

## *Planning and Administrative Perspectives on Adequate Minimum Personal Health Services*

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**A**S THE NATION MOVES, however slowly, toward enactment of national health insurance, some effort to define adequate minimum standards for personal health services must be included in the legislation. As these essays undertake to explore that theme, it is necessary to reflect not only on its scientific and clinical aspects, but also on its planning and administrative perspectives.

The assumptions that underlie our theme are clear. In the United States, we are going to make the federal government somehow responsible for getting adequate medical care to everyone. Therefore, we must start by defining what adequate care is, and base that definition on clinical and epidemiological evidence. To provide the resources for universal adequate care, we will have to redistribute material and personal resources among income groups and geographic areas. As we do so, we must determine what government or professional activities best contribute to improving health. That determination will probably lead us to cut down on various types of high-technology acute care, and to emphasize primary and ambulatory care, preventive services, and non-medical programs such as nutrition and environmental control. And that in turn will require more coercive regulatory action, especially to control waste and fraud.

To a political hypochondriac like myself, it is remarkable how generally these assumptions seem to be accepted. One might expect some agreement on them in the liberal intellectual circles of the main teaching hospitals, or in the publications of the scholarly academies.<sup>1</sup> But the assumptions also generally correspond to the priorities set by the United States Congress in its enactment of the planning goals of the National Health Planning and Resources Development Act of 1974 (P.L. 93-641, Sec. 1502). And they are even given the imprimatur of private enterprise by advertisements like the one on the following two pages, which appeared in *The New Yorker*.

If this degree of consensus on the planning and administrative approach to national health insurance exists, why has the nation been so slow to adopt it? In 1972 the Social Security Administration, anticipating early enactment of a national health insurance bill, had the National Academy of Public Administration conduct a conference on S.S.A. experience under Medicare, to see what administrative lessons could be drawn from that experience for a broader program (Smith and Hollander, 1973). Today, we seem little, if any, closer to the enactment of a more comprehensive program. Is something wrong with our assumptions? Or taken all together, are they less politically attractive than if they were proposed one by one?

The trouble does not seem to be the attitude of the general public. Patrick H. Caddell, the head of Cambridge Survey Research and an adviser on public opinion to President Carter, recently told a Blue Cross and Blue Shield symposium that the only program for which the American public was willing to have its taxes raised was health care (*Boston Globe*, 1977a). This summary statement is supported by various polls conducted by Cambridge Survey Research over the past two years. The polls show that the public favors, by substantial majorities, mandatory comprehensive health insurance

<sup>1</sup>For example, see John H. Knowles (1977).

*Next page: One of a series of two-page advertisements that appeared during September and October 1977 for Aetna Life & Casualty, emphasizing the excessive cost of high-technology treatment and advocating cost control by government regulation and professional review. "Private enterprise" may be a misnomer, since Aetna is an intermediary for the Social Security Administration in the administration of Medicare.*



# Alas, hospitals are only human.

They've got to keep up with the Joneses.

For the hospital board, it must seem a simple logic of survival. Beds are filled by patients. Patients are provided by physicians. Physicians, understandably, are attracted by the latest equipment.

But for us who pay the bills, that logic costs dearly.

Unnecessary duplication of expensive technology is fueling a rampant inflation! The hospital bill — and the health insurance which pays it — is now one of the fastest-rising costs in our whole economy.<sup>2</sup>

Can we slow it down? Aetna believes so. If doctors were to assign patients to *any* of several hospitals nearby, expensive equipment could be shared. Specialized facilities, staff, even beds would be more efficiently used.<sup>3</sup>

Establishing state commissions to set limits on hospital expenditures could help, too. In Maryland and Connecticut, such commissions have been at work since 1974. They've lopped some big numbers off hospital budgets,<sup>4</sup> without reducing the quality of care.

And Aetna is encouraging local medical societies to monitor doctors' use of hospitals. Was the length of stay appropriate? Was admission necessary in the first place?<sup>5</sup> If all of us involved continue to raise such questions, insurance costs *can* be controlled. Don't underestimate your own influence. Use it, as we are trying to use ours.

# Aetna wants insurance to be affordable.

<sup>1</sup> Consider the cost of the CAT scanner, the latest thing in diagnostic machinery. (The CAT — Computerized Axial Tomograph — takes pictures of cross-sections of the body.) If every one of the 6,000 general hospitals in America bought a CAT, the initial investment alone would cost us all nearly *three billion dollars*.

<sup>2</sup> Ten years ago, health care costs consumed about 6% of the gross national product. Today it is close to 9%. Center stage in this inflationary drama is the hospital bill, which has doubled in the last five years!

<sup>3</sup> This principle could eliminate many wasteful situations. In Philadelphia, for instance, 16 hospitals have

open heart surgery programs. But according to a government study, only five used them enough to be considered efficient. Waste applies to much simpler equipment, too, like beds. The government estimates there are at least 100,000 unnecessary hospital beds empty each day, at a cost of \$2 billion a year.

<sup>4</sup> As much as \$45 million

saved in Maryland alone, in 1975.

<sup>5</sup> Most medical societies have a "Professional Standards Review Organization" created for just this kind of review for Medicare and Medicaid patients. Aetna believes the potential savings justify such review of all patients.

administered by private employers and insurance companies, combined with federal or state controls over increases in hospital or physician charges, and over the quality of health care.<sup>2</sup>

This conclusion was supported even more strongly by the General Social Survey of the National Data Program for the Social Sciences in the spring of 1976. The survey revealed that the public, when asked which of eleven major problems the government should spend more money on, put health ahead of everything except crime control—well ahead of education, defense, environmental problems, and welfare. The same survey showed that the public, when asked in which institutions it had greatest confidence, put the leadership of medicine far ahead of all others including the scientific community, the military, the Supreme Court, the banks, and organized religion, with Congress, the executive branch, and organized labor at the bottom of the list (National Data Program for the Social Sciences, 1976).

