W. Reed and J. Tepperman, *Am. J. Physiol.* **216**, 223 (1969); M. L. Karnovsky, S. Simmons, E. A. Glass, A. W. Shafer, P. D. Hart, in *Mononuclear Phagocytes*, R. Van Furth, Ed. (Blackwell, Oxford, 1970).
83. V. Esmann, *Enzyme(Basel)* **13**, 32 (1972).
84. N. Kalant and R. Schucher, *Can. J. Biochem. Physiol.* **40**, 899 (1962).
85. L. Luzzatto, *Biochem. Biophys. Res. Commun.* **2**, 402 (1960).
86. A. Engelhardt and T. Metz, *Diabetolgia* **7**, 143 (1971).
87. J. H. Peters and P. Hausen, *Eur. J. Biochem.* **19**, 509 (1971); R. Averdunk, *Hoppe-Seylers Z. Physiol. Chem.* **353**, 79 (1972); J. W. Hadden, E. M. Hadden, E. E. Wilson, R. A. Good, R. F. Coffey, *Nat. New Biol.* **235**, 174 (1972).
88. J. W. Hadden, E. M. Hadden, R. A. Good, *Biochim. Biophys. Acta* **237**, 339 (1971); J. W. Hadden, E. M. Hadden, E. Middleton, Jr., R. A. Good, *Int. Arch. Allergy Appl. Immunol.* **40**, 526 (1971).
89. K. J. Isselbacher, *Proc. Natl. Acad. Sci. U.S.A.* **69**, 585 (1972).
90. R. E. Wood and H. E. Morgan, *J. Biol. Chem.* **244**, 1451 (1969); C. F. Whitfield and H. E. Morgan, *Biochim. Biophys. Acta* **307**, 181 (1973); H. E. Morgan and C. F. Whitfield, in *Current Topics in Membranes and Transport*, F. Bronner and A. Kleinzeller, Eds. (Academic Press, New York, 1973), vol. 4, p. 256.
91. K. P. Wheeler and H. N. Christensen, *J. Biol. Chem.* **242**, 1450 (1967).
92. This work was supported by grants from the Medical Research Council of Canada and the Manitoba Heart Foundation. I.B. is an Associate of the Medical Research Council.

What Next in Health Policy?

Eli Ginzberg

Little is to be gained by playing the game of guessing whether legislation for a National Health Insurance (NHI) bill will be passed this year. The new chairman of the House of Representatives Committee on Ways and Means has been quoted as saying that a bill will be passed and that it will have such widespread public support that the President will not dare veto it (a threat implied in his State of the Union message in which he stated that he was opposed to any new legislation involving new expenditures this year).

The chairman's remark can be interpreted as a gambit in the psychological warfare that often takes place when the differences between the executive and the legislative, between Democrats and Republicans, and among interest groups do not appear easily reconcilable. The last attempt to write an NHI bill (1974) foundered just because of unreconcilable differences. Although the new Congress is more to the Left, there is a new chairman of the Ways and Means Committee, and the election of 1976 is nearer; it is still not clear that even these three potent factors will provide the solvent required to reduce the combined barriers of philosophy and money. In any case, what could a new NHI act possibly accomplish?

Even if it were passed, NHI would not involve basic changes in the health infrastructure; that is, it would not modify seriously the stakes of commercial insurance and the Blue Cross–Blue Shield or the autonomy of physicians to practice and hospitals to operate as they do. Any NHI law passed would address primarily two issues: financial coverage for catastrophic illness and some broadening of entitlements for ambulatory care.

The next question is how the health services that are provided to the American people are likely to change, particularly services available to those people who have inadequate access at the present time. My tentative reply is very little. Services are provided only if people seek them and only if additional outputs become available. Currently most physicians are busy, and although they could cut down on the time that they allocate to each patient and thus increase the number they treat, those with a middle-class clientele are unlikely to do so. Consequently, a significant expansion in ambulatory services, particularly for the poor and the aged, particularly in the large urban centers, is likely to replicate the Medicaid experience: additional services will be produced by avaricious groups that have earned the nickname "mills," or by the expansion of ambulatory services at community and teaching hospitals. Neither prospect is encouraging if the past is any guide, and there is little reason to disregard it.

