

## REVIEW

*Welfare Medicine in America: A Case Study of Medicaid.* ROBERT STEVENS & ROSEMARY STEVENS. The Free Press, New York, 1974. Pp. xxii, 386. \$13.95.

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This extensive and well-documented case study of Medicaid<sup>1</sup> is a welcome addition to the literature on the history and current status of programs to provide and finance health services in this country. The services provided under this particular health services program have been substantial. Medicaid served twenty-three million low-income people in 1973, or ten percent of the population. Public funds totaling nine billion dollars were expended, representing about eight to ten percent of health service expenditures from all sources. Over one-half of this amount—five billion dollars—was provided by the federal government. The rest came from the states and localities, although much of this sum would not have been forthcoming without the stimulus of federal grant-matching.

The program was an administrative and fiscal fiasco. Services were unevenly distributed among the states, and sudden increases in the costs of medical care quickly outdistanced the states' ability to finance them, even granting their willingness. Within the three years from 1965 to 1968, Medicaid plunged from tremendous (and unrealistic) promise to a severe retrenchment that the authors aptly call the "Euphoric Demise." Such a decline might have been anticipated after the general excessive optimism of President Johnson's Great Society. Yet the authors feel that Medicaid has been "phenomenally successful" when measured by its sheer magnitude;<sup>2</sup> it reveals again that the American social and political system is capable of delivering "sheer magnitude" for a short time, and then retrenching in similar magnitude.

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1. R. STEVENS & R. STEVENS, *WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID* (1974) [hereinafter cited by page number only].

2. P. xvi.

## I

The authors are well qualified and well situated to write a case study of Medicaid. Both have written extensively on public policy: Robert Stevens on legal problems, and Rosemary Stevens on medical care institutions, particularly the growth of medical specialization in Great Britain and the United States. Robert Stevens is Professor of Law at Yale; Rosemary Stevens is Associate Professor of Public Health (Medical Care) at Yale. Both are originally from Great Britain and received their basic education there at well-known institutions, and further training at Yale; both have been consultants to various divisions of HEW.

As a chronology of Medicaid, the book is an exhaustive and excellent source of information about what happened where, at what time, at what cost, to whose benefit or loss, and so on. The vignettes about pivotal states like California and New York, which had different administrative structures but similar experiences (escalating costs), are additions to the literature as case studies. And this is what the authors apparently intended to write.

But one should not turn to this book for an explanation of how situations and events shaped Medicaid's policies, nor for a delineation of the constraints that are inherent in all attempts to achieve certain health delivery objectives. In setting forth their objectives and method of study, the authors write:

Medicaid might well be analyzed as an illustration of general principles or theories of political development. Equally, quantitative studies of selected aspects of the program, and especially its costs and utilization, are sorely needed. These approaches remain for others; indeed, one of our hopes for this book is that it will stimulate further research on Medicaid from both the theoretical and quantitative points of view. We chose the historical method for ourselves in the hope of providing a comprehensive understanding of how and why Medicaid developed, its major characteristics, its strengths, its tensions, and its weaknesses.<sup>3</sup>

This statement seems to imply that a "historical method" does not demand a conceptual framework—a theory of how the social matrix and political system influence the development of a given health service delivery system. If the authors had furnished one, they could have given us at least a partial explanation of why Medicaid evolved as it did. And they might have fulfilled their own

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3. P. xx (footnote omitted).

purposes more adequately, for they write: "Our aim has been to make it possible for our readers—whether they be scholars, civil servants, lawyers, social workers, welfare recipients, or politicians—to develop informed responses to the program's dilemmas and to be able to view other medical-care programs in perspective."<sup>4</sup>

Their only allusion to a formal model, Braybrooke and Lindblom's *A Strategy of Decision* (1963), exemplifies the casualness of their occasional hints that some kind of framework might be possible. The reference is in a footnote, which reads: "In many senses, for instance, our study reinforces the Lindblom thesis concerning the development of solutions to social policy problems. Historic comprehensive solutions are rarely available; means and ends are invariably interwoven; and solutions emerge rather than being created. In this sense Title XIX [Medicaid] is an example of 'disjointed incrementalism.'<sup>5</sup> The authors do not, as might reasonably be expected, go on to discuss whether "disjointed incrementalism" is the only method we have in policy formulation and program implementation. A rigorous analysis is entirely lacking. In fact, it is doubtful that the authors consistently adhere to their asserted acceptance of the Braybrooke and Lindblom theory. Taken as a whole, the book seems to embrace a contrary position: that it is possible to plan entire "systems" of health services, and further, assuming that directed planning is feasible, that it can be done in a political system that is not given to directed planning, but rather to building consensus in the hope that plans will emerge of themselves.

