

Standards for Adequate Minimum Personal Health Services

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THERE ARE AT LEAST THREE INTERPRETATIONS of *adequate minimum standards* for health services, each important enough to qualify as *the* problem. One, stressing “adequacy,” is the idea that too many people are not getting health services commensurate with their needs because they cannot afford them. As with education or housing, the central problem is low incomes. But there are additional barriers due to geographical isolation, language, discrimination, and ignorance. The terms “poor” and “disadvantaged” diagnose the deficiency: they need but cannot get what most of the rest of us get when we need it. With help, they could get it.

A second interpretation of *adequate minimum standards* is almost the opposite, stressing “minimum.” The difference is between a floor and a ceiling. This one emphasizes *costs*—the need to economize, distinguishing between what is *necessary*, what is *discretionary*, and what is *wasteful*. Expenditures on medical care have exploded during the past 15 years; and while some of the growth reflects more care and new kinds of care, and some the inflation of the general price level, health services have been becoming more high-priced. The problem is especially acute for those whose expenditures are large to begin with—the chronically ill and, especially, the elderly, often on modest fixed incomes.

Part of the escalation of costs is due to the simultaneous growth of medical and hospital insurance, especially the open-ended kind for which no "replacement cost" sets an upper limit (as it does with auto insurance) and for which the crucial decisions are controlled by physicians who do not have to collect the hospital fees. There is a growing appreciation that the terms of the most widely available insurance generate an upward spiral—qualified patients receiving service irrespective of cost, justified by reflecting that they have paid their premiums like everybody else, but all of us sharing in the total cost of what, when it's our turn, we take because it is prepaid.

These rising costs have two components. One is rising prices, as demand outstrips supply. The other is services that, though beneficial, are not worth what they cost. Everybody has favorite examples of people who stay an extra day in the hospital at \$100 or more, who would have been happy to take \$50 in cash and go home. And there is the alleged willingness of some doctors to relax the criteria for discretionary surgery and other treatments, exploiting the system that pays for the unneeded tonsillectomy or excessive testing or treatment.

Still a third interpretation of what minimum standards can mean is *quality control*. The same institutional arrangements that in recent years have relaxed the safeguards against excessive treatments and prices have also relaxed the safeguards against quality deterioration. Especially, as many kinds of surgery, X-ray, and drug treatments have come to be recognized as potentially harmful, so that their gratuitous prescription is not merely a waste of resources (to be paid for by some third party), those costs that used to be a barrier to adequate treatment can now be recognized as occasional filters against harmful treatment. Aggravated by fears of malpractice charges, and more concerned with the illness at hand than with remote probabilities of long-term effects, providers of medical services are apt to err in the direction of excessive "services." It was the *wastefulness* of this practice that was the focus of my second interpretation of "minimum standards"; it is the possible *harmfulness* that is at the heart of the quality control interpretation.

Furthermore, with a progressively aging population and an increasing tendency for the elderly to be without a family environment, a huge part of the medical services industry has come to be concerned, and will be more and more concerned, with the care of those who are chronically or repeatedly ill or who, not suffering illness,

suffer progressive immobility, discomfort, and physical jeopardy. In nursing homes and elsewhere, the line between medical services and life-support services becomes blurred. So does the jurisdictional boundary between medical ethics and innkeeper ethics. A “growth industry” is developing to take care of the frightened and the lonely as well as the sick.

To recapitulate these three interpretations of what “minimum standards” can mean, the first refers to an adequate level of services, a floor based on need, and is oriented toward the poor and the disadvantaged who lack access, usually but not always financial access, to the large medical services industry. The second is cost control, oriented both toward price escalation and toward excessive consumption of medical services, and is linked to the tendency of insurance to reduce the incentives to economize. And the third is quality control, emphasizing bodily harm as much as economic waste.

Redistribution: What’s to Be Redistributed?

There need be no conflict between the idea of a floor below which needs will not go unmet, and a ceiling above which services might be discouraged or, at least, not eligible for reimbursement. But additional financial resources to support the floor will add demand to an already inflationary medical services industry. And successful containment of costs, through imposition of a ceiling or otherwise, would help to counteract that inflationary pressure and might help to provide those extra financial resources.

Indeed, there appears to be room for a kind of “partnership” in dealing with these problems simultaneously. Those whose primary concern is the floor may feel dependent, for the resources they need, on the imposition of a ceiling. And those whose primary concern is the ceiling, not only for reducing waste but for controlling quality, may welcome the forced economizing that will have to come from meeting the demands of the poor and disadvantaged. (Many of us have observed that academic institutions are poor at controlling waste, and an occasional half decade of financial pressure is a great

excuse for trimming down to a leaner and healthier institutional body. Famine, in moderate doses, can be the partner of husbandry.)

