of resources (including their distribution, type of practice, and pattern of delivery of care). It is also hoped in this approach that the adaptation of supply to demand can be stimulated by a policy of selective incentives (mostly monetary) and by an increase in the overall supply of resources. Because of the great attention that is being paid to the HMO strategy in the "corridors of power," it is worth analyzing the assumptions upon which that strategy is based and

which reflect the underlying "market" ideology that supports them. The most recent version of this strategy, as updated by one of its popularizers, the American Rehabilitation Foundation, is found in a presentation to the American Enterprise Institute. Noting the weak position of the consumer in the decision-making process in the delivery system, the authors propose to diminish the power of the providers and restore sovereignty to the consumer by reviving prepaid group practice (rebaptized Health Maintenance Organization or HMO) and offering the consumer that choice. "The HMO is a market-oriented approach which relies upon the stimulating and pruning effects of competition between HMO's" (O'Donoghue and Carlson, 1972:12). And the consumer, once again the sovereign of the market, is to be the one who will choose. Within this market world, the authors suggest there is no need for planning since the "invisible hand" of the market forces will spontaneously direct the allocation of resources in the health sector. Accordingly, they propose to remove the resource allocation responsibilities of Comprehensive Health Planning (CHP) agencies (i.e., veto power on resource allocations and/or certification of need) since they interfere with those market forces. O'Donoghue and Carlson (1972) also question the representativeness of the government agencies, indicating that planning and regulating agencies, "as foreign experience has shown," tend to be controlled by the providers and by bureaucracy. Instead, they propose a new role for the CHP agencies, that of consumer advocate councils, which à la Nader will scrutinize, evaluate, and provide information to the public as to the "quality" of the providers, on which basis the sovereign consumer may make an informed "buy." Also, not to leave the CHP agencies completely naked, they can have the "power to sue (and be sued) to initiate class action on behalf of consumers." Since the authors exhibit great distrust of the government, it is somewhat paradoxical that they advocate the shift for decision and control from government agencies to the courts, another not less cumbersome bureaucracy that is even more isolated from public scrutiny than government.

In this market model, the consumer is supposed to be the one who ultimately decides. The authors (O'Donoghue and Carlson, 1972:17) recognize, however, that the HMO's (and the whole health care system) will still be controlled in a large degree by the providers:

> . . . even if effective internal grievance/arbitration systems are established, there are reasons to suspect that the power of consumers may still be disproportionately low compared to that of the providers . . . HMO's will be large organizations and it may be difficult for consumers to gain access to the decision points of such organizations even with effective internal grievance/arbitration systems.

It may speak of the intensity of the authors' commitment to the "market" ideology that they do not appear to see the conflict implicit in control over the delivery system by the providers on the one hand, and the sovereignty of the consumer on the other; this regardless of how strongly the consumer's position may be reinforced by purchasing power and the "information service" provided by the Consumer Advocate Council. It would seem to be obvious that the so-called market forces, left as uncontrolled, unplanned, and unregulated by the public agencies as these authors suggest, will further strengthen the power of what may truly be termed the "invisible hand," i.e., the providers.

The Weaknesses of That Strategy: The Monopolistic Behavior of the Health Sector

In the HMO and other approaches, there is an ideological commitment to a free market model of the health sector that has its counterpart at the political level in the concept of countervailing power and the pluralistic nature of that sector. This countervailing power theory of the health sector accords with the political and economic interpretation of American society expressed by Galbraith (1956). Since that time, however, Galbraith (1967) has redefined his pluralistic interpretation and postulates that countervailing power has greatly diminished (if not disappeared) because of the great concentration of economic wealth and power of decision in relatively few large corporations.

According to the pluralistic concept there is in the distribution of economic and political power an effective balance of the different participating forces—the medical profession, the hospitals, the trade unions, the private agencies, etc.—which represent the plurality of interests that compete within the system. These forces operate under the watchful eye of the democratic state, and achieve, as a result of competition, a rough equilibrium in which everybody has

power and no one has, or can have, too much of it. A representative view of this pluralistic interpretation of the distribution of power in the health sector has been presented by Somers (1972). This pluralistic approach is best presented by Dahl (1959:36) who proposes

> . . . that there are a number of loci for arriving at political decisions; that businessmen, trade unions, politicians, consumers, farmers, voters and many other aggregates all have an impact on policy outcomes; that none of these aggregates is homogeneous for all purposes; that each of them is highly influential over some scopes but weak over many others; and that the power to reject undesired alternatives is more common than the power to dominate over outcomes directly.