Thus, despite their unwillingness to theorize, the Stevenses still implicitly rely on a model of a social, political, and health services system. They invite us to envision a body politic and a government that practice perfect distributive justice, devoting little attention to costs and much more to benefits. In their model, health service is comprehensive, rationally planned, and regionalized; physicians are salaried; there is emphasis on prevention; the distribution of services is reasonably even; and the financing is equitable, that is, accomplished mainly through a progressive income tax. The Stevenses clearly sympathize with a view they ascribe to some reformers: that "national health insurance could put an end to eligibility difficulties, inequities, low-quality service, state greed, and

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4. Pp. xx-xxi.

5. P. xxi n.3.

subsidies for the providers of medical services.”<sup>6</sup> This is quite a promise and no such model can be found anywhere; the best existing programs only approximate it. Although the authors sometimes evince more circumspection than the foregoing passage might indicate, they seem bothered by economic and political realities, regarding them as annoyances rather than situations within which one is forced to work.

The authors take their model so utterly for granted as a norm that they do not strive to reveal it in its entirety to their readers. They assume, for example, that it is anomalous for a publicly financed program to carry out its mandate by contracting with a private intermediary. “Medicare . . . began with an apparent paradox. Private enterprise had failed, markedly, to provide adequate health insurance for the elderly: hence, the passage of Medicare. Yet private insurance was chosen to administer the new governmental system.”<sup>7</sup> This is no paradox; a failure of private health insurance in one context has no necessary relationship to the question of whether to use private carriers in another context. The government was faced with a need for quick implementation, and private insurance was the obvious answer.

Another example is their report that Illinois’s planned cutback in Medicaid support was expected to throw Chicago’s ghetto area doctors into a position of relying completely on the effective demand of ghetto residents. Some expressed fears that doctors would leave the area. The authors merely remark: “The neighboring Chicago School of Business economists would not have dissented.”<sup>8</sup> This is a rather cavalier way of dismissing the market-nonmarket debate regarding the distribution of health services; neither approach should be denigrated, since in most countries the sectors are mixed.

The authors feel that the spiraling costs of Medicaid are “at root problems of goals, authority, and administration”<sup>9</sup> because Medicaid was tacked on to the existing health services delivery system, which has always been open-ended in its rate controls—when it has had any—and in its volume controls. They assume, therefore, that goals, authority, and accountability, particularly goals, are operationally possible in the structuring and administration of a health services delivery system. I would take serious issue.

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6. P. 353.

7. Pp. 50-51.

8. P. 297.

9. P. 132.

All three of these ideals are inherently fuzzy in an enterprise, such as a health services delivery system, lacking both input and output measures of any meaningful sort. The authors bear out this observation in at least three quotations, although the implications are not developed. First: "In the hallowed tradition of welfare, costs were becoming more important than services."<sup>10</sup> I agree that this phenomenon is not peculiar to Medicaid. Second: "As a working philosophy, decisions were made to extend services to the poor up to a level that would not antagonize the general population and to increase fees to the extent necessary not to antagonize the health professionals."<sup>11</sup> I would say that political compromise is inherent in any health services system. Third: "Not surprisingly, there were to be almost immediate tensions between the practical realities of welfare administration and the expansionist rhetoric of mainstream medicine."<sup>12</sup> I would say that the tension is normal: any "mainstream" medicine worth having should be expansionist in its tendencies.

What we should have, the authors suggest, is a health service delivery model like the one implicit in the Committee of 100's proposed Health Security Act, then known as the Kennedy-Griffiths bill.<sup>13</sup> The authors are not sanguine that this solution is politically possible. They believe that politicians are unconscionably cost-conscious (as presumably are the taxpayers). Yet they maintain their faith that somehow we can reach comprehensive and "rational" health service, although in all likelihood—given the history of publicly financed services—it would be so inadequately financed that many Americans would opt out in order to gain more liberal benefits and amenities than a public system would be willing to fund.

## II

The Medicaid experience, as revealed in this book, teaches several lessons about the nature of health services delivery systems. These lessons also have implications for national health insurance planning.

First, we must design programs so that they are workable. No delivery system should rely on the concept—enshrined in Medicare and Medicaid—of reimbursing physicians on the basis of "prevail-

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10. P. 95.

