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America's Health Care System: The Reagan Legacy

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Because of the dominance of the private sector in health care in the United States, health conditions are not as susceptible to changes in public policy as they are in other Western countries. However, the elderly and young children are directly affected by the federal government's health care policies and while both groups were the focus of major changes introduced by the Reagan administration, these changes were opposed by Congress. Nevertheless, changes in health care funding and administrative arrangements have had a negative impact on the needy and, in addition, they have been exacerbated by the Reagan administration's wider social and economic policies which have contributed negatively to the health conditions of the poor.

Analyzing the effect of the Reagan Administration upon the American health care system is a challenging task. The subject is not health itself, but rather specific public health care policies and programs. Health as it is conventionally defined is relatively insensitive in the short run to political influence, due largely to the multiplicity of personal and societal factors that influence the health of individuals and groups, and the incremental effects of these factors on health. Many of the traditional indicators of health, such as infant mortality, for example, change slowly; important trends can be seen only over long periods of time. Also, most health care interactions occur in the private sector (Litman, 1990), and under limited, if significant, government influence.

There are two important exceptions to this generalization: the elderly and low-income women and children, two groups who are called "dependent" by Preston (1984) due to the fact that they are not part of the work force and are largely supported by that work force. It is within these two groups that the effects of governmental policy are most evident; this analysis

focuses on low-income mothers and children, the most dependent of these two groups.

This paper analyzes the Reagan effect on American health care by first describing the Reagan agenda and actions by the Administration. Next we assess early reactions by health advocates, and finally we examine the immediate and long-term effects of the Reagan Administration's actions on the American health care system.

The Reagan Proposals For Health Care

It is notable that the Reagan speeches do not contain references to a "health agenda"; health apparently was not a campaign issue nor a major part of the "Reagan revolution" except as it concerned the financing of health care. Greenberg (1980) noted that "Health policy, in fact, was barely touched on in the campaign" (p. 1542). Davis noted in 1981: "The most striking gap in the Reagan Administration health policy is the absence of any positive agenda to address pressing problems in the health care sector" (p. 328). Indeed, in one of the President's few direct comments on health in a speech at the annual meeting of the American Medical Association (June 23, 1983), the President concentrated on health financing, rather than health itself:

Health care costs are consuming a growing portion of the Nation's wealth, and that is wealth that cannot be spent on education or housing or other social needs. . . . It's high time that we put health care costs under the knife and cut away the waste and inefficiency. (p. 907-908)

He also reiterated a traditional, and arguable, conservative position:

We have the best health care in the world, because it has remained private (p. 908).

The health-related issue that did dominate the Reagan campaign was abortion, although it was cast not as a health issue but as a moral one. There is no doubt that Reagan presented himself as opposed to abortion. He stated this position during the Presidential campaign and courted support from the pro-life movement. Early on in the Administration, he stated

his position on abortion but did not support a constitutional amendment to ban abortion:

Now, I happen to have believed and stated many times that I believe in an abortion we are taking a human life. But if this is once determined, then there isn't really any need for an amendment, because once you have determined this, the Constitution already protects the right to human life. (March 6, 1987, p. 212)

Nathan and colleagues (1987) summarize the preeminent goal of the Reagan Administration as retrenchment in social policy in the broad sense. Toward this end, the Administration proposed a new philosophy of government, his New Federalism, and economic renewal initiatives as operationalized by reductions in spending.

New Federalism

Reagan made his views on the role of government known at the moment of his inaugural address, January 20, 1981, calling government the problem rather than the solution: "It is time to check and reverse the growth of government, which shows signs of having grown beyond the consent of the governed" (p. 1). These comments and the proposals that followed focused on the Federal government, although Nathan (1987) raises evidence to indicate that the Administration intended to achieve retrenchment at all levels of government. The Reagan analysis concluded that Federal government had grown beyond the intent of the Constitution. This growth in the size and role of the Federal Administration was attributed to the influences of special interest groups on the Congress. The Constitutional argument led the Administration to propose the strategy of returning powers and responsibility to the states: "It is my intention to curb the size and influence of the Federal establishment and to demand recognition of the distinction between the powers granted to the Federal Government and those reserved to the State or to the people" (January 20, 1981, p. 2).

Block Grants

The vehicle for implementing the New Federalism (devolving power to the states) was to be block grants, lump-sums of

money designated for broadly defined purposes to be spent according to the needs of the individual states. Block grants had their beginnings in 1966, when nine formula grants for various health programs (dental health, tuberculosis, etc.) were combined into the Partnership in Health Act. The principle that guided government's involvement in its citizens' health as the Reagan Administration assumed power originated with the Sheppard-Towner Act in 1921 and resulted in the Federal grants-in-aid system that was institutionalized in the Social Security Act in 1935. Title V of the Act was the vehicle through which the Federal government funded services to mothers and children, through grants-in-aid to the states on a matching basis. An enormous number of categorical programs developed over the years, creating a patch-work system of health care.

Now President Reagan proposed consolidating all or part of 83 of these categorical health programs into six human-service block grants of \$11 billion, claiming that the categorical programs burdened the states with regulations and paperwork:

Ineffective targeting, wasteful administrative overhead—all can be eliminated by shifting the resources and decision-making authority to local and State government. This will also consolidate programs which are scattered throughout the Federal bureaucracy, bringing government closer to the people and saving \$23.9 billion over the next 5 years. (February 18, 1981, p. 111)

The earliest objective of the Administration was to create a single health care block grant in which all of the discretionary, categorical Federal health care programs would be included. To implement this proposal, however, required agreement from a large number of congressional committees that had jurisdiction on various pieces of legislation. Important Congressional leaders like Robert Dole (Republican of Kansas), who chaired the Senate Finance Committee and had jurisdiction over all of the Social Security Act programs, would not relinquish any authority. Thus, Congressional opposition led to legislation for four block grants. These were: the alcohol, drug, abuse and community mental health grant; the preventive health services grant; the community health centers grant; and the Maternal and Child Health (MCH) Services Block Grant (Iglehart, 1983).