There are, however, two different ways that "resources" may be scraped off the top and used to fill the trough, or two different kinds of "resources" that we can think about. One is money. The other is the medical resources that money buys.

What is in question is the "redistributive" aspect of any program intended to provide additional services to the poor and disadvantaged. The question is, what is it that is to be redistributed?

According to one view, which I think is wrong, there are limits to the medical services ultimately available and, if more are to be available to the poor, fewer will be left for the rest of us. According to this view, there must be a *redistribution of medical services themselves*—of physician hours and hospital days and nursing services, life support and diagnostic equipment, pharmaceuticals and blood, ambulance and rescue and emergency services. In this view, providing money to the poor—third-party coverage of the expenses they incur—will only enlarge the competition for limited resources, fanning the inflation of medical costs, and oblige those who are not poor to spend more and more to get the services that they have come to expect.

An alternative view is that what is done about adequate minimum services for the poor and disadvantaged is only loosely connected with what is done about medical expenditures in the aggregate, and has only a short-run connection at that. In this view, the rising money demand for medical services is only part of the reason for the inflation of medical costs; the rest of the reason has to do with the inefficiency and lack of competitiveness in the medical services sector of the economy. Holding down aggregate money demand, at least in the long run, is neither necessary nor sufficient. In the short run, there are indeed limitations on the speed with which the medical services industry can expand its output, and any *successful* effort to get more made available to the poor will constitute, to some extent, a diversion from the rest of the population. But there is no long-term need to think of medical services as limited in supply.

Certainly there is nothing in the provision of medical services that suggests inherent limitations on supply. The medical services industry is not especially dependent on energy, land, water, minerals, or specific locations that are incapable of indefinite expansion. It

does not poison the atmosphere or threaten the ozone layer or change the earth's climate in ways that become increasingly unacceptable. Hospitals consist of machinery and masonry and bed linens and electric lights and laundry services and people with a mix of high school and college educations; and the number of college graduates willing to go to medical schools is unlikely to diminish during the next quarter century. There is no forecast shortage of the elementary ingredients out of which pharmaceuticals are manufactured. There is, in sum, no reason why the medical services industry cannot be of any size we demand.

True, we may be threatened with a nearly crippling insatiable demand for medical services, eventually spending not merely a huge 7% but a mammoth 12% or 14% of our total incomes on some kind of medical care. But if there is anything wrong with that, it is that we would be spending our money wrongly, not that we would be throwing money futilely at an industry that was physically incapable of meeting our demands. As consumers, we can be unwise; as vicarious consumers, our physicians can prescribe what we cannot afford; and, as participants in some universal insurance, we can forever individually purchase what we cannot collectively afford, lamenting our annual premiums and taxes while paying for superfluous services with drafts on the public treasury. It may be a grossly uneconomical way to budget our incomes. But it will not keep *medical* resources away from the poor. The physical resources will be there if they can afford them. And they can afford them just as well with money that our taxes divert from gasoline or baseball tickets or fattening foods, as with money diverted from medical expenditures.

There is a contrary argument. Those who want more stringent screening against extravagant or harmful medical services may like external limits on what can be provided. If medical resources are going to be redistributed toward the poor and disadvantaged, and if the ensuing scarcity will require rationing of services to us all, some kind of tighter screening will perforce be done and we can hope that it would be the right kind. If there are too many X-rays and tonsillectomies or too much expensive life support for the hopelessly ill, we can hope that those are what will get screened out under a rationing system. (The grounds for hope will be greatest, of course, if those are among the resources that are predominantly shifted toward the poor and disadvantaged.) So those whose aim is the elimination of wasteful practice, and especially of wasteful practices that may be

harmful, may hope that medical resources have to be diverted and rationed. For them, the scarcity would be good news. Like a family that, suffering reduced income, is forced to spend less money on high cholesterol foods, alcohol, and convenient junk foods, we may end up healthier.

But those who wish more and better medical services provided to the poor and disadvantaged, with the costs borne by us who are not poor and disadvantaged, already have enough opposition to overcome without having to fight over the medical resources that the rest of the population gets to consume. People who want medical resources for the poor to come out of the medical services the rest of us are receiving will unnecessarily create for themselves a highly motivated adversary. It will be vastly more difficult to get a rationed reduction in medical services accepted by and for the rest of us, for the sake of the underprivileged, than to get a gradual government assumption of *financial* responsibility that will have a diffuse effect on the taxes we pay.