Based on the pluralistic interpretation of the health sector, the strategy for change to correct the possible disequilibrium that may spontaneously appear is primarily through selective incentives, with state controls reduced to a feasible minimum. The main weakness of such a strategy is that it leaves the present distribution of economic and political power within the health sector untouched, and it is that distribution which is at the root of the present problem in the so-called medical care crisis. Indeed, the weakness of that strategy stems from the fallacious notion that there is a plurality in the locus of power in the health sector. The pluralistic view of the health sector is, in my opinion, inaccurate and, far from providing a guide to reality, constitutes a thorough obfuscation of it. As an American observer has indicated, "The flaw in the pluralistic heaven is that the heavenly chorus sings with a very special accent. . . . the system is askew, loaded and unbalanced in favor of a fraction of a minority." (Schattschneider, 1960:31).

Indeed, the present situation in the health sector is less pluralistic than monopolistic, dominated by the providers in general and the medical profession in particular, who determine the type of practice, system of payments, type of organization, and overall price of care that prevail in the health sector (Kessel, 1970). Actually, the fact that the medical profession and other providers number many thousands has led some to believe that medical services are an irrational jungle in which countless vested interests complete for the private and public dollar. As Kessel indicates, however, the fact that there are thousands of providers does

not detract from the monopolistic behavior of the medical profession, sustained by its control not merely of the supply of the medical schools and residencies, but also of its membership and their type of practice (excluding those who do not follow the authorized patterns of practice), and by price discrimination, which has, until very recently, given the American Medical Association (AMA) a control over the health sector in a manner more powerful than anything encountered in any industrial cartel (Kessel, 1958). It is part of an understandable political paradox that the AMA, usually a supporter of "right to work legislation," has at the same time strongly opposed a similar type of legislation for its own members, fearful of losing control over its membership if physicians could practice without belonging to this organization. That this situation is increasingly being challenged does not refute the monopolistic behavior still exhibited by the medical profession. And it is this behavior at the economic level of organized medicine that results in its overwhelming political influence on the health field, not only in the private but also in the public sector. This pattern is not always inviolable. As Posner (1971:11) has indicated,

> even organized medicine cannot expect to win every legislative battle, but it is in the nature of powerful interest groups that they cast outlast surges of popular concern of indignation that may succeed momentarily in pursuing adverse legislation.

This influence is not exclusive; rather, the predominant and determining influence held by the "practitioners" (who control the AMA) is shared with other groups within and outside the medical professions, including those whom Kelman (1971) calls the "patricians" or university-based physicians who control medical teaching institutions, the foundations, and part of the research agencies of government, and those whom Alford (1972) has defined as "the corporate rationalizers," primarily hospital associations. These different groups overlap to a certain degree but exhibit a uniform pattern of behavior that justifies such labels. Indeed, these groups, while representing different and divergent interests, are the dominant voices which influence the establishment of priorities and the distribution of resources within the health sector. And although, when defending their interests, they may be at odds and may even represent meaningful alternatives in terms of organizing

health services (within the boundaries of a common "free market" ideology), they share a series of beliefs and values that are grounded in their faith in the private sector, a faith that limits the boundaries of discussion and the possibilities of real alternatives. Indeed, based on their acceptance of the supremacy of the private sector (where they are powerful), they adopt as their strategy for change the one based on the use of incentives in that sector. By this rationale, the changes in the nature and distribution of health resources are supposed to be achieved through (1) changes in the amount and type of demand, (2) incentives (primarily monetary), and (3) an increase in the size of the supply (with, it is hoped, an accompanying redistribution of resources through competition and response to demand). A symptom of the political influence of the providers over the legislature is that most of the national health insurance proposals for change are based on these strategies. A partial exception to this is the Kennedy-Griffith proposal, to be discussed later.

The sharing of free market values which lead to this strategy extends also to academic centers, where the boundaries of debate are rather limited because of the unquestioning acceptance of most of the assumptions underlying those values. In reviewing one of these academic debates (Eilers and Moyerman, 1971), Silver (1971:66) has pointed out that

> it is interesting that among the formidable economists propounding or discussing, none challenges the implicit political dogma in the presentation, which automatically puts rigid limits on the economic analyses. One is reminded of the bitter criticism leveled against the White House advisory group with respect to the Vietnam War. So it is here, where the brilliant minds are put to work as technicians, not as thinkers.

The sharing of values which are implicit in an ideology that is all-pervasive in academia and other communication and information agencies makes the ideological boundaries of the present debate on insurance extremely narrow, and has led to the dismissal (paradoxically, as too ideological, i.e., "other" ideology) of any discussion of alternatives. This dismissal of alternatives leads to what has been defined as the success of a system, i.e., makes unthinkable the possibility of its alternatives (Marcuse, 1964).

It is my opinion that all strategies based primarily on incen-

tives will fail to have an effect on a reorganization of health care in the United States which would make its resources available to all the people. Instead, it can be argued that the most important factor explaining the type of system or nonsystem of health care in this country is the monopoly which the providers and especially the medical profession hold in the economic area, establishing at the political level a predominant influence in the decision-making process in the health sector in the United States. Indeed, the changes in the organization of medical care that are required to make its resources available to the entire population cannot be achieved unless there are concurrent changes in the control of the decision-making process in the health sector; i.e., control by others than the providers over the amount, type, and distribution of these resources. This implies a requirement for change in the system of control over the supply of resources; that is to say, the establishment of an infrastructure for national and regional planning in which the distribution of power is substantially altered from the present one, with a shift from the private to the public sector. Without such control, it is doubtful, for instance, that an increase in the supply of physicians could improve their distribution. Instead, the most likely outcome of an uncontrolled increase of supply would be a greater number of overdoctored areas, with consequent overutilization of resources by physicians.

