

# On Achieving Access and Equity in Health Care

RASHI FEIN

**T**HIS PAPER ADDRESSES SOME OF THE ISSUES RELATED to health care in the United States. In so doing, I give primary emphasis to questions involving access to health care. Even so, I limit the discussion of any particular topic to its most important facets. The principle of selection involves various criteria: insofar as possible, I discuss those issues that are important at a system level (particularly as they impinge on the allocation of resources), that involve economic arrangements influencing behavior and performance, and that can be illuminated by the economist's perspective. I attempt to give primary emphasis to those variables whose influence is far ranging.

In so doing, of course, we cannot examine every network of interrelations. Although this simplifies the discussion, we pay a price for incompleteness. There is little choice, however. One of the difficulties with the health field stems from the fact that everything is interrelated: that intervention on one front has "side effects" on other fronts; that intervention designed to accomplish one purpose sometimes fails to do so because other factors that appear unrelated are not changed. To discuss everything is impossible. On the other hand, to say *nothing* because we cannot discuss *everything* is irresponsible.

Finally, we will have to reach judgments even in spite of the relative weakness of the data available for analysis. We know far less, for example, about the availability of services (particularly if corrected for quality differentials) than we would like to. So, too, with the impact of differences in utilization on levels of health. The current refrain often seems to be, "But we have no output measures." That, regrettably, is frequently the case. Nevertheless, just as we cannot be silent because of

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the complexity of intertwined relations, neither can we be silent because of insufficiency of data. We can use experience and judgment to arrive at (tentative) conclusions. Not knowing everything does not mean we know nothing.

## Access and Equity: Financial Considerations

### *Why Be Concerned about Equity?*

The first question we address is, “Why is so much attention devoted to the health sector; why all the fuss about equity?” This issue is often raised by those who regard health as important, but who believe the relation is very weak between medical care expenditures and services (inputs) and health (outputs). They argue that monies that might go to the health sector to achieve equity might be better spent in other areas—e.g., housing, nutrition, education—even if the goal that is being sought is better health. All of us have heard the analysts who question the value of increasing the availability of health resources or services. We have heard distinguished leaders of medicine note that most disease is self limiting and that in a high proportion of cases physicians cannot intervene effectively.<sup>1</sup>

Some remarks are in order on the question of the importance of medical services. I do not intend to review the evidence on whether medical services make a difference (and to what degree) to the health of a population. Rather, I propose to consider the significance of the fact that the public believes the services to be important and, therefore, desires a greater equity in their distribution.

In the case of health and medical care, we are dealing with a sector in which, because of customs and folkways, image may be even more important than reality. Because some (even if relatively little) medical care deals with matters of life and death, because of fear, because of infatuation with science and technology—as well as because medicine oftentimes does help some individuals and, therefore, each individual can hope that it will help him—persons have come to believe that medical care services and intervention by the physician make significant contributions to health. This view is not likely to change.

It is quite likely that public policies will reflect what the public believes to be the case even if analysts find little evidence to support the

public view. Part of the reason that policy will respond to public belief relates to the attitudes that surround questions of health and of life and death. Part of the reason relates to the different perspectives of the public and the analyst. This difference in perspective, and in criteria used in decision making, lies at the heart of some of the major difficulties in allocating resources to the health sector.

The analyst is likely to examine issues—e.g., the impact of medical care on health—in terms of group phenomena. He is interested in a *rate* of return, in what happens on the average. The citizen—importantly, the provider as well as the consumer—is far more interested in the individual case. His behavior is responsive to the fact that intervention can make a difference in one case rather than to the fact that it makes a difference in only one per cent of the cases. If each individual believes or hopes that he may be the one who will benefit and if we do not know who the one will be and, therefore, require that the service be available to all who might benefit, we have a situation made for conflict. The analyst may say that *only* one per cent of the cases will benefit. The physician (trained to think in terms of the individual patient) and the patient (for obvious reasons) will focus on the fact that in one per cent of the cases there will be a benefit. Neither will want to be denied the resources needed for the particular case at hand. That case, after all, may be the one in a hundred.

This, I believe, is one of the basic difficulties in formulating and administering public policy in the field of health care. We reject market mechanisms that might allocate resources to and within the health sector, in part, because market results are at variance with our values. We say “medical care is a right” because we do not believe medical care should be rationed in terms of income. As a consequence, we need to develop other allocative and rationing mechanisms. Often these alternative processes will involve government regulation and program development. Government, however, will find it difficult to limit the resources allocated to the health sector and thus, in effect, to ration services.<sup>2</sup> In making public policy, provider and consumer attitudes (concern about the individual) weigh against the analyst’s benefit-cost ratios (reflecting concern about populations).<sup>3</sup>

Furthermore, when the consumer hears the analyst say that, in the light of the rate of return, we need not devote additional resources to the health sector (or to particular parts of it) he recognizes that the constraint on resources implies rationing. Existing American health care financing mechanisms provide little assurance that the rationing mechanism

will not be income related. Medical care, of course, is rationed in other economies and under other health care financing mechanisms: when central government allocates a given amount of resources to the health sector and when this amount is less than either consumer or provider could or would like to utilize, some “rationing” will take place. The issue, therefore, is not rationing itself, but the nature of the rationing process. Are the rationing decisions related to income or to medical needs or priorities?<sup>4</sup> Thus, groups who today receive less than what they consider their fair share of services are hardly likely to be impressed by an argument that they translate: “Some people do get more of certain services, but after all the services don’t—on the average—yield high benefits (relative to their costs). Therefore, though the rich may ‘waste’ their money in purchasing the services, we shall not invest government funds to increase the availability of the services. The poor should not be distressed—they are not being denied things of considerable value.”

In recent years, much of what has been said about medical services could have been so translated. This, however, means maintaining the status quo. It is not surprising that the translation is not likely to find favor among those whom the status quo has not served relatively well.

For these (and other) reasons, arguments that equity is not that important will not find favor among the general public. Most consumers will remain more concerned about distributional equity in the provision of health services than about equity considerations in the provision of most other goods and services. They will behave as if medical services do count for more and public policy will respond to their concerns.<sup>5</sup>

The issues raised in the above discussion are important in considering public policy. Should government allocate resources as the public might prefer, even if those resources will not accomplish that which the public desires? What, for example, is the proper mix for an antipoverty program, that which the analyst feels will eliminate poverty or that which the poor value highly? The two are not always the same. We avoid these important issues by suggesting that if government cannot “educate” the consumer or beneficiary it will have to respond to his images, tastes, values and beliefs.

What is the present situation in regard to equity in access to care? There are two parts to this question: the financial constraints and the delivery system performance. We shall need to examine both for we cannot assume that solving the problem associated with financing care would make services available, nor can we assume that increasing the

supply of services would enable persons to purchase them. Let us begin with the easier part: the financial barrier. I use the term “easier” because restructuring the financing of health care is, in many ways, easier to achieve than is a restructuring of the delivery system. The fact that we are debating national health insurance (NHI) rather than a national health service (NHS) is not a coincidence.

### *Why Provide Specific Financing for Health Services?*

Surely we need not belabor the point that financial barriers to health care exist in the United States. Little would be gained by once again citing the data that all of us already know. Prepayment and voluntary health insurance, largely the result of labor-management agreements, have reduced the financial barrier for many, but not for all Americans. Medicare, Medicaid and a variety of categorical programs addressed to particular population groups or to particular diseases have also helped. Yet, even so, financial problems remain. These are of two kinds: (1) the ability to pay for care, (2) the impact of payment on family income and assets.

In this connection, it is useful to remind ourselves of some of the history of the Medicare debate. That legislation was justified on the basis of two arguments. The first derived from the fact that many persons, ages 65 and over, were unable to obtain an appropriate amount of health care because they lacked the financial resources to purchase the care. The second justification was that, even though individuals might be able to pay for care, their financial resources were so limited that the care would cut heavily into their discretionary income.<sup>6</sup> Thus, the debate related both to the financial ability to pay for the care that was needed and to the impact of large and unpredictable medical expenses on the financial status of the aged.