Standards, Values, and Controversy

If the federal government should take on the task of setting explicit standards for the medical care that every citizen is entitled to, the government may not be allowed the privilege of assuming responsibility only in those areas of medical practice in which standards can be based on professional judgment and avoiding those that feel the weight of public opinion. Currently, the Congress and the legislatures of many states are demonstrating the impossibility of basing an important set of "minimum standards for personal health services" on purely professional considerations. I refer to abortion.

The earlier political battle over contraception is safely behind us, and most of us appear to believe that the decision went in the right direction. To a large extent, that issue was handled in the courts, as a matter of individual *rights* rather than of federal *programs*. The government's involvement, furthermore, was more foreign than domestic, relating to aid programs for developing countries that suffered undeniably from excessive births and whose development was crippled by expanding populations. The abortion

issue seemed about to be settled in somewhat the same fashion, in the courts rather than the legislatures, as a matter of *right* rather than *program*.

But now the issue is program. The issue is public money and what it can be spent on. Short of a constitutional amendment, the opponents of abortion appear to have lost on the prohibitionist issue. But spending money—their money—is different. The complex rights involved in the prohibition of abortion—complex because fathers as well as mothers have an interest, complex because people may have rights *not* to perform or attend an abortion, and because juvenile rights and parents rights may conflict—appear to many of us to be on a very different level from the right to have an abortion *paid for* at public expense, or to have it not excluded from the services to which one may be entitled under a comprehensive program of publicly financed medical care.

I don't believe there is any way that a program of publicly financed medical services can avoid or could have avoided the abortion issue. It is too large in numbers of people and costs to be ignored, or to be left to private charity that might assume a burden of controversy that governments cannot handle. And abortion as a moral issue, a political issue, an issue of women's rights, and of the rights of unborn children, matters too much to too many people to permit a casual evasion of the issue by a national program. Like contraception, it even raises questions of racially discriminatory eugenics.

Abortion is not unique in mixing the "standards of medical care" with deep, and deeply divisive, moral and political issues. Being allowed to die is an issue that will increasingly force itself upon the courts and the medical profession, and eventually on a national program of medical care. Karen Quinlan dramatized a particular way that the issue can arise: when there needs to be a determination of when a "person," or a "human being," or a human body, can be considered dead for purposes of continuing or discontinuing medical care. It can arise, as it appeared to in the Karen Quinlan case, when there are possibly benefits as well as costs from indefinitely continued treatment, and the patient herself is incapable of participating in the decision. And it can arise when the personal interests and professional interests of the many separate individuals who participate in the decision, actively or by default, feel bound to uncompromisable principles—nurses, doctors, family, and others.

These issues of allowing to die or helping to live arise in another area that has not surfaced to sustained public view quite in the way that the Karen Quinlan case did, but which may be waiting its turn and may make federal officials wish they didn't have to get involved in the setting of standards. This is the treatment of newborn defectives. Many of the same issues as in the Karen Quinlan case appear here: determination of whether an infant can actually survive indefinitely if treated, professional or ideological conviction of doctors and nurses and hospital administrators, tragic involvement of the child's own family, and inability of the infant to speak for itself.

But the largest issue of this kind in years to come will involve the people, mostly elderly, whose quality of life raises the question of when, how, or in what contingencies, they would like to be allowed or helped to stop living. I sense a genuine growing interest in the questions of how to die and when not to live any longer. The recent act of the California legislature in giving some status to "living wills," in which people may leave instructions for when they should be spared extraordinary efforts to keep them alive, demonstrates that this is more than a movement on the fringe.

There are several features of this issue that make it different from some of the other right-to-live and right-to-die issues. There are apparently people who find it easy to claim that they represent the unborn fetus or the unconscious victim of brain damage or the infant born with a spinal deformity. It is harder to elect oneself spokesman for some perfectly articulate adult who wishes to make his or her own arrangements, in the presence of family, physician, and attorney, for contingencies, like a paralyzing stroke, the consequences of which they can understand as well as anybody else. Unlike the question of when a person should be declared "dead," the question of when somebody might prefer not to keep on living is much less a professional or scientific judgment, more the kind of issue in which consumers may be perceived to have some sovereign rights to decide for themselves. That does not make it any easier to accommodate the issues within some comprehensive federal program. Euthanasia and suicide are not practices to which a national medical services program is likely to want to become an accessory.

One more area in which "standards" may have a strong subjective or political element is genetic screening. There are at least three sensitive characteristics of genetic screening. One is racial differences in the frequency of particular genetic diseases, and the

delicacy that attaches to apparent discrimination by race in the assumption of genetic imperfection. A second is the issue of mandatory screening, or strong moral pressure exerted by physicians, and the associated suggestion of eugenic control. And the third is discretionary abortion, especially as the screening techniques become more and more able to identify comparatively minor undesired characteristics, and even the possibility of selecting for sex of the child.