Even more surprising, the organized medical profession has relented somewhat in the vigor of its opposition to federal health insurance, and at least in some areas, medical and hospital professionals have come to tolerate the new planning and regulatory process required by the 1974 National Health Planning Act. In some cases these professionals have fully participated in the process (Codman Research Group, 1977).

Part of the reason for the apparently slow progress may lie in changes in the general political climate. The pressure to hold down the federal budget is increasing—a change that seems to result from something more fundamental than the difference between political parties. It is of course more difficult to adopt a program that does not merely distribute new benefits, but redistributes good things among classes or regions. Aside from the allocation of resources, more people are objecting to any increase in federal regulatory powers, or are demanding the deregulation of many private interests, and the judiciary is getting more deeply involved in social programs and cutting down on the discretionary authority delegated to administrators.

But a greater difficulty, I suspect, arises from a lack of realism in our basic assumption. I do not mean the explicit assumptions

<sup>2</sup>Data supplied by courtesy of Cambridge Survey Research, Inc.

summarized at the outset of this paper: they are really policy goals with which I find it easy to sympathize. Instead, I mean the implicit political assumption that underlies the way in which they are stated, and the method to be used in carrying them out. That is, the assumption that we, the American people, will not muddle through such an important problem, but will act collectively in a unified and rational way, the assumption that will decide what we wish to do, define the way to do it on the basis of scientific evidence, and design our actions and redistribute our resources accordingly.

If I suggest that this assumption is unrealistic, it is not because I find it unsympathetic. On the contrary, it has been the purpose of most of my professional career to try to make it a reality. But it is less than an accurate picture of the way the American political system presently works, and especially inaccurate with respect to the way that system has been manipulated to produce our present programs of medical care. I hope we can bring reality into a closer approximation of this model, but if we propose to do so we should first diagnose the ways in which reality differs from the model. Such a diagnosis might explain the complaint that a senator who is one of the leading advocates of national health insurance was quoted as making by an occasional adviser: "This is a mushy subject. When you go after a member of Congress to vote for or against the ABM or the SST, you both know what you are talking about. But on national health insurance everybody can say he's for it, but when it comes down to the details, and the actual vote, you never know just what it is you're supposed to be for."

### The Slippery Nature of the Subject

If we find it difficult, in the American political system, to deal with this subject in a rational way, moving from a general policy decision to the administrative measures that are needed to carry it out, it is primarily because the subject is inherently a slippery one.

Most obvious to the layman, perhaps, is the gap between what he needs in the way of health care, in some objective sense, and what he desires or is likely to ask for. Perhaps there is not even any relatively objective way in which needs can be defined. If that is so, it will be hard for this series of papers in *Health and Society* to evidence much progress. But if objective need can be defined by the

way the more skeptical medical professionals would judge it, by contrast with the way a potential patient might feel about his own case while lying awake at three o'clock in the morning, it seems likely that the gap might have its effect on the level of political support for a national health program. The voters might wish (or be encouraged by public relations campaigns on television) to support larger programs of medical care than would be judged desirable by epidemiologists in terms of medical results, or feasible by the more economy-minded administrators of hospitals or clinics or medical education. Or the voters might prefer to support programs that put emphasis on specialized aspects that are comparatively wasteful of resources—the technologically spectacular forms of therapy, or the care of those afflicted with diseases for which medical care is comparatively ineffective. Even if we ignore these comparatively irrational definitions of need, and turn to the way in which professionals might consider the problem, the difficulties are considerable and obvious.

The first and most obvious difficulty is the intrinsically comparative and arbitrary meaning of need, or of adequate care. This is much like the problem that welfare administrators confront in defining their clientele: Who is needy? The definition of poverty shifts greatly over time and by region. It will depend also on whether one wishes to emphasize ability to pay for some definite quantity of definable goods and services (not that the need for them remains constant over time and space), or whether one wishes to emphasize the importance of relative equality within society, which would call anyone poor who is by some proportion less affluent than the average.<sup>3</sup>

A second difficulty is the variation in professional judgment as to what is needed. This difficulty may be lessened by improvements in the scientific disciplines, such as epidemiology, which we are now discussing. But the definition of need will be subject to change as we learn more about the subject. As Nigel Calder once remarked, invention is the mother of necessity. As new types of tests and therapy develop, new social demands (supported by the threat of malpractice suits) may add them to the need list.

<sup>3</sup>For a summary discussion of these problems, see Samuel H. Beer and Richard E. Barringer (1970: 2-9, 94-103).

Third, the difficulty of definition grows when we go beyond the scope of the medical profession and its allied scientific disciplines, and consider related public programs that bear on health problems—social work, environmental programs, nutrition, and so on. The natural and social sciences have not yet devised generally accepted methods for calculating the comparative costs and benefits of the other health services that will compete with medical care for the interest and the appropriations of the public.

These three problems can be worked on within the professional and scientific community. That they are difficult should not discourage efforts to deal with them, since even modest progress may produce great benefits. But there is a final difficulty that cannot be dealt with entirely by scientific and professional work. That difficulty arises because the definition of need is not only an impartial and objective tool, but also a political weapon.