Current Health Needs

It is widely believed that tens of millions of citizens are handicapped by their lack of access to health services. The forms of evidence usually adduced are the statistical data which record higher utilization rates among those in the higher income brackets. No informed observer of the changing health scene would question that the poor, especially in the rural South, do not have easy access to medical care. But except for the rural South, lack of access per se is not the critical factor in obtaining medical care in urban centers, where there is a high concentration of health facilities and practitioners. The issue is not access to medical services, but the quality of care that the poor receive. Moreover, we must differentiate between surgical and medical interventions. As early as 1948, the poor, both urban and rural, were able to obtain access to hospitals when they required surgery, but they were not readily admitted to hospitals for medical conditions at that time (*1*). This problem has been substantially alleviated by the Medicaid and Medicare programs. The remaining issues of access to medical services involve access to ambulatory care.

It would be desirable for the protagonists of major health reforms to identify the health conditions of the underserved populations which are currently not diagnosed and treated and to relate this neglect to problems of access. It is important to keep problems of access to medical care separate from conditions important for health. Many poor people require improved housing, more income, new jobs, and other adjustments to better their health, adjustments which no medical care system can provide. I suspect that much of the pulling and hauling in health policy derives from the confusion between access to medical services and access to effective therapies. I suspect that the public is more aware of this than the health policy-makers since the public puts health reform low on its list of priorities.

How Much Money Is Needed for Effective Reform?

When the possibility of NHI first emerged a few years ago as a political reality, the costs of several bills introduced varied from under $10 billion to over $80 billion. Part of the difference was explainable by the range of services that were to be covered and the extent to which the consumer would carry part of the cost. Another explanation for the wide spread was the difference in the national total as com-

The author is A. Barton Hepburn Professor of Economics and Director of Conservation of Human Resources, Columbia University, New York 10027. This article is based on an informal presentation early in 1975 to senior government officials in the U.S. Department of Health, Education, and Welfare.

pared to federal dollar expenditures. But even the preliminary analyses undertaken by the staff of the Department of Health, Education, and Welfare and others revealed that a considerable part of the differences reflected varying assumptions about the demand for various services and the probable trend in costs.

For those in the forefront of the health reform movement it would be a worthwhile exercise to undertake some preliminary calculations about the dollar costs involved in bringing those who they believe now receive inadequate services to some acceptable standard. This would be a first step in a more complex exercise, which would eventually have to include estimates of the cost of providing the expanded health resources, personnel, and facilities, as well as the special inducements that might be necessary to deploy physicians and other health providers to care for the underserved populations. For example, the Armed Services have special permission to pay an additional $13,000 per annum as premium pay for medical officers with certain types of scarce medical skills.

Another way to approach this complex issue of the relation of new dollars to increased services for the underserved would be a retrospective one. One could go back to 1965 when the Medicare and Medicaid programs were enacted and compare the additional dollars from all sources that flowed into the medical care system as a result of this new legislation with an estimate of the increase in real services provided, with special attention to the recipients of these services. Much of the post-1965 experience has been an increase in the relative share of government dollars as compared to consumer dollars and, to the extent that the more affluent pay more of the taxes, such a shift in the sources of funding may be desirable. Even more to the point would be an inquiry into what additional inpatient and outpatient services were received by the low income groups, accompanied by an attempt to consider changes in the quality of the services available to them.

The proponents of many NHI proposals speak of net additional costs under $10 billion. Since total health expenditures in fiscal year 1975 are likely to exceed $120 billion, it is difficult to see how such a modest NHI proposal could have more than a marginal impact on the total quantity, quality, or distribution of health services which are currently available. No fact speaks more directly to the unreality of most of the decisions relating to health reform than the unwillingness of its advocates to consider the additional dollars required to overcome the lack of adequate services to low income groups.