That these issues will arise under a national program of medical care standards is no argument against formulating such standards. They will arise anyway; and if they could be evaded, it is not obvious that they ought to be. But the concept of standards should be developed in such a way that it can accommodate these issues, and some of the questions that arise with respect to them.

For example, if a system of standards entails both a floor and a ceiling, that is, some minimum level of medical services available to everybody together with some limitations to avoid excessive demand for scarce resources, can there be a difference between what is allowed and what is chargeable at public expense? If discretionary abortion for sex selection were to be permitted, i.e., neither made illegal nor denied under some rationing scheme, must it be provided at public expense? Or can there be discretionary medical and surgical procedures, especially morally and politically controversial ones, that are *permitted* under the standards but not *provided*? And will rationing be used, or appear to be used, to deny some elective treatment in a manner that prejudices a moral issue?

A somewhat related question is whether a national system of medical care standards may conflict with state laws and state programs. Contraception and abortion, not unlike sexual behavior itself, were, until recently, a matter for the states to decide, the federal government exercising jurisdiction primarily over the postal system. The erosion of state prerogative in these matters has been primarily the result of judicial decisions at the national level, decisions that reduced the scope for regulation. States have, however, been free to be more permissive in these matters than the minimum level of liberality required by the Supreme Court. But the scope for liberality at the state level is likely to be circumscribed by funding, the states becoming increasingly dependent on federal funds that may be restricted in the medical uses to which they can be applied.

Mental Therapy and Involuntary Confinement

The subject of states' rights and obligations leads into a huge domain of medical services that has been largely a state responsibility, a domain that raises the question of what "personal medical services" are, or will be, or ought to be? This domain is the treatment, and especially the confinement, of the mentally ill.

At the level of "personal medical services," both outpatient care and the care provided in private institutions to patients who are substantially "voluntary," there appears to be no ready convergence of views on standards of efficacious, safe, and cost-effective treatment. The treatment of mental illness is typically singled out for separate treatment in medical insurance plans and even academic health services, as though the eligible modes and quantities of treatment are even less susceptible to "objective" determination than with respect to other kinds of illness. Furthermore, some of the expensive methods of treatment are privately handled between physician and patient, apparently not under quite the administrative scrutiny that is unavoidable with surgery and intensive hospital care. The therapy itself is often within the personal judgment of the physician, especially in the absence of hospitalization. This will be an exceedingly difficult area within which to set "adequate minimum standards," one that raises questions of quality control as well as cost control.

But I am more concerned about the problem of medical services to the infants, children, adults, and elderly people who are confined by, often abandoned to, state institutions for the mentally ill. This is the area in which we are inclined to deplore a condition, rather than to confront a problem. A discussion of federal standards will likely bring certain conditions and issues out of the shadows and into the light where they are subjected to scrutiny. Despite efforts by journalists to bring state institutions for the mentally ill into our Sunday newspapers, even to elevate them to the status of scandal, there is a great collective capacity to keep that medical condition below the level of awareness that might convert it into a problem to be faced. Maybe that could not happen if mental health services were federalized under some comprehensive scheme.

It might be argued that the people confined to state institutions, like people in military service or penitentiaries, do not represent "personal medical services" and could be ignored in some national program. But the luxury of disposing of the issue in that fashion is

probably transient. The reason so many of the mentally ill are committed to public care is largely that there are seldom alternatives that the patients or their families can afford, and seldom in the past the kind of insurance that would take care of such protracted expensive care. Therefore, these people are thrown on the public mercy; this may be a special kind of poorhouse, as well as a special kind of hospital.

Once the federal government assumed responsibility for the decency of the medical care regularly available to the rich and poor alike, including those who would be made poor by the high cost of medical care, what might have been a "personal medical service" may no longer have to become, by default, a public institutional medical service. And the states themselves may be the first to clamor for federal standards federally funded.

Drawing the Line: Medical Care vs Care

There is increasing recognition that a large part of what medicine can do to keep us healthy it is already doing, and that important determinants of our health are beyond the reach of medicine. For a decade, a major government effort with respect to our health has been the attempt to bring under control a multitude of characteristics of our physical environment that poison and otherwise assault us in the water we drink, the air we breathe, the foods we ingest, and the lotions we spread on our bodies. Major legislation and new agencies of government are trying to give us cleaner and safer air, safer drinking water, fewer toxic substances, safer and more salutary workplaces, and protection against radiation. Additionally, the Surgeon General is telling us that preventive medicine against lung cancer, respiratory ailments, and heart disease can be more effectively practiced by not smoking than by anything that doctors can do for us; and we are repeatedly told that what we eat and drink and how much we sleep and whether we exercise and how we arrange our stress and relaxation may have as much to do with how long and how comfortably we live as any of the services we receive from doctors and hospitals.