It should be understood that I am advocating the public planning and regulating of the health sector, but not necessarily the public ownership. I further advocate that this infrastructure for planning and regulation should be developed within the established political machinery of the public sector, creating a pattern of relationships following the regular political channels at the federal, state, and local governments. The main rationale for this suggestion to shift the level of power from the private to the public sector is to increase public accountability in the health sector, to minimize the economic control and political influence of the providers (especially of the medical profession), and to maximize the influence of the consumer, the citizen, in the distribution of resources.

I am aware, of course, of the risk that the private sector may coopt the decision-making, planning, and regulating agencies in the public sector. Actually, many examples can be cited to show that this is happening already. At the national decision-making level, the Nixon Administration's recent shift of support to medical founda-

tions, due to the influence of the AMA (Iglehart, 1972), is a case in point. Also, Senator Kennedy's position has changed recently in that his proposal now allows room for medical foundations, and he denies that it intends to control the distribution of physicians (Kennedy, 1972). At the planning level, there are examples of the frequent cooptation of the Comprehensive Health Planning Councils (supposedly consumer dominated) by the providers; and at the regulatory level, the AMA has successfully rallied support for Congressional passage of the Professional Standards Review Organization legislation, initially drafted by the AMA, which confers regulatory power over the physician's practice on the medical profession. Actually, the fact that Congress changed its earlier position and did not fully accept the AMA draft explains subsequent AMA opposition. All of these are examples of the great influence (and some may say control) of private groups over the different organs of the state,[3] primarily over the executive and legislative levels of government, and may explain the skepticism expressed by some as to the validity of the distinction between the private and the public sectors in modern industrial societies. Actually, it could be postulated that the most important research for an understanding of the organization of medical care would center on the groups that influence policy and the mechanism whereby this influence is exerted. The ideological nature of the commitment to the private sector (and its assumption that the consumer is the main actor) and its prevalence in academia, government, and foundations may explain the lack of emphasis on those questions; instead, the focus is primarily on utilization studies and analysis of "consumer behavior" (e.g., effect of coinsurance on utilization). This research focus recalls, as Birnbaum (1971) has indicated, much of the sociological research in the 1960s on poverty, where most investigations were aimed at the study of the poor, not at the study of the system that produced them.

This powerful influence on government by economic interests, inside as well as outside the health sector, has led some authors to postulate that change in the distribution of economic and political power in the health sector cannot occur within the present overall

[3]The term, state, includes those institutions—the government, the administration, the military and the police, the judicial branch, and parliamentary assemblies—whose interrelationships shape the form of the state system (Miliband, 1969).

economic and political system in the United States (Alford, 1972). This argument, however, is unhistorical in the sense that it is based on assumptions that lack historical evidence. One such assumption, for instance, is that the economic and professional interest groups defined before do control government; that their overpowering influence amounts to practical control of government. But although the state (and within it the national government) is certainly not the arbiter of the economic and political debate, standing above interest groups, as is assumed by the pluralists, it is equally inaccurate to define those interest groups as the state. They do not constitute the state, as was true for the landowning classes and the aristocracy in preindustrial society. Indeed, even the enormous influence enjoyed by those interest groups does not automatically ensure that they do and will always achieve their purposes and can necessarily impose their will upon the state in regard to every demand. As Miliband (1969:164–165) correctly points out,

> Nor is it to suggest that other organised groups of every sort have not often waged highly successful campaigns, sometimes even against strong business opposition. Had business predominance been absolute, it would be absurd to speak of competition at all. There is competition, and defeats for powerful capitalist interests as well as victories. After all, David did overcome Goliath. But the point of the story is that David *was* smaller than Goliath and that the odds *were* heavily against him.

Given this unequal influence between the average citizen and large economic interests in different branches of government, the behavior of these economic interests is not uniform in areas that are not essential to the development of their interests. And in this respect, the professional group that may have a determinant influence in the health sector may still be in conflict with other economic interests that are more influential over the organs of the state. Indeed, the assumption that profound changes of the health sector are not feasible within the present economic structure of the United States ignores the nature of the social services (including the health services) in industrial societies, where the service industry (the tertiary sector) is a support industry for the primary and secondary sectors of the economy. And as such, its structure, nature, and priorities will be shaped and determined by the interests of those sectors. There is historical evidence that the economic groups that control the prima-

ry and secondary sectors could and would favor public control and even ownership (a possibility with very low probability in the United States) and socialization of the health services (as they did with education) when productivity requires it or when a "buffer" effect is needed to dilute any move threatening to their interests. In both the United Kingdom and Sweden, for instance, where most of the economy (the primary and secondary sectors) is in private hands, with large economic concentrations, the vested economic interests have allowed and actually encouraged the socialization of the health services. Indeed, it is possible that the first 100 largest corporations which, according to Senator Harris, control 60 percent of the country's corporate wealth (Harris, 1972), could well afford to support the socialization of health services without seriously affecting their great influence.