Federal Initiatives and Local Planning

When the National Aeronautics and Space Administration (NASA) succeeded in placing a man on the moon, many politicians and professors jumped to the simple conclusion that, if government could accomplish such a spectacular feat, it could surely remedy more mundane problems, such as improving education and health services, providing all Americans with suitable living accommodations, and rebuilding our deteriorating cities. But these many reformers failed to understand, first, that the significant accomplishment of NASA was based on the utilization of existing technology; second, that the more than $40 billion of federal expenditures was a boon to many industries, occupational groups, cities, and regions; and that the entire effort threatened no one, with the possible exception of a few establishment scientists who feared a deflection of government funds from their favored programs.

If for the moment we leave aside the matter of additional resources, the reform of the health system runs headlong into the entrenched interests of a great many powerful constituencies, including physicians, health insurance agencies, hospitals, and the pharmaceutical industry, which can no more be ignored than they can be easily neutralized or co-opted.

A further critical dimension warrants attention. The Apollo program was a tightly managed federal effort that was developed in close collaboration with a limited number of prime contractors. While Congress is in a position to legislate with respect to health—and to increase the flow of funding—it is in no position, short of instituting a federalized national health system, to alter the local production and distribution of health services. But only local changes are likely to increase and improve the services available to various groups, particularly those who currently are underserved. The reason that it has been and will continue to be difficult to introduce large-scale changes in the provision of health services is the leverage required to bring about alterations at the local level. Most state and local governments have demonstrated little capacity for effective planning in the provision of health services; most of the effective power resides in the nongovernmental sphere where physicians and hospitals make the planning more difficult. The recent health planning legislation will provide a second opportunity to see how fast and how effectively local planning agencies can be strengthened, a precondition for the rationalization of the health delivery system. Our earlier experience with the Hill-Burton legislation, Regional Medical Programs, and Comprehensive Health Planning suggests that we must not expect much.

Priority Objectives

I have always found it a useful analytic device to ask reformers which two or three changes they would most like to see introduced, disregarding the economic and political preconditions required to bring them about. I ask, what would they change if they could, and what would they expect the consequences of the changes to be. Starting with the reasonable assumption that a large number of Americans have limited access to desirable and desired health services, I ask what changes, if they were introduced, would be likely to improve this situation.

A review of recent legislative hearings and the proposals of various reform groups suggests that the advocates of change are placing their hopes on NHI; on the assignment of physicians to underserved areas accompanied by a reduction of specialists in favor of an increase in family care physicians; and on health maintenance organizations (HMO's) and professional standards review organizations (PSRO's). Since it was suggested earlier that the NHI plans now being proposed involve little new money (and little alteration in the existing health infrastructure), let us consider briefly the other dimensions of the programs for reform.

There is little prospect of enticing or forcing physicians to practice in the ghetto areas of our large cities. In some very large, very poor neighborhoods there often is not a single pediatrician in private practice; for example, Harlem is often without one. The real challenge in low income urban areas is to provide local clinics with effective hospital backup. Moreover, in staffing local clinics, interested nurse practitioners may have a distinct edge over recalcitrant physicians, and this is also likely to be the case in underserved rural areas.

We may have too many general surgeons or neurosurgeons, but it does not follow that if we reduce their numbers and increase the proportion who enter the specialty of family care that the difficulties which confront many Americans when they want to see a physician will be eased. After all, most specialists keep busy, even though some may undertake more extensive therapeutic interventions than good practice might suggest. Moreover, many specialists provide primary care. Who is to say that an older person in good health who has back pains receives less adequate care when he is seen by an orthopedist than when he consults a family care physician?

The growth of prepayment medical insurance plans has been slow and, while initial blame could be placed on the opposition of the American Medical Association (AMA), a current reading would have to point to the lack of interest among most physicians and the public. These plans are likely to grow but slowly. The reform of American medicine does not lie with HMO's.

