A Conversation with Dr. Theodore Cooper

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The Office of the Assistant Secretary for Health represents a wide-ranging set of responsibilities, reflecting the enlarged duties, conflicting policies, and emerging mandates of the federal government in the delivery of medical care. Traditionally, the occupant of the job has been described as "the government's top doctor," although he is directly responsible for only $6 billion of the $50 billion expended every year through federal health programs.

Dr. Theodore Cooper, who held the post during the last two years of the Ford administration, devoted more time to establishing a cohesive policy making process than to formulating substantive new policy, underscoring the critical need of the Department of Health, Education, and Welfare to better coordinate, manage, and organize its existing programs, rather than to design new endeavors.

Time and again in a wide-ranging, four-hour interview, taped in two sessions, Dr. Cooper emphasized that what HEW needs is not more statutory authority or operating programs, but an effective strategy for managing its ongoing efforts. He also stressed the need for making the Office of the Assistant Secretary for Health the focus for short-term and long-range HEW health policy making—"a cohesive, responsive health focus for all HEW health policy." And he pointed to the *Forward Plan for Health,* published annually by the office he headed, as an appropriate blueprint.

One of his major frustrations during his tenure was an inability to convince other influential offices within HEW, and at the Office of Management and Budget, to let the Office of the Assistant Secretary for Health chart policy. Dr. Cooper pointed out that a reorganization of HEW promulgated shortly after his departure, by Secretary Joseph A. Califano, Jr., would only exacerbate the diffi-

culty of Cooper's successor, Dr. Julius Richmond, in providing the critical focus for health policy making.

Cooper offered his view of what good health policy making is. It must be economically realistic, fill a medical need, and be politically viable. And he suggested that Congress must be more courageous when it debates future health policy questions.

Cooper asserted, for example, that government must come to grips with how it will provide services to the poor in the future. The critical question is whether freedom of choice is more important than assuring access to quality health care services. He also declared that government must resolve the conflict between the preeminence of the popular theme of the moment—controlling costs—and the national goal as expressed in the National Health Planning and Resources Development Act of 1974. That goal is to grant to every citizen access to quality medical care at a reasonable cost.

The following is an edited transcript of the interview, which was held last May, just prior to Dr. Cooper's appointment as Dean of the Cornell University Medical College.

Governance and Organization

JKI: During your two-year tenure as Assistant HEW Secretary for Health, you devoted a lot of time and attention to restructuring the Office. Do you conclude that a single, principal health officer for the nation is necessary? Would this lead to creation of a Department of Health?

TC: Because many different agencies send proposals directly to the Secretary he is not well or efficiently served, especially since there is no clear policy focus around which to weigh alternatives. That focus should be articulated by a principal health officer, and to accommodate it, a Department of Health is necessary. Such a department would ensure simplification of decision making, full-time attention to the important issues facing health, more effective management, and a resolution of conflict that comes between issues of financing and other important substantive concerns. A Department of Health must include all of the diverse health functions in which government is now engaged. This is the only realistic way I can see of reaching the dual objectives of improved policy making and improved policy implementation. Consolidation, integration, and simplification can

only be accomplished if there is vested administrative authority behind the process, and this, in turn, will require a new organizational entity.

JKI: I would like to act as the devil's advocate on your call for the creation of a Department of Health. Isn't such a call really a cop-out, an admission that people are more concerned with turf questions than with coordinating and consolidating social services where they count most, at the delivery end?

TC: Yes, I would agree with that. For three years I made a big distinction between consolidation and simplification, on the one hand, and vesting administrative responsibility on the other. But in fact, human nature being what it is, it seems to me that the only way you can accomplish real coordination is to insure that the organizational entity in which to do it is there. I think that's a perversion of logic, but a political reality.

JKI: Is the integration of services the most critical challenge facing the health service delivery system today?

TC: Yes. Integration and simplification in the interest of the patient and provider have finally come to be accepted as a fundamental national goal. P.L. 93-641 [National Health Planning and Resources Development Act of 1974], for example, is very clear about the national goal that every citizen have access to quality medical care at a reasonable cost. Note, the law doesn't say that everybody should have *equal care;* this would be a patent impossibility that's been often oversold, but it says *access to quality care at reasonable cost.*

Agreement on a general national goal, however, is not enough for effective policy. Its implementation falls apart because we have a couple of hundred different authorities with overlapping reporting channels, overlapping responsibilities, and hundreds of sets of regulations which are not in conformity with each other.

