

A Legitimate Role of
Government in the Private
Health Services Delivery System

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THE SPEAKER

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He received his bachelor's degree from Dartmouth College in 1953 and a master's degree in business administration from the Amos Tuck School of Business Administration at Dartmouth in 1954. At the University of Minnesota Program in Hospital Administration he served as Research Associate and Kellogg Foundation Fellow between 1956 and 1966. Mr. Derzon held various administrative posts at University Hospital, New York University Medical Center. In 1966 he was appointed First Deputy Commissioner of Hospitals of the New York City Hospital System by Mayor John V. Lindsay. In 1970, Mr. Derzon became Director of Hospitals and clinics at the University of California, San Francisco.

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THE OCCASION

Mr. Derzon delivered this lecture at the University of Chicago on June 1, 1979

A Legitimate Role of Government in the Private Health Services Delivery System

After two decades of steady administrative labor and now in the midst of a disquieting and often too interruptible HEW-imposed sabbatical, I find myself tripping over the uncertain terrain that marks the troubled interface between government spending for personal health care services and the private sector providers of those services. Two public policy strategies—government spending and private sector delivery—keep clashing in a cacophony that is harsh music to my ears and probably to yours as well. I have been distressed by the dissonance and rhetoric that have characterized this interdependent relationship.

One wonders whether the deep chasms that have developed between these potential partners—financing and production—are inevitable. I am trying to decide whether, in the face of constant combat, productive outcomes are possible for the beneficiaries of public programs. Is this adversarial pattern likely to secure the future of the essentially private health system on which we have relied since the beginning of the twentieth century? I am trying to determine whether government has exceeded sensible boundaries of control in health services and whether a freer private health system could address successfully the broader issue of responsibility for public health.

I am struggling with these issues at a time when conventional wisdom finds fault with government at every turn. Confidence in government has eroded drastically. Americans seem encased in a mood of self-doubt about the strength of our democratic institutions, our ability to generate national and international leadership, and our apparent incapacity to deal with energy dependence, budgetary stringency, and a host of intractable domestic problems.

We are not particularly “upbeat” at the moment and that insults my generally positive temperament. I worry that my personal faith and enthusiasm for this remarkable nation is a little drained. It may seem paradoxical, therefore, that I want to present a brief treatise on the legitimacy of government in health care at a time when I, too, am wary and have qualms about the capacity of government to deal with vexing health service issues. Perhaps I want to satisfy a subconscious yearning to balance the current debate on government’s role in health care. We need a periodic reminder that benign indifference by government is no more a resolution of important public policy dilemmas than is blind and unrestrained intervention.

I was raised to believe that government was noble in purpose and high-minded in its goals. During my two tours of government duty I was moved (in fact, removed) and deeply enriched. In 1965 the Congress and the president made a commitment to financing the care of the aged, the chronically disabled, and at least some of this country’s poor. One cannot be passive and disillusioned for long when confronted by the magnitude of this task and the internecine bureaucratic battles accompanying it. The intrinsic reward for working on behalf of those who are, for the most part, helpless and dependent is immense. The fact that government makes mistakes and is quite unwieldy has not destroyed my keen interest in improving its strengths and effectiveness. My bias is clear. I believe that an active, intelligent, and purposeful government is part of the structural underpinnings of a modern productive nation. I do not believe that government should be simply a passive spectator standing witness to the course of events.

We have been blessed with a rich heritage of democracy, constitutional stability, and a deep respect for civil and human rights. No nation has had success comparable to that of the United States in assimilating a heterogeneous population, adapting to industrialization, or

confronting and securing essential social reforms. In only two centuries we have witnessed active (not passive) government respond sensitively to foreign and domestic crises and to the needs of an energetic populace. I, for one, am not ready to disavow every activity of government.

Arthur Schlesinger, Jr., in a penetrating essay tracing the history of government intervention in the affairs of men, wrote:

The myth is that American economic growth was the product of unfettered private enterprise—as if we sprang by immaculate conception from the loins of Adam Smith. The fact is that government played a vigorous role . . . [in] what we now call economic development.¹

In the health sector, government intervention began early with the acceptance of responsibility for public health and the establishment of Public Health Service hospitals. The need for protecting the public’s health and safety was obvious and so, too, was the need to provide public health agencies with police powers. Few have challenged this obligation of government.