When scientific data become the standard of measurement on which important issues of wealth or power may turn, it is not easy to protect the integrity of the data. It helps to have the support of well-established guilds, and to deal with specific and demonstrable data. The National Bureau of Standards provides the definition of material quantities on which commercial transactions depend; their data are hard, and the National Academy of Sciences will rally to defend their work against tampering by politicians. Yet, from time to time even they have been in difficulty.<sup>4</sup> The Bureau of the Census produces each ten years the data by which political power is distributed among the states and congressional districts. These data deal with clearly identifiable units and a counting system that anyone can understand, and the courts and legal profession, as well as the organized statisticians, are alert to protect the data's validity.

But note the real basis for the integrity of the data in these two examples: the data may provide the basis for the answers, but the questions are asked by someone other than the scientist. The Bureau of Standards carefully refuses to serve as a consumer protection agency; that role would move the bureau away from physical measurement and into definition of consumer need or satisfaction. The Bureau of the Census delivers its body count and lets the

<sup>4</sup>For example, see "The Battery Additive Controversy," in E. A. Bock and A. K. Campbell (1962).



Congress and the courts wrangle over the reapportionment of electoral districts.

When scientists and professionals, on the other hand, are required or inclined to ask the questions as well as provide the answers, the business becomes more difficult. A politico-scientific uncertainty principle comes into play. If the military professional world bases its appeal for support on the need for parity of military power with an adversary, the intelligence data on foreign military capabilities (as in the "missile gap" of 1960) must be suspected of a degree of inflation. If a program in education or housing or community development seeks guidance in its policies by contracting for a formal evaluation of its program, it (or its executive or legislative superiors) must be on guard to make sure that the evaluation is not biased in any one of several ways—by the agency's asking the wrong questions or hiring of an evaluator whose position is known to be favorable, or by the normal kind of professional commitment to a particular line of policy. The forms of bias most difficult to deal with are those that arise not from corruption but from the highest motives of professional interest, sympathy with good causes, and a lack of interest in alternative possibilities.

It is tempting to assume that bias in the use of scientific data for the evaluation of alternative policies (past or future) arises from the lack of precision in the social sciences, by contrast with the natural sciences or technology. No doubt the softer the science the less objective may be the evaluation. But that is not the main source of distortion. If one examines such classic cases as the debate over the anti-ballistic missile, or over the effects of nuclear fallout, it seems that the great difference between the positions adopted by equally eminent scientists was not over measurements that were strictly scientific, but over either the specific questions that were being addressed, or the assumptions that were left unstated about the political, social, or economic factors involved in the issue (Doty, 1972). Such differences arise less often, even when the social sciences are involved, when the scientist is asked to address questions formulated precisely by someone else who understands just what types of questions can be answered by scientific methods, and when the assumptions about the nonscientific factors are clearly stated.

When we consider the definition of standards of health care, we are dealing with a question that is slippery not merely because it

depends on the subjective attitudes of patients as well as physicians, and because it covers a disparate collection of professional skills and public programs but also because the professionals concerned with this problem are not accustomed to wait until they are asked a carefully defined and limited question to which there is a scientific answer. Such professionals are accustomed to taking public leadership in the development of new policies, and advocating them with arguments drawn from scientific evidence. This mixture of roles—within the profession if not always within individual careers—makes it more difficult to develop standards of minimum care, based on scientific evidence, that will be persuasive to political leaders and the general public.

### Death, Taxes, and Malpractice Suits

To deal with our subject through the processes of government is difficult primarily because the subject is a slippery one—the basic data on the types of health care needed by the people are hard to define. The second great difficulty, it seems to me, is that it is hard to make the policy and administrative decisions required in this field because it is so deeply saturated with ethical imperatives. We are talking in these essays about giving everyone equal access to health care, which we assume can be done only by taking some types of care away from some people in order to give other types of care to others. This process involves some form of coercion, and an increase in government regulation.

For more than a century, no doubt, the main political trend in the modern world, and especially the United States, has been in the direction of politically enforced equality. Yet there is a fundamental conflict in political philosophy and practice between equality and freedom. If a government moves toward equality for all, it must restrict the freedom of those who have greater wealth or power. As the government of this country and others have done so, the elements in society that have spoken up most strongly in defense of freedom have come to be not the populists or the proletariat, in the style of the traditional eighteenth- and nineteenth-century revolutions, but the organized economic interests. Nevertheless, this opposition has been gradually overridden in most fields of the economy; the stock market, the banks, the manufacturers, and the oil companies have come under extensive government economic regulation.

If the medical profession and the hospitals have not been regulated in this way, it seems to me that it is only in part because they are organized in smaller units that are more administratively difficult to regulate. After all, small units of production characterize farmers, and the U.S. has socialized agriculture (through crop controls, subsidies, and related activities) more effectively than have most communist countries. Rather, it is more because the medical profession and hospitals deal with issues of life and death, which the public thinks about in ultimate ethical terms. Questions of profit and loss are hard to sanctify. Therefore, compromise, an appeal to the processes of the competitive market, and a certain amount of discreet bribery in the form of tax concessions or subsidies can lubricate the procedures of regulation of ordinary businesses.

It is more difficult to cut back on the economics of what we sometimes misleadingly call the health care industry, because any constraints on it may raise profound issues of ethical values and even religious beliefs. Benjamin Franklin remarked that there is nothing certain in this world except death and taxes; as the American public dreams of abolishing the former, it vastly increases the latter. It will be difficult to go on raising taxes, but the alternative—if we wish to equalize access to health care—is redistribution. And by what criteria do we deprive one citizen of health care to benefit another?

Sentimentally, and therefore politically, it will be hardest to cut down on those forms of therapy that apply to the most seriously ill. Unfortunately, these may be the most expensive forms of therapy, requiring the most expensive equipment. If it is hard to cut down on these uses of personnel and equipment, the problem of rationing may be reduced to a contest between regions, or between urban centers and rural areas, both of which will cause great anguish to political leaders.