JKI: Could you illustrate how simplification or consolidation have had a programmatic effect in a particular area?

TC: A good example is HEW's Rural Health Initiative, which received substantial attention in the *Forward Plan for Health.* Funds were taken from 15 different authorities to finance this consolidated undertaking. Under the blanket authority of the Rural Health Program, funds were disbursed to rural settings: to finance the development of local primary care facilities, to develop a sensible means of communication and referral, and to deal with the sense of isolation of the health professional in remote settings. Rural health problems are not going to be solved through satellite clinics, or by helicoptering everybody to everything. Reality being what it is, that's not what the future of health services is all about. There has to be an identification with, and service to, the person in his life setting. You can't send people to some medical Shangri-La for use of high technology—that kind of thing is not going to meet the aspiration for health services in this country.

JKI: Has the recent HEW reorganization which created the Health Care Financing Administration blurred rather than clarified this need for simplification and consolidation?

TC: Yes, absolutely. The reorganization has served to distort the relationship of management to administration, policy making, and problem solving. It portends that health care financing—i.e., costs—is likely to become dominant over all other policy considerations. The reorganization places the Assistant Secretary for Health in the position of shaping policy as a coequal with the Administrator of the Health Care Financing Administration and the Deputy Assistant HEW Secretary for Health Planning and Evaluation. The Assistant Secretary for Health has no primary responsibility; thus, the reorganization obscures the role of the Assistant Secretary for Health as the principal health officer. Nothing that has three heads can create constructively or provide decisive leadership. The Secretary himself will have to be the arbiter among the three interests, but, inevitably, his planning office for health will become first among equals. And believe me, as an old administrator and manager, the office owning that kind of authority, owns the ball game.

JKI: Reflecting upon your experience as Assistant Secretary for Health, what do you regard as your greatest accomplishment?

TC: When you spend a couple of years of your life trying to do something, and wonder whether you've done it, you come away with disquieting feelings.

I suppose that the most important function I performed was to give some credibility to the notion that the Department must develop a cohesive leadership position in health policy formulation: that there is a need to create a place where you can get information without taking 12 years; that there is a place where a health agency can be heard and get an answer, even if that answer is "No." I think my accomplishment was that I demonstrated that it is feasible to set down what it is you are attempting to do; I did that in the *Forward Plan for Health,* which the Office of the Assistant Secretary for Health has published annually over the past several years.

JKI: What was your greatest disappointment as Assistant Secretary?

TC: My greatest disappointment was a failure to thoroughly convince the entire policy making system of the critical need to integrate the budgetary and legislative aspects of policy development within a responsive health focus. I did not succeed in convincing the President's Office of Management and Budget of the need for integration. The OMB insisted on evaluating everything separately. Even other offices in the Secretary's sphere (the Office of the Assistant Secretary for Planning and Evaluation and the Office of the Assistant Secretary for Management and Budget) remained unconvinced.

The Making of Policy

JKI: I have the sense that the health professional in HEW has been ineffective in influencing policy on the basis of the results of scientific inquiry. What is your view on that?

TC: The difficulty here is that there is no one professional group, but rather several; health policy discussions between the different groups proceed from as many value systems. All have been burned in championing programs which have been disasters, and they are trying to avoid any posture which isn't backed by "proof and hard data," or what you call "scientific inquiry." But each profession's "science" is rooted in its own value system. For example, the doctor

(who is not without influence in Washington) tends to come into the policy discussion with anecdotal evidence from clinical practice. When he talks about the striking example, he can't relate it to large numbers, particularly in terms of national cost efficiency.

On the other hand, if health policy is to be influenced by those who rely on performance measures of public health statistics, then the twain can't meet. I have often been told that, with all the money spent on coronary bypasses, the real change in the statistics of heart disease is not terribly good—people aren't living that much longer. Therefore, the question is asked, why should we do it? My answer would be along the clinical value system: Why don't you ask somebody who has had a coronary bypass, somebody who was rendered nonproductive and who is now living a productive life? I don't know how to put that in numerical terms, if you're going to measure the value by a statistic. Somewhere along the line we'll have to seek a balance between those two concepts of evidence.