Following World War II the federal government began extensive funding of hospital construction grants, the first of several “capacity building” activities in health that it undertook over the next three decades. The Hill-Burton Act was an early warning signal that government emphasis was shifting toward improving access to acute care services, well-dispersed in small hospital units and presumably attractive to practicing physicians. Congressional proponents concluded that the acute care hospital, under private, voluntary, non-profit community auspices, would be the cornerstone of community health services. Improving dis-

¹Arthur Schlesinger, Jr., “The Evolution of the National Government as an Instrument for Attaining Social Rights,” in *Toward New Human Rights*, ed. David C. Warner (Austin, Texas: University of Texas, 1977), p. 14.

tribution of care by adding private sector capacity became a rational and respectable use of general revenues. Not many Congressmen took dissenting views as I recall.

But what if Hill-Burton had been a National Outpatient Clinics, Group Practice, and Office Construction Act? We could very well have found ourselves entering the 1980s with a less disjointed spread of technology, a smaller hospital employment base, a more regionalized hospital system, and a very highly developed air and land patient transportation system. Certain physician surplus problems might have been identified earlier. The Health Service Agencies, instead of reacting to many superfluous hospital requests, could at least in theory have led a more positive planning program. This alternative to the Hill-Burton approach is a reminder of the significance of government intervention once it occurs, and the importance of not only setting an agreed-upon goal (namely "access"), but choosing the correct mechanisms for it.

Improving access and protecting the public health were two interventions firmly rooted in societal values. So, too, was another capacity building notion—the development of the National Institutes of Health with the concomitant decision of American political leadership to support biomedical research at high federal funding levels. There was a desire to foster scientific resource development and to maintain international preeminence in science. Stimulating biomedical research was good politics since the flow of achievements, particularly in the post-World War II decade, was quickly transferable to the public welfare.

Charles Schultze, prior to his current chairmanship of the Council of Economic Advisors, observed that it is never easy but at least possible "to reach consensus on matters involving basic values."² The political lines are drawn

²Charles L. Schultze, *The Public Use of the Private Interest* (Washington, D.C.: The Brookings Institution, 1977), p. 88.

naturally and cleanly because they do involve values. "As society has intervened in ever more complicated areas however, and particularly as it aims to influence the decisions of millions of individuals and business firms, the critical issues have a much lower ideological and ethical content."³ The current arguments over energy policy, gasoline rationing, and national health insurance are excellent examples of complex policy issues, each with strong countervailing ideologic elements.

It was another undertaking of magnitude to move from public consensus for hospital construction and bioscientific research to a political consensus for public financing of privately rendered personal health services. It took over two decades to reach a consensus to assist the aged of the nation in meeting their costs of health care. The passage of Titles XVIII and XIX of the Social Security Act depended upon two conclusions that eventually came to dominate the debate. The first was the promise of independence and security for our elderly. The aged could not afford the financial insecurity of major illness (nor could the poor). Nor should there be a reliance upon children to meet the health care obligations of their parents even if the offspring had the means to do so. The second was the conclusion that government had the capacity to manage a carefully planned health insurance program in spite of the incredible range of critical details, the well-orchestrated opposition by certain essential providers, and the overall enormity of the task.

The decision to proceed with federal financing for the aged and poor, and eventually the chronically disabled, contained several important assumptions:

1. Medically necessary benefits under the program would be physician-ordered services that relieved discomfort and improved personal health status.

³Ibid., p. 89.

care. As is the case with so many government roles, this is not an exclusive or a preemptory responsibility, but one to be shared with non-governmental enterprise. The tragedy is that there are few, if any, forums where the confluence of joint and complementary private and public information and data efforts can be analyzed dispassionately and apolitically.

Government as an experimenter, a demonstrator, and an agent of change. Surely this has to be one of the most useful and innovative roles for government. Regrettably, there has been considerable tension between OMB and HEW on funding for the important experimental authorities that Congress so wisely endorsed in the past several years. Statistically valid conclusions from well-designed projects ought to contribute to the policy process.

In his excellent 1966 essay on the role of research in public policy, Odin Anderson quoted then-president of Brookings, Robert Calkins, who lamented that

in many areas policy and action continue to be improvised on the basis of prevailing beliefs more than on an informed appraisal of issues and alternatives.⁵

There is nothing more anti-intellectual nor more annoying than to hear the argument that policy will forever be made in empty-headed political vacuums totally void of facts and informed judgment. There has also been expensive and damaging "turf" fighting within HEW between Health, the Health Care Financing Administration, and Planning and Evaluation, all of which compete in the research and demonstration arena and in the control of new policy-relevant information.