In a situation that has the characteristics of a lottery in which some will be heavy losers, there will be great concern about developing insurance safeguards. That concern is undoubtedly increased by the fact that the lower the individual's income, the greater the losses as a percentage of that income.

In some cases, the lack of money to pay for medical care (given required expenditures on housing, clothing and food) will prevent people from seeking care. In other cases, the monetary conditions result in a

psychological barrier: individuals will postpone seeking care in the hope of avoiding an expenditure that would be large in relation to disposable income. In still other cases, persons may seek and pay for care but with a significant impact on their discretionary income.

It is necessary to distinguish between these different situations if we are to develop a public policy designed to meet the various financial problems. If I am correct, the public is concerned not only about the impact of the income distribution on the utilization of medical care, but also about the impact of the utilization of and expenditures on care on the income distribution itself. It is the second problem that calls for specific financing programs for health services rather than the provision of money to achieve a more equal distribution of pre-illness income.

Were we dealing with a category other than health care, it would not be as clear that the financing or provision of the specific good or service would be necessary. Outside of the health care sector, for example, it is often argued that an income distribution problem can (and should) be met by the provision of money.<sup>7</sup> This would permit the consumer to determine whether he chooses to spend those funds on the product that others had in mind or on some other product that he prefers. It is sometimes suggested that these considerations should also guide us in relation to health care, and that government should not provide assistance for specified services or support specifically for health expenditures. Instead government should provide individuals with money that they could use to purchase care (or insurance), but that they could also use for other goods and services if they so preferred.

If, however, our concern is the *ex post* income distribution, it is not sufficient to provide *ex ante* income (valuable as that may be) inasmuch as the sick would “lose” the money and the well would retain it. A solution to the various problems requires that health services, like education, be provided free.<sup>8</sup> Even if we cannot eliminate the “lottery” that causes some to be ill and others well, we can eliminate some of the monetary losses associated with the lottery.

There are additional reasons for the view that targeted dollars are required: (1) There is evidence that taxpayers prefer to support programs not people. The categorical, targeted legislation fares better than does the broad and all inclusive. Cancer support would fare better than national health insurance; the latter better than general income maintenance. Taxpayers want to retain a measure of control over the uses to which their dollars are put. (2) Unless funds are channeled through a single

payment mechanism, it is difficult to achieve important changes in the health delivery system. (3) In the absence of government intervention, private expenditures on health care may be sub-optimal because of “externalities,” i.e., my well-being is affected by the next person’s state of health (and the next person does not consider that when he determines his health expenditures).

### *Some Equity-Equality Issues*

What is meant by equity in the provision of health services? Were we speaking of tax matters and of dollars rather than services, the criteria would be simpler. In the health field a consensus on definitions is sorely lacking, in part because we have failed to specify objectives and the criteria by which to measure their attainment. Is our concern solely with the health producing aspects of the service or do we care—and if so, how much—about the amenities and the conditions under which the money or service is provided? What is the relation between equity and equality? Is equity realized when equal numbers of dollars (or services) are available for the health care of different persons, or when equal numbers of dollars (or services) are utilized, or when equal health outcomes are achieved?

As can be seen, the issues we discuss are not unique to the health sector. In different forms they are found in other sectors. The fact that they have not been solved adequately in other sectors can give us little comfort. Yet, we can gain some useful perspective from the experience elsewhere. In the field of education, for example, we find similar problems—and this in spite of the fact that in many important respects the educational sector is easier to understand than is the health sector. In the early 1960s, the definition of equality in education related to per pupil expenditures. Though we have not achieved even that limited goal, our definitions have changed and become broader. From a criterion of equality in dollar *inputs*, we moved to a definition of equality in terms of *outcomes*. At present, it is argued that there should be inequality in dollar inputs per student; inequalities that compensate for the dispersion of advantages and disadvantages that, in turn, make for variation in output per dollar of input and in outcomes. As they have in education, the newer definitions of equality will overtake the health field.

In education, we are still groping for answers to problems associated with equity and equality, with “basics” and “extras,” in the public sector. Recent court decisions will help in the search for answers, but the

achievement of equality at a basic minimum level is only one part of the problem. How do we deal with the fact that some persons will be able to purchase even more services than the basic minimum, that some communities will be willing and able to do more? If a community has no public kindergarten should we (can we) deny some individuals the opportunity to organize and finance their own kindergarten, i.e., to have a private kindergarten? If the school system does not provide librarians for all schools (and chooses, therefore, not to supply them to any) should we deny some (generally, upper income) mothers the right to volunteer their services as librarians in *their* school? The difficulty in saying “no” is clear. The implications of saying “yes” should be equally clear.

The battle of equity and equality has not yet been fought in the field of health in the United States. One can predict that, at some point in the future, it will be fought. If society, looking at the benefits to society, should decide not to provide various health services to the population, will it permit individuals who want those services and can afford to purchase them in the private market to do so? What if those services involve matters of life and death? If society were to conclude that it would not finance kidney dialysis for all who need it, will it finance it for some (and, if so, how will it select the “some”)? Will it permit individuals who have the resources to finance the service privately? If society should decide that it will not invest significant resources in keeping individuals alive in the latter stages of a terminal illness, will it allow the individual who has the resources to do so?

Nor is this a problem that exists only in the case of exotic and expensive procedures. It should not surprise us that in today’s market, a blend of the public and the private, similar issues arise in Medicare. If a physician, more highly qualified and providing a higher quality of medical care, charges more than the prevailing and customary charge in the community, the patient must pay the difference. This can be interpreted to mean that the Medicare program is prepared to pay for an average level of physician competence for all individuals while permitting individuals interested in a higher quality of care, *and who can pay* for that higher quality, to seek it out. Even though Medicare does, therefore, bring an adequate or average quality of service to all, it does not bring equality. It is clear that it does not provide what public officials often set as a goal: the highest quality for all. With limited resources one cannot have the highest quality for all. If the quest is for equality, the slogan might well be: the highest quality for none. That, however, is hardly a slogan that



will find its way into a Presidential message (in part because it is not of such slogans that Presidents are made).

It is not clear, of course, that the objective is full equality. It may be that a more limited objective—say the elimination of income as a rationing device—is sought. With scarce resources, society may decide not to withhold services from everyone because it cannot provide services to all, but instead to provide them to some who are selected on a basis other than their ability to pay for the services. Tables of random numbers or other criteria could be used to determine the allocation of the scarce resources.

Though I have raised these issues because it seems to me that, at some point, the body politic will wrestle in some continuing fashion with many of them, we should not be misled. The fact that there is no consensus on these matters and that they cannot all be solved does not imply that we cannot move forward. We are not required to have a solution to every possible dilemma before we develop a public policy to resolve those that we can do something about.

In considering equity, we can adapt some of the approaches used in discussions of tax equity. We can distinguish between horizontal and vertical equity. By horizontal equity we mean that the health care system shall provide essentially the same set of health services (or a distribution of services that equalize outcomes) for persons in approximately the same economic circumstances. Most often horizontal equity considerations are assumed to relate to questions of access affected by the availability of services (e.g., rural-urban differences). These, of course, are important. Horizontal equity, however, is also affected by the nature of government support for the purchase of health services. If such support, as in the Medicaid program, leaves the states free to determine eligibility and the level of benefits (i.e., if the system is based on matching grants rather than on 100 per cent federal funding) horizontal equity will not be achieved. Indeed, the existing inequities are likely to be compounded. The achievement of vertical equity requires government involvement in the financing of care. The achievement of horizontal equity requires that it be the federal level of government. This is not surprising for horizontal equity requires that the residents of different states be treated in like fashion (i.e., as Americans). Only the federal dollar can insure that that occurs.<sup>9</sup>

Vertical equity, “fairness,” in the provision of services for persons in different economic circumstances, is more difficult to define. Because

health benefits must be financed, an examination of the progressivity of the distributional impact must consider the distribution of the tax, premium or other device that finances the benefits as well as the distribution of the benefits themselves (the availability and distribution of the services). It must also consider the proportion of health care costs that is covered by the program. We achieve relatively little even if we devise a highly progressive tax structure, but one that finances services that play only a small part in the consumer's budget. If our goal is equity in the distribution of health expenditures, we must consider the distribution of total health care costs in relation to income.