But for the last five to eight years there has been a growing preoccupation with economics as a basis for policy. It is yet another value system being invoked, and one whose "science" and "data" haven't yet been shown to be any better assurance of good health policy.

JKI: What, in fact, are the ingredients of good health policy?

TC: Good health policy is based on three things. Realistic economics is essential; the day is over when we can say that because health involves life and death, anything goes. But it has to be *realistic* economics.

Another important ingredient in health policy is *need* on a medical or health basis. Then that should be cast against the background of what it is scientifically possible to do to serve those needs, as determined by experienced scientists and clinical practitioners.

The third ingredient is basic good politics—not politics in a pejorative sense, but rather that of facilitating what is feasible. Increasing amounts of the bill for providing and receiving care are paid out of public funds. Therefore, public participation becomes a very important lever, like any stockholder activity. So often the public's aspiration is quite distinct from the economists' assessment of what's good for them.

JKI: Technology and clinical practice seem to create their own need imperatives, which may not move in the same direction as other constructs of need. How do you sort out this paradox?

TC: Through attention to the three ingredients. The clinical need, as much as I would like not to have to admit it, does create its own demand in certain economic settings. Culturally, certain population groups do react to the availability of a service and seek it out, whether or not they need it. And, of course, the service will usually be provided, whether or not it is needed. I agree with you. The conflict is whether this is in the best health interests of a community, and that's why the public health input is important as a counterbalancing force. But, in general, public health practitioners have carried inadequate weight vis-a-vis clinical practitioners.

JKI: Why is the public health physician held in so little esteem by his clinical counterparts?

TC: I think it derives from a whole generation of physicians who have grown up in a system that is oriented to medical specialties and high technology. This has created a great deal of intellectual excitement. At the same time, some of the great scourges that keep the public health doctor in the limelight have subsided. But excellent science and intellectual activity need not necessarily be excluded from translating technological and scientific advances into the right preventive base. Quite the contrary; in the fields of nutrition and the environment, where there is great social interest and therefore an important potential economic lever, there will be a major drive. And since important good science is available to support that drive, it will accelerate.

Freedom of Choice

JKI: You have often made reference to a need to reform the Medicaid program. On a broader scale, what in the health care delivery system as it applies to the poor should be reformed?

TC: If we want to achieve the twin objectives of *access* and *quality*

then I think the financing system for the poor will have to be redone. You cannot continue to make believe that Medicaid buys quality care, knowing full well that it cannot, under arbitrarily low reimbursement rates. Nor can we continue to ask other third-party insurers to make up those fiscal deficits which would result if quality were in fact pursued in the open market. Unless we make serious reforms here, we would probably be better off if the poor were channelled to prescribed facilities that render quality care—in other words, eliminating their freedom of choice.

JKI: Would such a policy be "un-American" in your view?

TC: I am not troubled by the notion of restricting access, by individuals who cannot afford to pay, to government-run health facilities. I think, on the whole, they would receive better medicine than they now receive. More fundamental to the American way, in my view, would be to provide *all* citizens with quality medical care without financial barriers. I don't think Medicaid provides real freedom of choice, despite the political rhetoric. What does freedom of choice mean? If you go to a small town in Iowa where there is one doctor, what difference does freedom of choice make? Or if, in an urban area, there are many doctors but you lack the finances, how much freedom of choice can you exercise? When you live in society, you always have to yield some freedom of choice for other values. Theoretically, it's an important value, but it must be placed in a realistic context. What we really want the poor to have is more than a "Hobson's choice." They need to be able to choose effectively between receiving decent medical care or taking care of themselves.

JKI: I would like to turn to the subject of health care cost containment. There is sharp disagreement between direct health care providers and those who are more concerned with economics. This conflict is apparent within HEW as well as outside in the field of medicine. Within the Department, you sided with the health professionals in most policy conflicts with the economists. What would you do specifically to attack the problem of soaring costs—the problem of constraining a system that seems out of control?

TC: First, if rising costs border on a major national catastrophe, as some of the rhetoric suggests, then I think the President ought to

impose wage and price controls across the board. If that's what we need at the moment, programs which pass through labor costs are not likely to be very effective cost-control programs.

