Who Should Make Public Policy for Health?

Public Law 93-641* shifts much of the responsibility for health policy from government to cartel-like health systems agencies. This power shift is well documented in the National Governors' Conference Report on health planning;[1] it may lead to a much-needed debate on the question of whether Americans want health policy decisions to be part of the general debate over directions and priorities in our society or whether health policy should be considered a technical issue with decisions made by health professionals.

What can explain why Congress has chosen to exclude elected state and local government from health planning and policy making? First Congress, and now the Department of Health, Education, and Welfare and state governments have been pressured to move public health decisions out of general purpose government. Most of the pressure can be attributed to the fact that public health policy now includes policy for medical care. In the past, *public health* meant programs like VD, tuberculosis, immunization, safe drinking water, and occupational health. Now, public health policy will guide the whole $100 billion health sector. It is not surprising that there are private groups who want to be health planners and policy makers for the public.

Part of the effort to move responsibility for health policy out of government manifests itself as a series of attacks on state and local government and their health departments. Mr. Mason's letter in this issue of the Journal questioning the credibility of health departments is the kind of rhetoric that encouraged Congress to create Health Systems Agencies, bypassing elected local government.[2] But is credibility the issue?

What are the consequences of shifting health policy to private health agencies? What kinds of problems are we going to place in the hands of the health industry? A few questions will illustrate what is at stake and make it clear that health policy belongs to the American political scene together with energy, jobs, and the environment in which we live.

Do we spend too much on medical care? Americans now spend $547 per capita each year on health—mostly on medical care. In a few states, health is the largest sector of the economy. Spending on medical care competes very successfully in both household and government budgets with other desirable purchases. Can we leave this question to be answered by those who are committed to the economic vitality and growth of the health care industry?

Does everyone get his fair share of medical care? This is a far more complicated question than we originally thought, but is still not a problem for professionals alone to solve. It is now clear that inequity is not restricted to rural areas and inner cities. Within apparently homogeneous regions there are vast differences in the amount of care received. For example, appendectomies occur more than twice as often in one part of Vermont as in another.[3] We are certain that there is no such difference in the occurrence of the disease appendicitis. And the equity problem is complicated by taxes and health insurance which redistribute costs, often blind to the income transfers involved.

Which medical care really helps us? Should we even out the distribution of medical care and distribute the costs explicitly if we do not know which services do any good? The problem is not restricted to the costs and benefits of complex and uncommon therapies. Tonsillectomy remains the most common cause of hospitalization of children, despite evidence that it is a procedure of very limited effectiveness.

Who weighs the risks of medical care? As new diagnostic tools and therapies are introduced, the risk of unwanted consequences is often very great. When new technology is introduced, it is reasonable to ask what is being done to prevent harm. What institutions are looking out for the patient and the community?

Obviously, policy problems in health are numerous, complex and important. I think these four questions suggest why their resolution cannot and must not be left to the technicians. Concern about cost, equity, effectiveness, and risk are inherent in the malpractice debate; the *New York Times* reflected these concerns in its January series on medical care.[4] Representative John E. Moss' Subcommittee on Oversight and Investigations of the Committee on Interstate and Foreign Commerce, and other Congressional inquiries, have provided additional evidence of the public's doubts. It is ironic that, as this consciousness develops P.L. 93-641 promises to remove health policy from the hands of elected officials.

Dr. Miller[4] has issued a cautious call to support the new Act; Mr. Mason urges that APHA accept the law as the "rallying point for public health professionals." But, in the final analysis, it does not seem likely that the public will accept an arrangement which puts health decisions in the hands of health industry organizations, and allows non-government bodies to organize the spending of tax dollars.

ANTHONY ROBBINS, MD, MPA

*The National Health Planning and Resources Development Act of 1974

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Address reprint requests to Dr. Anthony Robbins, Commissioner of Health, State Health Department, 60 Main Street, Burlington, VT 05401.