care programs. New types of individuals with new types of talent, who may not be on present staffs of health departments, need to be recruited for these jobs. The rapid entry of health departments into medical care programs dictates the need for this.

In conjunction with concern for medical economics, health departments must control the new tool of data processing, both the input and output. In today's management world, management information systems control operations, as much as dollars. The computer, as the focal point for these activities, must be an adjunct to the health department's involvement in Medicaid. A simple syllogism points the way:

> Knowledge is power.
> The computer is knowledge.
> Hence, the computer is power.

Medicaid should be separated out of traditional welfare activities. Medicaid is not welfare. The program will never realize its legislative potential unless it is so conceived. Planning to implement this philosophy should be pursued before any program is structured.

At this point in time, probably the best administrative model for a Medicaid program can be found in the insurance industry. There needs to be enrollment and certification of beneficiaries, providers of service to give care under certain guidelines, and payment made to the providers after certain conditions are met. These three functions, if brought together under single-management direction, would comprise a workable operation.

It is not too late for public health professionals to act. It is clear that Medicaid will be modified by legislation in the near future. We must now translate our experience into programs, and avoid the mistakes of the past. This is vital if we are to fulfill our public and private trust.

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This paper was presented before a Joint Session of the Conference on Health Planning and the Medical Care Section of the American Public Health Association at the Ninety-Sixth Annual Meeting in Detroit, Mich., November 14, 1968.

III. *REALPOLITIK* IN THE HEALTH CARE ARENA: STANDARD SETTING OF PROFESSIONAL SERVICES

Lowell Eliezer Bellin, M.D., M.P.H.

WHAT is exhilaratingly revolutionary about Medicaid is neither the program's more generous enrollment of the medically indigent, nor even its delightful smorgasbord of comprehensive health services. No, Medicaid's critical innovation lurks elsewhere—in its exclusive assignment to the Health Department the heady tasks of standard setting, surveillance, and enforcement of quality in every aspect and every locus of publicly funded personal health care. The crucial legal right under Medicaid to suspend errant professionals and institutions from reimbursement gives to Title XIX administrators "fiscal lever-

age," an indispensable supplement to exhortation and peer-group suasion to promote excellence.

What is the administrative methodology of the New York City Health Department in fulfilling its Medicaid responsibilities? To set fiscal and quality standards of Medicaid reimbursable services, the department consults with advisory committees of professionals. Because one advisory committee cannot competently deal with the often conflicting objectives of fiscal reimbursement and of professional quality, we have isolated the two subjects from one another within two separate functioning committees, each composed of different species of members. A "Negotiating" Committee handles questions of reimbursement. A "Quality" Committee preoccupies itself with standards. We have representatives of town and of gown: professionals from both academe and from high Medicaid catchment areas in the city. On the Committee on Physician Care are included the representatives nominated by the five county medical societies of New York City and from the Society of Osteopathic Physicians. Thus, organized medicine and academic medicine are represented, as well as medicine from the Medicaid arena and even unorganized medicine. This committee mix is a yeasty microcosm of the actual, if not always publicized, countervailing forces of the professions within the community. The mix is productive. At one committee meeting, certain general practitioners demanded that generalists henceforth be reimbursed by Medicaid for x-ray diagnostic work, only to be rebutted by strident neutralizing protests on the part of a board-certified radiologist and other specialists on the committee.

The Medicaid Advisory Committees on Quality Care, stemming from each of the health care areas, help the Medicaid administration to promulgate health care standards in four categories: (1) ingredients of service; (2) time per service; (3) ingredients of administration; (4) qualifications of professionals.

Standards of care so adapted cannot be reasonably categorized as the arbitrary decisions of a Medicaid staff, suspected of harboring illusory public health visions. The standards incorporate the recommendations of prominent practicing and academic professionals in the community, and are therefore relatively sacrosanct. The staff writes up these standards in bulletins for providers. These bulletins become the work manuals for all providers of health care reimbursed by Medicaid.

At meetings with advisory committees —and even more particularly as one speaks before professional groups—it is imperative to memorize the vocabulary of conflict within the semantic portfolio. The following incomplete lexicon of synonyms is not intentionally facetious. The words and phraseology depict the flavor of discussion in the early stages, as one establishes rapport with professionals and institutions.

Medicaid terminology

1. Auditing
2. Controls
3. Administrative staff
4. Standard
5. Regulations
6. Fiscal responsibility
7. Unwarranted economies

Opponents' definition

1. Gestapo-like spying
2. Idiotic red tape
3. Bureaucrats (generally characterized as stupid, rigid unimaginative, incompetent if not altogether venal)
4. Restriction: undue interference with medical practice
5. Bureaucratic tyranny
6. Unwarranted economies
7. Fiscal responsibility

Introduction to Case History

The health care administrator in government exerts awesome power as redistributive arbiter. He negotiates with vying interest groups, all of whom view

themselves quite winsomely as misunderstood altruists. He parcels out macroquantities of public monies, staff, equipment, and services to favored institutions and people. The stakes are no less enormous than the prizes, for any blunders of his in strategy or distribution can mean organic maiming and death to thousands. It is high time, therefore, that the health care administrator stop playing the innocent. The case history on hearing care standards that follows demonstrates how Medicaid compels him to jettison his delusion that he is just a dispassionate professional, and rarely, and ever so reluctantly, a practitioner of *realpolitik.*

The illustrative history is typical of many others we might present, not necessarily as examples of objectively "correct" executive decisions, but rather as demonstrations of the relevant factors that facilitate, impede, modify, and generally impinge upon the process of decision-making itself in negotiating health care standards. The case history, in representing what goes on, will provide extractable insights and useful generalizations for health care administrators enmeshed in similar problems of Medicaid standard setting elsewhere.