The MCH Block Grant consolidated seven previous categorical programs: the basic MCH program (which provided maternity and infant health care and pediatric services), Crippled Children's Services, special services for disabled children receiving Supplemental Security Income, lead-based paint poisoning prevention, Sudden Infant Death Syndrome services, genetic screening and counseling services, hemophilia treatment services, and the adolescent pregnancy program.

The legislation to implement the block grants was carefully crafted. The Administration had done a tremendous amount of homework to identify all the relevant pieces of legislation and the corresponding citations and cross references to the health legislation. In addition, they carefully identified all of the regulations attached to these laws as the regulations were often highly prescriptive.

The legislative vehicle for enacting the block grant consolidations was the Omnibus Budget Reconciliation Act. Using this process, the Administration was simultaneously able to circumvent the process of Congressional hearings and debate and at the same time, achieve the budget reductions. David Stockman, the Director of the Office of Management and Budget, was able to use the reconciliation process in Congress to evade the powers of the appropriations committees and introduce program changing legislation through the budget bill. That procedure has dominated Federal policy-making ever since and introduced the acronym, OBRA (The Omnibus Budget Reconciliation Act), into the American political lexicon. (The most recent Congress enacted a new budgetary vehicle called "pay-as-you-go" that replaces OBRA (Congressional Quarterly, 1990).)

In addition to creation of the block grants, the Administration made changes in Medicaid that enhanced states' abilities to limit benefits. Medicaid is a partnership between the Federal government and the states, with states permitted to set eligibility standards and reimbursement levels within broad Federal guidelines. Changes in 1981 permitted states to negotiate rates of reimbursement rather than paying "usual and customary" rates, and allowed states to assign recipients to providers instead of selecting the providers of their choice (Nathan & Doolittle, 1987).

Deregulation

As part of devolving power down to the state level and restructuring the Federal role in the funding of programs, the Reagan Administration sought specifically to reduce regulation. The regulatory aspects of health care seem to have been imbedded in a more fundamental assessment of government regulations as interfering with the competitive forces of the market place. And on this issue the Administration had done its homework; in a February speech, President Reagan already knew the number of pages of law and regulations that would be reduced by block grants and deregulation:

In the health and social services area alone, the plan we're proposing will substantially reduce the need for 465 pages of law, 1,400 pages of regulations, 5,000 Federal employees who presently administer 7,600 separate grants in about 25,000 separate locations. Over 7 million man and woman hours of work by State and local officials are required to fill out government forms. (February 18, 1981, pp. 11-1)

In the case of health care, however, the drive to deregulate was tempered somewhat by the self-interest of the Federal government in reducing its massive health care expenditures. The Administration believed that competition would reduce health care costs (January 27, 1987, p. 70), and cited the experience of the Carter Administration in trying to reduce the expansion of health care costs through regulation. Certificates of Need and other cost containment strategies were generally seen as failures, although evaluation data were scarce and could be interpreted as showing some slowing of the expansion of hospital capital costs (Davis, 1981). Reagan introduced the conservative notion of treating health care as a commodity and using competition in the market place as the vehicle for reduced expenditures.

One case involving Federal regulations illustrates the President's tendency to approach social policy issues through anecdotes and his preference to address them through personal intervention. Early in the Administration, he learned of the plight of Katie Beckett:

The incident of just a few days ago that I know you're all aware of—that almost accidentally came to our attention—of the little

3 1/2-year-old girl who had never lived at home with her parents and couldn't, actually, because of a regulation with regard to the government grant they had to have for medical expenses of 10 to 12 thousand dollars a month. And Dick Schweiker found out within 24 hours after we made it public that, by golly, he could change that regulation and got it changed. And I had the pleasure of calling those parents and speaking to them and their unspeakable happiness that the fact that their little girl was going to come home. (November 18, 1981, p. 1072)

Katie Beckett was a child with serious chronic lung disease owing to premature birth and resulting in dependence on an artificial respirator. She spent much of her young life in hospital. Under the SSI-DCP (Supplemental Security Income-Disabled Children's Program), Katie was eligible for SSI benefits and Medicaid while hospitalized. The Becketts, an educated family, wanted to take Katie home and take care of her with home-based technology. Were this to happen, however, Katie would no longer be eligible for SSI and Medicaid because her parents' income would be counted. Despite the fact that the government could have saved thousands of dollars in expensive hospital costs, they would not provide Medicaid to Katie once she went home.

This little case—you know an example of what we're trying to cure is this one that, God bless them, Dick Schweiker grabbed a hold after I made it public the other day of the little girl out in Iowa, and how quickly we made this change. To think that our government—and I was wrong; I had old-fashioned figures when I said \$6,000. It was costing between \$10,000 and \$12,000 a month for Medicaid, and even the doctors said she should be home, that she'd be better off at home, and it would cost \$1,000 a month at home. But that was more than her family could afford, so they couldn't take her home because they couldn't take over the cost. But here was the government shelling out \$10,000 or \$12,000 every month, when a silly regulation stood in the way of them getting it for \$1,000 a month. Dick found a way to ignore that, make an exception to that regulation, but you wonder how many more cases are out there in the country like that. (November 19, 1981, p. 1076)

The President's decision, of course, was correct. The policy was foolish and short-sighted. However, rather than undertake

a comprehensive reform of the way Medicaid, SSI and other Federal programs for the disabled interacted to create disincentives to appropriate care, Reagan preferred to solve the single dramatic case. Regulations were subsequently written to allow states to seek Medicaid waivers in the cases of other ventilator-dependent children.