Government as planner and anticipator. This role is a logical extension of its fact gathering and analytical capacity. In our complex society,

⁵Odin W. Anderson, "Influence of Social and Economic Research on Public Policy in the Health Field: A Review," *The Milbank Memorial Fund Quarterly*, Vol. XLIV, No. 3, Part 2 (July 1966), p. 12.

where politics is preoccupied with short-run opportunism, and special interests are heavily engaged in influencing the future as well as the course of present events, we should rely on government to be the objective analyzer and predictor of trends and forces in health. The planning process in HEW is an example of blending goal setting, public program priorities, and private-public performance expectations.

What worries other levels of government and the private provider community is the extent to which the federal government uses the planning process to introduce change, reshape societal goals, and highlight problems—all essential ingredients, of course, of any worthy planning process. Some public policy formulation however, requires historical perspective, a clear view of the world as it is, and a sense of trends and futures. Presumably, government acts as a knowledgeable participant in this role.

Government as a private market protector and stimulator. Last year on this platform, Alain Enthoven presented his case for a "consumer choice health plan" and said,

To bring such a competitive market into existence and to make it work effectively to achieve efficiency and equity in health resource allocation, we need positive action by government.⁶

It comes as no surprise to you that not only do we have an extensive body of law and regulation to protect and promote competition in the United States, but that additional legislation must be passed to deal with the vagaries of an oligopolistic health delivery sector. Although I am the last one to be persuaded that the poor and high-risk aged populations will be enthusiastically marketed by competing alterna-

⁶Alain C. Enthoven, "Consumer-Choice Health Plan: A Rational Economic Design for National Health Insurance," 1978 Michael M. Davis Lecture, Center for Health Administration Studies, Graduate School of Business, University of Chicago, p. 11.

tive health systems, I strongly endorse many of the Enthoven proposals. Were Michael Davis alive today, he, too, would have found the emphasis on prepaid group practice and capitation perhaps the most redeeming aspect of this emerging strategy. In his book, *Paying Your Sickness Bills*, he noted that in a totally non-selective group, insured for all expenses for acute hospital care and for all professional acute care services, an \$8-15 annual premium was ample.⁷ The year was 1931. Allowing for health maintenance organization enrollment experience of better-than-average risks, the 1931 price could well have been in the \$5 per year range.

The curious bottom line is that as we attempt to stimulate competition and fair market testing, we need more laws and special regulations to encourage the development of new organizations of care. New law will be necessary to guarantee fair play among competing organizations, to protect beneficiaries against unscrupulous operators, to mandate multiple choice health insurance offerings, and to modify current tax expenditure policies. In that legislative process, undoubtedly, we will hear from a new battery of government critics who will condemn the fresh intrusions of big government into industrial management and collective bargaining.

I will close this brief discussion of government as a stimulator of the market place with a clarifying comment. Despite occasionally ghastly regulatory encroachments of little redeeming virtue, major segments of the private sector in health could hardly be freer of controls. Except for institutional providers, fee-for-service strongly predominates. Can anyone imagine a system more entrepreneurial than unilateral fee setting by physicians based on usual, customary, and prevailing charges—a system not only tolerated by government, but in fact employed by it to determine Medicare

⁷Michael M. Davis, *Paying Your Sickness Bills* (1931; reprint edition, New York: Arno Press, 1972), p. 229.

allowances? And ever present, of course, is the added fillip of ignoring Medicare allowances altogether (as in the practice in 50 percent of all claims) and simply charging the patient whatever the traffic will bear. There are practically no government-imposed economic restraints on licensed physicians, and only a few on other independent practicing health professionals. No realist expects fee-for-service to be easily discarded, but many believe (as I do) that UCP is faulty beyond repair.

Despite current efforts in health planning to deny project approvals, it appears that capital flow and formation is about as strong as ever. Large health equipment manufacturers have record sales and profits and hospitals' depreciable assets have increased regularly, at least at a pace with inflation; so, too, have the numbers of acute beds. Through government loans, loan guarantees, and tax-exempt bonding, the stimulus to preserve an active institutional provider market place has not waned. Only recent events in New York State suggest an opposite trend.

It is easier to describe several legitimate roles of government than it is to describe the legitimate conduct of the bureaucracy and the Congress in fulfilling these roles. The critical nature of government intervention and its processes have profound impacts not only upon the citizenry targeted for help, but also upon those providing the services. I intend to devote the balance of this discussion to the government-health provider relationship, and to certain serious "zones of combat" that are causing a deteriorating interface between public buyers and private sellers of personal health services.

