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Commentary

Poor People, Poor Policy:
Government Programs For The Disadvantaged
by Fitzhugh Mullan

Health care for the poor is an important, troubled, and seemingly permanent item on our agenda as a nation. With 15 percent of Americans living below an objectively determined poverty line and a large number of near poor for whom health insurance benefits are minimal, there are easily 45 million Americans who do not have ready financial access to medical care.¹ The provision of services to these people presents a major ethical, economic, and technical challenge to the public and the makers of public policy.

Since the prevalent mode of medical finance and delivery in the United States has been private and since the charitable capabilities of private systems are limited, the question of health care for the poor has become a governmental issue. Although governments at all levels—federal, state, county, and municipal—have grappled with the problem, the federal government has, in recent years, been the primary benefactor. Since 1980, however, there has been increased pressure for state governments to take the lead in policies and services for health care-disadvantaged populations. Are state governments ready and/or able to assume a greater role in this area? Indeed, are state-federal relations in health care sufficiently clear that new initiatives can be undertaken with the expectation of success?

Policy Origins

The health care of the poor has not always been on the national agenda, and it did not arrive there suddenly or definitively. Rather, its arrival into public attention was subtle, as the demonstrated technical benefits of medicine increased, public expectations grew, and the nation prospered economically. The roots of publicly sponsored health care for

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the poor in this country go back to the sanitary reform movement of the nineteenth century. Newly established state and local health departments concerned themselves with issues such as refuse disposal, sewage, and housing—all of which were most problematic among the urban poor. Little by little, local health departments became involved in services for mothers and children, nutrition, and infectious disease control and treatment, programs that were often described as “preventive” but that, from the patient’s perspective, provided essential health services. These developments were abetted by federal programs that increasingly funded state and local governments for categorical service delivery activities. States and localities also sponsored a growing number of institutions to deal with the mentally ill, the developmentally disabled, and, in the case of cities, the acute hospital care needs for poor people. In some areas, modest programs of medical assistance were added to welfare payments for particularly ill or aged poor people.

This array of programs, taken as a whole, varied significantly from state to state in eligibility, availability, and comprehensiveness. Federal grants-in-aid were available for some activities such as maternal and child health services, but, for the most part, the programs were supported from state or local tax revenues, subjecting them to the vagaries of local finances and attitudes. Moreover, state-sponsored health care programs were often opposed by private doctors and medical societies who considered health care to be their own domain.3

The Federal Epoch

States entered the latter half of the twentieth century with an important but irregular role in the provision of health care to poor people. By the 1960s medical care was a well-established and expanding part of American life as reflected in the growth of private health insurance, hospital use, and the percent of gross national product (GNP) devoted to health care. At the same time, a popular sense of inequality in health care was developing between “the other America” and the majority of the population as measured by the epochal federal legislation that was enacted during this period. The Kerr-Mills program of 1960 providing funds to state governments for medical care of the elderly was followed by the enactment of Medicare and Medicaid in 1964. The Neighborhood Health Center Program of the Office of Economic Opportunity, the Community Mental Health Center Act, the Migrant Health Act, the Children and Youth and Maternal and Infant Care Amendments to the Social Security Act, and the National Health Service Corps followed. Among these programs, only Medicaid called for significant participation by states, establishing the federal government, in consequence, as the principal provider of health care for the poor and eclipsing previous
state leadership, such as it has been, in this area.

The new legislation, however, left the previous programs of state and local government largely untouched, so that public health offices continued to deliver a traditional mix of categorical services, and states continued their coverage of the institutionalized mentally ill. County and municipal hospitals as well as long-term care institutions for the elderly and the developmentally disabled benefited from Medicaid and Medicare funding, but the federal financing program embodied little consistent policy that would weave the state or local programs into a comprehensive system of care for the poor.

In recent years the state-level ambiguities about health service delivery for the poor have been complicated by growing organizational complexity. Programs for health care of the poor are part of two important public traditions—health and welfare—which are usually housed in separate agencies of state government. State Medicaid agencies are usually located in state welfare departments, whereas maternal and child health, health service, and prevention programs are in state health departments. Mental health and institutional programs are found in one or more of several different state agencies. In addition, thirty-four states now offer a variety of state and county programs to assist the medically indigent. A number of states also have an office of rural health located as a freestanding agency or in the governor’s office to stimulate health care in rural underserved areas. Such program or policy coordination as exists between county health agencies and state governments is subject to the variabilities of state-local relations within the specific state.