There are many diseases that kill us or deprive us of the full life we think we deserve, but among the greatest destroyers of potential life—the things that kill young people more than the elderly—are

suicide, homicide, and accidents. Among the great extenders of life expectancy in this country and abroad during the years since World War II, antibiotics have been spectacular, immunization, too, but also insecticides and nutrition. Among the ways to avoid some diseases, or to treat them, is keeping warm; fuel and weather stripping are not usually thought of as preventive medicine or therapy, but if the government were to guarantee minimum standards for *health*, not *medical* services, food and fuel might have high priorities. Indeed, air conditioning may be tax deductible before long, as a defense against cardiac and respiratory risks.

In thinking about standards of health care under a permanent assumption of responsibility by the federal government, designed to last lifetimes, it will be important not to get trapped into particular definitions of "personal medical services," or "health care," as those terms are professionally defined in the 1970s and 1980s. It is a reasonable assumption that income per capita will continue to increase and the standards of care will rise perpetually. Most of us barely remember when, in taking a hotel room for the night, the main choice was between a room with bath and one without; hospital facilities are improved as much as hotel rooms since 50 or 25 years ago.

It is becoming ever more widely recognized that much of what hospitals do for you can be done in your home at lower cost, if only Blue Cross and the Internal Revenue Service would learn to monitor the expenditures and verify their legitimacy. We have all heard of the people who spend the night before surgery in the hospital, just to be there at 7:00 in the morning, when they could have stayed at the nearby Howard Johnson's for a fraction of the cost, but the system couldn't make it economically worthwhile. The line between "medical care" and "care" is increasingly blurred.

It is going to make a great difference, a difference that becomes larger as time goes by, whether the health services whose adequacy is to be assured are those provided by physicians and hospitals, together with pharmaceuticals and "medically" specialized equipment like wheelchairs and eyeglasses, or will come to include the rudiments of a healthy life and environment. Will it include the services of a dental technician but not an electric toothbrush, a day to recover from childbirth in the hospital but not maid service for the first few days at home, treatment for rickets but not sunlamps, for diseases carried by insects but not fumigation against rats and fleas,

for a sprained back but not hired help to do your lifting for you? If the object is to circumscribe the program to keep it within the domain of licensed medical practice, it will be important to make that clear, and to avoid language that, built into some "health bill of rights," leaves the system open to claims for nutrition, shelter, and rest.

If the broader concept is allowed to prevail, it will be hard to keep the program from taking on most of the characteristics of an anti-poverty program, one that contemplates shoes as well as eye-glasses, school lunches as well as school nurses, bathing facilities as well as public toilets. If the line is not drawn at the services of licensed physicians and hospitals, it isn't at all clear where it can be drawn. But the awkwardness of drawing the line there will become anomalous as the poor, or the geographically isolated, or otherwise disadvantaged, become increasingly eligible only for the kind of help and relief that hospitals and physicians can provide. When getting sick provides the only passport to escape from poverty and ugliness, the only opportunity to see how the other four-fifths live, the only way to enjoy 24 continuous hours in clean and tasteful surroundings, even the poor will wonder whether that's really the way they want their public money spent on them.

If we keep a strict definition of medical care, the difference between "minimum adequate care" and "best available care" may not diverge greatly, and the social embarrassment of guaranteeing second-class care for the poor while the well-to-do go first class can perhaps be substantially avoided. Once we depart from the "purely medical," it will become harder and harder to make sense out of the notion that the poor should receive, at public expense, treatment equivalent in quality to what the non-poor (directly or via insurance premiums) are willing to purchase. And the reason is a simple one: the poor, being poor, need other things badly, too. Everybody wants straight teeth, invisible scars, painless articulation in all of his joints, and unrestricted diet, freedom to engage in strenuous exercise, perfect hearing, short convalescence, and no pain. But if novocaine in the mouth costs \$30 a shot and the well-to-do usually paid it, there would be many among the poor to whom 30 minutes' pain for half a day's wages would be a good bargain, and they'd rather settle for \$15 cash than receive 30 minutes' and \$30 worth of anesthesia.

With the novocaine, we might sensibly choose to deny them the option. It may offend us to let the poor suffer pain because they'd

rather have the money, and it may offend us if on a larger scale somebody would rather have half the cost of an elaborate elbow operation in cash than the full comfortable use of an elbow with which he or she doesn't play tennis anyhow. And it may be good for the morale of the medical industry not to let the poor trade their medical privileges for cash.