The Infrastructure for National and Regional Planning

A number of different groups are required to generate the infrastructure for national and regional health planning in the United States. The following analysis postulates that a shift in the distribution of power from the private to the public sector has the potential for bringing about the restructuring of health services that is required if health resources are to be available to the whole population.

However, it would be useful to define planning, which can be described as a stage within the decision-making process where the latter is understood to include the development of goals and objectives, the selection of the alternative to be implemented, and its actual implementation. This process embodies different functions that are usually carried out by different groups—decision makers, planners, regulators, administrators, and evaluators. The decision makers are those who choose from among the various goals, objectives, priorities, and alternatives and define the constraints within which the preparation, implementation, and evaluation of the plans should take place. These goals and objectives, the definition of priorities and of available alternatives are developed by the planners for the decision makers. The alternative chosen is implemented by the administrators or implementers, guided, stimulated, and/or regulated by the regulators. The implementation of the plan generates information, collected and processed by the statistical group, which, after being analyzed and evaluated by the research and evaluation group, is passed on to the planning group as a basis for the

preparation of further plans. Of course, this division of functions is somewhat arbitrary; frequently there is no clear-cut distinction between them nor between the groups that are supposedly responsible for them. For instance, by controlling much of the information that reaches the decision makers, planners tend to share in the decision making with the latter group. Nonetheless, and taking into account the limitations implicit in any categorization, it is useful to consider separately the functions relating to the preparation of the plan, its implementation, and its evaluation.

Policy Planners at the National Level

In the United States, the top policy planners and analyzers in the health sector are dispersed in the White House offices, mainly among the staff of the Council of Domestic Advisors and the Office of Management and Budget, and in the Secretary's office of the Department of Health, Education, and Welfare (HEW). These staffs, and also the staffs of the Congressional committees, Presidential commissions and the different agencies within HEW, prepare policy proposals. Top personnel of these agencies and offices, primarily those in the Executive Office, are political appointees and, as such, change according to political vagaries. Thus, they are unable to provide a sense of continuity at the senior civil service level. Indeed, this discontinuity in office leads to a lack of long-term perspective, and to an emphasis on short-term perspectives that determines their active role as crisis solvers rather than as policy planners.

As has been suggested by some authorities in the field, it would seem a condition for long-term strategy in health planning that first, a group within the HEW Secretary's office be appointed which would have primary responsibility for long-term policy planning and analysis in the health sector in the federal government, and second, that this group should comprise senior civil servants who would be in a position to establish continuity and "institutional memory" in the planning process (Seidman, 1970; White and Murnaghan, 1973). It is important to note that this group would prepare but not choose the plans, choice being the prerogative of the decision makers or political appointees, in accordance with the political structure and philosophy of the country.

At the second level of policy in the United States, i.e., the Health Services and Mental Health Administration (HSMHA)

within HEW, there is a profusion of programs, most of them categorical in their orientation, e.g., disease-, age-, or income-oriented. These different programs have responded to

> the vending machine concept of social change. Put a coin in the machine and out comes a piece of candy. If there is a social problem, pass a law and out comes a solution (Gardner, 1968:28).

Or, as Senator Ribicoff (Congress of the United States of America, 1968:2) has stated,

> because we rely so heavily on the programmatic approach—passing a program whenever we discover a problem or a part of the problem—and rely so little on a comprehensive manner—our efforts often are marked by confusion, frustration, and delay.

This pattern, which applies to most federal activities, is particularly evident in the HSMHA administration and reflects a categorical rather than a functional approach. The approach followed in categorical planning is partly explained by its lack of conflict with the levels of power discussed before, primarily within the medical profession. The evolution of the RMP (Regional Medical Program) legislation from a program to stimulate regionalization to its actual adaptation to the control of cancer, stroke, and heart disease is an example of conversion from a conflicting to an adaptive approach (Navarro, 1971).

Indeed, in the profusion of different programs, e.g., Medicare, Medicaid, Maternal and Child Health, Children and Youth Comprehensive Health Services, Comprehensive Mental Health, Migrant Labor Health, Health Maintenance Organizations, the Regional Medical Programs, etc., each has its own eligibility, funding, and administrative requirements that frequently conflict with those of other programs. The different programs have different political constituencies that actively support the sector of the federal agencies responsible for them, and these agencies, therefore, are not independent of the decision-making process. Thus, to consider the federal agencies as neutral and independent of the political structure is highly inaccurate. In this respect, the greatest structural difference between the National Board of Health in Sweden, for instance, and HSMHA in the United States is that the latter follows a

categorical approach and the former has now adopted a functional approach, e.g., planning, administration, research, and development. In the proposed structure of the Department of Health and Social Security in Britain, a similar functional approach is being taken (Yellowlees, 1972).