Reductions in Spending

As the 1970s drew to a close with steep increases in the cost of health care and rising Medicaid and Medicare expenditures, cost containment was the major by-word. Federal efforts to curtail health care costs had been evident in efforts by Presidents Nixon, Ford, and Carter in the 1970s to set limits on reimbursements to hospitals and physicians (Aaron & Schwartz, 1984). Further efforts were made by state governments (Bovbjerg & Holahan, 1982). Thus when President Reagan assumed command in 1981 cost containment was already a major health care issue, and much of the focus was on the cost of the Medicaid and Medicare programs.

Two areas were prime targets for spending reductions: the entitlement programs of Medicaid and Medicare, and the new block grants. The powerful lobbying arm of senior citizen groups made Medicare (Title 18 of the Social Security Act, enacted in 1965) less of a target than Medicaid. Moreover, Medicare, which financed medical services for the elderly, enjoyed wide popular support, in part due to its image as an insurance program, in contrast the Medicaid, which was viewed as welfare. Nevertheless huge Medicare expenditures were a major concern of the Administration's as they had been of previous administrations. Doomsayers predicted the complete collapse of the Hospital Insurance Trust Fund and the Medicare program itself (McCarthy, 1988). As a result, Public Law 98-21, the Social Security Amendments of 1983 were enacted to limit Medicare spending.

The new legislation limited spending by creating a system of prospective payments to hospitals based upon a system of categorizing all diagnoses into 383 Diagnosis Related Group (DRG) categories with preset reimbursement levels. Certain adjustments were made to the payments made based on location

of hospitals (urban vs. rural) and local differences in wage rates. Although hospital costs for the Medicare population nonetheless continued to rise, DRGs did result in reduced admissions and lengths of stay for the Medicare population (Dougherty, 1989). Although the effects of the DRG system on the quality of care for the elderly are more difficult to ascertain, many physicians feel that pressures on physicians to reduce costs are resulting in patients being discharged "quicker and sicker" (Dougherty, 1989).

Medicaid (Title 19 of the Social Security Act, also enacted in 1965), which financed health care for certain categories of poor persons who were believed to lack access to care, was originally almost a tack-on to Medicare and was generally believed to be quite unimportant. It was a Federal grant-in-aid program, with the amount of Federal match (between 50 and 80%) being higher for states with lower per-capita incomes. The popularity of Medicare lay in part in its image as an insurance program, in contrast with Medicaid, which was viewed as "welfare."

The Federal government had become a major payor of health care costs through Medicare and Medicaid; the two programs accounted for more than 39% of all Federal health care expenditures in 1980 (U.S. Health Care Financing Administration, 1988). Because Medicaid and Medicare are entitlement programs (open-ended, and all eligible persons must receive included services), Administration objectives to reduce Federal taxing and spending had to be met through mechanisms other than restructuring to block grants. (On the other hand, Nathan and Doolittle (1987) maintain that Reagan hoped to restructure Medicaid to a functional block grant.)

Thus, claiming that the program was not cost-effective, the President proposed: "... to put a cap on how much the Federal Government will contribute, but at the same time allow the States much more flexibility in managing and structuring the programs (February 18, 1981, p. 111).

There was an early proposal to swap Federal and state responsibilities for Aid to Families with Dependent Children (AFDC) and Medicaid (State of the Union, January 26, 1982, p. 76). Under this plan, the Federal government would have assumed all the costs for Medicaid while the states made

welfare-AFDC-an entirely state program. Legislation to implement the idea was never proposed, perhaps due in part to opposition by the National Governors' Association (Iglehart, 1983).

In the 1981 OBRA, the Administration reduced spending in two ways. First, the eligibility level for AFDC was reduced. Thus in 1982, at the end of a recession with increasing poverty, there were 597,000 fewer recipients of AFDC than there had been in 1980 (U. S. Social Security Administration). Because AFDC conveys automatic eligibility for Medicaid, these women and children also lost their health insurance. After a decade of improvements in access to health care for low-income women and children, advocates feared reversals.

In fact, some reversals did occur—in prenatal care utilization, for example. Low-income and minority women, who do not generally receive the same level of prenatal care during pregnancy as more advantaged women, but whose risks for poor pregnancy outcome are greater, made significant improvements during the 1970s that generally were attributed to Medicaid and Federal Maternal and Child Health programs (Davis & Schoen, 1981). As Figure 1 shows, these gains were partially lost in the 1980s, although of course it is not possible to demonstrate conclusively why this occurred. Health advocates were particularly concerned that no progress was made in improving prenatal care for black women.