But when it comes to helping protect an elderly respiratory patient from excessive heat and pollution, we are not likely to want to procure air conditioning at public expense for as many rooms as the well-to-do in similar health would buy for themselves.

Any egalitarian approach to a national system of health care will therefore require a restrictive definition of eligible services, probably a restriction to services and commodities that have value only to people undergoing medical treatment. (Even so, it is unclear just how this principle applies to privacy and other amenities in the hospital itself.)

Being Sick and Being Poor

In a recent paper, Davis and Reynolds¹ pose the question of just what constitutes "medical care" and what treatment should the poor and otherwise disadvantaged wish to receive equally if limited public funds are available to provide some limited kinds of equality. They say that:

[E]ven if utilization of services is adjusted for health needs in the population, the poor may still not participate in mainstream medicine, receiving care of comparable quality, convenience, and style to that received by more fortunate persons. Poor persons may continue to be treated in crowded and dreary clinics, enduring long waits and receiving few amenities. . . . [T]here is evidence that the poor do not obtain care in the same setting, from the same kind of physicians, and with the same ease and convenience as higher income persons. . . . The poor spend 50 percent more time traveling and waiting to see a physician than do higher-income persons.

¹Davis, K. and Reynolds, R. 1976. The Impact of Medicare and Medicaid on Access to Medical Care. In Rosset, R.N., *The Role of Health Insurance in the Health Services Sector*. pp. 394, 398, 399. Washington, D.C.: National Bureau of Economic Research.

There can hardly be any question whether that state of affairs is deplorable. To be kept waiting when you are sick, in dreary surroundings, and to spend a longer time traveling for help when you're not well, is to miss a significant measure of the comfort and security that the well-to-do typically receive. But is this a special case of inequality in *medical* care, or just another manifestation of what it means to be poor? The poor who are merely sick and in no need of a physician's attention, who spend the day in bed not feeling well, do it in drearier surroundings than sick people who are well-to-do. People who are lame or arthritic or fatigued who have to ride crowded buses are worse off than those who can afford taxis. The sick and injured who have to get out of bed and cook their own meals are noticeably worse off than those who can afford help. And this is truer of those who never feel well, who hurt during whatever they do, who have trouble breathing, who are partly paralyzed, or who are so old that even having to remain standing is a mild form of torture. It is not easy to distinguish between those whose discomfort or fear is due to the poor surroundings in which they receive medical care, and those whose discomfort or fear is due to their being poor.

Most of us, when we discuss health care for the poor, are discussing health care for somebody else. We are usually discussing how to spend somebody's money to help somebody else. Until the budgetary question is clearly posed, it may not be evident what the alternatives are. Are we discussing whether the *poor who are sick* should be made better off compared with the *sick who are not poor*, or whether they should be made better off compared with the *poor who are not sick*?

If we stay within the limited domain of medical care, we can be impressed with one particular manifestation of what it means to be poor, and motivated to allocate resources from those who have enough, to those who have too little. If our concern is not the sick but the poor, we may be unimpressed with the argument that those whose discomfort can be alleviated by medical treatment deserve amenities during the course of that treatment that are denied to those whose conditions are not improvable by medical treatment. The elderly poor spend most of their time in dreary surroundings, waiting longer for whatever service they receive than the well-to-do, often as afraid and uncomfortable as if they were qualified for medical care. But if their problem is diagnosed as poverty or age, not health, they get no benefits under a program that seeks to eliminate

health care differentials between rich and poor but takes no cognizance of the other differentials.²

Designing a National Program

There is a difference between approaching the vast subject of medical services in a comprehensive manner, and doing it piecemeal. I want to say a few words in favor of the piecemeal approach. If "piecemeal" sounds not up to the task, I'll call it the multiple-independent-program approach. I would favor breaking the subject into large pieces that are minimally dependent on each other, so that success in one area is not negated by failure in another, and so that the structure doesn't collapse for failure of all the parts to succeed together.

The comprehensive approach, when it succeeds, is bound to achieve more than the piecemeal approach. It is when parts of the effort are likely to fail that the looser structure may be the safer one.

And, in this medical services enterprise, success is not assured. Financing the needs of the poor and disadvantaged, and eliminating some non-financial barriers between them and adequate medical care, is a major undertaking. It is a smaller enterprise than the Social Security program, but more complicated; perhaps Unemployment Insurance is analogous. But neither Social Security nor Unemployment Insurance has to pay any attention to how people spend their money, whether the things they need are available on the market, and how to provide them if they are not, or whether there are unique problems of price inflation related to the particular things that may be purchased with retirement or unemployment benefits.