It would take an evangelist to believe that the quality of health care would be significantly improved by the establishment of PSRO's. The several levels of government and the organizations like Blue Cross and Blue Shield have long known about examples of poor practice in hospitals and among physicians. If they had wanted to follow up many of these shortcomings could have been reduced and eliminated. The simple fact is that inertia has weighed against acting. There is no reason to believe that inertia would be diminished by the establishment of PSRO's, which, it must be remembered, were conceived to serve the objective of cost control and, only indirectly, quality improvement.

Certainly there are ways to improve the health delivery system; but the nostrums identified above are unlikely to contribute significantly to the task. We need the mobilization of effective forces of reform within each local area, an identification of priority needs, the introduction of additional resources, and, equally important, the reallocation of existing resources so that the underserved groups can receive better care. This is, admittedly, a difficult and slow task. But significant health reform cannot come easily.

Expectations and Reality

The foregoing comments are not a rationale for not attempting significant reforms in the health services delivery system. But I do believe that the reform program should be more sharply delineated, differentiated with regard to the level of governmental intervention—federal-state-local—and that the roles of the other parties that must participate in the process must be addressed. There are useful functions that the federal government can perform on its own. This is true also of state and local governments. But the burden of these cautionary remarks has been that the number of interest groups is large and that significant improvements in the production and distribution of quality health services involves eliciting cooperative action primarily at the local level, for it is there that the resource pattern must be augmented and altered.

We have heard a great deal during the last years about the "crisis in health"; this is a difficult concept to evaluate at a time when the American people have been pouring large additional resources into the system. Perhaps 8 percent of the gross national product is not enough, but it is twice what we spent some years back. Would 12 percent solve the "crisis"?

I submit that the nub of the difficulty lies in the uncritical expectations that have been formulated by the enthusiasts of health reform, such as the Committee of One Hundred, which has contended that a federally directed NHI would provide all Americans with access to almost the entire range of desirable health services at little additional cost since the structural changes mandated by the new system would result in enhanced efficiency.

It is impossible to prove the enthusiasts wrong. But they should explain how the significant gains they anticipate are likely to occur. The current scene does not indicate that the principal interest groups are about to withdraw from the fray. If their present behavior is any clue to the future, they will fight to maintain their power and leverage on the system. It will require money or other benefits to elicit their cooperation.

Of course, an indignant electorate could ride roughshod over entrenched interests. But the examples in American history of legislative insurrections are hard to find. They never occur except when the electorate is exasperated. Opinion polls give no evidence of exasperation; in 1975 the American people have concerns more pressing than their health system.

The situation appears to be that many politicians believe that a large part of the electorate wants and needs more protection against the threat of catastrophic medical expenses. And many people, in and out of political life, realize that the poor do not have adequate access to essential health services. These two perceptions are sufficiently widely held that the federal government will probably legislate some form of NHI in the late 1970's.

But the thrust of these observations is that such legislation will have only a marginal effect on how the health care system operates and will result in only a marginal improvement in the quantity and quality of the services that are available to the currently underserved. The foregoing analysis has also argued that short of complete federalization, which is not on the horizon, basic reforms will require detailed planning and organization at the local level, which is a slow and difficult process.

In the meantime, those concerned with health policy should stop talking in slogans, stop pursuing utopia, and confront the increasingly difficult economic, political, professional, and other barriers that stand in the path of large-scale transformation of the system. It can and will be altered, but only slowly.

We should remember that even a radically altered health delivery system—one commanding 12 percent of the gross national product (half again as much as at present)—would be unlikely to contribute significantly to improving the quality of life. And it is improvements in the quality of life, not in the health delivery system, that should be the focus of the citizenry's concern.

References

1. E. Ginzberg, *A Pattern for Hospital Care* (Columbia Univ. Press, New York, 1949).