The recent creation of the Division of Health Care Development within HSMHA in HEW may represent the intention to coordinate these different programs and assume a more global approach. Still, the absence of a department of long-term planning in HSMHA which could assist the policy planners in the Secretary's office and the White House in preparing long-term proposals for the health care of the entire population may be a serious handicap in the achievement of a long-term strategy of health planning in the United States.[4]

The Comprehensive Health Planning Office within the Division of Health Care Development, the group that could, at least in name, constitute a long-term planning group, is several layers below the policy level, buried in the structure of HSMHA. At present it is stimulating the development of A (state) and B (local) Agencies across the country and thus the infrastructure for a planning process that would take place on a nationwide basis. However, it lacks the function of proposing alternative plans to the Director of HSMHA, or to the Secretary of HEW. It does not (nor does it apparently intend to) stimulate and assist state and local planning agencies in preparing long-, medium-, and short-term plans, nor does it have the regulatory functions and power over manpower and facilities of, for instance, the long-term planning department of the National Board of Health in Sweden (Navarro, in press).

Considering the experience of that country, it would seem advisable to establish a long-term planning group, working with or within the CHP Office at the federal level, that could assist (as does the Department of Planning in the National Board of Health in Sweden), the policy planning group at the Secretary's level in preparing the various long-term federal plans for the health sector. Also, as part of the required long-term perspective, the CHP group in the federal government should stimulate the preparation and development of long-, medium-, and short-term plans by the state and

[4]The recent changes which have occurred in the Department of Health, Education, and Welfare do not change the nature of my comments or their applicability.

local levels of government; i.e., federal funds in the health sector should not be approved at the state and local levels unless the anticipated expenditures are justified according to state and local long- and medium-term plans. Actually, it is my opinion that, unless the planning process encompasses a long-term perspective, there is little chance of solving the short-term problems.

Planners at the State and Local Levels

A similar situation exists at the state and local levels. At the state level, the Comprehensive Health Planning A Agency has, at least in theory, the mandate of planning health services (personal and environmental) for the state. This mandate is increasingly being strengthened, with these agencies adding some teeth (control and regulation) to the planning process (Richardson, 1972).

The B Agencies at the regional level have a similar function, with their decisions subject to approval by the A Agencies.[5] Both A and B Agencies, however, have not done much planning. Since they were virtually powerless until recently, their planning was largely voluntaristic in approach and categorical in nature. To date, only one state has actually prepared a state plan, highly categorical and not unlike the plans previously prepared by state health departments (Oregon State Department of Health, 1971). Absent from both agency and state plans were long-term perspectives (long- and medium-term plans) and a comprehensive approach, i.e., a plan of medical care for whole populations, as opposed to care for only a few sectors or conditions. In reality, most planning agencies, whether at the state or local level, are not at all engaged in preparing comprehensive long-term, medium-term, or even short-term plans. For the most part, they merely have established guidelines for the approval of local projects or groups, and currently have a coordinating rather than a planning role, with coordination independent of their still largely undeveloped planning function.

It is interesting to note that there is, in fact, a growing demand, mainly at the local level, for both states and localities to develop such plans. Until recently, when a local community wanted to build a hospital, for example, it was up to them to prove or disprove the needs of the proposed facility. Needless to say, the local

[5]Region is used here to denote a smaller unit than the state, i.e., equivalent to area.

community very rarely has the information or the competence to develop its justification, and when its request is not approved, as happens more frequently now due to the strong concern with costs, the response from the local level is to demand the needed "proof" from the regional and state levels. In turn, regional and state health planning agencies find it increasingly difficult to prove or disprove anything without state or regional health plans which would place guidelines and priorities within a space and time perspective. Aware of the limitations imposed by the present situation, some state health planning agencies have started preparing statewide health plans which, while not constituting rigid master plans, could offer points of reference for generating the criteria for planning and regulating the health services within their states. Therefore, it is to be expected that more state and regional health planning agencies will follow a similar pattern; i.e., they will begin to prepare long- and medium-term state and regional health plans (Navarro, 1972).

In theory, the CHP legislation is aimed at providing decision-making power to the public sector—primarily at the state level—through which the health sector can be reorganized. In practice, however, the elements of decision making and control are quite minimal, for, despite the large sums of tax dollars spent in the health sector, the percentage of funds over which these agencies have regulatory power is very small. Regulatory power in CHP legislation for the most part is restricted to veto power over allocation of capital investments. Much of the money that is spent in the health sector is outside their control, as are most other real regulatory powers, in accordance with legislative design. Indeed, analyzing the initial law, it can be said that although in theory the agencies may have been given the mandate to plan personal health services comprehensively, in practice they have not been given the decision-making power and control mechanisms to accomplish this mandate.

