TOWARD IMPLEMENTATION OF AN URBAN HEALTH AGENDA: THE ROLE OF GOVERNMENT

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ABSTRACT Government has several essential roles in the implementation of an urban health agenda. Government acts as a direct agent in the financing and delivery of services, as a rule maker for the financing and provision of care by others, and as a forum for political debate. Discussions of access to care, control of health care costs, and the maintenance of quality all include a role for government. A period of apparent rejection of comprehensive governmental health care policy has nevertheless included numerous examples of the persistence of government's many roles.

In a recent issue of the Sunday *New York Times*, the "Week in Review" section contained a headline, above an article written by Kirk Johnson, that said, "Washington Steps Back, and Cities Recover."¹ It was a balanced article. The author essentially noted improved economic activity in some of our urban settings and highlighted the juxtaposition of a period of relatively passive urban policy involvement from the federal government with these local examples of economic improvement. He asked if the absence of urban policy has been a blessing in disguise; the headline suggests that it has.

What the article really said was this: At the end of six years of unprecedented economic growth, the American economy has managed finally to trickle some resources into areas that have been most deprived of those resources over a period of time. Surely we can find examples of revitalization and renaissance in certain pockets of urban areas, but for the purposes of this discussion, the headline suggests that we are in a circumstance in which we can expect miracles to happen in a vacuum. The question, as appropriate to urban health as it is to urban economic development, is, "Will these problems solve themselves?"

In health care, the answer is no. Today, at the end of six years of economic

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prosperity in our country, the number of uninsured people has grown to 43 million. Moreover, after what perhaps will turn out to be a temporary phenomenon of limited growth in health care costs, there are numerous indicators that the health care inflation dragon is again about to roar.

As urban communities see growing numbers of uninsured and health care cost inflation threatens, will business, academia, insurance, and community advocacy be able to solve the problems of our urban communities? I think not. But then, consider the corollary: Will government solve these problems? The answer is equally, and as powerfully, no. Because it is clear that, while government may very well be a necessary component or condition of any comprehensive solution, it certainly is not sufficient for government to act alone.

As we examine the role of government in developing and implementing an urban health agenda, I do not draw a substantial distinction among the levels of government—federal, state, and local. My examples are drawn from all three levels, and for all three, we may speak of three roles of government: as agent, as rule maker, and as political forum. In its agency role, government is a direct participant in the provision of health care services as a payer of care, a deliverer of care, or both. In this capacity, government is a direct actor in the system. As rule maker for the system, government sets the expectations and limits for other participants and occasionally acts as referee. As political forum, government offers the opportunity for ideas to be exchanged and voices to be heard.

GOVERNMENT AS AGENT

As one looks forward to the solution of any of the sweeping problems related to urban health care, one must observe that government pays directly for the health care of 70 million people in this country through the Medicare and Medicaid programs. If we extend the definition to include military programs and benefits for federal, state, and local government employees, the number is substantially larger.

Further, in both Medicare and parts of the Medicaid program, beneficiaries tend to be the more costly patients in American health care. Clearly, there are costly cases distributed elsewhere within other payer categories, but the demographics of the Medicare program focus on universal eligibility at age 65 and beyond and include those with disabling conditions who have become eligible for Medicare at an earlier age. Medicare supports those that, in the aggregate, are more costly patients.

The same point can be made, although not as clearly as for Medicare, about the combined state-federal Medicaid program and the roughly 36 million people it covers. Medicaid can be described as four programs in one. Medicaid is health

insurance for poor people—mostly women and children—through the linkage, or former linkage, to cash assistance. Mothers and children are, or were, eligible for the Medicaid program along with their eligibility for cash assistance. While two-thirds of the people on Medicaid's eligibility rolls are in this category, they account for less than one-third of Medicaid expenditures.

Medicaid also pays for one-half of the institutional long-term care expenditures in the country. In some states, such as New York, that amount would be between 80% and 90%.

A third element of the Medicaid program pays the cost-sharing requirements that enable low-income beneficiaries to participate in the Medicare program. This program covers about 10% of Medicare beneficiaries.

Medicaid is also the principal health care funding source for persons experiencing a wide range of physical and mental disability conditions. This fourth Medicaid component has been the engine that has allowed a powerful societal change to occur during our generation as persons with disabling conditions have moved to residence and activity in community settings. Medicaid is a major source of funding to support this greater personal independence.

Medicaid, therefore, includes coverage for many individuals with costly health problems. Through Medicare and Medicaid, government is at the center of health care financing and simply cannot be ignored in any policy discussion.