**Beyond The Program Snarl**

This commentary on the administration of the programs designed to provide health care for poor populations is not intended to be judgmental of the administrators or legislators responsible for the programs but, rather, to focus on the historical absence of a cooperative state and federal policy applying to health services for the poor. The principal problem underlying the service dilemma is that we have neither a system of universal entitlement that wraps the care of the poor in with the care of the rest of the population nor an explicit, comprehensive strategy for care for the poor outside of the dominant private system. We have a surfeit of programs and a dearth of clear and consistent policy. Too often policy has been made in a piecemeal fashion, whether parsimonious or grandiose. As a result, when one tallies up the state and federal programs put in place over the years to address one aspect or another of the care of the poor, one finds a snarl of agencies, activities, and authorities. There are literally dozens of would-be, makeshift strategies at work all at once, ranging from the multibillion-dollar Medicaid program to token indi-
gent funds in small rural counties. While it is generally agreed that many of these programs are inadequately financed, it is hard to assign an accurate dollar figure to this multiplicity of efforts and, if one could, it would not have the import of a real budget since the programs are so varied. Most importantly, the programs themselves are inconsistent, occasionally redundant, and frequently not amenable to coordination because responsibilities lie at different levels of government.

This is a critical concern not only because of the inconsistency that occurs within the programs but also because of the policy shifts that have occurred on the federal level since 1980. The Reagan administration has consistently called for authority in this area to be returned to the states. To this end and with the support of the Congress, block grants have been established in the areas of maternal and child health; prevention services; and alcohol, drug abuse, and mental health; awarding broad policy responsibility and somewhat diminished budgets to the states for their management. The Omnibus Budget Reconciliation Act of 1981 relaxed a number of Medicaid standards, allowing states to exercise greater independence in eligibility, reimbursement, and comprehensiveness. A variety of other federal initiatives, ranging from the Task Force on Minority Health to recent recommendations of the Secretary of Health and Human Services for catastrophic health coverage, feature state governments as prominent participants in the proposed strategies.

Most countries—certainly all industrialized nations—have systems that share responsibility for health care between the national government and regional governments. In Canada, for instance, a nation whose health care system is frequently commended to our attention, the provincial governments play a primary role in administering the country’s health insurance system. This, however, is done under clear and cooperative guidelines from the national government. In this country, states are not intrinsically good or bad agents of public policy in health care. They cannot, however, be effective instruments of health care for the poor without being tethered to a clear national policy on the subject.

A Strategy For Reform

A reform strategy built on this analysis would have at least three essential aspects. The first would be the establishment of a single agency of state government that would assume responsibility for health service programs in a comprehensive and definitive way. Medicaid, the health services components of the public health agency, community mental health services, and elements of the state institutional structure would be placed in this new agency. Its charge would be to manage the policies and budgets of these programs in a coordinated and effective fashion. Second, this agency would be responsible for developing and maintaining
databases on health service indicators for vulnerable populations and the uninsured, as well as population data pertinent to issues of health status and health care finance. The third element of this reform would be the restructuring of the management of federal programs aimed at health care for the poor in concert with designated state health service agencies. This would mean that legislative strategies, as well as program management for the entitlement and discretionary health programs of the Department of Health and Human Services, should be unified and coordinated, to give meaning to the concept of a health care policy for the poor.

There are those who would argue that a modification of state-federal relations of this sort would promote the continuation of two systems and, hence, two classes of health care in the United States. This strategy, indeed, accepts the existence- of a predominant private sector and a remedial public sector in health care. While respecting the concerns about further institutionalizing inequities, this strategy intends only to make explicit the existence of the public sector and to ransom it from its present state of ambiguity. A well-coordinated and clarified national system of health services for the poor would allow Americans, rich and poor, to know what they are getting for their money, and to live with it or modify it as they see fit.

NOTES

4. Randolph A. Desonia and Kathleen M. King; State Programs for Assistance for the Medically Indigent (Intergovernmental Health Policy Project, 1986).