Nowhere is there greater potential for misunderstanding, defensiveness, and an adversary relationship than the economic combat zone surrounding arguments for public payment at levels and in circumstances acceptable to private providers. Government payment practices critically affect hospitals, which are 55 percent dependent upon public programs, as

well as nursing homes and extended care facilities that have a 57 percent dependence. Government payment practices meet 24 percent of physicians' services.⁸ The pattern of payment is no less a concern even where government has a fractional financing role. Medicaid payments for drugs, based on state formularies, generic dispensing, and maximum allowable costs—the infamous MAC program—as an example, are thought to be precedent-setting for future expansions of public coverage.

The payment situation is aggravated by the breadth of benefits covered, the assorted professional traditions of fee setting and cost reimbursement, and the incredible number of individual and corporate providers, each of whom tends to deliver only a fraction of an individual's health care services. The Medicare law clearly narrows the latitude of administrative bureaucrats by stipulating that they can take no actions that will "exercise any supervision or control over the practice of medicine or the manner in which medical services are provided,"⁹ and by stipulating that program entitlement shall allow free choice from any qualified provider.

Government deals annually with over 23,000 institutional providers and well over 300,000 physicians, therapists, laboratories, and medical suppliers. The undertaking is massive and expectedly weak in many of its aspects. The worst defect, in my view, is the pervasive attitude among providers that government is unreasonable, unfair, and so remote from the conditions and circumstances of the delivery of personal services, that it cannot possibly effect equitable payment. A corollary complaint is that there is no plausible way for government managers to address the concerns and dif-

iculties of tens of thousands of providers. Under such circumstances program managers are believed to have become autocratic and calloused. Providers become resigned to depending on their associations as the only hard-liners against government. The net result is a communication breakdown that runs the risk of increasing antagonisms between the parties involved.

The bureaucrat's life has become more difficult on a second front. Although beneficiary access, client satisfaction, and full provider participation were the first goals of Medicare, utilization controls, cost escalation, auditing, fraud and abuse detection, and management reform are necessarily diluting those early program values. These new objectives are a direct reflection of congressional and executive branch actions to protect the public dollar as well as the public beneficiary. These new initiatives have further stressed the provider relationship, and created a genuine paranoia among hospitals and physicians. Increasingly, providers speak of the "conspiracy" of public officials to destroy private health enterprise; and increasingly, providers are intensifying their lobbying activities in the form of cold, hard, campaign cash.

Some of this is traceable to the current administration. The president is alleged to hold physicians in low esteem. He has also spoken out succinctly on hospital costs and his experience as an unenlightened hospital trustee. Secretary [Califano] of HEW has established himself as a highly vocal dispenser of strong rhetoric, and has helped construct one side of the stone wall that now exists between HEW and the provider community. I think the hospital industry, in particular, has over-reacted and has mistakenly adopted a war mentality. This evaluation is neither an apology nor a criticism. What concerns me most deeply is the absence of dialogue between the combatants and the clear need to moderate their massive assaults on each other. We in the private sector

⁸Robert M. Gibson and Charles R. Fisher, "National Health Expenditures, Fiscal Year 1977," *Social Security Bulletin*, Vol. 41, No. 7 (July 1978).

⁹The Social Security Act and Related Laws, as amended through December 31, 1976, Title XVIII, Section 1801, p. 407 (Washington, D.C.: U.S. Government Printing Office).

do not have the luxury of closing the doors to the government. I am terrified that every major and minor health financing payment policy is going to be batted around in wars of political nerves by players other than the protagonists. The onslaught against government grows as fast as health care costs and encourages the best of our government establishment to leave. The worst eventuality for the private health sector is to have a government in health void of skilled bureaucrats and totally void of experienced private health practitioners.

If I thought this condition was a short-term or transitional one, I would hardly dwell on it here. The brutal facts are that there can be no let-up on at least two fronts. First, the public share of all health expenditures, although finally leveling off at 42 percent in fiscal 1977 (after steadily moving upward from a pre-1966 base of less than 25 percent), will increase to nearly 46-50 percent of all health expenditures if any health insurance program is enacted which broadens government responsibility. This share will increase if Medicaid is repaired to include some of the 8½ million people who are below the poverty line and without Title XIX benefits. Moreover, if hospital and nursing home costs rise faster than other medical costs, government's share of the total automatically will be magnified. The certain prospect of tougher government bargaining as its financing stake rises is an elementary prediction.