Further, with respect to government as agent in the delivery of services, focus on just one example: the New York City Health and Hospitals Corporation (HHC). This observation is from the data that we, at United Hospital Fund, distribute on a quarterly basis in our *Hospital Watch* publication. The report in September 1997 showed a trend: the hospitals of the New York City HHC have experienced a decline of about 1.5% in share of hospital patient discharges in the New York City health care market over the last five years. Interestingly, when disaggregated by payer source, the numbers show a decline of about 5% in the share of Medicaid admissions and an increase of over 10% in the share of so-called self-pay (often nonpay) patients. While there is a modest decline in HHC's total share of the market and a somewhat greater decline in Medicaid patients, the public sector of the hospital system in New York is picking up a significantly greater share of the self-pay/nonpay category.²

Data regarding ambulatory patients who are self-payers and their use of hospital clinics make the point in an even more dramatic way. Of those patients, 64% used HHC facilities in 1996.

Rather than a phenomenon of the voluntary sector abandoning patients, the increase appears related to an enormous surge in the number of uninsured in New York City. Over a five-year period, the uninsured population has jumped

from 2.2 million to 3.1 million—an increase of almost 1 million people in the 1990s.

While the data as yet are inconclusive, I suspect that a great deal of the increase has to do with the surge of new residents arriving on our shores and the unlikelihood that, as those new residents enter the work force, they find jobs, at least initially, with health insurance coverage. The magnitude of New York's uninsured problem has grown significantly. During a period of discussion about privatization of the HHC, there has also been an increase in our dependence on the public system for care of the uninsured, even while voluntary hospitals have continued to maintain significant levels of responsibility.

In these examples, government acts as both payer of care and direct deliverer of services and is clearly in the center of urban health care.

GOVERNMENT AS RULE MAKER

Much of the financing of our overall health care system is guided by the tax advantages given private health insurance expenditures. Moreover, through licensing of the health professions, oversight of the private insurance industry, maintenance of consumer protections, and, occasionally, regulation of provider behavior, government establishes many of the terms under which the rest of American health care operates. New York State has been known for decades as an active government regulator of health care. Even as New York, in recent years, has adapted to a more competitive health care market, state government has preserved significant levels of subsidy allocated toward so-called public goods (e.g., care of the indigent, and medical education) within the system. In New York, competition among health care payers and providers operates within limits that acknowledge broader societal obligations of the participants.

The debate about government as rule maker is also currently ongoing in Washington. There was a very interesting early discussion, perhaps to the embarrassment of the leadership in both houses of Congress, in which several members of the Congress, including the junior Senator from New York, are sponsors of legislation aimed at setting national standards for the quality of care provided in managed-care organizations. This discussion is contrary to the "less government—let the marketplace work" rhetoric we hear from many congressional leaders and sets the stage for what is obviously going to be a volatile debate during 1998.

Even some health maintenance organizations (HMOs) are joining in support of national standards, while others are raising the question of whether this is an inappropriate intrusion into the marketplace. Four years after the rejection of President Clinton's health care reform proposals, the fact that new rules of the

game are being advanced by members of both parties in both houses of Congress is significant: it reinforces the pervasiveness of the potential for government to set rules under which the rest of the health care system operates.

GOVERNMENT AS POLITICAL FORUM

In some respects, most of us do not recognize how much debate there is around the issue of government's role in health care. Since the 1992 elections, we have had four, or perhaps five, distinct waves of policy discussion. A review of the experience since the 1993 Clinton health plan debate is instructive.

In 1993 and into 1994, motivated by some preliminary changes in the 1990 elections and more-profound changes in the 1992 elections, the nation debated a proposal advanced by the Clinton administration for comprehensive health insurance that would cover virtually the entire population and associated with restructuring of the health care delivery system. No sooner had that debate been concluded than health care issues were among those influencing the fall elections of 1994. The dramatic change in congressional leadership, including the surge of Republican majorities in both houses, but particularly in the House of Representatives, led to a second wave of recent health care debate, one that moved the debate to the absolute opposite end of the spectrum from the Clinton health plan.

The new congressional majorities proposed a major devolution of policy responsibility from the federal government to the states through a total restructuring of Medicaid and even the elimination of Medicaid as a national entitlement. As responsibility devolved to the states, so too would revenues—in the form of revenue sharing or block grants. From a discussion of national and uniform entitlement to coverage in 1993 and 1994, debate shifted away from Washington as problem solver to a discussion of fiscally limited, state-by-state allocation of resources to competing health care demands.

The President vetoed that approach in December 1995. The debate continued into 1996, with discussion shifting to targeted federal standards for those temporarily without coverage and culminating in the so-called Kassebaum-Kennedy legislation.