If it comes to the need to ration scarce resources or forms of therapy, some will recommend giving preference to people of high moral merit; a rational physician may well believe that society cannot afford to make scarce medical resources available to those who deliberately choose unhealthy life styles. But there are so many cases in which illness occurs at random, so many in which one person suffers from the misdeeds of others, and so many that are unpredictable, that it is hard to imagine a set of administrative regulations that would sort out the sinners from the righteous.

Similarly, the idea of distributing resources according to social merit conflicts with the fact that everyone needs medical help most at stages of life during which he is least productive, and conflicts with the argument that society should try to make up for the deficiencies in environment and in background that limit various groups in their contribution to society.

The appeal to the laws of supply and demand, and the rules of the free market, come up against similar difficulties. To a limited extent, this can be administratively useful. Co-payment, deductibles, and similar procedures may well be important ways of constraining unnecessary demands on health care. But the consumer's typical ignorance of what he needs, and the imperative nature of some types of treatment, limit the utility of this approach (Outka, 1976).

Compare two other government programs: welfare and the military. Welfare costs are constrained by the ethical conviction of many lower-middle income workers that, because nonproductive citizens do not contribute to society, they are undeserving of support. The charitable (or political) impulse in the opposite direction is somewhat constrained by the fact that the basic needs to be met by welfare recipients, even though they may vary in public estimation by time and by region, are still more nearly uniform among individuals than is the need for health care, and more comprehensible to the average taxpayer. The average voter or his elected representative may well think that he can decide, as well as any social worker, what income a family may need in order to live at minimum standards.

But with the military it is different. The military profession, like the medical profession, deals not with average cases but with issues of life and death. The military therefore gains profound emotional support for its political cause, and great deference to its judgment. And most to the point, it is nearly impossible for political authority to face the profession and instruct it, in specific terms, to cut down on a specific expenditure in a way that might imperil lives, in order to reallocate funds in ways that might on balance save more lives. The process of developing a fighter airplane, for example, tended to produce in the United States planes that were more complex and far more expensive than were being built by potential enemies. Each expensive gimmick was justified by the argument that in combat it might save the pilot's life, even though the transfer of funds to other

purposes might have been more cost-effective in terms of overall security.

It has been difficult in Great Britain to equalize access to medical care by class and region. Under the British system, fewer physicians depend for their income on fees for individual services, and the patient population, by contrast with Americans, are more accustomed to obeying social discipline, and less optimistically inclined to believe that all problems can be solved. In the United States, it would be difficult to expect the average citizen to accept a system that in effect rations the supply of medical care by the waiting time at doctors' offices or for admission to hospitals.

Various types of health maintenance organizations or of group practice may lessen the incentive to use more medical care simply because someone else pays for it. But such group or corporate practice may contain incentives that will increase the costs of care. The more the public believes that modern medical care should be able to cure any illness, the more the patients (and the courts) will suspect that they have been defrauded when they are not cured. This attitude is of course not the only reason for the tremendous growth in malpractice suits. The enterprise of some lawyers is another. And so is the tendency of courts to consider a patient's claim against an insured doctor the way earlier courts looked on a farmer's suit against a railroad that had run over his cow. But whatever the reason, the threat of malpractice suits seems to provide an incentive to physicians to administer a great many expensive tests that may or may not be necessary. And this incentive may have a more powerful effect on the specialist in institutional or group practice, where there is less of a bond of personal confidence between the physician and the patient and his family, and where administrative requirements may call for more paper records (and potential evidence) as a substitute for that personal relationship.

The sins of commission are always more interesting to study, and sometimes more fun to commit, than the sins of omission. A great deal of ethical debate has been devoted to the dilemmas of the medical profession in the care of terminally ill patients. When should these patients be kept alive by extraordinary means, and when should they be permitted to die in peace? In such cases, of course, considerations of cost are overridden by the impossibility of putting a dollar value on a human life. Less attention is paid to the sins of omission, that is, the failure of society (the doctors are involved, but

no more than the rest of us) to face up to the costs of whatever we do to distribute medical care more equitably throughout the population. The problem of the terminally ill was not a political or administrative problem when it was handled between a family doctor who could not do much about the case anyhow, and members of the patient's family. It becomes a public issue when scientific techniques can prolong life well past the point of benefit to the patient, and when the decision is being made in an institutional context, on the public record. The problem of distributing medical care equally has been made a public issue in a similar way, and the problem's political and administrative difficulties must be faced squarely.

For the present, the conflict between the freedom of the medical and health professions on the one hand, and the demand for egalitarian justice on the other, has been moderated by two things: the professional status of the individuals involved, and the nonprofit status of many of the hospitals and other institutions. It is harder to denounce the hospitals than the oil companies for ripping off the public. But the schools and universities considered themselves only a few years ago to be relatively immune to government regulation, and their recent experience with regulations designed to guarantee equal access is not encouraging to those who assume that the institutions of health care can resist the egalitarian trend.

It might be a mistake, however, to assume that because the drift of public opinion is generally toward equality, and because the public favors payment for more medical care, it will support the measures necessary to redistribute medical resources more equally. Minimum standards for health care, on which we may base a redistributive policy, will have to shift the emphasis from curative to preventive services with, as preliminary discussions have suggested, particular attention to high technology developments in curative medicine.

This carefully noncommittal terminology reflects, one may suppose, a growing consensus among the intellectual leaders of the not-for-profit institutions in the health care field,<sup>5</sup> to the effect that much of the highly expensive and technical curative medicine (Dr. Lewis Thomas calls it "halfway technology" medicine) costs much more than it is worth, by comparison with alternative uses of the money

<sup>5</sup>For example, see the articles by Drs. Knowles, Thomas, Rogers, Bennett, and McDermott (Knowles, 1977).

for health purposes, and may in some cases be useless or actually harmful.