Standard Setting in Hearing Care

Originally, New York City Medicaid adopted the standards of the Handicapped Children's Program in dispensing hearing aids to Medicaid enrollees. A patient with a hearing problem that might be responsive to a hearing aid was obliged to receive (a) first, a medical evaluation from a board-qualified or certified otolaryngologist; (b) then, consultation with an audiologist, and possibly a clinical psychologist and other personnel, at an approved speech and hearing center; and (c) next, fitting of a hearing aid by an approved hearing aid dealer. Thereafter, the patient would reverse the procedure; i.e., revisit the speech and hearing center and the otolaryngologist to verify that the hearing aid dispensed was as prescribed and was therapeutically satisfactory.

As Medicaid enrollment grew, the number of speech and hearing centers in New York City that dealt with patients referred by their otolaryngologists became clearly inadequate. The backlog was particularly bad in the borough of the Bronx, a high poverty area, where the borough's sole speech and hearing center had a waiting list of at least 14 months. The absence of an approved speech and hearing center in the borough of Richmond compelled residents there to travel to Manhattan and other boroughs. The aged and infirm especially suffered hardships. In effect, in the name of high quality, patients who required hearing aids were being denied them.

Seeking counsel, we communicated separately with representatives of each of the three provider groups: specifically otolaryngologists, audiologists, and hearing aid dealers. In summary, the opinions were as follows:

Otolaryngologists agreed that for patients below the age of 21 the services of audiologists were indispensable. These physicians had diverse views about how patients over the age of 21 could best be handled. Otolaryngologists on the staffs of hospitals with an approved speech and hearing center tended more to support the usefulness of audiologists for patients even older than 21, whereas otolaryngologists not on such hospital staffs tended to be less enthusiastic.

Audiologists unanimously agreed that their services were necessary for all age groups, although they conceded that they were indispensable for patients below 21.

Hearing-aid dealers agreed that work-ups by an audiologist, or by an otolaryngologist who could perform audiological tests, were most desirable for patients below 21. They insisted, however,

that for the overwhelming majority of patients over 21, the work-up by an audiologist was superfluous.

The more critical members of each group hinted that financial kickbacks between hearing aid dealers and (a) referring otolaryngologists and/or (b) referring audiologists were not unknown. Some audiologists claimed that many otolaryngologists were incapable of performing comprehensive audiological testing, and were content to scribble the words "hearing aid" on a prescription sheet. They referred the patient to a hearing-aid dealer who did the actual fitting in the absence of more specific directions. A few otolaryngologists expressed their irritation with "subprofessionals" who were allegedly presumptuous enough to try to replace doctors. The hearing aid dealers, one of whom was an audiologist as well, generally characterized certain attitudes of the audiologists as pretentious, alleging that for most patients over 21 a hearing aid was fitted by trial and error in any case, and that the alleged precision of prescription by an audiologist was usually without foundation.

When the Medicaid Advisory Committee on Quality Hearing Care met, there was a replay of this debate, albeit with less overt emotion. Each of the three provider groups read aloud sections of papers from its own professional literature, only to face prompt rebuttal by opponents with eloquent citations from selected portions of papers from *their* professional journals.

Basically, the question was: is it better for a Bronx patient, aged 65, to wait 14 months for an appointment at a speech and hearing center, or to circumvent the speech and hearing center consultation and perhaps receive an inferior and possibly more expensive hearing aid? It is not unknown for an elderly person to be struck down by a car whose warning horn he did not hear while crossing the street. Is an inferior hearing aid (even assuming that this is an inevitable consequence of skipping the services of a speech and hearing center) worse or better than no hearing aid at all?

We made the decision on hearing aid standards that patients 21 and below would still be required to follow the old route from otolaryngologist to speech and hearing center to hearing aid dealer. Patients above the age of 21 would proceed either to a speech and hearing center or directly to a hearing aid dealer, at the discretion of the otolaryngologist, whose professional decision would be supported by the Health Department.