### *Paying for Medical Care: Present Patterns*

At the present time, the individual's medical care costs are often met both by out-of-pocket expenditures and by voluntary health insurance benefits. Out-of-pocket expenditures occur because voluntary health insurance coverage usually involves deductibles and co-insurance, is not comprehensive in its scope and sets upper limits on benefits. This approach has a long tradition and has found its way into public programs, e.g., Medicare.

Deductibles and co-insurance are supported on two rationales. The first is that the larger the amount the individual must pay on an out-of-pocket basis, the smaller the premium charge (or tax) can be. The second rationale is based, if not on empirical analysis of the demand for health care, on well-established economic principles. It is assumed that if the individual is required to share in the cost of care at the time that the care is sought his utilization of care will be reduced. In the absence of deductibles and co-insurance, care is "free." At that zero price the individual would seek more care than if he were required to pay a small sum, sufficient to deter him from seeking unnecessary care, but insufficient to deter him from seeking care when it is required. This second rationale is closely associated with yet another that is put forward: if the consumer is required to pay a share of the cost, he will be more cost conscious than would otherwise be the case. This cost consciousness, in turn, will induce providers of care, including hospitals, to exercise price restraint and to compete on a price basis.

Although these arguments carry some weight, it is possible to advance arguments on the other side of the co-insurance and deductible issue. It is clear, for example, that a fixed deductible and a fixed percentage co-insurance cannot hit with equal impact on families in different income

brackets. The amount that is appropriate for one family (i.e., it deters only unnecessary medical care) may be trivial for another (serving not to deter at all) and too large for yet another (serving to deter even important care). It is true that, in theory, this particular objection can be met by letting the size of the deductible or the per cent of co-insurance vary with the income of the family. Yet, deductibles and co-insurance may entail significant administrative costs and the more refined the approach, the greater the costs of administration. Nor do we have the requisite information to construct a sliding scale that would have the particular impacts we desire. One must, therefore, ask whether the claimed benefits of deductibles and coinsurance are sufficient to justify the costs.

We have little information concerning the degree to which utilization would be affected by different co-insurance and deductibles.<sup>10</sup> We also lack information that would enable us to assess whether an increase in utilization is unwarranted. Costs of travel and waiting time, possible loss of income from work, fear, concern and so forth, all associated with visiting the physician, may lead persons to underutilize medical care services. If utilization should be higher—even then it would be at a zero price—one would not want to erect a financial deterrent.

We can also indicate some doubt concerning the effectiveness of deductibles and co-insurance as cost-control devices. Even in spite of existing financial barriers, the health sector has not had an enviable cost-control record. Furthermore, though we know relatively little about how prices and expenditures are determined in the marketplace, what we do know suggests that the physician is the critical actor in the determination both of unit costs (the price of the product) and total cost (unit cost times quantity, the degree to which the product is utilized). The largest savings on the expenditure side are likely to come as ways are found to affect utilization (rather than price). Since utilization is largely physician (not patient) determined, efforts to contain the total costs of a program require that the programs be structured to provide incentives to change *physician* behavior.<sup>11</sup> Deductibles and co-insurance (at levels that do not deter necessary care) are not likely to do that.

Costs associated with treatment for conditions not covered through the insurance mechanism are also part of out-of-pocket expenditures. The failure of insurance to be comprehensive in scope has taught us that the medical care system can be distorted by virtue of what is and what is not covered through insurance. Economics does make a difference. In theory, such distortions could be for good or for bad. One could, presumably, structure a health insurance program so as to reduce unnecessary and

expensive procedures. It would, however, be difficult to leave the most expensive procedures without coverage. Even though, for example, some may overutilize expensive hospital procedures, others utilize the services because they need them. Shall they be uninsured?

As contrasted with other types of insurance, our problem is compounded by the fact that the provider and consumer help determine whether the insured service is utilized. If some services are insured and others are not we are likely to find distortions in utilization. Because we are called on to insure expensive procedures, we are providing incentives for their use. One is, therefore, almost inevitably led to comprehensiveness of coverage, in part for medical reasons, in part to prevent unfavorable impacts on the allocation of resources within the medical system and in part to achieve the equity we spoke of earlier.

There is a third element of medical care that is paid for by the patient on an out-of-pocket basis: those costs that occur after the insurance has reached the upper limits on the number of days of hospital care or on the total cost that will be covered. In many ways this is the anomaly in the insurance field. Had health insurance not originally been developed by the hospital sector as a way of protecting itself from bad debts, we would likely have had larger deductibles and greater protection at the upper end. Since most patients spend a limited amount of time in the hospital, the emphasis, however, was on shallow-end coverage. The consequence—incorporated into federal legislation in the Medicare program and duplicated in a variety of proposals that have been offered to the Congress—is that those who stay in the hospital the longest time (and who often are most sick) run out of benefits. Insurance, in general, tries to protect against high expenses that occur relatively infrequently and the occurrence of which is not under the control of the person having the insurance, but that upper-end coverage is lacking. The costs associated with exceeding the upper limits may not significantly affect the distribution of medical care costs by income class (because the upper limits are seldom reached). Nonetheless, the costs are a severe problem for those who must bear them and require relief.

### *Paying for Medical Care: Future Possibilities*

In my view, a comprehensive insurance program is called for with coverage at both the upper end of the cost spectrum (if high-cost services are to be available) and at the low end (there is little evidence that deductibles

and co-insurance yield important benefits). I refer to coverage both at the upper end and at the lower end, so I could, of course, be asked about my trade-offs: would I rather have the one or the other? If the question assumes that, for political reasons, we cannot have both upper- and lower-end coverage, it is meaningful to pose the issue. This is not the case, however, if the question assumes that we can afford one or the other, but not both. Costs are incurred whether or not they are covered by a national program. We are not talking about new dollars (except to the extent that utilization is increased, and that increase may be one of the desirable consequences of the program). In largest measure we are talking about old dollars in new clothes. The question is how shall the cost be borne; i.e., shall the expenditures for medical care be private or public?

For the legislator, the trade-off question is meaningful. Legislative bodies are concerned about increasing taxes even if these taxes pay for services that would otherwise be paid for by private expenditures. Part of the dilemma of the legislator is the result of the fact that he has failed to educate the public as to what the issues are. Education is never easy, and the task is made even more difficult by the cynicism and mistrust that is the legacy of our recent past. Yet, it is a task that cannot be avoided except at the risk of creating more mistrust.

Quite often, the difficulty in explaining what the public might receive for its taxes lies in the fact that expenditure programs are not tied to specific tax revenues. This is one of the strengths of our fiscal system. It permits the Legislative Branch to choose between programs (presumably) to maximize welfare. Nonetheless, the absence of a link, at least in the consumer's mind, does make it more difficult to associate particular benefits with the general taxes that we pay. These considerations are relevant in examining the method by which funds might be raised for a program that would distribute the costs of medical care more equitably.

The most progressive part of our tax system is the federal personal income tax. Given a progressivity goal, one could, therefore, argue in favor of financing a national health insurance program out of general revenues, in large part, derived from the federal personal income tax. Furthermore, appropriations from general revenues increase the competition between dollars for health and for other programs. This can have a significant and desirable effect on the Congressional desire to control costs. Arguing against the use of general revenues to support the program is the lack of a visible link, as seen by the taxpayer, between the tax and

the program. Such a link might increase the public's understanding that public dollars for health compete with private expenditures and, thus, would be useful in generating consumer concern about cost control. It is possible, therefore, to argue that general taxation increases Congressional concern about prices and costs, whereas the levying of a special payroll tax increases the consumer's concern. If it is necessary that all parties understand that there is no such thing as a free lunch, it may be desirable to use both types of taxation in funding a national health insurance program.