The use of such diplomatic language suggests that we are aware of the political difficulties that would be involved in cutting down on high technology medicine. Such a reduction would involve a fight with a powerful lobby, led by masters of the art of influencing Congress. This force has been more effective than any business interest or any military influence in breaking down the political discipline of the president's budget over the past quarter-century. Its special power, it seems to me, comes from the fact that it unites two usually contradictory forces: the power of sophisticated science with the power of superstitious credulity. Americans seem to have been particularly susceptible for more than a century to all sorts of faith healers and quack cures, to the great distress of the organized medical profession. But since the Second World War, the argument that "If we can make an atomic bomb —," or a little later, "If we can put a man on the moon —," has amounted to an appeal to a belief in miracles that is more persuasive than anything encountered at Lourdes. With this appeal, the medical scientists have converted the superstitious schismatics into supporters of their established church, and in spite of the defection of some few to the heresies of krebiozen or laetrile, the establishment has kept the secular authorities, and especially the appropriations committees, well in line.

Now I certainly mean no disrespect to the great contribution that modern science has made to the practice of medicine. That is too tremendous and obvious an accomplishment to need any tribute from me. I speak only of the motivation of the popular support for high technology medicine. One who, like me, has no glimmer of understanding of the scientific basis of such medicine, must take this scientific foundation on faith, or on confidence in the testimony and reputation of those who do, or on observation of its effects on the limited range of patients with whom one is acquainted. Since the medical profession itself has not bothered to support to any adequate extent the epidemiological research to provide evidence in this matter, much of the popular acceptance and political support of high technology medicine is based on intellectual processes not much more rational than old-fashioned superstition. It is important to recognize not only the popular faith in the ability of scientific medicine to cure our ills, but also the way in which that faith has sup-

ported the creation of strong vested interests that would dislike any constraint on high technology care.

When President Truman proposed a four-part health policy, two of its parts were denounced and defeated: federal aid to medical education and national health insurance. The other two parts were the support of medical research and hospital construction. Since Truman's time, support for medical research has been the policy that (building of course on earlier trends in the profession and in private philanthropy) has determined the development of the new hospitals (built more often in major university centers, as Abraham Flexner would have approved, rather than to serve rural areas, as Senator Hill and Representative Burton intended). And this support has been bootlegged into the initiation of the two policies of federal support that Congress rejected a quarter-century earlier: medical education and health insurance (Strickland, 1972).

This has happened in four main ways:

1. The highest prestige within the medical profession and the hospitals has gone to the most advanced scientific and technological specialties. The best medical students, seeking internships at the best hospitals, think they have to affirm an intention to practice in a specialty; this is understandable, since the resources of a top-flight hospital would otherwise be wasted. It is probable, too, that the pull of medical research funds has lured the best students into research and away from practice (Zeckhauser, 1967). All this may be less true today than a decade ago; medical students may be beginning to react to the same concerns that this paper addresses.

2. Schools of medicine and public health, being flooded with research funds and pinched for teaching, have used research money to support teaching. The line between the two, in any form of advanced education, is, or ought to be, impossible to draw precisely. When zealous auditors exposed this practice here and there, the reaction in Congress was less indignant than might have been expected. One may cynically suppose that the most influential members were tacitly assuming that it would be better to tolerate a bit of osmosis between funds for research and for teaching, in order to keep out of the difficult issues of support for education.

When direct support for medical education was finally enacted it of course had to be fitted into the current system of the medical schools and teaching hospitals, with educational subsidies fixed in



proportion to the number of students. The schools with the highest prestige were those with the greatest emphasis on the high-cost specialties. Against the incentive system that this prestige ranking established, the effort to redirect emphasis toward primary care by specific statutory constraints on the curriculum, or on the career commitments of students, was of course vigorously resisted by the leading medical schools, and shows no great promise of success.

3. While the financing of actual medical care remained restricted to the old, the poor, and various special clienteles, the biomedical research programs, especially at the National Institutes of Health, began to move into new and tentative experiments involving actual medical care (Foley, 1975). These programs were in the guise of helping to disseminate medical knowledge and to conduct demonstration and community programs. The National Institute of Mental Health nearly two decades ago was inclined to insist that its research programs require a certain amount of community service activity in order to give adequate push to the development of mental health programs. This phenomenon has not been unique to medical care. In the United States, many new programs of government service that began with research activities went on to demonstration projects, and finally became massive programs of financing or operating programs of service. Staff members of two principal congressional staff agencies (the Office of Technology Assessment and the Congressional Budget Office) showed their awareness of this pattern when they began to press the National Institutes of Health some time ago to cut back on the support of those lines of scientific research that would probably lead to high-cost technology in medical care (Strickland, 1978).

4. Lay interest groups and consumer representatives, rather than restraining the trend toward high costs and high technology, have on the average been inclined to support it. The main support for private philanthropy in medicine and health has been organized around the campaigns against specific diseases. The same pattern has prevailed in the organization of the National Institutes of Health and in the motivation of the lay members of many local hospital boards. Just as the civilian officials in the Pentagon are often more belligerent in their policies than the generals or admirals, the lay members of hospital boards are often as eager as the doctors to compete with their nearby counterparts in elaborate equipment and

procedures. This tendency is increased by the fact that local community leaders are often eager to build up local institutions with the help of subsidies from the federal government, or from the states through Medicaid (Sapolsky, 1977).

