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EXECUTIVE OFFICE OF THE PRESIDENT
BUREAU OF THE BUDGET
WASHINGTON, D.C.

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before the
Conference-Workshop on Regional Medical Programs
Washington, D.C.
January 19, 1968

A NON-PROFESSIONAL LOOKS AT REGIONAL MEDICAL PROGRAMS

I am pleased to have this opportunity to be at the Conference-Workshop on Regional Medical Programs. I always welcome an occasion to show to an unbelieving public that the men in the Budget Bureau do not wear green eye shades or sit upon high stools in their counting houses. In a recent talk at this same hotel, Dr. Ivan Bennett, Deputy Director of the Office of Science and Technology and one of my principal mentors in the health field, described us in these words:

"Some of you, I know, have had experience with the Bureau of the Budget, where, since the multiple-crack system does not exist and there are no fissures that allow for penetration of local interests into national policy decisions to influence decision-making and allocation of resources, one has recourse only to putting together a balanced, persuasive, and factual argument. It is with real respect and admiration that I say that here are the beady-eyed, hard-nosed skeptics, receptive to opinion but demanding iron-clad factual details--a demand which for me, and indeed, all of my colleagues who have been exposed to it in depth, has meant a reorientation of thinking, a new level of objectivity, and above all, a lasting respect for a much-maligned and little understood executive agency."

I quote Ivan at length so that I may publicly accept his compliments while at the same time deny that we are beady-eyed, and hope that we are better understood as a result of his efforts. Also, despite our passion for anonymity, we now find that the stage on which Federal programs are played has become so vast that we do have to allow for a few occasions which permit us to see local interests at work, or, as we say at the Bureau, the real world. For it is to help in shaping this real world that Presidential goals, policies, purposes, and proposals are eventually fused into what is termed "the program of the President." It is the translation of that program into dollar terms which leads us in the Budget Bureau to pursue the facts, to question the purposes of programs, to analyze--alas, all too imperfectly--their costs and benefits, so that the decision-maker--in our case, the President--can look at alternatives and evaluate relative payoffs from different kinds of public investments.

As availability of public funds for public purposes becomes tighter, the need for questioning is heightened. Our thirst for knowledge is quickened as we understand that when budget decisions are made we are affecting not only your hard-earned personal income but also the way in which society utilizes its people and its natural or physical resources, and the services or social purposes which these resources produce. The allocation process is never ending--the larger the Federal budget the greater the responsibility that Government assumes to channel and direct its resources according to rational choices.

I have no crystal ball to tell me how large the level of Federal spending will be or ought to be. I would only be speculating, and I would be especially speculative if I engaged in the game of "what if we had no Vietnam?" The level will remain high, however, and the competition for the dollars increasingly acute. This acute competition means that we in the Budget Bureau must concern ourselves with the goals and objectives and the hoped-for results of health and other programs. We try to refuse to go along with the proposals that shoot from the hip.

What I am saying is that while we in the Budget Bureau have no special wisdom or formulae for sorting out our budgetary goals and priorities, the President wants his program to be tuned to the problems of our society and the need for developing solutions to those problems. He wants his final choices to be not only good choices, but better than other proposals to accomplish the same end, and to show better returns for the same investment of public funds. To be sure, the budgetary process is neither clear-cut nor infallible, and, as I have indicated, our analytical techniques are still probably not as solid as we would like.

Still, I hope you will accept that this budgetary effort is no simple accounting task, but one in which after we fall back exhausted--incidentally, that will occur for 1969 very shortly--we have helped the President find a balance first, among the national goals of national security, foreign affairs, education, health, abolition of poverty, environmental quality, recreation, housing, transportation, science and technology, and so on;

and second, among the programs most likely in action to give him progress toward these goals. There is never enough to go around, and it is little wonder that Maurice Stans, President Eisenhower's last budget director, called budgeting the uniform distribution of dissatisfactions.

There is ample room to demonstrate that the worth of social investment is subject to quantifiable assessment. There is rather a widespread effort today in the Government to produce these assessments, going under such names as systems analysis or program planning and budgeting. Thus, investment in education is said to be more than socially "good"--we say it is economically productive, and we can even say by how much. We can, by better analysis, show that the rehabilitation of the handicapped is not only socially useful but economically advantageous. In medical science, similar reasoning can and has been applied to show favorable cost/benefit and cost/effectiveness ratios--for example, it has been done in studies in the Department of Health, Education, and Welfare of the health of the poor and the health of children.

