

# Perspectives on Government Policy in the Health Sector

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*Health expenditures and prices have accelerated markedly in recent years, both in absolute and relative terms. The pressures for some form of governmental intervention have generated widespread debate about national health policy. Determinants of health are complex, and policy development must follow the identification of issues and review of theoretical policy analysis. Formation of a theoretical basis will have a significant impact on substantive policy outcomes. Unfortunately, past and current proposals and policies have given insufficient attention to the traditional public finance criteria for government intervention; as a result, the importance of market forces has frequently been overlooked. Before wholesale rejection of the market as a means of promoting rationality, government should examine alternatives that foster increased effectiveness of the market mechanism. Even within this context, however, some forms of regulation will be necessary; also, traditional public finance norms would allow certain kinds of expanded government intervention. Market-perfecting policy instruments would result in different kinds of government programs, and much of future policy will be shaped by political decisions about substantive health policy issues.*

The debate over a national health strategy is likely to continue as an important political issue for some time. The issues must be dealt with in broad terms in recognition of the wide variety of components that enter into the "production" of good health. Moreover, the theoretical foundation on which governmental action can be justified must be clearly identified and articulated because the policy consequences of choosing a theory of intervention are significant. The options available for governmental intervention are numerous, but before moving to an exclusively regulatory approach, government should attempt to reinvigorate the market as a device of social ordering in the health sector. This strategy would call for increased governmental regulation in areas where the market cannot reasonably be expected to function (for example, where a natural monopoly exists), but it would emphasize use of policy tools that retained

the decentralized market system of decision making where possible and feasible. Government policy would then be aimed at restoring the ground rules and promoting the conditions that are prerequisites for an effective market. Consistent with this orientation, government could rationally justify support of compulsory insurance programs for emergency care and functional dislocation (or catastrophe). In addition, government could reasonably act to reduce the incidence of such illnesses through preventive measures. Although presentation of these areas of additional governmental intervention is not intended to be exhaustive, the discussion serves to illustrate the kinds of programs that could be justified under traditional public finance criteria for intervention.

## Background

National health outlays have expanded both in absolute and relative terms at a staggering pace in recent years (Cooper and Worthington, 1973). For example, in fiscal 1972, national health expenditures amounted to \$83.4 billion, an increase of \$7.8 billion above the previous year and a rise of 10.3 percent, yet the rate of increase in health expenditures in fiscal 1972 was the lowest incremental rise since fiscal 1966.<sup>1</sup>

The enactment of Medicare and Medicaid in 1965 is in large part responsible for the recent spurt of growth of the health sector. The Medicare and Medicaid approach expanded the effective demand for medical services but did not simultaneously spur short-run increases in supply. Over the past seven years, the predictable has occurred: The substantial increase in demand, unmet by any similar short-run increase in supply, has resulted in acute stress on the system. As would be expected by conventional theory, the system has reacted to this imbalance by generating higher prices. Between 1965 and 1970, as measured by the Consumer Price Index of the Bureau of Labor Statistics, consumer prices in the medical

<sup>1</sup> Over the years 1940–1970, the percentage of Gross National Product (GNP) spent in the health sector went from 4.0 percent to 7.1 percent, and in fiscal 1971 and 1972 the health component of GNP rose to 7.6 percent. Thus, in the 25-year period 1940–1965, the percentage increased from 4.0 percent to 5.9 percent, while in the seven-year period 1965–1972 the percentage jumped almost as much as in that entire period (5.9 percent to 7.6 percent).

care sector skyrocketed, rising at a rate of 6 percent, compared to a similar overall price increase in the economy of 4.2 percent (Rice and Cooper, 1972). Some subsectors within the medical sector have experienced even greater price inflation, with prices in the hospital subsector rising by 10.6 percent in 1972, for example (Cooper and Worthington, 1973).