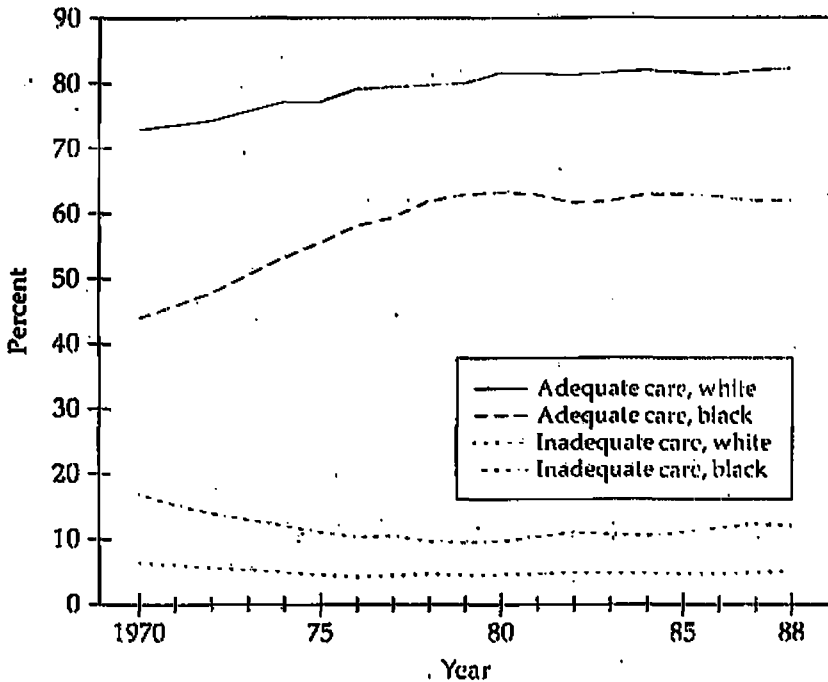
It was in the area of lost benefits that the President's greatest image problem plagued him. The President played on the old American notion of a truly needy class and the existence of a safety net of supports to meet their basic needs. The net was intended to prevent the undeserving poor, the working and able-bodied poor, from benefiting:

We will continue to fulfill the obligations that spring from our national conscience. Those who, through no fault of their own, must depend on the rest of us—the poverty stricken, the disabled, the elderly, all those with true need—can rest assured that the social safety net of programs they depend on are exempt from any cuts. (February 18, 1981, p. 110)

A cartoon by the syndicated cartoonist Dan Wasserman is illustrative. It portrayed David Stockman, Director of the Office

Figure 1

Percent of pregnant women receiving adequate prenatal care and inadequate care by race, 1970-88*



* Adequate defined as starting in the first trimester; inadequate defined as starting in the third trimester or having no care during pregnancy.

Source: Vital Statistics. National Center for Health Statistics.

of Management and Budget (OMB) and the chief architect of the Reagan budget proposals, in four frames saying, "To simplify the fight over budget cuts," "we're planning an elimination tournament..." "The farmers can take on the elderly, the jobless vs. the school kids, etc." "The winner gets to go one-on-one with the Pentagon."

The President clearly bristled at this image of cruelty:

Contrary to some of the wild charges you may have heard, this administration has not and will not turn its back on America's elderly or America's poor... The entitlement programs that make

up our safety net for the truly needy have worthy goals and many deserving recipients. . . Don't be fooled by those who proclaim that spending cuts will deprive the elderly, the needy, and the helpless. . . (January 26, 1982, pp. 74-75)

In 1986, James C. Miller succeeded Stockman at OMB. Wassermann portrayed a Congressman asking, "Mr. Miller, you call for cuts in Food Stamps, Medicaid, nutrition and job training." "How does that square with the President's pledge not to balance the budget. . ." "on the back of the man who is poor?" And in the final frame, Miller replied, "Congressman-these cuts would mostly affect women and children!"

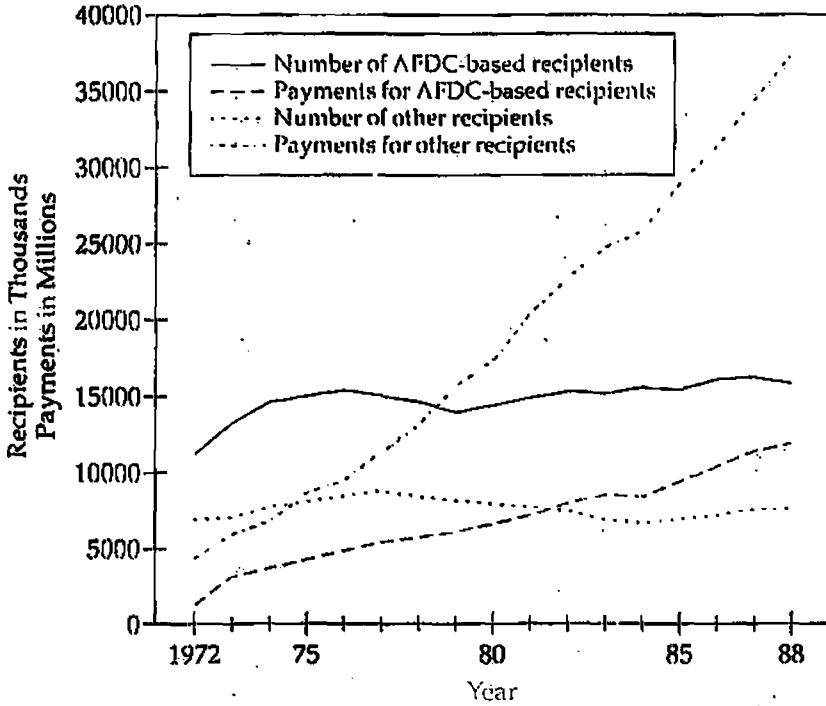
The second proposal to cut costs was to reduce the Federal burden for Medicaid by placing a cap on the percentage of Federal contribution to the program. Congress, under pressure from the nation's governors, modified this proposal to reduce the percentage of Federal matching to Medicaid. The net effect was a 5% reduction in Federal expenditures for entitlement programs between 1981 and 1982 (p. 50).