It is interesting to note that selective investments and federal expenditures in parts of the health sector are already considerable. For instance, a large amount of the operating funds for all hospitals in the urban areas of the United States comes from tax money, and in some cities, such as New York, the proportion is as high as 75–80 per cent (Battistella and Weil, 1969). If the A and B Agencies were to be given regulatory power over all public funds (i.e., tax money) spent in this sector—both capital and operating expenditures—as well as over the distribution of manpower, they

could reorganize most of the health sector following a scheme of regionalization. The fact is, however, that in the initial federal law, as well as in its implementation in most of the states, the A and B Agencies were not given the authority needed to regulate the public funds. This may be one indication of the influence over the national and state legislative bodies enjoyed by the professional and other interest groups discussed before, whose planning power would be curtailed to some degree if regulatory authority were given to those agencies. The power of these interest groups was also reflected in the CHP legislation itself, in a paragraph similar to the one in the RMP law, stipulating that the work of the CHP agencies should not conflict with the present patterns of medical practice.

Lacking power, the first priority of these agencies has been to obtain it, mainly by establishing large advisory boards which include most of the groups that intervene and decide within the health sector. In so doing, they have followed the voluntaristic approach referred to before, which assumes that a commonality of objectives can be reached among diverse and conflicting groups (Hiscock, 1971). In the absence of power, however, it is doubtful that this approach, which failed with voluntary planning, can succeed in these agencies.

Again, the voluntaristic approach assumes that different institutions coming together on a voluntary basis can achieve common objectives through mutual reinforcement. This commitment to a common objective, though, is highly correlated to the benefits each institution expects to receive from such an arrangement. And it is quite doubtful that participating institutions would favor the curtailment of their autonomy that planning and regionalization might require. Furthermore, it is doubtful that the different institutions would ever have such a concert of interests. In addition, physicians with privileges in certain hospitals might perceive the transfer of services to other hospitals, a likely result in any process of planning, as a loss of patients and, thus, of income. For "when a voluntary hospital surrenders a program of care to another hospital, its medical staff stands to lose income from the care of private patients" (Klarman, 1963:325). Due to the great influence that physicians have upon hospital decisions, this might represent an insurmountable obstacle to planning and regionalization.

Coordination among this array of institutions would be difficult under any circumstances, but, given the actual lack of desire for

cooperation, it is almost impossible. It would thus seem justified to suggest that for all these reasons, the voluntary philosophy in state and regional planning is "an apology for maintaining the status quo" (Bodenheimer, 1969:1146).

Recently, however, there has been a trend toward giving the A and B Agencies greater power and more regulating functions, which leads to the discussion of functions of the regulators and controllers.

Regulators and Controllers

Regulators and controllers are those in charge of stimulating and regulating the implementation of the plans. The strategies for stimulation and implementation vary in their degree of directness and can be categorized as follows:

1. Simple communication of objectives (the most indirect strategy);
2. Forecasting that permits interested parties to adjust their behavior by taking forecasts into account;
3. Use of tax and other incentives and subsidies;
4. Dependence on detailed norms and standards backed up by legal codes and sanctions;
5. Direct intervention and initiation of change by assuming ownership of resources.

In the United States, planning of personal health services at the federal level has been stimulated mainly by strategies 1 and 3. Strategy 4 has also been used for facilities through the Hill-Burton legislation, whose strengths and weaknesses have been discussed by Levin (1972). To strengthen this strategy, several states have now started designing certification-of-need legislation.

In the field of manpower, however, stimulation of change by the federal government has been based on the incentive philosophy, leaving, for the most part, the allocation of resources to the "invisible hand" of the free market mechanism. It is questionable, however, as indicated before, that incentives will provide enough leverage for the required changes in the supply of resources. For instance, it is doubtful that incentives alone will solve the problem of the "underserved" areas in the United States. Indeed, it is difficult to see how this problem can be solved without solving the question of the "overserved" areas. It is equally doubtful that the redistribution of

resources required to solve both problems can be effected without recourse to measures belonging to strategy 4, i.e., controls backed by codes and sanctions. One may well postulate that it is next to impossible to address the problem of maldistribution of physicians, for instance, unless the federal or state governments have the power, as does the central government in Sweden, of controlling, in consultation with the medical profession, the distribution of physicians in the country. Actually, no country, whether socialist or capitalist, has minimized the unequal distribution of health resources between classes, areas, and regions without controlling the supply (including distribution) of those resources. It should also be noted that no country has "solved" this problem, if by solving we mean distributing resources only according to need. But it is obvious that countries that have adopted measures of distribution control have minimized the unequal distribution of resources more than those whose strategies have centered around incentives. Those countries, like the United Kingdom and Sweden, where there is control over the distribution of supply, have a less unequal distribution of resources by class, region, and area than is found in the United States (Anderson, 1972). Sweden and the United Kingdom, for instance, similar to the United States in that both are capitalist economies with great concentrations of economic wealth, have minimized the unequal distribution of health resources by preventing physicians (their salaries partially or totally funded by tax monies) from practicing in overdoctored areas, while allowing them to practice in underdoctored areas. In this approach, the state does not order physicians where to practice; but rather stipulates where they cannot practice. This distribution of human resources in both countries (but primarily in Sweden) is done according to national and state plans and priorities. In Sweden, where the central government does not own, administer, or fund the health services, the strategy for implementing national plans is to control the distribution of human resources, primarily physicians, by reserving the power of approval for all new posts for generalists (and since 1972 for specialists as well) available at the local level. Also, the central government has to approve any local capital investment above specified limits. And physician distribution and new construction must be in accordance with long-, medium-, and short-term plans prepared by the local authorities and already approved by the central government (Navarro, in press).