Again, the debate changed focus somewhat in 1997, redefining the discussion away from health care and toward the balanced-budget debate. Despite a broadly held perception that dramatic changes in the Medicare program were rejected in the final version of the Balanced Budget Act, this was not the case. While highly symbolic changes (such as changes in eligibility age and income-adjusted premiums) were not adopted, Medicare began to change fundamentally. In the Balanced Budget Act, Congress chose to fragment the pool of Medicare partici-

pants. Every Medicare beneficiary, beginning in 1999, will have new choices among plans within the Medicare program. Whether the new rules will ultimately maintain equity or not, an enormous element of beneficiary choice has been added to the Medicare program.

Another wave of discussion in the political forum of government focused on health insurance coverage for children. Whereas the Congress had rejected expansions of health insurance in 1993 and 1994, in 1997 a newer Congress found itself, in bipartisan fashion, agreeing to expand coverage to children across the country. Congress made a credible advance toward this goal with a five-year allocation of resources, even in excess of amounts originally debated, to states for expanded health insurance coverage for children.

Most recently, what began in 1997 as a modest discussion about national standards for managed-care plans is moving toward a much larger debate in 1998 about the role of federal policy in the quality of health care services. A presidential commission's recommendations and various congressional initiatives are competing for attention.

In the short period from 1993 to 1998, several waves of policy discussion, some startling in their reversal of past direction, have appeared in the political forum of government. The election results in 1990, 1992, 1994, and 1996 sent differing signals to government. The 1998 election message and the policy debate that follows may, no doubt, be just as contradictory of past results. The electorate is still volatile on questions of health policy; therefore, government as public forum for debate among components of the health care system—providers, purchasers, payers, academic interests, and the like—and for the broader society can be expected to reflect that volatility.

THE ROLE OF GOVERNMENT: A MATTER OF DEBATE

These issues—the role of government in paying for care, delivering care, deciding the rules for insurance coverage, and ensuring quality of care—are still unresolved. Those who harken back to 1993 and say that the rejection of the Clinton proposal ended the debate on government's role are not interpreting accurately the events in the last five years. There has been an enormous amount of policy movement—in different, sometimes opposite, directions—that persistently returns to debate about government's role in the access to and quality and costs of health care.

There are three major variables of concern: access to care, cost of care, and quality of care. In terms of general access to care, can the private sector solve this problem without government, and can government reduce its role as agent in providing care? I do not believe so. At the end of six years of unprecedented

prosperity, there are more uninsured people than there were at the beginning of that period. If, in a free market, one could expect an employer-supported health care system to increase health insurance coverage, it would have been under these favorable economic conditions. It did not occur. In fact, the trend was in the opposite direction, and should recession or slowdown occur in the economy, we can anticipate only more-rapid growth in the numbers of uninsured.

Can we look forward to government receding, or withdrawing, in terms of direct provision of services? The evidence, at least in the large New York City urban market, is that reliance on governmentally sponsored services is increasing.

While we have been in a period of temporary slowdown in the growth rates of health care costs, many analysts anticipate growing health care cost increases in the years immediately ahead. There is an additional unresolved problem hidden in the demographics of the Medicare population: in future years, more people are likely to require more care for a more-extended period of time.

As part of the Balanced Budget Act, the Congress committed itself to many new payment systems to reduce post-acute-care costs. Commitment is a long way from implementation, however, and it remains to be seen how future challenges, especially in meeting the costs of long-term chronic illness, will be resolved.

The area of quality may be the most dynamic and the most interesting to watch. The participants in the quality discussion to date have been big business and government purchasers of care and big health care providers, all talking to each other. Full credit is deserved by those leaders in the business community who, working with larger managed-care organizations and the academic community, have forged methods for better measurement of quality outcomes within the health care system. However, these efforts have not begun to permeate all sectors of the population or all parts of the health care system. The attention being given this issue by the White House and Congress is evidence of the unsettled nature of the debate.

In the next five years, an interesting transnational dimension will emerge in the debate about quality. While discussions about access and cost will focus within the geographic limits of the United States, as within other national systems of care, the debate about the measurement and improvement of health care quality, largely driven by the concerns of multinational corporations with employees spread around the globe, will be the first of the health policy debates to adapt to trends of globalization. A number of medical professional organizations and accrediting bodies now regularly engage in transnational discussions. Governments increasingly will be drawn to the discussion of health care quality.

As we mark the turn of the century, we have every reason to assume that

there lies ahead a very dynamic and undecided period with respect to policy making in health care.

When we hear comments on the greatness of our health care system in New York State, they are often references to the clinical and scientific excellence of the system. What we need in the future is a parallel vision of greatness, a distributed vision of greatness, one that essentially envisions greatness in the system by our ability to distribute resources and services to a growing and ever more complex urban population. Designing this vision of an urban health agenda, and developing the planning and implementation strategies, will require government, in its roles as agent, rule maker, and political forum, to work in partnership with business, academia, the health care community, and advocacy organizations.

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