On the supply side of the market, regulating the medical industry for quality control and cost control would be of an economic magnitude to compare with oil, gas, and electric power, mileage standards for automobiles, insulation standards for construction, and the promotion of mass transit. But in complexity rather than size, in the need to deal with tens or hundreds of thousands of different entities subject to control—physicians, clinics, hospitals,

²For a discussion of the wretched who, neither treatable nor dying, need help but not "medical services," see Yondorf, B. 1975. *The Declining and Wretched*. *Public Policy* (Fall): 465-82.

nurses, laboratories, blood banks, emergency services—regulating the medical industry is as challenging as regulating the entire public school system. Nobody knows how to raise quality and lower costs in the public schools in inner cities. A proposal to assert federal responsibility for “adequate minimum standards of public education services” would be met with skepticism or incredulity, as well as resistance. A proposal to do something ambitious with the medical services industry may be received more sympathetically because, not having been tried, it has not yet a long history of failure.

Regulating the medical industry to control costs is not only a formidable task on its merits but can be compared with federal government efforts to control costs in other industries. There are a few kinds of regulation that attempt to promote competition; in some industries that appear to be natural monopolies there is no prospect for competition, and the regulation is supposed to reflect a consumer interest in fair prices and a fair return to the company; but a notorious consequence of regulation in some industries has been to protect firms—airlines, for example—from competition. Regulatory agencies, or the people who comprise them, can become captive to the industries they regulate, often because the agency must be staffed with people who know the industry and identify with it, sometimes because they are unwilling to allow the cruelty of the market to harm an industry and its people, sometimes because the industry can make a scene and discredit the regulators, and often because the regulators do not have the political strength and immunity to withstand unions concerned with job losses and wage increases.

The medical services industry is particularly difficult to control. Physicians produce a multitude of extraordinarily unmeasurable “products,” mostly in exceedingly small businesses. The policy management of hospitals, somewhat like that of universities and churches, is elusive, and even the main participants are sometimes sincerely unaware of how policy gets made (or perpetuated, or unmade) and what determines the evolution of policy over time. Insurance organizations are of a size and formality and have procedures and records that make them amenable to examination, but all but a fraction of their costs are the benefits they approve and pay, over which any control they have is at best indirect and hard to prove.

The prospects for any radical restructuring of the medical profession in the interest of cost control or quality control, or a

better distribution of its services among the population, are surely problematic. Physicians are a powerful body, and they are acknowledged to know more about their own business than most of the rest of us. Furthermore, they belong, on the whole, to a financially successful profession with a slow turnover, and are not likely to cooperate enthusiastically with legislators or bureaucrats who try to change the way they heal the sick or the way they are remunerated.

My little inventory of obstacles to progress toward reform of the provision of medical services is not for the purpose of discouraging the effort. It is, rather, to remind us that we face a bundle of disparate and difficult tasks; that many approaches may fail before we find some that succeed; that the degree of success and the pace of progress will not be uniform among the different tasks; and that it may be wiser to avoid assembling all of the programs into a single convoy.

Breaking Down the Problem

One convenient way to break apart this medical services complex in the search for manageable pieces is to distinguish the supply side of the market from the demand side. The supply side is enormously variegated, involving hospital management and labor unions, medical specialization and medical education, nurses and paramedical personnel, blood and pharmaceuticals, the status of Mexican medical degrees, the restrictive trade practices of optometrists, and the policing of the profession against harmful miracle cures. That supply side of the market is so variegated that, though some overall responsibility might want to be lodged at a single point somewhere in the government, the policies and programs to deal with it would be divided among a multitude of offices and bureaus and agencies, from the anti-trust division of the Justice Department to the Treasury Department, the Department of Labor, the Food and Drug Administration, the military services, and of course the Department of Health, Education, and Welfare.

In contrast, the demand side of the market consists essentially of two parts that merge one into the other. The first and largest part, though not necessarily the most important to take care of, is federal policy toward the financing of medical care for those of us who,

through one or another kind of insurance, will pay most of our own way. The second, smaller in aggregate scope but motivating much of the concern for national programs, is the federal role in financing medical services for the poor and the disadvantaged. Because there is a continuum from the poor to the not poor, and because this problem is largely financial, these two problems represent a series of points along a scale rather than a dichotomy. A third set of issues, which overlays both of these, is what system of incentives on the financial side needs to be contrived to help damp the inflationary trend in medical expenses.

What Kind of Help: Medical or Financial?

For the poor, we should take notice that the efforts of the past dozen years have not been in vain. Medicare and Medicaid added fuel to the inflation of medical costs but they have worked a striking improvement in the access of the poor to personal medical services. While it is important to acknowledge that a decent minimum of medical care is not yet available to the poor and the disadvantaged, it may be equally important to recognize that this has been an area of dramatic social progress. There are many social problems that have not been solved by throwing money at them, but in medical care money makes a difference.