Another problem of manpower maldistribution in the health sector relates to the poor distribution of specialties within the medical profession. Several studies have indicated that there are twice as many surgeons in proportion to population in the United States as in England and Wales, and more surgeons than pediatricians (Stevens, 1971). It is doubtful that these maldistributions will be solved merely by incentives. Left to itself, the unneeded specialty may well increase in oversupplied areas, increasing the overutilization of resources by physicians.

Here again, the Swedish experience, with its regulation of specialty distribution within the medical manpower pyramid, is worth considering. A paragovernmental body, comprising government officials from the national health planning agency and representatives of the medical profession and of the medical schools, decides on the type and number of residencies that should be available each year and thus indirectly controls the output of the medical teaching institutions according to the needs of the health sector and according to the priorities set by the National Health Planning Council.

However, none of the proposals for a national health insurance suggests such a control of the supply in terms of geographical and specialty distribution, on the assumption that the free market forces coupled with incentives will by themselves "solve" the problem of maldistribution of resources. A variant of this is the Kennedy proposal, which suggests controlling the supply through controls over physicians' fees and hospital charges, following a public utility model. Trying to regulate the structure of the system by regulating the prices, however, is to confuse symptom with cause. Indeed, prices are only a symptom of the organization of care; they are not the cause. Therefore, it is highly doubtful that reorganization of the system will be achieved by regulating prices. This proposal ignores the fact that the purpose of public utility regulation is to allow (but not guarantee) a fair profit (not an excessive one) in a monopolistic situation. It does not intend to direct or guide the structure of the monopoly (Posner, 1969). Price controls are not intended, nor are they effective, as redistributive measures. A similar argument could be made against budget controls as a redistributive measure, particularly where the nature of this control is left as vague as in the Kennedy bill. Again, unless controls over the distribution of human

resources are incorporated in that particular proposal, price regulation and budget controls will be of limited value in reorganizing the delivery system in a manner allowing coverage of the full population, the stated aim of national health insurance. Unless control over the supply of manpower is added to the control of capital investments provided in the certification-of-need legislation, it is doubtful that a redistribution of services can occur. I postulate that to achieve that redistribution of resources, control and regulatory power must be used by the regulating agencies according to the criteria of long-, medium-, and short-term plans prepared by the CHP planning agencies, and approved by the state and local legislatures. The fact that none of the national health insurance proposals outlines these strategies leads to some skepticism about their potential for stimulating change, in spite of political pronouncements as to their being the solution to the "crisis of our medical care nonsystem."

As Professor McKeown (quoted by Silver, 1972:455) observed in the *British Journal of Social Medicine* 25 years ago, "the American political parties" (and, I would add, national health insurance proponents) "practice a form of political contraception, in which no matter how suggestive the preliminary movements, there are no embarrassing legislative consequences afterwards."

It may be postulated that some embarrassment may be necessary if there is to be satisfaction.

Acknowledgments

The assistance of Kathy Hastings in preparing the manuscript and of Renate Wilson and Barbara Koeppel in editing it is much appreciated.

Vicente Navarro, M.D., D.M.S.A., DR.P.H.
Department of Medical Care and Hospitals
School of Hygiene and Public Health
The Johns Hopkins University
615 North Wolfe Street
Baltimore, Maryland 21205

This work was supported in part by grants (5R01 HS 00110 and 5T01 HS 00112) from the National Center for Health Services Research and Development and (5D04 AH 00076) from the National Institutes of Health, U. S. Department of Health, Education, and Welfare.

References

Alford, R. R.

1972 "The political economy of health care: dynamics without change." Politics and Society 3(Winter):127–164.

Anderson, O. W.

1972 Health Care: Can There Be Equity? The United States, Sweden, and England. New York: John Wiley and Sons.

Battistella, R. M., and T. P. Weil

1969 "Comprehensive health care planning." New York State Journal of Medicine 69(September):2350–2370.

Birnbaum, N.

1971 Toward a Critical Sociology. New York: Oxford University Press.

Bodenheimer, T. S.