To a significant extent, the current emphasis on health care issues results from the runaway cost of medical services to consumers. This striking increase in costs has dramatized, in a politically potent way, the importance people have placed on medical care. As a result, great political pressure has arisen for the federal government to intervene to remedy the situation it helped create (U.S. Congress, 1971).

With full recognition of the extraordinary cost of this inflation, there is still an argument that the unbalanced strategy adopted in the mid-sixties succeeded in compelling full-scale, comprehensive consideration of basic issues in the health field much sooner than would otherwise have been the case. Some have argued that the inability to make important decisions is a major governmental shortcoming. Induced official decision making, in response to shortages and bottlenecks, may therefore prove beneficial in the long run. The stress on the medical sector brought about by the unbalanced strategy of demand stimulation has dramatized the weaknesses in the system, making the consuming public acutely aware of the system's inadequacies. In just seven years it has not only become apparent but also widely accepted that there are serious problems which necessitate some form of significant governmental response.

The impact of the "unbalanced strategy" of Medicare and Medicaid has led to federal efforts to develop a coordinated health program. Typically, federal intervention in the health area has been on an ad hoc basis without any overall plan, formulation of objectives, or theoretical underpinning. In 1969, Robert Finch, then-Secretary of the Department of Health, Education, and Welfare, candidly acknowledged (U.S. Congress, 1970: 224) that:

. . . up to and including the present there has never been a formulation of national health policy, as such. In addition, no specific mechanism has been set up to carry out this function. As a consequence the national health policy is a more or less amorphous set of health goals, which are derived by various means and groups within the Federal structure.

In February, 1971, and April, 1972, President Nixon sent messages to Congress in which he outlined the need for developing a national health strategy, and in May, 1971, the Administration issued a detailed position paper. The liveliness of the ongoing debate seems largely attributable to the stresses resulting from the one-sided reliance on demand stimulation of Medicare and Medicaid. Whether the costs will have been worth bearing is uncertain and depends in part on successful identification of federal health objectives, formulation of federal health policy, and implementation of a federal health strategy.

## The Basis for Government Involvement in the Health Sector

Public policy considerations regarding an appropriate federal role in health must not be restricted to a medical services orientation. To be sure, most of our discussion will focus on the medical care sector, but the complexity of the concept of health and the varied factors that contribute to its "production" must constantly be borne in mind.

### *The Concept of Health*

The concept of health has a large social component. Illness may to a large degree be conditioned by culture, and its definition may be the product of a social bargaining process.<sup>2</sup> There is a second important social consideration which must enter into health policy formulation. A biological systems approach to illness, of course, is a critical aspect of defining the scope of the policy problem. Nevertheless, it is insufficient for policy purposes unless the functional elements of illness are incorporated into the analysis.

<sup>2</sup> An illustration of this social factor arises from the women's rights movement. By custom, working women in many occupations have been required to take a maternity leave after the fifth or sometimes the sixth month of pregnancy. An example of this bargaining process is the effort of the women's rights movement to eliminate automatic, mandatory maternity leave provisions, claiming, in effect, that this definition of "illness" imposed on women by society is illegal discrimination on the basis of sex. (See Wilson, 1970:3-12.) The United States Supreme Court has agreed to decide whether the claimed discrimination is unconstitutional (*Cleveland Board of Education v. La Fleur*, 1973:3565).

Health is not an ultimate but an instrumental value—an enabling condition, which helps lead to what is now typically labeled an improved “quality of life.” Consequently, from a policy perspective, it may be important to look at the impact of an illness in determining what the appropriate governmental response should be. In this regard, it might be helpful to shift our emphasis from health or illness to disability and dislocation.

### *The “Production” of Health*

Physicians are trained to look at the human being primarily as a physical specimen—a functioning biological organism. Coincident with this orientation, it is no wonder that they are likely to view the question of health from a biological systems approach. The biological orientation is understandable for those who are engaged in the delivery of medical care and may be serviceable for the medical practitioner, but it is not adequate as a basis for public decision making since the provision of medical care is not the only input in the “production process” of health. Normally, one thinks of going to the doctor because of an ailment and having the physician prescribe a cure. Except for certain fields like public health, which emphasizes preventive medicine, the medical profession in the United States has been remarkably cure-oriented. Only recently has the notion of health maintenance received the public prominence that it should have. But still, we tend to think of health largely as the result of a successful visit to a physician for a remedial service.

