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COMMON DECENCY IN HEALTH AND WELFARE PROGRAMS

by Alvin L. Schorr

EDITOR'S NOTE: The author is Leonard W. Mayo Professor of Family and Child Welfare, Mandel School of Applied Social Sciences, Case Western Reserve University, and author of ***Common Decency: Domestic Policies After Reagan****. Schorr prepared these remarks for delivery to the conference on "The Decline of Worker and Family Security in the U.S." (April 27-28, 1988). LCR is pleased to present Schorr's address as a guest article.*

It is a paradox of our times that people who are good family members and good neighbors can, in a crowd or as a body politic, behave brutally. An illustration is this possibly apocryphal story about President Reagan. He was in a meeting about the national budget, and had to leave to be photographed for an Easter Seals poster. He was touched by the disabled child that he posed with, and said afterward that he would have done anything to help her. Someone was passing who had just left the same meeting, and he said, "Mr. President, you have just cut from the budget $350 million for children like her."

We measure decency these days by what we do with the people immediately around us, and seem to lack the imagination to project decency into public activity and public policies. Yet most of us would be lost without the order and support provided by public policies. How to make that leap is my subject and is, as well, a working definition of policy—what decency requires of us beyond the circle of our family and friends.

This is important now because a lot of trouble lies ahead. I don't have to review for you how many people are in trouble. Nor do I have to explain how difficult it will be for a new administration, whatever its party, to cope with reconstruction in the face of difficult problems of national debt and trade imbalances. We face a time of great social danger. Some expect sharpened class conflict and some have warned of a turn to corporatism—that is, more centralized control to contain the disaffected. Neither outcome is to be desired.

Principles to Build National Community

I teach college students and know that such warnings sound alarmist to young people. But I remember the smell of burning buildings in downtown Washington. I remember clearing the government building I worked in because of a bomb scare. And I remember that military control arrangements were made when the Poor People's Campaign came to Washington, just in case. That was just after the assassination of Martin Luther King. On the other hand, when the dimensions of the troubles we face are borne in on the country, that will also be a time of opportunity. In order to diminish the danger and to make the most of that opportunity, we have to know what our objectives are. We have to work deliberately at bringing people together, at healing wounds, at building a sense of national community—that is, a sense of common fate and common prospect. We have to project the decency of the American people on the national scene.

Now, I am not proposing a new slogan for a new administration, or exhorting the population to *feel* a sense of community. The allegiance that slogans bring is transitory, and people who cannot pay the rent will find slogans of their own. Rather, I propose that we redirect the vast array of government programs towards building national community.

Five such principles are first, fair share or less inequality in income. We have more inequality now than at any time since the Census Bureau started keeping track. Why? Because of lower wages and high unemployment, for two reasons. For another, because of government policies creating greater inequality. For example, the Budget Act of 1981, the first Reagan budget, all by itself cost low-income families $23 billion a year in income and services, while it added $35 billion to families with after-tax in-

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come of $80,000. *There* is redistribution for you! And so *less inequality* is the first principle of community.

The second principle is a lower unemployment rate. The third is integration—not just desegregation, but actively pursuing communication between ethnic groups and developing the capacity to live and work together. The fourth principle is what I call mainstreaming in the development of social insurance and social service and health programs—that is, less use of means-testing and relatively more use of programs like social security. And the final principle is selective decentralization of authority—federal to state, state to city, and city to neighborhood.

Proposals to Implement These Principles

My new book, *Common Decency: Domestic Policies After Reagan*, makes dozens of proposals for change that are in line with these five principles. Proposals in the field of housing, social security, tax and welfare policy, and health policy are all worked out at level cost—no net increase in cost. This is to make it clear that the issue is *how* the government should spend, not *how much* it should spend. I also distinguish between incremental proposals—smaller or larger adjustments in well-established programs—or proposals representing substantial departures from our current way of doing business. I will offer you one illustration of each type, with an incremental proposal first.

In 1983, Congress increased retirement benefits under social security for those over 65 who continue to work. Naturally, that change costs money. Only a minority of the aged, maybe one person out of seven, continues to work for pay after 65. By and large, these are the professionals and entrepreneurs, who have had better than average income all their lives. At 65, therefore, they generally have high social security benefits, other retirement income, and savings. In the same legislation, in order to *save* money, Congress postponed the age when one could draw social security from 65 to 66 and then to 67 (taking effect about twenty years from now). This is a little odd because for many years workers have been tending to retire earlier and earlier. Of course, those who retire earlier tend to be poorer. They are the people who had many different jobs, earned relatively little, may have disliked their work, and may not be entirely well besides.

Now, a one-year delay in retirement is effectively a seven percent cut in benefits, saving just enough government or social security money to pay for the increased benefits to those over 65 who continue to work. So in these twin measures Congress moved money from those who have little of it to those who would, in any case, have more. Among western, industrial countries, the aged of the United States have the most unequal distribution of income. That is, there is more inequality *within* the aged population here than in any of the countries that are somewhat like us. I have just given a small example of how we exacerbate that inequality. And so I propose that the so-called normal retirement age be returned to 65, and that those who work for pay after 65 (as anyone who wants to can do), receive only half of their ordinary social security benefit, instead of two-thirds, as now provided.