Furthermore, if insurance is available, a large part of the problem ceases to be medical, and becomes financial. And it is not the financial cost of treatment, but the cost of insurance, that measures the problem. The insurance can take the form of a subscription in a prepaid plan, or purely financial insurance against the cost of care; but what poor people need on a regular basis is to help with the price of an insurance premium.

Here we come to another fork in the road. One path leads to the provision, at government expense, of certain medical benefits or, more accurately, of *payment* for certain medical benefits. The other path leads to one or another kind of government subsidy of participation in a health plan or insurance scheme for which the government has no direct responsibility. One way, the government assumes responsibility for the *kind of medical care* that people are eligible for, and perhaps responsibility for seeing that they can acquire it; the

other way, the government deals with the matter as a *financial* relation between the citizens and the government, not as a matter of medical care.

My own medical relation to the federal government, as far as I know, is confined to my income tax return. I am neither poor nor elderly now; the government subsidizes my medical insurance and will share, through income tax deduction, in any large medical expenses that my family may incur. But we have an understanding, the government and I, that this is a *tax* matter, not a *medical* matter. Bad medical care is just as deductible as good care! And I have to find my own medical care—the government won't bring it to me. The government and I may have an altercation about whether peach pits or sunlamps are tax deductible, but any argument I have is with Internal Revenue agents, not health officials.

I may change my mind as the years go by, but I currently would elect the path that makes the medical care of the poor and the elderly and the disadvantaged a *financial* responsibility, not a *medical* responsibility, of the federal government. I would assimilate the problem more to coping with poverty than to organizing the medical industry. I would establish continuity between the government's participation in the financing of medical care for the poor, somewhat on the model of the negative income tax.

What I have in mind is federal participation through the income tax in the costs that families incur in subscribing to medical plans or medical insurance. For the poor it would be a subsidy, and as income rises, the subsidy would taper off and blend into something like the present tax deduction for medical insurance and excessive medical costs. The arithmetic need not concern us here, but the order of magnitude could be several hundred dollars per person per year with an addition for age, collectible as a tax refund for families that had lesser tax liabilities, the subsidy tapering off at a modest income level and blending into the present treatment of deductible medical insurance.

What I am proposing is that "adequate minimum standards" should be set in financial, not medical, terms; that the poor not be guaranteed levels and types of treatment, but financial assistance, at arms length through something like the income tax, with which to take care of their own medical needs on the open market. (Doing it through the income tax is incidental; it could be done through a Social Security administration or any agency that was able to coor-

dinate the subsidy with the income tax.) I am proposing that the government commute its responsibility for adequate standards of health care into a responsibility for adequate financial assistance.

I am not proposing that the federal government, having done that, wash its hands in the matter. There remains the vast area of managing or influencing or controlling the supply side of the medical services market, and seeing that there are competitive experiments in health plans and health insurance. Medical school admissions, hospital management, physician assistants and the price-listing of pharmaceuticals, are not being ignored by this proposal; they are simply not part of the proposal.

What I'm trying to do is to separate from the formidably complex issues raised by the structure and behavior of the medical care industry the special medical problem of the poor, which is that they are poor. The federal government is good at providing financial assistance. It can legislate and monitor a financial assistance program for a specified class of services, namely medical services. It can do this efficiently and on a large scale, without an enormous regulatory bureaucracy, without promising care that it cannot deliver, and without any administrative dependence on successful solution of a variegated multitude of problems that are not yet guaranteed soluble.

Even a subsidy to medical insurance plans has its problems. They are the familiar problems of tax fraud and determining what expenditures are eligible. An analogy may be the G.I. Bill of Rights, which made no effort to provide schooling for returning veterans, to improve curricula, or to make the educational system more efficient; it merely financed tuition, living expenses, and other educational expenses, in the belief that what the returning G.I.s needed most was money. There was fraud and corruption; a lot of people went to school for a vacation; but by and large, the purpose was served because the government attempted only the achievable. Educational reform was not tied to the G.I. Bill.

We do not yet know how to reform the medical services industry. We may have good ideas, but we cannot make promises that we are bound to keep. The federal government can, however, devise a financial system that will help the poor and the disadvantaged to participate more nearly like the rest of us in the benefits that the medical care industry can provide. This is no radical departure; federal programs have already been moving in that direction. But

much can be done to unify and streamline the system if the essentially financial dimension of the problem can be acknowledged and the several federal financing efforts, including the various "tax expenditures," can be brought into a single system.

If that can be done, the groundwork may be laid for some more ambitious system. I do not yet know what that more ambitious system will ever turn out to be.

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