Secondly, when the Health Care Financing Administration reports calendar 1978 health expenditures later this year, they will likely show that health expenditures will be close to \$192 billion, 9.1 percent of the GNP, and \$860 per capita (the latter figure up from \$737 in fiscal 1977). It is inescapable that Congress and this president, or any subsequent president, cannot avoid dealing with costs that will claim one in seven federal dollars within a few short years.

The tasks of public-private accommodation are hardly made easier by these trends. What these trends suggest is an ever-increasing

interdependence between public dollars and responsive private providers. They suggest to me that the present commitment to intransigent opposition by both parties is not only misguided but dangerous. No one, least of all me, expects these two natural adversaries to enjoy wholly common interests and mutual goals. Neither buyer nor seller can invoke "the public interest" as his sole domain.

Is there a chance to relieve this confrontation of wills that has so charged the atmosphere of the late 1970s? Can the course of events be altered so that a modicum of trust and confidence can replace irreconcilable and deep-seated antagonisms? I would like to think so, but the task will not be easy.

Failure to achieve mutual compatibility invites the political right of the private provider sector to withdraw and serve only the employed and the wealthy. The growing conservatism of big labor adds plausibility to the prospect. Failure to achieve mutual compatibility invites the political left to push for separate government-operated and directed health organizations. It also encourages more "command-control" regulations upon an embattled private industry. None of these eventualities would be correct for the American public.

If we can agree that the public interest can only be served by a government-private partnership, how do we get back on track? I have four avenues of rapprochement to suggest to you. Actions within each component would ease the tension and redirect the energies of the disputing parties. Meaningful progress should be attempted in four sectors:

- 1) Change the attitudes of the protagonists.
- 2) Modify the regulatory and legislative processes for health care.
- 3) Stabilize government organization.
- 4) Develop joint public-private ventures.

Of the four, attitudinal change is the most vital. If there is any crisis in health care, it is the lack of private sector understanding of the na-

tional condition and government's increasing diatribe against the care givers. The private sector must remind itself constantly that the health care of over 50 million Americans is financed substantially by government. As the population ages and gaps are filled, the number will increase—I hope not too much. Taxpayers, you and I, and contributing beneficiaries expect that government spending will be prudent and tight, and that at the very least, no blank checks will be issued. We also expect that government will not enrich its contractors unreasonably. The national condition is that government must pay billions for services while simultaneously stimulating efficiency in the health system it is purchasing. The private sector must recognize the legitimacy of government's public responsibility and stop resenting its preoccupation with cost, value, and quality assurance.

A change in government's attitude is also in order. Washington officials have no appreciation of the "lead-hand" image they have created and the rancor that is caused by endlessly ballyhooing fraudulent practices and health systems deficiencies. Government should engage, not constantly inflame, an industry that can help. If we have inflationary reimbursement and payment programs—and we do—let's deliberate together with industries and professionals in search of viable alternatives. Hospitals, for example, feel that government is castigating them for bed surpluses and poor occupancy. Yet government surely shares the responsibility for the nation's bed supply. Government and health politics are now inextricably entwined, with the result that political opportunism is molding some unfortunate government attitudes. A little old-fashioned high-minded statecraft might restore some order. Most health professionals and hospitals are willing and able to improve our nation's care. Government ought to be willing to accept that assumption. Then, we could begin to whittle away at questionable services and expensive redundancy. We could start real initia-

tives in reimbursement reform, quality enhancement, and health promotion.

Moderate changes in operational methods should be considered by government. First, the regulation process in HEW should be opened wider. Regulation is one way government must conduct its business. More public hearings prior to preparing and publishing preliminary rules would afford some balanced two-way communication. Secondly, in regulation preparation there must be increased tolerance for both formal and informal consultation with knowledgeable experts in the field, not all of whom are hand-picked by associations. Most rule-making affects the economic interests of health providers and practitioners and requires intimate understanding of the field. Critics will argue that this is an industry "sell-out," but in these highly technical areas, government does very poorly when the only input is from the bureaucracy. The Hill-Burton charitable service requirements and planning guidelines are two examples of important regulatory efforts in which there was little advanced private sector consultation. A more open regulatory process and adequate consultation is not a panacea for harmony, but it can reduce the mail load and court suits, and moderate some private sector antagonism. I am not arguing that regulation be softened because often it cannot be, nor should it be. A more cooperative process with regulation at the front end, however, is more apt to assure a compliant performance at the back end.