Working against these trends is the fact that much of the intellectual leadership of the medical world, especially in the teaching hospitals and private foundations, is convinced of the need to hold down high-cost and high-technology therapy in order to redistribute medical care more equitably. But if one is to try to assess the obstacles to such a course of action it would be necessary to note that these leaders are in the hospitals that will be constrained most severely by the procedures designed to effect their purposes. In Boston, for example, the Massachusetts General Hospital is publicly rebelling against the constraints posed by state regulation (*Boston Globe*, 1977b). An outsider may well be somewhat skeptical that the intellectual leadership of such institutions can maintain the support of its constituents when the pinch of regulation begins to be felt.

Let us turn to look more closely at the patterns of administration and of policy making within which the conflict between high-technology medicine and the policy of redistribution might occur.

### Patterns of Administration and Policy Making

Charles G. Dawes, who served as budget director under President Harding and ambassador to Great Britain under President Hoover, used to reflect on the basic differences between the processes of government in the United States and the United Kingdom. Most of all, Dawes liked to ruminate on this question: Why in the United Kingdom do governments get elected on radical platforms and turn conservative, while in the United States they are elected on conservative platforms and turn radical? By radicalism, he usually meant extravagant government spending, and by this definition the control of the cost of socialized medicine in the United Kingdom fits his description as well as did the policies of a Ramsay MacDonald. Similarly, the rapid increase in governmental expenditures on health and welfare programs under the last several administrations in the United States does not seem to have been affected very much by the supposed conservatism of the Republicans or the liberalism of the Democrats.

It seems to me very likely that this increase is to be explained instead by several significant structural features that make the United States government unique among representative democracies:

1. The legislative body has extremely weak party discipline; its committees are free to initiate or amend the proposals of their own legislative leadership or of the executive, and equally free to appropriate money that has not been requested by the executive, as well as money that has. The influence and procedural authority of the leadership within Congress, especially that of the Speaker of the House, has been weakened substantially over the past quarter-century, while proposals to reform the committee organization in order to rationalize their respective jurisdictions have had rough going. As a result, the field of health and medical care is dealt with by at least three major committees of the House (Ways and Means, Government Operations, and Interstate and Foreign Commerce) while in the Senate, the Senate Finance Committee and the Health Subcommittee of the Committee on Human Resources are deeply involved. The Senate refers national health insurance bills to both the Senate Finance Committee and the Committee on Human Resources, while Medicare and Medicaid legislation in the House are dealt with both by Ways and Means and by Interstate and Foreign Commerce. This multiplicity of power centers increases the opportunity of special interest groups—especially those with high-minded dedication to the public welfare—to find patrons who will protect them against reduction of their budgets by an unsympathetic administration. Recently the groups representing the blind and the crippled were insisting on their right to deal with congressional subcommittees rather than the Department of Health, Education, and Welfare on relatively minor issues. As the chief of the Washington office of the National Federation of the Blind put it, the blind have little in common with other handicapped persons—“wheelchair guys want the curbs out; we want them in”—and neither category of beneficiary wants the difference arbitrated by non-political administrative authority (*New York Times*, 1977).

2. The higher civil service is not composed of a class of generalist officers with a common type of background and common set of loyalties, such as exists in the higher civil service of the United Kingdom and the major Western European democracies. Two-thirds of those in the so-called supergrades have come up from scientific,

technical, or professional backgrounds, with experience primarily in specialized agencies, where their success depended on their connection with equally specialized congressional committees.

It was of course this domination of the career service by professional specialists that enabled the Institute of Mental Health in 1959 and 1960 to fight off the effort of the Public Health Service to reorganize into a more coherent pattern of administration. Dr. Robert H. Felix, as Director of the Institute, and as President of the American Psychiatric Association, could muster political support far more significant than that of his hierarchical superiors (Carper, 1965). It was similarly this kind of reliance on a specialized corps that made the Public Health Service as a whole slow to enlarge the scope of the traditional functions of the public health officer. The Public Health Service showed a constraint of vision that led the Congress to assign the medical insurance function to the Social Security Administration and to transfer environmental protection first to the Interior Department and later to the Environmental Protection Agency.

3. Many of the major programs of social action (especially those developed between the First and Second World Wars) are conducted by federal grants to states and municipalities. In the development and control of such programs, the specialists at the state level are free to deal with the specialists at the federal level without control or discipline by responsible political officers at either level—a pattern of relationships that makes the imposition of discipline or the calculation of trade-offs among programs extremely difficult.

The direct alliance between a specialized bureaucratic interest at the state level and its counterpart at the federal level is supported politically by the organized lobbies of state and local governments in Washington. The efforts of the American Public Health Association or the more specialized medical groups are supported, when the issue is one of raising more federal subsidies, by the general-purpose organizations of the states and local governments—the National Governors' Conference, the Council of State Governments, the United States Conference of Mayors, and the National Association of Counties, among others. But this support works only in a single direction—no one would expect the governors or mayors to lobby against increased appropriations for a special interest. There have occasionally been naive federal bureaucrats who dreamed of having

all grants-in-aid channeled from the Treasury Department to the corresponding departments in the state governments, in order to cut off the direct connections between specialists at the federal and state levels and to introduce a measure of coherence and discipline to the process, but such ideas never reach the stage of serious consideration.