The payroll tax, in its present form, however, is hardly a tax that can be considered progressive. Its deficiencies are well known: e.g., it does not take account of family size, often discriminates against multiple-earner families, considers only certain kinds of income. It is proportional up to the wage base and then regressive. Raising the wage base would help, but other adjustments are also desirable: e.g., low-income families could be given a refund for the payroll tax deducted. Over the last decade we have had a number of personal income tax cuts even in spite of the social needs pressing upon the nation. The nonprogressive payroll tax has, therefore, come to have an even larger impact on the tax burden by family income. Today a family of four earning \$4,000 pays \$32 in federal income tax. Yet it pays over \$400 in payroll taxes (if we include the employer's contribution). If income tax rates reflect our judgments about the tax levels that are fair or appropriate at the various income levels or about the relative tax burden by family income, we can hardly add a very substantial payroll tax and assume that we are not distorting the very standards that we have set.

The payroll tax does have important political strengths. It is to be hoped, however, that we would not embark on payroll taxation as the method of financing national health insurance with the belief that a few years later we could amend the payroll tax to improve it. Such amendments will not come easily. The time to press for a more equitable payroll tax is before the program is enacted.

Earlier we have discussed the importance of cost control. Although indicating that it would be useful for the consumer to recognize the link between costs of the program and tax levels, one can hardly expect that the individual will be influenced in his utilization of medical care services by such considerations. This is the case for two reasons: first, because no individual believes that his utilization will affect the general price level, the total utilization and the tax rate. Little personal gain is to

be derived from acting in a socially responsible fashion. Second, decisions regarding utilization are more often made by the physician rather than by the patient. Consumer awareness about costs should be increased. Ultimately, however, costs will depend on how the system is structured and on physician behavior. We must, therefore, now turn to those things within the system that can affect the physician in his determination of appropriate utilization.

We are also compelled to turn to the question of system because the financing of services is only one part of the equity consideration. We cannot assume that if financial barriers are removed, the distribution problem would be solved through market adjustments—as might, for example, be the case with food. To assure a more equitable distribution of food is relatively simple (conceptually, if not politically). In general we need only provide families with sufficient money (or with food stamps, if we want to reduce the possibility that the “currency” provided would be used for nonfood purchases). We are not required to open grocery stores. We can assume that a food distribution network exists or will expand to meet consumer demand. The level of skill demanded of grocery store managers does not necessitate a long lead time to train supply (surely not as long as that required to educate and train physicians). Nor, in contrast with physicians, would we have to attract managers to the Ozarks from New York. In the case of health services the situation is quite different—and particularly so in a system as highly fragmented as ours. Access to health services requires that health resources be available (not simply that the “health stamp” be distributed to families). Physicians are people, not commodities. They prefer certain locations, certain kinds of situations, certain types of associations. Under those conditions, providing equal access (however we choose to define it) requires that we address the delivery system’s characteristics. We thus turn our attention to some of the issues related to the allocation of resources to and within the health care system.

### Access and Equity: System Change

The health system is a complex network many parts of which we do not fully understand. In the search for equity we must consider that system and the allocation of resources within it for access is, in part, determined by the allocation of resources. That the system suffers from a variety of

ailments in its resource allocation is clear. What is unclear is which of the problems are interrelated and to what degree. We are, therefore, often at a loss to understand the nature of the required therapy. Too often we tend to approach each ailment or misallocation as if it requires direct action and intervention. Seldom do we explore the possibilities that actions on another part of the system may, in an indirect manner, affect the variable that is our concern.

The bias in favor of direct intervention is clear. It seems simpler to attack a problem in a frontal fashion. The disadvantages should also be clear. Too often the problem we see is really a manifestation of more basic difficulties and is the logical consequence of a more basic structural deficiency. It may, therefore, resist intervention, recur again or require periodic intervention as it manifests itself in some new manner.

To suggest that one knows the single root cause of our difficulties and that that cause can be described in specific terms would be foolish. Nor is it even clear that there is one single cause to all our problems. Actions on a number of fronts are required, though little in the American tradition suggests that, even if we had the understanding, a rational and organized approach would be followed. We are far more likely to move in fits and starts, first in one area then in another. Nonetheless, it is useful to recognize the interrelations within the system. At the margin this knowledge can affect our public policies. It can prevent us from dissipating energy on policies that would have little impact, could enable us to devote our effort to actions that have basic effects, could keep us from taking an action in one area that negates what we are doing elsewhere in the system. It should be clear that as we examine basic problems and discuss them in more specific terms than "what we need is a reorganization of the delivery system," we cannot help but be controversial. The existing system has its rewards for many providers and consumers. It is hardly to be expected in a field as important to the consumer and as rewarding to the producer as is medicine, that important changes will be welcomed by everyone. At the minimum there is the fear of the unknown. At the maximum there is the recognition that the particular individual may not gain through change.

The fact that controversy is present means that the health sector is politicized, a phenomenon not to be deplored but welcomed. No longer can the sector be viewed as belonging solely to the "experts." What is to be deplored is that many first-class analysts have played the role of second-class politicians. Desirous of change and improvement, they have



presented analyses and recommendations that are far reaching but that stay within the limits of what they conceive of as political reality, within their definition of what is possible. This is regrettable, on at least two grounds. The quest for political acceptability has tended to focus the discussion on technical matters, as if there were no ideology. As a result, the most important areas of controversy, the ones that require debate and on which people disagree, have been neglected. The effort to “sell” a program steers one to the technical nonideological issues and replaces passion with blandness. This lowers the quality of the discussion and does less than is required for the education of the public. In addition, there is little to suggest that the political analysis is necessarily correct. Too often the analyst, in playing politician, rejects proposals that have greater political viability than he imagines. Although it is true that one can offer proposals so politically unrealistic that the advocate as well as the proposal is rejected, that danger, it seems to me, should be considered important only in the center of the political arena; i.e., on the Washington scene. The problem, perhaps, is that too high a proportion of those concerned with American medicine are (imagine themselves to be or hope to be) directly or indirectly part of the Washington scene.

We need only remind ourselves of Phases I and II, to recognize that one can underestimate what is possible. Similar examples exist in other areas. Before the health analyst rejects a proposal as politically unrealistic he might ask whether it is more “daring” than a trip to China, a proposal to impose a moratorium on a category of court decisions, a budget deficit of over \$25 billion. Surely, asking that question will suggest that one need not be inhibited about being “far out” in his suggestions.

### *Regulation and the Market*

What are some of the more basic elements of the health care system that would benefit from change? What organizational and financing structures have influences so pervasive that changing them might result in fundamental changes in the allocation of resources and, therefore, in access?

Many of our difficulties in the health sector relate to the fact that we operate in a never-never land, somewhere between the free market and the results it might bring and government regulation and its consequences. Rejecting the market because the characteristics of health care suggest that market results would not meet our preferences, rejecting

tight government regulation because of American traditions and the difficulties inherent in the regulatory process, we have found ourselves in an untenable situation. Our difficulties will not disappear; indeed, they could grow even more severe with the enactment of measures limited to the financing of the purchase of health services. Many persons would be aided by such legislation, but unless these programs (or accompanying legislation) address some of the issues that affect the delivery of services, we will provide a good deal less health or equity than we should with the resources available. This, after all, has been the record of Medicare and Medicaid. To suggest, as some do, that these programs have only caused inflation is fallacious. They have offered financial protection to many and have provided additional services to some. Nevertheless, it is also true that while helping to solve some problems, they have contributed to the worsening of others. In my view their pluses far outweigh their minuses. Nonetheless, it is clear there have been minuses. Furthermore, they have, unfortunately, led to a certain disillusionment.