1969 "Regional medical programs: no road to regionalization." Medical Care Review 26(December):1125–1166.

Brotherston, J. H. F.

1972 "Trends in the British National Health Service." Bulletin of the New York Academy of Medicine 48(January):58–65.

Congress of the United States of America

1968 Modernizing the federal government. Hearings Before the House Committee on Government Operations. Washington: Government Printing Office.

1971 National health insurance proposals. Hearings Before the House Committee on Ways and Means. Washington: Government Printing Office.

Dahl, R. A.

1959 Social Science Research on Business: Product and Potential. New York: Columbia University Press.

Eilers, R. D., and S. S. Moyerman (eds.)

1971 National Health Insurance Conference Proceedings. Illinois: Richard D. Irwin.

Galbraith, J. K.

1956 American Capitalism: The Concept of Countervailing Power. Boston: Houghton Mifflin.

1967 The New Industrial State. New York: New American Library.

Gardner, J. W.
1968 No Easy Victories. New York: Harper and Row.

Harris, F.
1972 "The real populism fights unequal wealth." The New York Times (May 25):45.

Hiscock, W. McC.
1971 "Planning by coalition strategy." A.P.H.A. News(December 2):1.

Iglehart, J. K.
1972 "Health report." National Journal 4(September):1404–1408.

Kelman, S.
1971 "Towards the political economy of medical care." Inquiry 8(September):30–38.

Kennedy, E.
1972 Address to the American Academy of Family Physicians. New York, September 27.

Kessel, R. A.
1958 "Price discrimination in medicine." Journal of Law and Economics 1:20–53.
1970 "The AMA and the supply of physicians." Law and Contemporary Problems 35(Spring):267–283.

Klarman, H. E.
1963 Hospital Care in New York City. New York: Columbia University Press.

Lampedusa, Giuseppe de
1960 The Leopard. New York: Random House.

Levin, A. L.
1972 "Health planning and the federal government." International Journal of Health Services 2(August):367–376.

Lichtman, R.
1971 "The political economy of medical care." Pp. 265–290 in H. P. Dreitzel (ed.), The Social Organization of Health. New York: Macmillan.

Marcuse, H.
1964 One-Dimensional Man; Studies in the Ideology of Advanced Industrial Societies. New York: Beacon Press.

Miliband, R.

1969 The State in Capitalist Society: An Analysis of the Western System of Power. New York: Basic Books.

Navarro, V.

1971 "The city and the region." American Behavioral Scientist 14(July/August):865–892.

1972 (ed.), Proposal for a Comprehensive Health Plan for the State of Maryland. Baltimore: Maryland Comprehensive Health Planning Agency.

in press National and Regional Health Planning in Sweden. Washington: Fogarty International Center of the National Institutes of Health.

O'Donoghue, P., and R. J. Carlson

1972 Actual and possible relationships between HMOs and CHP Agencies. Presented at a Conference on Health Planning, Certificates of Need, and Market Entry. Washington: American Enterprise Institute.

Oregon State Department of Health

1971 Oregon State Comprehensive Health Services Plan. Salem: Oregon Health Planning Section of Executive Department Program Planning Division.

Posner, R. A.

1969 "Natural monopoly and its regulation." Stanford Law Review 21(February):548–643.

1971 "Regulatory aspects of national health insurance plans." University of Chicago Law Review 39(Fall):1–29.

Purola, T., E. Kalimo, K. Nyman, and K. Sievers

1973 "National sickness insurance in Finland: its impact and evaluation." International Journal of Health Services 3(Winter):69–80.

Richardson, E.

1972 Address to the Institute of Medicine. Washington, D.C., May 10.

Rimlinger, G. V.

1971 Welfare Policy and Industrialization in Europe, America and Russia. New York: John Wiley and Sons.

Saward, E. W., and M. R. Greenlick

1972 "Health policy and the HMO." Milbank Memorial Fund Quarterly 50, Part I(April):147–176.

Schattschneider, E. E.

1960 The Semi-Sovereign People: A Realistic View of Democracy in America. New York: Holt, Rinehart and Winston.

Seidman, H.

1970 Politics, Position and Power: The Dynamics of Federal Organization. New York: Oxford University Press.

Silver, G.

1971 "Review of R. D. Eilers and S. S. Moyerman (eds.): National Health Insurance Conference Proceedings." Inquiry 8(December):66–68.

1972 "Health politics and the November elections." International Journal of Health Services 2(August):455–458.

Somers, A. R.

1972 "Who's in charge here? or Alice searches for a king in Mediland." The New England Journal of Medicine 287(October):849–855.

Stevens, R.

1971 American Medicine and the Public Interest. New Haven: Yale University Press.

White, K. L., and J. H. Murnaghan

1973 "Health care policy formation: analysis, information and research." International Journal of Health Services (Winter):81–91.

Yellowlees, H. C.

1972 (Deputy Senior Medical Officer, Department of Health and Social Security, London, England.) Personal Communication.