4. The principal new federal programs between the First and Second World Wars were initiated through federal grants to the states for public health, highways, transportation, housing, welfare, and so on. After the Second World War, the pattern of federal initiative was quite different, following the model established by the scientists in the Office of Scientific Research and Development and the Manhattan Project. This was a pattern not of grants to governments, but of grants to or contracts with private institutions—a pattern that is sometimes called federalism by contract. Like the space program and the poverty program, the new programs in the medical and health field tended to follow this pattern. The Medicare program, which many believed would set the pattern for comprehensive national health insurance, was administered by the Social Security Administration through arrangements with private insurance companies including both the not-for-profit Blue Cross and Blue Shield plans and commercial carriers like Aetna and Prudential. Similarly, the federal program of aid for the construction and development of hospital facilities (the Hill-Burton Act and its successors) channeled funds through the states, but in ways that encouraged the allocation of funds to private as well as publicly owned hospitals.

Each of these four features is nearly unique to the United States. Taken all together the features have two general effects. First, they give great scope to the influence of scientific and professional specialties in the initiation of policies and programs. It is easier to adopt a program of action after experimentation and research have established its feasibility and its nonpartisan status. As a result party politics and ideological doctrine have comparatively little influence. The second effect is to favor the expansion of expenditures for new technology, and to discourage the effort to calculate trade-offs among competing programs or to find less expensive ways to accomplish similar purposes. American politics is reductionist in the sense of preferring to deal with component technical pieces of the

general policy, but is the opposite of reductionist in the popular sense of economizing.

It seems to me significant that the field of medicine and health care is the one major field in which all four of these characteristics work at full force. The military programs of the government have to deal with most of these characteristics, especially with federalism by contract ("the military-industrial complex," as President Eisenhower described it). But the military is comparatively free of the complications involved in federal, state, and local relations (still only comparatively, as the histories of the National Guard and of the maintenance of military bases suggest). Agriculture, welfare, and housing have by contrast been handled on a basis of governmental federalism, with comparatively few of the complications involved in federalism by contract.

When we consider the effect of these structural patterns on the programs of medicine and health, and add to the picture the unique aspects of the emotional content of the programs, the dispersed nature of the economic units involved, and the strong tradition of professional self-government, we can appraise the difficulties to be encountered in any effort to gain central administrative control for the purpose of reversing the trend toward high technology and expensive medical care and of redistributing the benefits of modern medicine. This complex and pluralistic pattern helps to explain some of the curious ways in which our present programs have developed.

The strength of the specialized interests was sufficient to defeat the efforts of Secretary Elliot Richardson in the early 1970s to break down the detailed eligibility requirements in the systems of categorical grants, and to give states and localities much more discretion in applying for and in expending federal funds for various allied social and health expenditures. This proposed Allied Services Act was given little attention and no support by the Congress (*Evaluation*, 1976). The Nixon administration drafted legislation for this purpose but was not able to get the relevant congressional committees even to hold hearings on it.

The expansion of programs in the field of medicine and health, like other government programs, has been by successive categories of beneficiaries, not by types of care. Merchant seamen, prisoners, mothers and children, the aged, the indigent, and the victims of several dramatic diseases—where do we go from here? Is it worth

noting that this approach makes it harder to define a basic standard of essential medical care that could be provided for everyone on a relatively equal basis? But any such definition is difficult enough, given the rapidly changing science and technology of medicine and the difficulty of defining equality in a population where needs vary so greatly by age and personal circumstances.

Clearly we have not discovered an acceptable system of financial control. The federal government, through Medicare and Medicaid, supports the demand for medical services, and the states through their regulatory mechanisms (with some federal support and encouragement) are expected to control the supply. The states vary tremendously in their administrative discipline, but many must be like Massachusetts, where the effort of the Department of Public Health to cut down on unnecessary health care facilities led the backers of those projects to go directly to the state legislature for exemption from the certificate-of-need process (*Boston Globe*, 1977c).

In any case, the responsible authority of the administrative system is reduced by its pluralism and complexity. Medicare could probably not have been enacted except on a basis by which the private companies were the intermediary insuring agencies, and those agencies can hardly be expected to serve as the agents of tight discipline. The Health Maintenance Organizations, if they were to become the dominant agencies for medical care, could perhaps transform the whole system by removing the incentives of fees for individual services, but their rate of growth does not give much basis for confidence. In the meantime there is a measure of rivalry between the regulatory departments of the state governments on the one hand and the Professional Standards Review Organizations (PSROs), on which the federal government places substantial reliance, on the other. Recent congressional hearings have revealed a considerable degree of rivalry and antagonism between the PSROs and the state agencies charged under Title XIX of the Social Security Act with administering Medicaid programs. In late 1976, the chairman of the Oversight and Investigations Subcommittee of the House Committee on Interstate and Foreign Commerce was claiming that fraud and abuses under Medicaid were costing the government a billion dollars a year. Assistant Secretary Morrill of HEW was agreeing with him, but arguing that PSROs were not a suitable instrument for investigating fraud cases, which ought to be the responsibility of the states—a judgment that was shared by the

chairman of the board of the American Medical Association (U.S. Congress, 1976). Experience in other fields suggests that federal regulatory agencies, when they seek (or are pushed by Congress) to control detailed activities in highly technical programs often become the virtual prisoners of the regulated interest. This experience is not comforting to those who may seek to rely on the PSROs (or for that matter, Health Systems Agencies) as the primary agents of federal administrative authority.<sup>6</sup>

### Possible Lines of Improvement

There is no reason to hope that we may find an easy answer to our problem. But the problem's importance and the magnitude of the resources involved may force the nation to take it seriously enough to find a solution. No such solution will be possible without strengthening those forces in our system of government that (1) make it possible to consider in a more comprehensive way the relationship of one policy to others, and (2) strengthen our government's ability to decide long-range issues on the basis of humane purposes, rather than drift at the mercy of some technical innovations.