During the decade of the 1960s—in the days of the optimism of the New Frontier and the Great Society—we enacted a wide variety of social programs in a number of areas. The characteristic of many of these programs was that the federal government appropriated funds with which to buy goods and services from the private sector. It did not produce the goods or services itself, nor did it take over the control of the particular sector. Medicare and Medicaid are examples of this approach, but the examples extend beyond the field of health. The programs were underfunded and, in some cases, poorly managed, but those were not the only difficulties they faced. Watching dollars flow out of Washington and observing that the dollars would not change delivery systems (an observation that should not have come as a surprise) many who believed in the aims of the legislation gave up hope too quickly and began to consider the virtues of the market as a regulatory device. This process was accompanied by a disillusionment with government itself. Considered impersonal and unresponsive, bureaucratic and inefficient, the call was for withdrawal: “Give it back to the market, call in the for-profit institution, sell the city hospital (or post office), turn to a voucher system in education, and so forth.”

It is perhaps the case that we had chosen the most difficult of all worlds. I do not suggest that to operate a nationalized sector effectively is easy. Indeed, that is not the case. Neither do I suggest that the solutions arrived at through normal market forces (and it is not clear what these are in the health sector but surely they are not those of pure competition)

are desirable. That, too, is not the case. But operating a mixed economy (perhaps in the health field the phrase “mixed-up” economy would be more appropriate) may lead to higher costs with relatively little increase in output or redistribution for the increased dollars. It leads to a high level of frustration.

It is difficult to administer effective regulations—regulations designed to allocate resources and to make a real difference. In part, this is because regulation runs counter to a number of our traditions. In part, the difficulty stems from the fact that we know less than we should like to, especially about the production function for health. Regulating the construction of health facilities, for example, requires more than just a “feel” for the “right” number of hospital beds. No regulator can easily withstand the political pressure if his chief weapon is his intuition. The recognition that he lacks technical knowledge that might buttress his case against political pressures tends, therefore, to cause the administrator to shy away from regulation. Instead of saying “no,” he says “yes.” Instead of redistributing resources he calls for more dollars and more resources in the hope that some of these will trickle down and solve the particular problem with which he was initially concerned.

To say that today’s health economy is substantially unregulated (where it counts) is, however, not to imply that government regulation that says “this you must and that you can’t do” is the only solution. Much that is wrong today in the health sector derives from the fact that the structure of the health industry provides the wrong incentives. It is possible, therefore, to effect change, not by regulation but rather by substituting a different set of incentives and permitting the system to adjust to these incentives. If such a mechanism could be developed, it would have a number of advantages: it would appear (and often be) less arbitrary; it would provide us with “signals” as a feedback to tell us how the system is operating.

Let us examine some of the issues. In so doing, we shall focus on the physician because he is the critical actor in the health care system, because access to his services is a key equity issue and because, in large measure, he determines the utilization of other parts of the system.

### *Fee-for-Service: Physician Control of Market Forces*

Much of our difficulty relates to the set of incentives that impinge on the physician and the setting in which they operate. Physicians are

self-employed, small businessmen and, in many critical ways, are viewed in that light. They are among the relatively few Americans who are self-employed: of the 75 million persons employed in nonagricultural industries in 1970, only 5 million were self-employed. Though there is a trend toward grouping of physicians, many of them still practice in solo, independent practice. They are subject to relatively little control or oversight. The quality of their performance may be good or bad—there is no real way to know because a data system does not exist that will record relevant information or a mechanism for performance review by impartial observers. Once licensed, they remain licensed without reassessment of their performance. With licensing and entry restrictions (generally justified as protecting the consumer and maintaining quality) but without continuing or periodic quality assessment, we have a system that, to a significant extent, protects the producer by sheltering him from the forces of competition while not requiring performance standards.

Though many small business markets bear some resemblance to the physician market (though with different supply constraints), those sectors, most often, must meet a market test. That, perhaps, is the critical difference in health services. Consumer ignorance of medicine and health, combined with fear and customs, prevent the consumer from performing his own quality assessment, from evaluating physician performance, from examining prices. More than that is involved, however. The consumer's utilization of services is largely dependent on *physician* decisions. The physician (businessman) is one of the relatively few American entrepreneurs who can expand the demand for his services (and without advertising or at the expense of a competing firm). The power to influence, if not determine, the level of demand is a strong power, indeed. That there are inducements to expand demand is also clear. The system of payment, fee-for-service, is at issue. Given a payment system that has characteristics of a piece-rate wage, the power to determine the number of pieces (with "piece" defined as a procedure rather than the attainment of a desired outcome, say "cure"), and little control of quality (including excess visits or surgery and unnecessary procedures as poor quality), it is easy to see that normal market forces are not likely to involve the kind of adjustment processes that operate to equilibrate other markets. The essential factor is that the physician can control his market to a substantial degree, administering price, quantity and quality.<sup>12</sup>

Today's system preserves the freedom of physicians to practice where they want, the kind of medicine they want (by specialty), as well as with

population groups they prefer. The physician is free to allocate his resources as he sees fit. This is a freedom given to few others in the society. Even though it is the case that government regulation does not often direct labor (allocate it by skill, occupation or location) or business, other regulatory devices (called economic incentives) do operate. They provide for allocations that are acceptable or that we believe tend to distribute the supply of services in relation to consumer demand. The quest for profits, the desire to take advantage of economic opportunity, to win the test of the marketplace, is the lubricant that, presumably, makes the story end happily. It is not clear, of course, that there are as many happy endings as our illusions suggest. Unfortunately, there is increasing evidence that rigidity in various economic sectors interferes with the adjustment process. Bigness, for example, plays its interference role; discrimination plays its interference role; licensing restrictions play their role; differential tax rates play their role; government regulation, often times converted to the protection of the regulated, plays its role. Nonetheless, the small business retail service sector does exhibit a number of competitive characteristics. Some establishments succeed and others fail. The fact that some fail means there is a test. The health sector, however, is different. It does not even offer the illusion that the forces of competition are at work to respond to consumer demand. Furthermore, meeting consumer demand for health care, as expressed in the marketplace, would not be sufficient. Today our concern is with consumer need. We cannot as readily accept the nonadjustment process that prevails in the health market.

Suppose, however, we do not consider the physician as a businessman. Surely then his freedom, say, to settle where he would like, to specialize as he might like, is the same freedom others have—or so it might appear. Is that the case, however? As already noted, the vast majority of Americans are not self-employed. Most Americans take jobs, and this is true at all levels of the occupational ladder, including professionals. They enter fields in relation to income potentials and a projection of job opportunities. Their choice of a place to live is, in part, determined by job opportunities. In many cases, of course, these job opportunities exist all over the nation; e.g., school teachers, clothing salesmen and so forth. In other cases, the range of choice is limited. If one wants to be an aeronautical engineer, chances are one cannot live in South Hill, Virginia. If one wants to be a Supreme Court Justice, one must reside in the Washington, D.C. area. The allocation of labor and of its productive services is determined by market conditions. Many of us may be

unaware of the economic controls over our behavior because they are so much a part of the system that we do not recognize them explicitly, and because they appear impersonal and not arbitrary. The young man in a small community in New England who would like to live in that small community but who would also like to be a petroleum engineer most probably does not consider that his “freedom” is restricted because he must choose between the two. Physicians in academic medicine hardly consider their freedom restricted because they cannot be both in academic medicine and in Springfield, Massachusetts (there is no medical school there). The crux of the issue is that most physicians are not employees and, therefore, meeting a test of demand by employers; but at the same time as self-employed individuals, they are not required to meet the rigorous market demand tests that other self-employed individuals face. They are insulated from the forces of competition.