The impact of this decision was predictable. The number of hearing aids sold in New York City increased almost immediately, although the average cost per hearing aid did not change appreciably. Hearing-aid dealers were jubilant. Most otolaryngologists seemed neutral about the subject. A few otolaryngologists, who were chiefs of hospital departments with speech and hearing centers, immediately wrote letters criticizing the decision. It was evident in the weeks following that otolaryngologists were being encouraged by audiologists or hearing aid dealers to write letters to the Health Department, rejecting or supporting the decision. Possibly a few physicians wrote without such instigation. Angered spokesmen for the audiologists predicted in the local press an imminent decline in standards of hearing care throughout New York City. A representative of an organization, claiming spokesmanship for the poor, publicly protested the decision and accused the Health Department of acting "expediently," rather than with appropriate concern for health-care standards.

Bitterness prevailed among some audiologists who accused the Medicaid administration of having made a political deal with hearing aid dealers. The terms of the alleged deal were obscure. The

routine appearance of the Health Department's assistant commissioner of insurance and of the executive medical director of Medicaid as speakers at a dinner meeting of the Hearing Aid Dealers Association in order to discuss the new standards was cited by some audiologists as evidence of such a deal. Some hearing aid dealers made the counteraccusation that a certain prominent audiologist was applying financial pressure on hearing-aid dealers by threatening to withhold future referrals and hearing-aid orders until they disassociated themselves operatively from the decision of the Medicaid administration. Rumblings of the controversy continue even today, and possibly will persist until sufficient speech-and-hearing centers are established so that the old rules may safely be reconstituted.

Generalizations from Setting Standards

In the process of establishing workable health care standards within a health care program, one operates in no continuum of Euclidean geometry. The shortest distance between two points—the point where one is and the point where one would like to be—is never a straight line. Experience verifies the following generalizations:

1. Medicaid's mechanism, whereby standards of quality are backed up by potential forfeiture of reimbursement, has stimulated an unprecedented interest in standard setting on the part of professionals and institutions.

2. Professionals and institutions are ready today to accept the City Health Department as the ultimate decision-making authority for setting health care standards, provided the professionals and institutions are permitted to participate in the deliberations.

3. The Health Department is obliged to identify and coordinate the diverse and often isolated forces within the health care world that favor the establishment and elevation of health care quality. To be effective, the Health Department must skillfully tap the conflicts smoldering within this world. The conflicts may be between profession and profession, between specialist and generalist, between institution and institution, and between institution and government.

4. Participants in the standard-setting drama are neither to be categorized as "good guys" nor as "bad guys." It is strategically more productive to consider them as human beings and institutions with differing perceptions of wherein lies their self-interest.

5. It is the routine article of faith of each participating professional or institutional provider of care that the provider's legitimate self-interest is necessarily identical with the best interests of the recipients of health services. In short, "what is best for me is, of course, best for my patient—and I shall determine what is best for me."

6. Ideology is inconsistent. Pragmatism and perceived self-interest generally prevail over abstract ideology in determining how professionals react to any proposed standards. Each category of professionals zealously resists what is deemed to be unwarranted encroachment by functionally contiguous groups, and will favor or oppose specific standards accordingly.

7. In conflicts there is no surety that the rules of intellectual discourse with relevant argumentation of merit in favor of specific standards will prevail. Adversaries may try to discredit not only the argument, but the proponent of the argument. Adversaries may utilize whatever levers of power are available to them to frustrate their opponents in setting inimical standards.

8. To set health care standards the administrator must thoroughly comprehend all the hidden agendas inside and outside the department. The ultimate objectives of one's one administration may

sometimes conflict even with the immediate objectives of one's own staff, and most certainly often conflict with the immediate objectives of the guardians of the status quo outside the Health Department.

9. The recurring problem in standard setting is the fundamental operative dilemma in public health of reconciling limited resources to limitless objectives. A precise match being logically impossible, one must resign oneself to an imprecise match via a system of priorities that derive from a specific value system. Standard setting in health care, then, must always represent the irritating compromise of settling for the immediately achievable, rather than resolutely holding out for the theoretical ideal.

Final Comment

Doubtless, one can extract analogous generalizations from the daily interplay within any administrative arena besides the *sturm und drang* of establishing health care standards. These generalizations suggest, however, that the wary novice would be advised to keep in mind that health-care administrators, just because of their explicit preoccupation with altruism, most assuredly dare not eschew the tactics of *realpolitik*.

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This paper was presented before a Joint Session of the Conference on Community Health Planning and the Medical Care Section of the American Public Health Association at the Ninety-Sixth Annual Meeting in Detroit, Mich., November 14, 1968.

IV. PEOPLE, PROVIDERS AND PAYMENT—TELLING IT HOW IT IS

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STANDARD setting of health care services must be damned as academic futility unless it provokes surveillance of the quality of care plus the enforcement of these adopted standards. In granting the medically indigent patient the free choice of practitioner, Medicaid has stimulated a shift in the locus of ambulatory health services from the hospital outpatient department to the office of the private practitioner. In the comprehensive assessment of the quality of publicly funded care, it is now required that there be on-site visitation of the offices of private practitioners. A brief overview of the conflicting arguments concerning these on-site visits is in order.

Objection 1—It is presumptuous for government to evaluate the quality of the services of private practitioners.

Response—Government exercises the traditional prerogative of the purchaser when it determines whether it is receiving services according to its original stipulations. To do otherwise, is for