But let me quickly hasten to disabuse you of any idea that budgeting and its associated decision-making is strictly for budget professionals. This is no system of pushbuttons or whirring magnetic tapes. Public policy is still made in the political arena, and it is in this arena that the budgetary decisions are made.

A better grasp of the role of public expenditures in creating social assets does not by itself tell us when to spend or how much to spend.

Our pluralistic society responds to pluralistic demands whether they are supported by a dispassionate array of facts and figures or not. Many human needs clamor for passionate attention, and many problems cry out for solutions as neglected areas of public concern. Certainly, our planning and analytical capability is not great enough to have given us in so short a time rationality to develop our present array of Federal human resource programs. About 459 such programs are described in the annual catalog of Federal assistance programs produced by the Office of Economic Opportunity. I commend this catalog to your attention. It may help you not only to find out whether there is a grant program to finance your favorite project, but it will also rather forcibly impress upon you the sweep of Government activity in the social field.

The use of the phrase "human resources" has become fashionable in today's intellectual parlance, but I think it signifies that the programs grouped under this banner constitute a new type of governmental effort, not to be compared with social legislation of the past--either the New Freedom of Wilson or the New Deal of Roosevelt. That legislation--fair labor standards, child labor laws, food and drug controls, unemployment insurance, social security, to mention a few--reflected a simpler social philosophy that Government should provide a basic underpinning by interdicting various behavior patterns or by providing certain minimum income guarantees. Today, the revolution of rising expectations in the less developed world is paralleled by unrest in our own society, and Government is responding by provision of services

on a very broad front. The 89th Congress alone produced 21 new health programs, 17 new educational programs, 15 new economic development programs, 12 new programs to meet problems of cities, and 4 new manpower programs.

From our early days, we Americans have been a "practical" people. And so our society tends to bring into being human resource programs that are targeted to specific action areas. These may be categories of disease or specific population groups, and--I may add--are too often controlled by the professional specialists. Too often, the professional insists on assumptions, approaches, programs, or technology of universal applicability. Lest we "dehumanize" human resource programs, may I stress that the primary focus of Government in managing this array of programs ought to be on the individual no matter who he is--underprivileged, poor, aged, migrant, veteran, child, mother, nonwhite, retarded, rural, uneducated, or other statutory category.

These programs, and I include Regional Medical Programs, have created a new dimension for Federal management and for relations with the private sector and State and local governments. Unfortunately, for those who approach governmental relations simply, no one has contrived a simple formula for the execution of these programs. On the contrary, we have adopted, probably not always consciously, the approach of pragmatic experimentation. There is not always time to wait for the perfect solution. So, we grope toward it, accepting some risks. We place a

high premium on close cooperation and a flow of information among equals, and, above all, we are willing to see institutional change come about in many forms. We have had to try to move more and more decision-making out into the field, recognizing that coordination of programs cannot all be achieved by Federal action. The benefits of decentralization, however, must be accompanied by the costs of anomalies, diversity, inconsistency, and even downright error. But deep-rooted social and economic problems are complex in nature and cannot be attacked by simple-minded, single-shot approaches.

In his report to the President and the Congress on Regional Medical Programs, the Surgeon General set forth at length a number of issues and problems which face the Regional Medical Programs. Some derive from characteristics of the general health setting in this country--for example, its essentially voluntary and private nature, the magnitude and complexity of what is often termed a \$43 billion industry, manpower limitations, and rising medical costs. Others relate to the law itself--definition of a region, significance of disease categories, use of advisory groups, dissemination of information relating to advances in diagnosis and treatment, and others.

In time these and other issues will be dealt with in the public, executive, and legislative forum. But, as I see Regional Medical Programs in the context that I discussed earlier--our problem of allocating resources of men, money, and materials--its prime worth to our society will be in its capacity for improvement of our system--or systems--of medical care for the

people served. Let me stress the word medical because too often in the past in this country we have used "health" as a euphemism for medical in view of our unwillingness to confront on a public level the problems of medical care.

By now it is established that Government has set its face in the direction of tackling the problem of assuring to all its citizens the access and availability of high quality medical care. I regard as idle the discussion whether we mean such care is a right, like public education, or a privilege. The goal is clear, and if we are serious about it, we must constantly make painful choices as to where we will put our monies and equally painful decisions on how to arrange our institutions.