Figure 2 shows the number of Medicaid recipients and expenditures from 1972 through 1988 and demonstrates two important facts. First, the cuts in numbers of recipients are not obvious; this is due to the effects of the recession of 1981-82, with increasing numbers of persons qualifying for Medicaid despite stricter requirements. If not for the stricter requirements that moved many women and children from AFDC eligibility, there would have been a steep increase in AFDC-based recipients during the early 1980s. Second, despite moderations in the number of recipients, costs continued to climb due to the increasing cost of health care. This is particularly evident for non-AFDC-based recipients, who are mostly comprised of elderly and disabled recipients. The bulk of Medicaid payments for this group consists of hospital and institutional care costs, which are very expensive.

Creation of the block grants also provided the opportunity to reduce spending. Part of the rationale for block grants was that greater efficiency and reduced duplication would reduce wasteful administrative costs (Omenn, 1982). Yet the General Accounting Office (1982) was unable to find evidence that block grants resulted in cost savings. (This appeared to be due to the

Figure 2

Medicaid recipients and payments by basis of eligibility¹, Fiscal 1972-88.



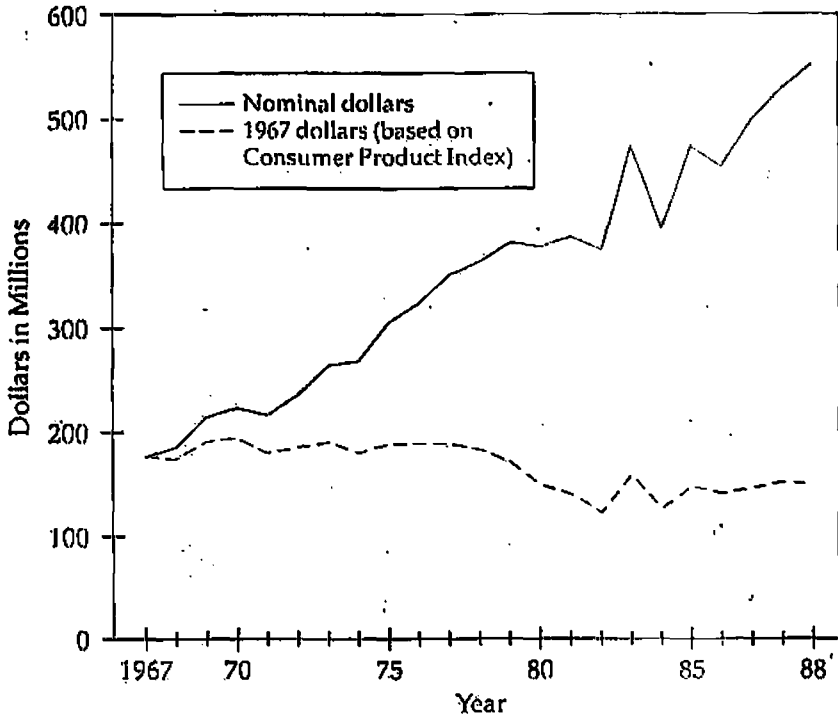
¹ AFDC-based recipients includes children and adults receiving Aid to Families with Dependent Children benefits. Other recipients of Medicaid include the elderly, blind and disabled.

Source: U.S. Health Care Financing Administration. Health Care Financing Review.

lack of requirements for evaluation and accountability by the states.) Reductions in spending authorization varied among the four block grants. Mental health and preventive health services were reduced by the 25% that had been proposed; the Maternal and Child Health (MCH) Block Grant authorization level in FY 1982 was about 13% below the total (in real dollars) for the individual categorical programs in fiscal 1981 (Iglehart 1983). (See Figure 3.)

Figure 3

Title V or MCH Block Grant Appropriations in nominal and 1967 C.P.I. adjusted dollars, Fiscal Years 1967-89.



Source: Division of MCH Health Resources Services Administration, Public Health Service, DHHS.

Successes and Failures of the Reagan Proposals

Reactions to the Reagan Administration's plans and proposals were swift and generally full of rhetoric. Some feared polio epidemics (Boston Herald American, February 11, 1982) or "dead babies" (Boston Herald American, November 25, 1981), while the Children's Defense Fund called Reagan policies "an unconditional war on children" (Boston Globe, 1982). Statistics on child deaths due to Administration policies were widely quoted (Common Health, 1984).

More restrained reactions also emerged. Davis (1981) noted:

This policy represents a profound shift in direction in the health sector. It encompasses a far-reaching reexamination of the role of the federal government in financing health care services, administering direct programs to promote preventive and primary care services, regulating costs in the health sector, sponsoring biomedical behavioral, and social science research, and supporting the training of health professionals. (p. 312)

The Block Grants

Rosenbaum (1983) of the Children's Defense Fund, a highly effective child advocacy group, noted some positives in the MCH Block Grant, including some useful guidelines for planning. In fact the MCH programs had always been very loose with regard to regulations, and the Block Grant provided some improvements. For example, although no regulations were included to guarantee implementation, OBRA 1981 prohibited discrimination and contained requirements that addressed the issue of quality of care.

But neither did the block grants come out of the Congress in the way Reagan had originally proposed. Congressional committees exercised their influence, and special interest groups were not about to be pushed aside. President Reagan complained that his plan to consolidate 86 "duplicative, regulation-ridden" programs into block grants had been rejected and criticized the legislation (June 19, 1981, p. 545):

First, many of the measures that are needed to curb the automatic spending programs have not been adopted. These reforms would target programs more directly toward the truly needy while they help to eliminate waste and abuse.