Any such effort would have to move forward on several levels:

1. The most essential change, it seems to me, is an impalpable one—a matter of political theory. I do not suggest that we need a clear-cut resolution of the age-old conflict between those who see freedom and those who see justice as the primary good. The former are interested in rewarding differential merit, and the latter tend to favor equality. This is the classic conservative versus liberal distinction. I do not see any need for one side or the other to win a victory;

<sup>6</sup>In his unpublished manuscript, "Health Care Coalitions and Public Policy," Lawrence D. Brown notes the unique weakness of the planning and regulatory agencies set up by federal legislation in the health care field and dominated by the professional interests, with legally enacted strict and detailed regulations, but little power or money. See also Bruce C. Vladeck (1977). Recent press reports indicate more pressure from the federal government in the direction of stricter regulation: *New York Times* headlines report "Harsher Penalties Set for Health Care Fraud," October 30, 1977; "U.S. Seeks to Cut Amount of Unnecessary Surgery," November 2; and "U.S. Report Challenges Efficacy of Medical Review Organizations," November 9.



the continued contention between them is normal and healthy. But what we have now is a situation in which each side is clinging to an approach that has been made obsolete by fundamental changes in science and technology.

The conservatives need to see that economy and constraint at the federal level cannot be accomplished by a weak government. A strong executive, supported by a higher civil service with enough competence and breadth of loyalty to cope with the pressures of the professional specialties, would be more able to assure economy in the use of resources and more inclined to delegate responsibility and thus to protect private institutions against highly detailed regulation. The pressure toward detailed and niggling controls comes from weakness in administration, and from reliance on irrelevant procedural rules, more than from self-confident strength. It should be appropriate for conservatives to justify a new approach by an appeal to traditional Hamiltonian doctrine.

As for the liberals, they have come to rely for the protection of human rights and the extension of human services on action by the courts, and on highly detailed procedural requirements enacted into statutes at the behest of specialized interests. These approaches have been pushed to the point where they are in conflict with each other, and exceed the capacity of the federal government to administer them. A return to the more traditional political approach of American liberalism or populism—a measure of party discipline in the Jeffersonian or Jacksonian tradition—might well be in order.

The important thing is to avoid enacting and trying to administer mutually contradictory programs based on contradictory theories, such as was done with the General Revenue-Sharing Bill when the liberals insisted on basing the allotment funds on factors that measured need or poverty and the conservatives insisted on rewarding merit or the effort of local governments, and the two formulas canceled each other.<sup>7</sup>

2. After greater clarity of political doctrine, one may rely heavily on the power of organized knowledge. More precise knowledge of the effectiveness and costs of various types of medical care by comparison with other health programs would of course be required. So would the broadening of our education for the fields of

<sup>7</sup>The General Revenue-Sharing Bill was formally entitled The State and Local Assistance Act of 1972, Public Law 95-512; 86 Stat. 919.

health and medicine, with special emphasis on those disciplines that serve to integrate our understanding of the specialized programs involved (Beer, 1976). It may be useful to emphasize that the advancement of knowledge and education does not exclusively depend on the reductionist specialties; the modern disciplines of the social sciences are contributing also to the development of professional skills in the analysis and synthesis of policy, in ways that may help control technological specialties in the interest of humane values.

3. At the level of institutional reform, in both the legislative and executive branches, some progress toward the integration of the processes of government in the direction of greater responsibility, and of the control of competing technological specialties, may be on the way. In Congress, the new Congressional Budget Office and the Office of Technology Assessment are both efforts to provide the knowledge and procedures by which some integrating authority may override the interests of the specialized committees.

On the executive side, the Congress has again given the president authority, subject to congressional veto, to effect administrative reorganization. More important than organization is personnel. Nothing is so influential in the determination of future policy as the incentive systems that guide the education of a career service, focus its attention on the problem to be solved, and control its loyalty. It is encouraging to learn that the continuous but timid efforts over the past forty years to develop a higher civil service less committed to specialization and more loyal to the broader purposes of government are being revived and intensified by the new chairman of the Civil Service Commission.

The Public Health Service itself, which formerly was the dominant institution for the administration of the health programs of the government, has been reduced to a personnel system to be used by HEW, but without its former institutional influence. If a broader personnel system, something along the lines of the proposed Federal Executive Service, could retain the administrative flexibility of the commissioned corps, while broadening its scope of interest and policy concerns, we would be much further ahead in our effort to deal with this problem.

4. Finally, it is important to realize that much of the capacity to deal with the provision of medical care and the definition of basic standards will have to depend on the state and local governments. In

recent years developments on this front have included some encouraging news. Beginning in 1966 with the "Comprehensive Health Planning and Public Health Services" amendments (Sec. 314, Title III, of the Public Health Service Act), grants have been made for less narrowly defined categories, and later acts have emphasized a broad planning approach (Wilson and Neuhauser, 1974). Various state and local jurisdictions have undertaken to consolidate health services—and sometimes combined them with related welfare services—by various types of administrative reorganizations. Half the states have established these "umbrella agencies" to coordinate the policies of their various human services programs, including health. A few have even gone on to decentralize and integrate such services under regional directors. But these are at best tentative steps over which there remains a great deal of political controversy (Lynn, 1976).

America has long been committed to two ideals—equality and progress, with progress being identified with the advancement of science and technology. An old backwoods maxim holds that "it ain't what you pray for that you believe in, but what you bet on." We have prayed for equality, without being quite sure what we mean by it, but have placed our big bets on technological progress. Now a great many people believe these two ideals are incompatible. It seems to me that they need not be, but to reconcile them will require more national self-discipline, and more willingness to control technology in the interest of humane values, than we have characteristically displayed. The field of health and medicine is not the most crucial one in which we must settle this conflict—there remains of course the threat of nuclear war—but it will serve as a good test case.

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