The largely unrestricted freedoms physicians have are not the freedoms most Americans have. Yet we have somehow come to believe that to restrict the physician’s freedoms is to single him out and engage in discriminatory action. Physicians, in criticizing the organization of medical care in other nations, often complain about the loss of freedom (say, to be a neurosurgeon and to practice in a particular city whose hospitals have no unfilled posts in neurosurgery). They would do well to consider that if the market in medical care were truly competitive (the results of “free enterprise,” which the very same physicians praise) significant (albeit impersonal) economic controls would influence their decisions. It is not surprising that physicians prefer the United States pattern under which they can control the market forces. What is surprising is that the layman has come to accept that situation as an essential freedom.

The market for some other professionals may exhibit characteristics similar to that which the physician faces, but his advantages are somewhat greater. These derive from two considerations: the first relates to the fact that the physician, though he does not have total control over the market, can exercise greater control than most and, thus, reduce the economic differentials that might otherwise obtain. The second relates to the fact that, in general, we consider medical services to be more important than various other services; indeed, it is because we so consider them that the physician faces a relatively inelastic demand curve for his services and that he can push that demand curve to the right.

The picture we draw is an extreme one. There are limits, of course. The physician does not have complete control (or freedom), but he does

have sufficient control to affect the market so that the signals that it would normally send regarding shortage and oversupply are missing. Within the limits of the existing supply of physicians, the pressures to reach an equilibrium position that reflects needs are far too weak. One can hardly imagine that, if we had ten times as many physicians, they would be distributed as they are today. Market adjustments would take place. We do not, however, have ten times as many physicians, nor could one responsibly advocate a policy to solve market disequilibrium by increasing supply until, on some trickle-down or overflow basis, our poorer areas would be served. The costs of producing that manpower, as well as the cost of "overdoctoring" in areas that would be even richer in physician supply than they now are, can hardly lead us to advocate that solution.

Finally, of course, we must recognize the unhappy set of coincidences that exists. If, after all, we argue that part of the problem is that the pressures to fill medical needs can be resisted because of the nature of the medical marketplace, that in no way suggests that they must be resisted. After all, there is no inexorable law of nature that says that physicians' desires must be at variance with society's needs. One could imagine a world in which both society and physicians placed a high value on primary care and in which physicians wanted to practice in inner cities and in rural areas. In that case, physician control would be less troublesome because, even in its presence, physicians would be moving to the very areas where they were needed. But the world does not end that happily because of two factors in physician preferences.

### *Specialization and Location*

The first factor is that for a variety of reasons an increasing proportion of physicians moves away from primary care and in many cases into specialties not closely related to the primary care function (e.g., pediatrics, obstetrics and gynecology or general internal medicine). Despite the fact that leaders of American medicine and observers of the American medical scene may deplore the movement into specialties and the emphasis on surgery and on subspecialties, the energy devoted to discussing the problem has failed to change the pattern of movement. The pressures seem to be too great. One such pressure comes from the larger society from which medicine does not stand independent. The forces at work to increase specialization in other areas of activity also affect medicine.

As knowledge explodes and is transmitted in innumerable journals, the pressure to specialize grows greater. As the number of specialists increases, the generalist comes to be considered as the nonexpert, and this in a society that places a high value on expertise.

These pressures are further reinforced by the process of medical education. The National Institutes of Health have helped enlarge the subspecialties and create a research endeavor and a reward system that many students have seen as denigrating the physician who delivers general care and is not doing research. The culture of the medical school, the nature of its faculty, the heavy emphasis on clinical teaching in the hospital (the world of the specialist), all tend to reinforce the pressures that already exist. Trained in the hospital where one sees the sickest patients, where things are happening, where time is compressed (which is one of the reasons the hospital is used as a training institution), it is no small wonder that specialists become the role model. These pressures in themselves might be sufficient, yet the nature of modern medical practice adds to them. There are significant disadvantages to being a primary care physician, particularly in individual solo practice, a type of practice that places heavy demands upon the physician.

The fact that the physician can validate his decision to be a specialist, in part by control of the market, leaves little hope that, in the existing system, the primary care needs will be met (except, perhaps, in the hospital outpatient department, which has special characteristics that would enable it to “succeed” or by new nonphysician kinds of personnel).

The second factor that inhibits the development of a more equitable geographic distribution of physicians is that physicians, like most Americans, prefer locations other than the rural area or the inner city. Furthermore, this is reinforced by the bias in medical school admissions in favor of applicants from families in the upper part of the income distribution, whose background is not likely to be the rural area or the inner city. In addition, the decision to specialize affects the geographic distribution because the specialist needs a different population base and may require different facilities, a network of relations with other physicians and so forth. Finally, the nature of practice—particularly the way medical services are disorganized at the present time—makes solo practice in the inner city and rural areas less desirable: the risks are greater, practice is hard and frustrations are many. With greater mobility than most persons physicians are able to satisfy their geographic and location preferences.



The critical issue, however, is not that physicians decide to be specialists and offer less primary care than needed. Nor is it that the geographic supply is maldistributed. These are results not causes. They are the outcomes of a process that permits the physician to determine the allocation of resources (his as well as much of the health sector) without the constraints set by the normal requirements of meeting consumer demand (which he can influence) or government regulation (which is weak at best and often absent). Because the allocation of resources determines access, the other side of the equity coin, we face the prospect of continued inequity even in the face of more comprehensive financing mechanisms.

It can, of course, be argued that under a system of universal financing, the distribution of physicians by specialty and by location would show some improvement. Surely there are physicians who, today, do not practice in locations with a high proportion of low-income families because of the difficulty that they envision in achieving a desired income level. Given an alternative financing pattern, we could expect some improvement in the maldistribution. Medicaid, after all, has made services available to some who otherwise would have gone without services. Yet the Medicaid story suggests the difficulties involved in using this approach to solve a distribution problem: the re-allocation of resources is not likely to take place in an efficient manner, quality differentials remain and so forth. We cannot assume that we will achieve the desired distribution and equal access by giving the poor money so that they will be better able to compete with the nonpoor. Even though the dollars of the poor are as green as the dollars of the rich, the poor are not likely to compete on equal terms. This is especially the case if the nonpoor can outbid the poor because they have more dollars with which to purchase the limited supply of services; i.e., if a private market continues to function.

### *Maldistribution: The Difficulty of the Direct Approach*

If equity and access are to be achieved, the distribution of physicians and of their services must change. Such changes will not come through exhortation. Intervention is required. The question is, "What kind of intervention, direct or indirect?"

Three approaches, not involving a restructuring of the basic organization of the medical system, can be examined. The first attempts to

select medical students with characteristics that, it is hoped, will alter the probabilities of various specialty and location choices. The second attempts to use the regulatory process (and coercion). The third attempts to use incentives (most probably economic in nature).

American medical education uses the first approach to a limited extent and in a rather haphazard fashion. On occasion, applicants from rural areas are given preference. A number of schools give preference to minority applicants, hoping that this will increase the services available to inner core city residents.<sup>13</sup> There is little hard data, however, that would provide confidence in selecting applicants with specific characteristics in an effort to change the geographic and specialty distribution of physicians. Furthermore, even were such data available, it is likely that the individual medical school admissions committee would prefer to maintain traditional standards “relying” on other medical schools to make the adjustments. Finally, the stock of physicians is so large, relative to the annual inflow of new United States graduates, that change in the distribution of the total number of physicians would occur very slowly even if new admissions’ policies were established and these were successful in attaining their objective.

The regulatory process, applied to specialization, would also require collective action. One could hardly expect individual hospitals or medical schools—except in rare instances—voluntarily to limit the number of residencies available in the various fields. However much physicians in Medical School X may feel there are too many residencies in the nation in Specialty Y, they may also feel that their residency provides better training than the next school’s and that that school should make the needed changes. Responsible action on the part of one medical school is insufficient, and competitive forces are not likely to bring responsible action by all medical schools. Furthermore, we cannot help but recognize that in the heavily hospital-oriented present system of medical care house staff members provide a significant number of services. Voluntary action on the part of the hospitals in the absence of new financing mechanisms, and a greater emphasis on nonhospital care is, therefore, unlikely. The system is too intertwined to permit action on one front alone.