Unfortunately, the House committee has adopted only one-third of the savings that these reforms would bring. And the result, if unchallenged, will be \$23 billion in additional red ink and inflationary pressure in the next several years. Doing only one-third of the job is not good enough.

Secondly, certain House committees have not yet received the message of last November that the American people want less bureaucratic overhead in Washington and less red tape typing up State and local government.

Nonetheless, one year after taking office, President Reagan would report the success of his New Federalism:

Together, after 50 years of taking power away from the hands of the people in their States and local communities, we have started returning power and resources to them (January 26, 1982, p. 73).

Not only did Congress not pass the block grants the way the President wanted; they were not implemented as the President had hoped they would be. States used a number of tactics to blunt the effects of the block grants. Feldman's (1985) study of the impact of MCH Block Grant cuts on five states (Texas, Massachusetts, Michigan, New York, and California) and four large urban areas (Boston, Detroit, New York City, and San Antonio) found that states used "carry-over" funds and increased their own contributions to block grant programs to reduce the impact of spending cuts. Some states delayed implementing the block grant mechanism for a year. There was great variability in cities' abilities to draw on other funds, however. With the exception of San Antonio, real service reductions did occur in maternity and pediatric services. Nathan and Doolittle's (1987) extensive study of the effects of Reagan's policies on the states also emphasizes the states' successes in forestalling many effects of the cuts. This expansion occurred through the replacement of Federal funds with state dollars, new fiscal coping mechanisms, delaying measures, and administrative reform. Some 38 states raised taxes and increased real spending during the years 1984-86 (GAO, 1984; Nathan, 1987). Indeed, their study showed that several states used the increased flexibility in Medicaid to expand their programs, rather than contracting them.

Perhaps most important, however, is that after an initial period of dramatic success, a kind of political blitzkrieg, Congress reclaimed authority and after 1981, rejected most of the Administration's proposals for further budget cuts and even approved some new domestic spending. Most notable, in 1983, Congress reacted to the steep recession of 1981-82 with an emergency jobs act that added \$2.8 billion to domestic programs, including many of those cut in earlier years. For example, passage of the bill added \$105 million to the original \$373 million appropriation to Title V. The FY 84 appropriation had been

\$399 million, 35 percent lower than necessary to maintain 1980 service levels (Feldman, 1985). Federal aid outlays stayed about the same (in real dollars) from 1982 through 1984, then increased in 1985. Outlays were below the 1981 levels, but considerably above what the Reagan Administration had planned (Nathan & Doolittle, 1987).

Medicaid Reductions

President Reagan's efforts to reduce Medicaid also were short-lived. Although OBRA 1981 reduced the Federal match for Medicaid, total Medicaid expenditures increased each year between 1979 and 1987 (Health Care Financing Administration, 1988). (This occurred despite changes in AFDC that removed over half a million recipients from the program.) Moreover, while the President was working to reduce Medicaid, child health advocates were working to expand the program. In 1984, Federal matching levels were returned to the levels they had been in 1981 (Children's Defense Fund, 1984). Other changes that year returned Medicaid to many families by restoring their AFDC eligibility.

That year also marked the beginning of a series of expansions that included the Child Health Assurance Program (CHAP). The Children's Defense Fund called these changes, which uncoupled eligibility for Medicaid from categorical programs such as AFDC, "the biggest victory in Congress for poor children and families in several years" (p. 1). Oberg (1990) documents how legislation passed each year beginning in 1984 expanded Medicaid to include women who were pregnant for the first time, women in two-parent families, and children from birth to age five, and then age eight. States were first permitted in 1985 to include individuals up to 100% of the Federal poverty level, then permitted to include those up to 185% and in 1988 required to include those up to 100% (OBRA 1989 further mandated pregnant women and children with family incomes less than 133% poverty.)

Community Health Centers

A major failure of the Reagan plan was the destruction of Community Health Centers (CHCs), identified early by the

Administration as an "infrastructure for a national health service" (Clark, 1984). CHCs began as part of the War on Poverty, and were designed to address the problem of lack of access to health care in many areas. Freeman, Kiecolt, and Allen's (1982) analysis of a large data set on two surveys in five communities found that CHCs were the primary source of care for many low-income persons—disproportionately so for children. Moreover, they found CHCs to reduce the use of more expensive hospital clinics and emergency rooms and to lower hospitalization rates.

The Community Health Centers (CHC) program had been funded in FY 1981 at \$324 million; 845 centers were funded to serve about five million persons who were mostly women and children (Wallace, 1983). Funding for the converted block grant was \$281 million in FY 1982, but was increased to \$360 in FY 1983 (Library of Congress, 1984).

WIC

Reagan also wanted to fold the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) into the MCH Block Grant (Rush, 1982; Food Research Action Center 1983), but Congress rejected this idea, as well as cuts that would have reduced funds substantially. (The WIC program, enacted in 1972, provides certain highly nutritious foods, and nutritional counseling, for pregnant and lactating women, and young children. Services are available to low-income women and children who are deemed to be at nutritional risk. Although the evaluation data are mixed (Rush, 1982), most MCH advocates support the program (Paige, 1982).) The President did manage to cut other nutrition programs by about one third in inflation-adjusted dollars (Robbins, 1983).