I do not anticipate that we will experience major trade-offs in Government spending between previously well-funded activities that were of less public controversy--such as biomedical research and academic science--and new activities designed to finance and make available the medical knowledge we have. However, it is also clear that extremely high on the health agenda is the distribution of our medical knowledge--what we call the organization and delivery problem. I think that it is in solving this problem and in bringing medical care to people that the Regional Medical Programs potential lies.

Medicare and Medicaid alone account for over \$8 billion of the Federal expenditures of \$15 billion for health programs. They have virtually eliminated financial barriers for the aged and have made it possible

for poor and near-poor in three-fourths of our States to receive an increasing volume of medical services. These landmark laws of 1965 are accompanied by others in maternal and child health.

Ironically, many people--and especially medical professionals--are troubled over this outpouring of Federal funds to diminish the financial burden of paying for medical care, and they are rightly troubled, because with demand for medical care now effective, as the economists say, the pressure is on the profession to deliver. In addition, of course, there is the vocalized but as yet not effective demand of citizens not yet covered--for example, the disabled, the migrants, or the rural and urban poor not eligible for Medicaid. None of us needs to be an economist to know that when more funds are poured into the arena for purchase, the selling system must be more efficient or its supply must be enlarged or the infusion of funds may simply be eaten up by price inflation. Debate continues--and I am no expert--on the extent to which Medicare contributed to rising medical costs, but the rising costs are with us and therefore spur us to examine our system of medical care.

Many speak of Regional Medical Programs as a unifying focus for the health resources of a region, linking patient, physician, hospital, and medical centers to provide the latest advances of knowledge to the people in this region. But health functions are a continuum, and Regional Medical Programs will have to consider the problems of distribution, cost and organization of health care. I would think that, because of the tremendous

scope of heart disease, cancer, stroke, and related diseases, the task of improving organization and delivery of medical care through Regional Medical Programs has to be viewed in the context of comprehensive health services and not in a narrowly-based disease approach.

This task will have in the long run serious implications for medical centers and medical schools. The comfort of biomedical research and individual case treatment or teaching may be replaced for many by the raging controversies over medical care costs, doctors' fees, etc.

"Interesting medicine" may become not disease-oriented, but the area of organizing the system of care. Of course, another impact, still only seen in general terms, will be seen in the need for production of more doctors faster. The President's Health Manpower Commission recommended that we develop economic incentives to make this possible. Oliver Cope wrote somewhat despairingly of this problem of medical education a few months ago in Harper's Magazine. I would hope that in time we could overcome his despair by responding to the prod of the Commission.

Through the National Center for Health Services Research and Development, Regional Medical Programs will get invaluable assists through a rising level of supporting investigations and experiments. Another significant actor on the scene is the "Partnership for Health," and I guess we still have to establish with more clarity how we want this experiment to tie in with Regional Medical Programs. There is a tendency to regard this program as just another State support program. This is an error in judgment, and you will find that it is regarded here in Washington as a

pilot program of some significance. It is a major breakthrough in changing the proclivities of professionals and their executive and legislative supporters to opt for narrowly-based categorical programs. There is a serious effort afoot in this town to create more manageable packages which permit the local private and public sector to act decisively while preserving the right of the Federal Government to establish priorities of national significance.

In the Budget Bureau we have read with considerable interest the Surgeon General's priority statement for Partnership for Health issued in November. This priority statement is very topical, and I suggest that it has great meaning for many of you. This statement establishes three budget priorities that are relevant to Regional Medical Programs:

First--The requirement for comprehensive health care, directed to individuals and families, not diseases;

Second--Improvement of the health status of the indigent; and

Third--Use and training of neighborhood residents, and involvement of neighborhood residents in planning and implementation of health projects.

I would only bore you were I to recite statistics about the health status of the poor. The evidence of unusual disease and high prevalence of ill health identifies them as a high-risk population. While the middle and upper classes in this opulent society have a malaise and uncertainty about their own lives, the health status of the poor is part and parcel of that complex called poverty which is much greater than just lack of income. It is what Colin McLeod, in his recent AAMC address, eloquently

called "the lack of hope that one can ever rise beyond the despair of being forever a hewer of wood and a drawer of water; it is the despair of being unable to aspire to the expression of his potential as a human being; it is the despair of having no future except that of mean survival in misery loaded enclaves surrounded by an opulent society."

There has now been mounted in the Office of Economic Opportunity a program by the "medical radicals," as Marion Sanders calls them, of Neighborhood Health Centers. Today, 46 centers are in operation or to be funded, and medical schools at all levels are in the business. This is more than an incidental change in attitude. It is recognition that the Nation's health business lies in making medical care available to all, and the role of medical schools and centers is crucial in this. May I as a layman suggest that heart, stroke, cancer, and related diseases--significantly related or not-- will be found among the poor in the Neighborhood Health Centers. Undoubtedly, many medical schools are or will be deeply involved in both Regional Medical Programs and Neighborhood Centers and both programs should profit from each other.