Government, because it is involved with all parts of the system, could apply the regulatory process. The difficulties in this regard are clear: applied to specialization on a yes-no basis, government would receive few “signals” back to inform it that adjustments are called for. This common problem in regulation may be even more severe in the health

sector. To apply regulation to locational decisions—extremely difficult to imagine, given American traditions—is also difficult. One can picture a system of coercion; e.g., two years' service in various locations. Such an approach may have merit, if we are unprepared to attempt more basic institutional reform, but it is an incomplete solution because, like other regulatory or coercive devices, it does not attack the cause of the problem.<sup>14</sup>

A third alternative approach to changing the manpower distribution involves the use of economic incentives. Here, too, one can generate little optimism. We have little information on the level at which incentives would have to be set to materially affect the distribution. We do, however, know this: incentives are expensive. Extra payments to physicians to enter certain fields and to practice in certain areas cannot be offered as rewards only to those whose behavior we are trying to change. They must be offered to all. In the first place, we cannot tell whose behavior is changing and who would have "done the right thing" anyway. In the second place, it is difficult to justify an administered payment mechanism that rewards the individual who is induced into a field, and discriminates against the one who would have entered it voluntarily. Incentive payments, therefore, must be given to all. They must reward those who would have accepted smaller payments with the same amount required to induce the marginal individual to change his behavior. Finally, given the high income of physicians and present tax rates, economic incentives in the form of higher income (as contrasted with, say, vacations) are not likely to have much influence.

### *Alternatives to Fee-for-Service: The Advantage of Prepaid Group Practice*

These direct approaches to the distribution question, however, are not the only ones we need consider. Our earlier discussion suggested that many of our difficulties (and not only ones involving the distribution of physicians) stem from the fact that physicians are not subject to various market constraints (that they can influence demand and price). Is not the better approach to change these conditions? We need to intervene on the organization side rather than try to correct the consequences of the unfavorable organization.

The elimination of the fee-for-service payment mechanism would go a long way toward eliminating the incentive to overdoctor and the

incentive to create one's own market demand. Today, fee-for-service may lead the consumer to restrict his demand, but it provides the physician with the incentive to expand it. Because the physician is more powerful in the physician-patient relationship, the consequences are apparent. Given a different method of payment, the incentives would be altered.<sup>15</sup>

We can consider various alternatives to fee-for-service. Two such alternatives are capitation and salary. In either case the physician's income no longer depends on the volume of services rendered to the patient. Furthermore, if the supply of dollars available is related to the number of patients (including adjustments based on the relation between their demographic characteristics and needs; e.g., age) the available dollars will serve to cause labor market adjustments. Such a payment mechanism could be adjusted at periodic intervals in response to the way physicians distribute themselves. It cannot, however, respond to validate those decisions by making unlimited dollars available.

To say that the incentive has been changed is one thing. To say that the new incentive is neutral is fallacious. The situation that leaves the physician dominant *vis-à-vis* the patient remains, but now the patient faces a physician whose incentives are to underdoctor. This, however, seems a better situation for a number of reasons. In the present system medical ethics do not seem to be at variance with the danger of extra procedures: is it unethical to ask for one more test, one more visit, one more procedure? One should certainly like to believe that the medical ethic would inhibit the physician from underdoctoring; i.e., not doing things he should do.

Yet, this is not necessarily the case nor can we be assured that it is. Furthermore, we have already alluded to the fact that today's system exerts little control over and provides little knowledge about quality. A different payment system in itself does not insure a change in this situation. Other changes are required, though even then we cannot be fully optimistic as long as our knowledge about quality (the input and output relationship) is meager. Nonetheless, if the physician is in a situation in which data review is possible, peer review is present, consumer involvement likely and standards are set, the outcome is likely to be improved. Such a situation prevails when physicians are grouped together.

To suggest that grouping physicians and using salary payment mechanisms assures quality performance would be fallacious. We have, after all, had sufficient experience in recent years to be sensitive to these matters. Our schools and prisons, for example, place institutional constraints on

salaried workers (who, in many cases, are professionals). Yet performance is not always responsive to the needs of the persons to be served. Our universities are staffed with salaried professionals, yet we know little about the output of the faculty. One cannot assume the prepaid group will do significantly better unless attempts are made to structure the environment, to gather data and monitor performance, to build in consumer review and involvement. Even so, we may fall short of the desired goal. We can note, however, that if we fall short it is, in large measure, because of the behavior of physicians. Is there any reason to prefer today's approach, which relies on fee-for-service to insure better performance? Does a fee-for-service mechanism in solo practice provide assurance that patient interests come first? The answers are hardly in the affirmative. That problems will remain, even in a prepaid group practice setting, is clear. That such a setting offers greater potential for solution of problems should also be clear.

The prepaid group practice model in which there is a fixed sum of dollars and a defined population would affect physician distribution markedly. Physician distribution would take place in accordance with supply and demand conditions (but the demand conditions would be heavily influenced by needs and by the dollars made available through the national health insurance program). If group practices had little need for the services of additional neurosurgeons, medical students would (of course, with lags and slippages) adjust their plans accordingly. Income of neurosurgeons would tend to fall if an excess supply were competing for available opportunities, thus providing yet additional "signals" to prospective entrants into the field. A similar situation would prevail as regards geographic location decisions.

The prepaid group practice model yields an additional benefit: the creation of a unit of responsibility (larger than the single practitioner, smaller than a regional authority) to which the consumer can relate. We need such institutions, for the physician-patient relationship is not a relationship of equals. The patient may, and sometimes does, have complaints and dissatisfactions. Yet, he finds it most difficult to voice them to his physician. Nor does one change physicians easily. In the absence of an institutional responsibility, the patient must deal with the physician in a one-to-one relationship. This may be appropriate for medical affairs, but it is inappropriate for other matters. The prepaid group practice—with consumer involvement—provides a mechanism that permits someone to speak for the patient (and permits the patient

to speak to someone other than the physician). The individual patient is not dealing with the individual physician.

The discussion of prepaid group practice could examine a number of additional issues: hospital utilization, use of nonphysician personnel and so forth. Rather than extend the detail we have focused on what we consider the critical variables: the advantages of institutional responsibility with the potential that provides for institutional decision-making on allocation of resources within the institution and for consumer involvement in the delivery system; the constraints of a predetermined budget, and the potential advantages of such constraints on rational decision making; elimination of fee-for-service with the potential advantage of salary and capitation is changing the behavior of the physician and the allocation of physician manpower. Various of the advantages can be obtained under other arrangements, but it is not clear that other arrangements can permit all of the advantages to be obtained.<sup>16</sup>

### Some Concluding Thoughts

We turn to the implications of a system of universal financing in conjunction with a delivery system in which physicians are paid on a salary or capitation basis.<sup>17</sup> In such systems the potential for an equitable distribution of health resources and services would be present. Departures from equity would depend in part on the degree to which a privately financed sector were permitted (or, if not permitted, to the degree that a black market might exist) and in part to the degree that the quality of services provided might vary with the attitudes of physicians to particular patients. These departures would be significantly less than is the case today, than would be the case with universal financing and a continuation of fee-for-service or with prepaid group practice and a continuation of private financing of medical care.

What would such a system cost? There is no specific answer. We recognize that the aggregate to be devoted to health can be determined in two ways. The two approaches are perhaps illustrated by the contrast between the United States and Britain. In the United States we are able to estimate *ex post* what we have spent (and then only with a considerable time lag). These estimates are derived, essentially, by adding up the expenditures as determined by the millions of decisions made by consumers, providers and other participants in the health care system.