11. P. 102.

12. P. 73.

13. S. 3 & H.R. 22, 92d Cong., 1st Sess. (1971).

ing and reasonable" fees. There should be negotiated fee schedules, in order to give the administrators at least a degree of cost predictability over time. Likewise, no delivery system should rely on cost-plus reimbursement to hospitals (although, indeed, Medicaid rates to hospitals commonly fell below cost). Prospective reimbursement has greater promise. Another point is that the concept of medical indigence is administratively unworkable; it has no meaningful operational definition. Setting expenditure magnitudes by income level is the only objective criterion.

Second, our choice of funding mechanism should derive from a conscious balancing between desired expenditure levels and other considerations. If a health services system is funded from general revenues, it will receive less financial support than if a variety of funding sources are used, including payroll deduction.<sup>14</sup> Furthermore, exclusively public funding of health and welfare services will inevitably lead to a system with tight funding and chronic understaffing. A plurality of funding sources will keep the system loose. To some people, on the other hand, cost containment is the primary purpose of a health services system. From this perspective, centralized funding and planning would be preferable, even assuming a lack of meaningful output measures. With such centralization, politicians would also be sensitized to the length of various queues and would have some basis for knowing what measures were needed to achieve more or less equal access to services. There would be a clear structure and over time the actors within it could reach a politically tolerable equilibrium.

Third, this country will not—and should not—leap into a national health insurance system that is comprehensive in the services it provides. Medicaid demonstrates the fiasco of trying to achieve sudden comprehensiveness through massive public funding. I think the authors are realistic enough that they would agree, albeit reluctantly.

Fourth, in the interests of distributive justice, it might be better to improve on Medicaid for a large number of lower income families, earning, say, up to \$10,000 a year. If, instead, their health care is encompassed in a national health insurance scheme in which they have to scramble for services in competition with the other forty percent of the population, their problems are likely to be buried, as I believe is the result in such schemes in other countries.

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14. The authors might reject the latter approach, however, both in the interests of progressivity and in order to allow government officials flexibility with which to reorganize and manipulate the system.

The authors might agree with this observation also—grudgingly, however, because a nonuniversal plan would violate their concept of equity.

### III

In the final chapter the authors express an interesting belief about the potential disadvantages of using a piecemeal or incremental approach to building an eventually comprehensive and rational health services delivery system.<sup>15</sup> They believe that incremental development will result in more surveillance and regulation than would be found in a quickly enacted, highly structured health service, presumably resembling the British model. The actors in the British system know its boundaries; consequently, there are not specific controls on the volume or services and costs. Costs have gone up, but not as drastically as those in the United States or in the national health insurance systems of other countries.<sup>16</sup> It would be fallacious, however, to make easy extrapolations from the British scheme. British doctors tend to believe that the efforts of their welfare state are legitimate. They bargain hard within the structure of the system; income and working conditions are constantly negotiated. So far, however, they have not complained of interference with their professional prerogatives to diagnose and treat.

As a matter of fact, policy makers, planners, and administrators in all countries with which I am familiar seem to assume that there is a single rational model for an ideal health services delivery system. Supposedly this model can transcend the historical and contemporary matrix of any given country, providing a universally optimal "fit" between population needs, financial and personnel resources, and professional judgments about diagnosis and therapy. The model apparently is thought to resemble a blueprint by which one can rebuild an Italian Fiat factory in Leningrad (as was done), with Russian workmen being trained to repeat all the mechanical motions, so that in due course a Fiat rolls off the assembly line, although with a different name.

To me it seems unlikely that any health service model could transcend its own milieu. We witness a wide range of health deliv-

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15. P. 360.

16. Even so, Great Britain is exceedingly cost conscious within its tight structure. Every country I know of, except the USSR, believes it is spending too much money on health services.

ery systems that ostensibly work and are related to local economic, social, and political conditions. Nevertheless, all health service systems are taking on more structure and boundaries, with greater centralization of control. Presumably this is being done to even out inequities and, more important, to enable the government to predict and control costs. In the future, personnel will more often be salaried, and the allocation of facilities and personnel will be planned more comprehensively. Hence there will be less freedom for individual units in relation to the whole, and fewer chances for optional action outside the system. Medicaid (like Medicare) can be regarded as an object lesson in this long-term process, by virtue of its staggering eruption of costs. As the authors indicate, it may well accelerate legislation for national health insurance, American style, with the controls built in. The logic in the broader evolution is relentless, because no system knows how to fashion a "proper" health service. I think that the Stevenses have reluctantly come to the same conclusion. But their "historical method" does not help the reader to get there.