Reimbursement policies must be redesigned. If we all really believe that the reason why some people do unnecessary things is because we pay them a lot to do so, then let's stop paying them a lot. For example, if there is a great concern that surgeons make too much money per unit, then either stop paying them on a per unit basis or reduce the amount per unit. We simply must change the incentive structure and build a system of capital resource allocation. However, recognize that the process of developing new and less capital-intensive systems (e.g., self-care, intermediary care, home health) will themselves require investment capital. You can't develop systems without spending money on them first.

Furthermore, we have too many systems of utilization review. Although I am skeptical that utilization review by itself is going to serve as a powerful containment on cost, it will be of some help and it is necessary to insure the quality of care. Then, I think we must develop a strong program of health education so the public will recognize the limits of medicine. When I see popular celebrities on television selling some of those insurance policies that add benefits on top of other ones, I worry about this inflationary effect on the system.

JKI: Isn't there a contradiction between government concerns about cost containment, on the one hand, and continual expansion of the health system on the other?

TC: Certainly—the paradox is striking. We are calling for more services, for more people, for a higher minimum wage, for new regulations to make sure the handicapped can be accommodated, and on, and on. All of these elements increase price. At the same time, we're saying, "Hold down costs." People just aren't thinking of what they're saying. When I note that we are spending $160 billion a year on health care—8.6 percent of the Gross National Product—people look at me and say, "So what?" Is 10 percent of GNP a bad figure? If so, why? The discussion of *"why"* has not been held in this country. If individuals and interest groups say we can't afford 10 percent because everything else that is competing for those resources is of greater societal importance, then we ought to have a broad-ranging public discussion of that issue.

However, the health system is a major economy unto itself. Five million workers are involved. If you start putting caps on hospitals, you lay off people. Even if you cut down on CAT scanners, you're going to lay off people. In short, government can't continue to say "Stop spending" at the same time its policy makers are saying, "Let's provide better health service to the people," and "More employment for the labor force."

Roles and Responsibilities

JKI: How would you characterize the changing functions of the federal government with respect to support of medical education?

TC: There is great need for redefinition of appropriate roles with respect to medical schools. While support of research is clearly an appropriate and needed federal responsibility, a more limited role in educational support is indicated. We're on the verge of having too large a federal role in the education of physicians and other health professionals. It has gotten to the point where the federal government is close to coopting the curriculum, and, when you coopt an educational system, that is a very serious ideological step. I do not favor it.

In the 1976 Health Manpower Amendments, for example, Congress has gone on to a new step; now it is not socially adequate for schools simply to produce good doctors. Congress wants them trained in family practice and other prescribed areas.

JKI: These amendments, as I recall, enjoyed rather broad bipartisan support.

TC: Yes, that's right. The Ford administration actually proposed some, and I have to take responsibility for that. I was convinced in talking to many medical schools that they had a compelling need to continue receiving capitation subsidies. Such public subsidies, which were instituted in the 1971 law, had become vital operating monies for medical schools. Rampant inflation, fired by the energy crisis, hit these schools hard. I felt that capitation grants should continue for a limited period of time—I didn't think they should be open-ended. To continue these subsidies, though, the administra-

tion and Congress wanted a *quid pro quo*. The political price was deeper federal intervention in the internal affairs of the schools, dictating curriculum and the like.

JKI: But you can't place the blame entirely on the government. The schools have aggressively encouraged more federal funding for many years, and more public dollars always bring heavier government involvement, whatever the undertaking.

TC: I'll buy that 100 percent. I had to be encouraged by the schools, and ultimately I was persuaded by their persistence and their data. But I also cautioned them to be wary, that they had to bear the responsibility in part—in serious part—for what they were advocating in the way of federal support. It is not worth the price of intellectual independence every time.

JKI: I'd like to turn briefly to national immunization policy, a subject with which you are very familiar. Are major changes in policy needed?

TC: There's no question that the legal liability for all immunization programs is going to require a different policy. It may be, for example, as simple as a different consent form, although I don't think the problems will be resolved that simplistically. Any biological program I'm aware of that's been administered to large numbers of people has had some consequences which weren't anticipated. How that's dealt with is now perceived publicly as a different kind of issue from what it was 20 years ago. Measles vaccine has some complications—serious ones; so does polio vaccine. There are small numbers of deaths involved when such vaccines are administered to millions. Is it all right to have 12 deaths? If 12 is acceptable, how about 13? I don't know that answer.