The WIC program was the source of a major confrontation between the President and the health community. The Food Research and Action Center (FRAC) had released data in 1982 that it claimed showed increasing infant mortality in many states and linking those increases to proposed cuts in the WIC program. There was wide press coverage, and Edward N. Brandt, Assistant Secretary for Health, DHHS, testified before a Senate subcommittee. Although Brandt's testimony mainly consisted of

clarifying the data and noting some true methodological shortcomings of the FRAC report, this controversy contributed to President's cold-hearted image.

When the political cost of attempts to cut WIC became too great, the President (with the support of Senators Robert Dole and Jesse Helms) conceded the need for the program for pregnant women and infants but attempted to remove older children from the program. Again, the President failed and WIC was left relatively untouched.

Research

Two health-related areas did receive the President's support. The first was Federal funding for research. The only area of expansion of the Federal health budget in 1982 was the proposed \$168 million for the National Institutes of Health (Davis, 1981). How this occurred is not entirely clear, but the President's industrial and business supporters placed high value on the nation's scientific position (Greenberg, 1980) and DHHS Secretary Richard S. Schweiker was a vigorous advocate of the National Institutes of Health (Iglehart, 1983).

During the campaign Reagan had criticized the Carter budget cuts for research (Greenberg, 1980). The President's announcement of a \$100 million increase for biomedical research during his 1982 State of the Union message was the only health-related reference in the speech (p. 75). In fact, Congress approved considerably more than the Administration requested (Iglehart 1983).

Yet although research fared well, the related item of data and information systems did not do well. One of the early victims of the Administration's cuts was the *Morbidity and Mortality Weekly Report* (MMWR), a publication from the CDC. For 20 years, the MMWR had become a trusted and valued publication, sent free to thousands of official agencies and practicing physicians. As a budget-saving device, the Administration initiated a very expensive subscription that had the effect of reducing circulation of the MMWR dramatically. It is not easy to interpret this event. By reducing the availability of the MMWR the Administration undermined the notion that a Federal agency might be viewed

as highly effective and essential. The effort also fits with other efforts to reduce Federal data systems (Reiman, 1982).

These other efforts include cuts in national health interview surveys, and reductions at the National Center for Health Statistics. It is possible that the Administration intended to limit the availability of Federal information as a method of preventing any links between Federal cut-backs (in budget and role) and adverse health outcomes for the population. If the information was not available, then critics could not draw the associations.

Medicare

The second health-related area that was the subject of the Administration's interest concerned catastrophic health care coverage for the elderly. In contrast to the President's dedication to reducing social services programs and spending, and in opposition to many of his usual allies, he declared his interest in this program at his 1986 State of the Union address. On July 1, 1988, he signed the Medicare Catastrophic Coverage Act of 1988 (PL 100-360). The bill marked the most significant expansion of the Medicare program since its 1965 inception (Iglehart, 1989).

The program would have expanded Medicare to include insurance against treatment for major acute illness, and it also ended the necessity of one spouse's becoming impoverished in order to entitle the other to Medicaid coverage of long term care. Nevertheless, the program still left many gaps in health care coverage, including the most important one of long-term care. In the end, however, the bill was repealed not because of its many gaps, but because of the opposition by the elderly, whose copayments and premiums would have financed most of the program. Approximately one-third of the costs of the program would have come from a fixed monthly premium, while the rest would have come from an income-related surcharge paid by approximately one third of the more affluent elderly (Levitan, 1990).

Deregulation

On the goal of deregulation, President Reagan appears to have been successful. At a news conference in October of 1981

he held up six pages of block grant regulations and boasted that they replaced 318 pages of regulations for 57 categorical programs that had been replaced by the block grants. In his State of the Union Address one year after taking office, President Reagan would report: "Together, we have cut the growth of new Federal regulations nearly in half. In 1981 there were 23,000 fewer pages in the *Federal Register*, which lists new regulations, than there were in 1980" (January 26, 1982 p. 73).

Federal involvement was reduced under the block grant approach, although it has begun to spring back under the Bush years. The OBRA 89 amendments to Title V give the Federal government renewed authority to specify how funds are spent, and they require the states to submit an application for their block grant funds in a format now prescribed in "guidance" (not by law or regulations).

Abortion

On abortion, the President accomplished little that was substantive. In fact, he probably learned that he had relatively few tools with which to influence the abortion debate. He did, however, nominate Dr. C. Everett Koop, a nationally respected pediatric surgeon from Philadelphia, to the position of Surgeon General of the United States, in part because of Koop's well known opposition to abortion. In one of the great ironies of the administration, Koop became converted to the public health mission. He campaigned for strong government positions on smoking and other public health measures that may have rankled Republican supporters of the President. He took a national leadership position on AIDS. And, finally, he equivocated on the abortion issue.

In 1983, the Administration acted to close down one of the few explicitly abortion-related activities of the Federal government, the Abortion Surveillance Branch at the Centers for Disease Control (CDC). The director of that unit, Dr. Willard Cates, had carried out numerous studies showing that legal abortion was much safer for women than either illegal abortion or, in many cases, pregnancy itself. Cates' work was frequently quoted by prochoice advocates. Dr. Cates was transferred to the

CDC's section on sexually transmitted diseases activity. Later in the Administration, however, it became evident to the prolife lobby that they no longer had any data on which to make their case that the number of abortions being carried out in the U.S. was excessive. In another reversal, the Abortion Surveillance Branch was put back to work to revive its annual reports.

Late in the Administration, Surgeon General Koop was asked by the Administration to come up with the data that showed the psychological damage to women of abortions (July 30, 1987, p. 898). An expert committee was convened at the CDC. Their report indicated that there was no scientific evidence for such an effect and a large scale study was unwarranted. It appears that Koop himself was convinced by this finding and moderated his stance on abortion. The Administration and its right-to-life constituency were said to be furious. It is likely that this episode was an important component of the decision of the new Bush Administration not to reappoint Koop as Surgeon General in 1989.