The other important operational system in need of repair is legislation and legislative formulation. In HEW, this process is attached to budgetary planning because most legislative proposals have attendant federal budget impact. While HEW prepares its legislative ideas in isolation, congressional staffs often prepare their legislative programs in all-too-close harmony with special interests. The politicization and enlargement of congressional staffs began after World War II. Prior to 1946 the few con-

gressional staff members were non-partisan professionals who were generalists and educators to the Congress. The congressional staffing budget grew 45 times in the 30 years prior to 1977, and is now a \$1 billion enterprise.¹⁰

There are few laws in Congress that are more detailed than Title XVIII of the Social Security Act, and as a result, technical understanding is critical. Staff members of the substantive committees are among the most skilled and also the most opinionated, often having authored substantial sections of the original act. Because HEW is so large and legislation is one discrete organizational function, it cannot produce good legislative proposals or meaningful analysis without operating personnel. The rapid assumption of critical policy formulation at central HEW levels, far removed from the actual programs, places HEW at a great disadvantage. Poorly drawn proposals, such as the 1978 and 1979 Hospital Cost Containment Bills, are the natural outcomes. By constitutional mandate Congress shall legislate and the president shall execute. Our marvelous constitution never could have anticipated the hundreds of pages of detailed law that guide the management of government. In the health financing area we need program operators at the legislative table with the effected interests and the congressional staffs. They are vitally necessary to determine feasibility, cost, and management of new legislative initiatives.

Ideally, if we could set politics and the *Federalist Papers* aside for one month a year, we could probably succeed with a legislative program that would not only simplify our health financing laws, but even produce legislative proposals that could pass through the four health subcommittees, their parent committees, and the conference process. The current health legislation triangle of industry, Congress, and HEW will always exist, but it can be made to

¹⁰Michael J. Malbin, "Our Unelected Representatives: I. Who's in Charge Here?" *The Public Interest*, No. 47 (Spring 1977), p. 17.

function more effectively with internal changes in HEW and a receptiveness for collaboration in Congress.

On organization I will be brief. We need a formal advisory mechanism in government for health and health care financing. The Carter administration has eliminated large numbers of commissions and committees including a dormant HIBAC (Health Insurance Benefits Advisory Committee). We need a National Advisory Board on Health Financing to which we can refer difficult payment policy issues. Government is going to be paying health bills directly or indirectly for a long, long time and it needs a strong, analytical panel.

We should also reorganize the appeals process for reimbursement disputes. There are several proposals for reorganization, including one which would grant final decision-making authority to an administrative judge instead of the secretary of HEW. Although I think the secretary has not abused the Provider Reimbursement Review Board, his presence as the final arbiter of compliance with his own rules and regulations will always be questioned.

The most serious organizational issue in HEW is the quality of the staff and the management of agency components. This is particularly true in the long-term operation of entitlement programs. Stability, esprit de corps, and professional growth are valued commodities for such activities. The merging of Federal Health Care Financing activities is a sound step, provided the price of disruption is not too awesome. There has been too much preoccupation with organizational form instead of organizational performance and policy substance, the two principal interface points with the private provider world.

Lastly, we can begin rapprochement with some joint public-private ventures, perhaps on less testy issues than cost containment. Why not have a collaborative effort to assess medical efficacy, or on ways to handle the introduction of new technology? These are common concerns

for all of us. Why not a joint venture with the private sector to test the value of competition in health care in one or two small areas of the country? Why not a joint venture that assesses ten current prospective reimbursement programs? There are many worthy private-public ventures (just waiting for a go-ahead) that could advance the knowledge and practice of health care delivery and financing. Putting individuals and organizations from both sectors together could provide a foundation of understanding and build some good will.

In 1972, Anne and Herman Somers wrote:

We do not have to abandon all of the assets of private initiative to obtain the advantages of governmental financial strength, social equity or democratic control. Nor is it necessary to bind the hands of government to harness the capacities of the private sector in the public interest. We can assimilate both to mutual advantage.¹¹

This is where I land. The virtues of both the public and private sectors in health must be re-discovered and fully savored. There are public and private responsibilities in health care that can only be met through the combined strength of public financing and private care givers. It is not too late for the key players, government and private care providers, to realize that simple but currently elusive fundamental.

¹¹Herman M. Somers and Anne R. Somers, "Major Issues in National Health Insurance," *The Milbank Memorial Fund Quarterly*, Vol. L, No. 2, Part 1 (April 1972), p. 202.