I've learned a lot about it and worried about it, but the solution is not to be found in trying to set exact limits, but rather in finding out what to do with the fact there must always be some number of people falling beyond *any* limit. You can't give a vaccine that is 100 percent safe; you can't give anything that's 100 percent safe. So if you want to have a program where well people are going to take risks for their personal protection, as well as for a perceived benefit

for the community, then the community has to have a policy to deal with this problem. We used to assume a willingness to pay the price as a community for the risk of X number of people dying, and if you happened to be one of them, that was tough luck. That doesn't hold any more.

Furthermore, in future policy we must address the question of who's going to pay for it, if it's a societal need. If individuals have to pay $15 a shot, many won't do it, and it's difficult to urge people to spend money they don't have. A lot of people will not do it voluntarily unless there's an imminent scourge. As for the poor, you can include it as a benefit under Medicaid but then you have to revise the benefit package. One reason that I bought the swine flu program, and a very important reason, was to see whether our capacity to attack what I still consider a serious disease could protect the poor, the disadvantaged, and those without physicians.

JKI: Congressional concern seems to be growing around the biomedical research community's involvement with clinical practice through either assessment of treatment modes or technology. What is your view of the appropriate role for the research community?

TC: A lot of different things come under the roof of research. If you mean an independent assessment by people who have competence to assess, who happen to be in the research community and not involved in application or in the clinical decisions about use, then it is useful to have an assessment. I think, however, you have to avoid a few things in speaking of "assessment," and one is that every kind of treatment technology be tested the same way. Frankly, you don't need a double-blind randomized clinical trial for everything in order to make an assessment. Certain members of the research community—by no means all of them—by virtue of their expertise and involvement in the evolution of the information leading to the technology, have a particular responsibility to serve as the scientific authority for the appropriateness of the claims, the propriety of the implementation, and the safety. Therefore, yes, they have a role but they are not a regulatory agency and they should not be.

JKI: Are you concerned that in some quarters of government there is an overreaction to the scanner phenomenon on the technology front?

TC: The scanner is a symbol for cost containment concerns, and one element of the system that drives cost up is technology. I don't think that has to be apologized for. In some instances, new medical technology introduced is health effective but not cost efficient. It is usually possible, theoretically at least, to provide alternative technologies at different effectiveness-efficiency levels. Technology can eliminate the need for other things and can itself be brought down in cost, quantity, and application—like some drugs. Technology can become cost effective as well; management information systems in hospitals have some potential for that. Now the CAT scanner, because of its purchase price and the current cost of using it, has underscored the potential for abuse. The question of responsible use, in my judgment, is not one of the scanner needing a clinical trial. But I don't think it's a piece of technology that can be responsibly used if it's placed in every hospital.

JKI: I'd like to tie together the several strands of our conversation in an overarching question: How would you design a national health insurance program?

TC: There's no way you're going to satisfy everybody on that score because you're going to have to make decisions which set limits. I would favor further attempts at standardization, correction of deficiencies, filling gaps—such as some form of catastrophic limit. In that sense, I would develop a plan not terribly different from the Nixon and Ford administration's Comprehensive Health Insurance Plan proposal. I think the tough issues will be how an NHI plan will be financed, administered, and regulated.

JKI: Is the way to go about designing a national program for the government to establish a minimum level, to which every citizen would be entitled?

TC: In a sense, what you're saying is that "This is the minimum benefit package." But what you have to establish for fiscal reality is some minimum which can assure that everybody will receive at least so much. For example, nobody who's acutely ill should be denied service. Everybody should get certain preventive services as a regular feature of a national health program. And nobody should have his or her savings wiped out by expensive chronic illness. So, I think

there are minima that should reflect the national perception of the importance of health care as a social priority.

The second thing to be dealt with in terms of minima is that the providers offer their services only after demonstrating specified personal and professional qualifications. There is great geographical unevenness in the number and quality of providers, and some people want to solve that problem through federal licensure. I'm not in favor of that; licensure responsibilities should remain, both for ideological and management reasons, at the state level. If people will be dishonest, they can be dishonest with a federal license or a state license. If they're incompetent, or for other reasons should not be licensed, federal licensure isn't going to ensure that they don't get in by mistake on a federal program rather than a state program. It is a mistaken impression that we can solve all the problems of performance and perfection by federalizing the system.

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