If I am right that Regional Medical Programs has not been sufficiently concerned thus far with the problems of the poor, I can extend this lack of concern to the cities generally. Not that I ignore the rural poor. The Breathitt Commission reminds us most forcibly that urban poverty has deep roots in rural poverty. But the crisis of the cities is a human resources crisis and the cities are where we will find most starkly the poverty of which Colin McLeod spoke.

For too long our society has invested resources in only the physical aspects of the city, but the Model Cities program is ample testimony that human and social needs are the dominant theme today. 63 cities have been selected for first generation grants under this top priority program, designed to improve the quality of urban life, declared by Congress to be the most critical domestic problem facing the United States. These 63 cities now have the initiative by law to develop programs for selected neighborhoods so as to remove or arrest blight and decay, to make marked progress in reducing social and educational disadvantages, ill health, underemployment, and enforced idleness, and to provide educational, health, and social services necessary to serve the poor in the Model City area. You should be aware that this is a program run through the Department of Housing and Urban Development, but that HUD places primary reliance on other agencies for evaluating the human resources program proposals of these Model Cities plans.

The Model Cities program, born in the inspiration of a few, dealing with the institutional arthritis of Federal, State, and local bureaucracies and frustrated by the professionalism in health, education, and welfare, may yet turn out to be our boldest experiment. Regional Medical Programs tries to develop, on the basis of local initiative, new institutions and techniques to solve health problems. In a sense, Model Cities is Regional Medical Programs writ large upon the total human resources scene.

The Model Cities program has another lesson for Regional Medical Programs-- the necessity of citizen participation in program development and his

access to the decision-making process. There are many roles which we can attempt to define as being logical and effective for the private citizen in health affairs. Hospital trustee or planning body member are obvious roles. Not so obvious and perhaps somewhat more nebulous is the role of the private citizen as a member of the board of directors of a regional medical program. I know many of you are thinking about this role of the citizen which, incidentally, would parallel the consumer representation found in the Partnership for Health program. In any case, the non-professional role in planning a regional medical program warrants expansion and the community members, to play this role, will have the responsibility for asking a number of unpleasant questions about the quality of the medical care in a region, the availability and accessibility of comprehensive health services, or the usefulness of Regional Medical Programs in inhibiting the rate of cost increase in medical care.

May I suggest, however, that there is another consumer role which must be considered. It is an inevitable role if human resources programs are to reach the people whom they are designed to serve. I am speaking here of the citizen in the neighborhood who will not be satisfied with past patterns of consumer representation, but wishes rather through neighborhood organizations to make his views known. The requirement of participation of the citizens in the neighborhood in determining the programs which serve them is found increasingly in Federal law, Model Cities and Office of Economic Opportunity being only highlight examples. The prescription of the participation may vary in differing statutes as

may its administration in practice. But one thing is certain: the voice of the citizen consumer will be heard at the grassroots level in the deliberations affecting his future.

The need of community involvement and citizen participation is unfamiliar to the medical profession, which has survived a long time in this country under the slogan "you are the doctor." But Paul Ylvisaker very astutely pointed out at last year's conference in this hotel that the Regional Medical Programs has too narrow a professional base, and he stated that, if the health professions do not become consumer oriented, "within two years your medical schools will be picketed by a combination of the American Mayors Federation and CORE. And I wonder," he said, "if your medical faculties are ready for that experience."

Not too long ago Public Broadcast Laboratories televised the sharply polarized views of the police and the militant Black Power advocates regarding law enforcement by police. It was a fairly chilling experience for the advocates of moderation. But I found provocatively thoughtful the minister from Atlanta who calmly told a nationwide audience that all our social, education, and health efforts were hampered by an essentially negative attitude of Americans toward the poor and the Negro. If we expect human resources programs, including Regional Medical Programs, to realize their investment potential to serve human beings, the professional's attitude must be one that not only permits him to help the poor and Negro, as he did in the past eras of social legislation, but also motivates him to urge their involvement and give them access

to the decision-making process. That is our goal in Model Cities, Office of Economic Opportunity, and Partnership for Health. It should be no less in Regional Medical Programs.

May I thank you for this opportunity to be present at this Conference, and wish you well in your endeavors.