President Reagan expressed his support for the Constitutional Abortion Amendment in a September 8, 1982 letter, and in a speech on September 14 made an astonishing claim: "I think the fact that children have been prematurely born, even down the 3-month stage, and have lived to—the record shows—to grow up and be normal human beings, that ought to be enough for all of us" (p. 1151). The bulk of the President's action on abortion during his two terms consisted of such rhetoric. He often spoke of abortion, nearly always linking it with the issue of school prayer, in numerous appearances before religious groups such as the National Association of Evangelicals (March 8, 1983) and the National Religious Broadcasters (January 31, 1983). He regularly offered support for the Hyde Amendment, prohibiting Medicaid payments for abortions, and other legislation. At a luncheon for members of a conservative Political Action Committee on February 20, 1987, he said:

Last week we sent to Congress legislation to enact on a permanent, government wide basis the Hyde amendment restriction on Federal funding of abortion. Our proposal would also cut off funding, under title 10, to private organizations that refer or perform abortions except when a mother's life is in danger (p. 167).

Although the President was not successful in passing a Constitutional amendment, once again he did achieve some objectives in the financing aspect of abortion. His other success, in keeping the conservative position before the public, is more difficult to measure but was certainly not a complete failure. Subsequent failures in several states to further limit access to abortion would suggest that neither was his rhetorical campaign a complete success.

Summary: The Legacy

Overall, the legacy of the Reagan Administration on America's health care delivery system was not the catastrophic one that was predicted. The worst of the spending reductions, while severe, were relatively short-lived and partly compensated for by the states. The most significant cuts occurred in 1981; overall, there was a 7% cut in Federal grants-in-aid to state and local governments— 12% in real terms (Nathan & Doolittle, 1987). In the case of the MCH Block Grant, a major vehicle for delivery of services to poor women and children, the Reagan cuts only continued a trend of erosion of funding. In the case of Medicaid, the Reagan efforts were off-set by a powerful advocacy movement. In fact, the expansions that occurred in the mid-to late-1980s and will continue to 2002, are profound and, in the absence of creation of a national health insurance program, will provide health care security for hundreds of thousands of low-income women and children.

Yet no mistake should be made: the effects of the reductions in spending on health care fell most dramatically on the poor, and particularly on poor women and children. At least for a time, maternity and infant services were lost. The Children's Defense Fund reported in 1983 that in the previous 18 months every state had reduced health services for the poor (New York Times, January 17, 1983).

The Children's Defense Fund also reported (New York Times, January 17, 1983) that the reduction of funding for the Community Health Centers of 18% to (to \$373 million) had resulted in 725,000 persons being denied services, with 64% of those being children or women of child-bearing age. Certainly many of those services were later restored, but some damage

probably occurred from the interruption of health care experienced by many persons. It is difficult to assess the additive effects of cuts in Medicaid, which provided access to private sector health care, and these other cuts which reduced the availability of public-sector health care.

Second, it is clear that the Reagan efforts to reduce Federal authority in favor of the states has resulted in greater state power (Nathan & Doolittle, 1987). What is not entirely clear is what that greater state power means for health care for the poor. Although liberals have always assumed state authority to correspond with retrenchment in social policy and more restrictive programs and policies, this does not appear to be universally so. Larger, more liberal states spent more than more conservative ones, but most buffered Federal cuts to some extent. Long-term effects on health and welfare programs will be difficult to assess until the economic recession abates.

A more profound impact on the health care delivery system may be due to the deficit left by Reagan's simultaneous tax cuts and increases in defense spending. When he assumed office in 1981, the deficit was \$78.9 billion, and he said "this kind of irresponsibility can't go on" (March 2, 1981 p. 177). When President Reagan left office, it stood at \$155 billion (Office of Management and Budget). Nathan and Doolittle (1987) emphasize the long-term meaning of the deficit: "... what is not debatable is the inhibiting effect of the deficit on proposals for new federal programs. The signal from Washington was clear; new social program initiatives would have to occur elsewhere" (p. 13).

Some other profound influences are more philosophical. First, the Reagan Administration clearly reversed the commitment to the "working poor" that had been evident in the Carter Administration. Yet with the Family Support Act of 1988 (which extended Medicaid eligibility for six months for families who leave AFDC due to finding employment) and the uncoupling of Medicaid from AFDC, much of that commitment seems to have been recovered.

Second, the Reagan years continued a pronounced shift in concern and resources away from children and toward the elderly. By 1984, for example, Federal expenditures per child were

only 9% of the per capita expenditures for the elderly (Preston, 1984). During the 1980s, the real benefits of Medicaid eligibility for AFDC children decreased by 30% while the benefits for the elderly increased 10% in inflation-adjusted terms (Schlesinger, 1989). The results are clearly demonstrated in increasing numbers of children in poverty, contrasted to decreasing numbers of elderly persons. It is difficult to determine exactly how this shift has occurred, but demographic changes, as well as a strong political lobby on behalf of the elderly, have probably been influential.

In conclusion, there is no doubt that the Reagan Administration made a significant impact upon the American health care system. Some of the negative impact on low-income mothers and children remains; much of it has been ameliorated by states and subsequent Federal action. In the long run, however, the major impact of the Reagan Administration on the health care of women and children and low-income families may have occurred through the Administration's social and economic policies, which are discussed in other articles in this issue.

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