I will not take time to discuss other social security proposals, except to advocate improving unemployment insurance, which has been greatly undermined in recent years, and substituting a refundable tax credit for the improved personal exemption in the income tax. I mention these only because Congress is considering a welfare reform bill—a pernicious bill, in my view. I believe that true welfare reform lies *outside* welfare, just as true public health lies outside hospitals. Taken together, the kind of measures I have just mentioned would reduce welfare caseloads by one-half or more. Relying on carefully designed programs that are not means tested—mainstream programs—is the route other countries most like us have travelled, and it is the way our welfare reform ought to go.

A "Substantial Departure" Health Care Proposal

So much of illustrating increments. The *departure* I want to discuss is in the field of health care. Despite heroic efforts at control, health care costs are still headed upward. We spend three times as much per person on health care as Japan or Great Britain, without producing a longer life expectancy or a lower infant mortality rate. We have the professional and technological capacity to deliver the best health care in the world, but only the relatively privileged can count on getting it, and they too often fail to get good preventive care.

The currently stylish diagnosis of the health care system's trouble is couched in the language of incentives, to show that the financial interests of hospitals, health corporations, and physicians draw them into poor practices. Other diagnoses have to do with medical ethics, or its failure; with the superiority of group practice over independent physician practice; and with the difficulties of designing effective regulation. It is an irony of our times that regulation now proliferates while every one touts free enterprise for medicine.

All these diagnoses have merit, but the deeper and more basic problem is a national failure to take command of the health care system and plan it. After the Second World War and again in the 1960s, the United States launched multi-billion dollar improvements of health care delivery, but each time failed to use the leverage of increased investment to think through and organize an integrated health care delivery system. Some of these improvements contributed a great deal to patient care; others quickly disappeared from sight. However, none changed the *system* in ways that would improve overall care, and many created serious, unanticipated problems. For example, Hill-Burton funds built hospitals where they were needed and also where they were not needed, and so in time contributed to higher costs. Or, Medicaid encouraged people to seek outpatient treatment in hospital emergency rooms, where care is terribly expensive and necessarily episodic. Now, in the grip of an overriding concern about cost, we are moving to a two- or three-track system of health care; which is to say, poor care or no care for many people while others get excellent care.

Other developed countries used the intention to invest in improved health care to construct a controllable system, for example the national health insurance program in Canada and the National Health Service in Great Britain. If we wish to take hold

our health care system, to rationalize it and be able to control we have the same choice of alternatives.

This argument is not new, of course. What may be new is the observation that, in a shift so far hardly noticed, recent health care developments are making such a choice politically feasible. The physicians who fought for autonomy and private practice are increasingly practicing in groups and bureaucracies. And in their daily practices, our physicians feel the hand of regulation far more heavily than their Canadian or British colleagues. Patients' freedom of choice, that article of faith of organized medicine, is now extensively compromised—because medical corporations and insurance companies have now joined the government in imposing controls.

Most important of all, middle class people are now widely dissatisfied. Employer plans and private insurance arrangements once assured them affordable and satisfactory health care, and so they opposed a national system. Now they pay far more for insurance, and they are told that they have to see this doctor and go to that hospital, they find that their employers are cutting back on their health benefits. The American public tells surveyors, by a ratio of three to one, that the health care system "requires fundamental change." The coalition that for so long stalled deep-seated reform is coming apart.

And so we should choose between national health insurance and a national health service. The first alternative may seem more compatible with our beliefs, although it may once again be too late to choose health insurance. I am not sure about that. But in the next two, three, or four years, the issue will be seriously debated—I am sure about *that*— and this time we should proceed one way or the other to fundamental reform of the entire system.

Conclusion: Building for Fair Shares

It was popular, during the 1960s and 1970s, to seek packaged solutions that would achieve major domestic goals: a negative income tax to replace welfare, an employment strategy to interrupt the cycle of poverty, and so forth. Meanwhile, in countless small ways such as the social security illustration I gave you, we have been undermining these very objectives. It is incremental change rather than packaged change that applies itself to our political system as it actually works, permitting progress here while we mark time there; testing an approach in one place before trying it in another; and seeking deep reorganization only when the case for it i compelling. The trick is to move these incremental changes towards objectives that build national community.

My proposals tend to reduce inequality and diminish the role of means-testing. If I were to go on spelling them out other principle objectives—integration, decentralization, full employment—would also be served.

I have a friend in Washington whose name many of you would know. When I met him, maybe twenty years ago, I thought him solid, but for my taste, somewhat conservative. He would have said much the same thing himself. He told me the other day that I would be shocked at the positions taken by people I once regarded as liberal. They now think *he* is liberal, while he thinks he has changed hardly at all. He is right, of course. The center of political discourse has moved so far to the right that, with honorable exceptions, all we hear is, in various guises, scorn for the unsuccessful, and shades of free-market approaches to national problems.

Still, I think the climate is shifting. I believe that we are now graduating from college young people who have no personal experience of Vietnam, the decline of the War Against Poverty, or Watergate. They look at the world around them and it appears to need correction. In the time-honored way of young people, uncorrupted by dramatic lessons in cynicism, many are prepared to try to secure reform. I think, too, that many older people are revolted by the greed we have seen, and will join them.

We should build not catch-as-catch can, as we often seem inclined to do. Down that road lies chaos. We should build for fair shares, for an approach to full employment, for reasonable decentralization, for integration, and through mainstream programming. To do that will take sophistication and knowledge, but we have large numbers of people with these qualities. Political will and cohesion among the people who seek such ends are what requires building. If I am not mistaken, within the next two or three years we shall be tested with respect to our health care system.

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