There is no decision making at the macro level; the macro is the sum of the micro. Even Phase II will not change this picture, for Phase II controls prices, and the total expenditures are determined by price and quantity.<sup>18</sup>

The British approach contrasts with that of the United States: aggregate expenditures are determined by government, and a host of microdecisions are made within the constraint that has been established. One could say that in the United States the real decisions are made by the actors in the health system drama and the Treasury must adjust to those decisions. In Britain the decisions are made by the Treasury, and it is the people in the health service drama who must adjust.

Under a national health insurance program, it would be possible to decide the level of resources that would be made available to the health sector in any particular year. This would be an important advantage. I do not suggest that discipline be exerted in quite the way that it is in Britain. Traditions in our health care sector are different. Furthermore, a national health insurance program rather than a national health service would permit of many more leakages and slippages and, very likely, a much larger role for private expenditures. Nonetheless, it would be possible to exert greater control than is the case at present in the determination of the allocation of resources to health in a given year. The determination of expenditures at central level for the given year is, however, not the only issue. We must also ask how the microdecisions adjust to the macro during the year and what pressures, therefore, build up to change the allocation to the health sector in subsequent years. Over the long run, government cannot make macrodecisions that must be translated into microdecisions that are unacceptable to providers or consumers. Similarly, providers and consumers cannot make microdecisions requiring an unacceptable macro-response.

In a national program we will have to face these questions. Their solution will require changes in attitude and behavior and a restructuring of the total reward system (not simply economic rewards) in medicine. We will also have to develop ways to provide signals regarding consumer preferences within constraints that equity not be violated. How, for example, will consumers indicate their preferences for more resources in the health sector in the absence of supplementary private or local government expenditures? At present we have few answers to these kinds of questions for they are relatively new to us.

Perhaps the answers for America will ultimately lie in a more equal distribution of income between the various states and regions. Were that achieved (and it is achievable), less reliance would have to be placed on the transfer powers of the federal government *vis-à-vis* the health sector. Greater consumer participation and control of a variety of institutions at local level would then permit diverse tastes and desires to send their signals to local and regional decision makers. We are far from that equality today and federal intervention is, therefore, called for.

These issues are not uniquely health issues. They are among the most important issues facing our society. Cast in different clothes, they are the old issues—as yet unresolved—of how much we are one nation and one people. They are yet another formulation of the question to what extent are we Americans, to what extent North Carolinians or Californians.

The health system can address some of these questions but the limits on its answers will be given by the total society. The sector can only change as part of a process of organic development. It is a part of our social order not apart from it. It is difficult to be optimistic about solutions to our health problems—but, perhaps, because it is difficult to be optimistic about America. Yet, because of the link between the two have we any real choice in our behavior? Optimistic or pessimistic, we have to continue to try to find the answers to our problems. To give up is to say we are certain we would not succeed in our search. Can any of us be that certain?

## References

1. It is depressing to report, however, that analysts in various other applied fields seem to reach the same conclusions about their field; e.g., in the recent past the education economist has questioned the benefits of general increases in the resources devoted to education. Oftentimes this seems to be the case because of strong skepticism about the structure and effectiveness of particular government programs. Sometimes the absence of output measures seems to be at issue. An important research question is whether the disenchantment with increased resources in various fields tells us more about the field itself or more about those who are disenchanted. Perhaps analysts suffer from an overdose of skepticism (“if we can’t document it, it isn’t so”). Perhaps in their commendable zeal to be hardheaded, they have become hardheaded.



2. It has proven impossible, for example, for government to withhold expensive procedures offering little (but some) likelihood of success under the Medicare program.
3. In addition, it is unfortunately the case that benefit-cost ratios tend to emphasize the maximization of output rather than its distribution. Equity is sometimes neglected because it is difficult to quantify.
4. In the absence of radically new financing mechanisms, income and price rationing is likely to become more, rather than less, important. Medical science and technology make possible diagnostic, curative and life-prolonging interventions that often turn out to be costly and that create an ever-increasing problem for significant parts of the population.
5. This may strike some as a “straw-man” argument. I do not believe that to be the case. Quite often colleagues and students, not especially involved in the health area, place relatively little emphasis on a more equitable distribution of health services, not because they are less “decent” or “humane,” but because they do not consider those services that important. They then wonder why there is all the pressure, say, for national health insurance.
6. This line of reasoning was used in appealing to the children of the aged for support for the legislation. It was suggested that, in many cases, the financial impact of illness of their parents would fall upon them.
7. But the income distribution problem is a simpler one because, once determined, the distribution is not affected by the “involuntary” consumption of the good or service itself, by untoward events; i.e., by the “lottery” effect.
8. Some would argue that this is true only for “essential” services. Defining “essential” is difficult. We cannot ignore our earlier discussion on the importance of public attitudes.
9. Stuart, B., Equity and Medicaid. *The Journal of Human Resources*, 7: 162–179, Spring, 1972.
10. See two recent studies: Scitovsky, A.A., and Snyder N.M., Effect of Coinsurance on Use of Physician Services, and Phelps, C.E. and Newhouse, J.P., Effect of Coinsurance: A Multivariate Analysis, both in *Social Security Bulletin*, 35, June, 1972. The coinsurance provision was 25 per cent. This high rate did lead to a substantial decline in the demand for physician services.
11. Some important insights into these matters are provided by Victor Fuchs in Eilers, R.D., and Moyerman, S.S., *National Health Insurance Conference Proceedings*, The Leonard Davis Institute of Health Economics, 1971, pp. 184–207.
12. It is important to realize that a number of different factors help create the situation that makes the consumer relatively powerless:

- medical ethics, the white coat of the physician and so forth. The economic relations reflect other relations.
13. This, of course, is not the only rationale for increasing the proportion of minority students in medical schools. At least two other rationales can be offered. One involves the educational impact on nonminority students; the other involves the attempt to overcome the legacy of discrimination.
  14. Such an approach may have benefits other than on the distribution side of the question. One should be clear what those benefits might be if one supports this mechanism.
  15. Although it is possible, within limits, to alter the specialty and geographic distribution of physicians even with retention of fee-for-service, by fixing the total number of dollars available to the health system (or to physicians) for the care of a given population, the preservation of fee-for-service means the preservation of fee-for-service incentives. Given that the consumer is not in a position to determine which particular service he needs, and in the presence of competition between physicians for scarce dollars, we could have continuing problems with, say, excess surgery. Furthermore, if fee-for-service is preserved, we have little assurance that all members of the community would have equal access. If the community includes poor and nonpoor, the former are likely to suffer in the competition (because the physician can still maintain his income by increasing the quantity of services made available to the nonpoor). If we agree that any system of medical care will entail rationing, our aim ought to be to structure the system in such a way to increase the probabilities that the rationing of scarce resources will be in terms of medical need. The retention of a fee-for-service arrangement will not induce the needed changes in the medical ethos. It hardly impels the physician to consider the group as well as the individual patient.
  16. A separate discussion is required for the special problems of rural areas. It should be clear, however, that there would be a potential for organization and linkages of rural practitioners to group practices and other institutions in the urban setting in the mechanisms we describe.
  17. Prepaid group practice is the element that offers various protections to the consumer. In theory, solo practice with capitation or salary—with adequate monitoring and if the number of dollars available in an area were controlled to prevent misallocations—could yield results similar to group practice along a number of axes. We believe prepaid group practice has a number of additional advantages not discussed in this paper.
  18. Indeed, even if Phase II is successful in combating inflation in prices it may work in a perverse fashion in controlling the increase in

health expenditures. Price control can lead to higher utilization. Reductions in the unit cost of a day in hospital can be realized by an increase in occupancy rates, but this will increase total expenditures in the health care system. Part of the difficulty arises because of the confusion about prices and expenditures, which is reenforced by the fact that, in measuring price, we are often measuring the wrong variable. We measure the price (unit cost) of a service, not the price (total cost) of taking care of a particular condition.