However, if greater attention is to be given health maintenance, with functional dislocation the major concern of policy, then serious questions of resource allocation arise within the health sector. Rational allocation of health dollars may require heavy investment in nonmedical items. In some societies, for instance, emphasis on such things as improving the quality of the community water supply or spraying against disease-carrying insects might result in the greatest overall increase in the community's health (Zubkoff and Dunlop, 1973).

As we have noted, health maintenance has begun to receive attention among health professionals, but the concept still carries with it a top-heavy medical service orientation. Most significant for our society, there are a considerable number of environmental factors which contribute substantially to our health problems; any governmental decision to become involved in the health sector must

consider possible allocation alternatives in personal and nonpersonal environmental areas as a means of promoting health.

Three families of environmental problems which contribute to poor health are especially worthy of note. First are what might be called technological factors resulting from industrialization. The most common example of this type is air pollution. Unsafe working conditions and accidents resulting from defective equipment are other examples within this category of environmental factors which contribute to health risk.

A second category of environmental considerations might be called personal health maintenance. Under this heading are such things as overeating and failure to exercise. Health experts now believe that personal lifestyle habits have an important bearing on the incidence of disease. Also in this category are accidents of another type—those which result not from defective machinery (which of course might also arise from careless workmanship) but from personal carelessness or negligence. Accidents, caused both by defect and by human failure, account for a substantial amount of the cost associated with the health sector (U.S. Department of Health, Education, and Welfare, 1971:28-30).

The third category of environmental considerations is socioeconomic status. It seems that the poor experience greater incidences of illness and shorter life expectancy; however, this is only partly the result of inadequate medical services (Antonovsky, 1967). A significant factor is poverty itself because it is accompanied by such things as inadequate sanitation, overcrowded housing, and bad nutrition (Lave and Lave, 1970: 255; Kadushin, 1964). In this regard, governmental programs which seek to alleviate specific conditions related to poverty have a significant health component; in determining an appropriate governmental response to health problems, the alternative allocation possibilities and their potential effect on improving health must be considered. It may be, for example, that emphasis on personal medical services may be an uneconomic allocation of health dollars unless a certain minimum standard of environmental quality is established (McDermott, 1969).

### *The Rationale for Government Action*

In developing a federal health strategy, the government must identify its objectives. And implicit in this process of problem identifica-

tion and goal formulation is an adoption of some theoretical basis on which to center governmental intervention.

The principles that have evolved in the field of public finance are founded on some normative judgments. Public finance norms assume that the market is the best means for allocating scarce resources. There is also an implicit assumption that the government in a democratic society promotes the welfare of individual citizens and does not necessarily act for the welfare of an organic society. This basically individualistic ethic is not limited to public finance theory but is reflected in other fields such as law.

A major policy question is thus whether to accept the public finance criteria for determining an appropriate federal role. Before addressing that issue, though, the traditional criteria for intervention will be discussed.

The basic economic justification for governmental intervention is as a remedy for some market failure. In essence, the traditional basis for governmental involvement has been remedial, when the market, for one reason or other, does not achieve an efficient allocation of resources. When traditional criteria serve as the basis of governmental action, substantive policy outcomes are left to the decentralized, impersonal marketplace; government's role, in this traditional regime, is primarily procedural, restoring the process of the market (or if necessary approximating the results which would have been achieved by a functioning market).

*Traditional Criteria.* Four traditional public finance criteria for government intervention are (1) externalities, (2) public goods, (3) monopoly, and (4) other market imperfections.

*Externalities.* Where there is a divergence between private and public costs and benefit, the competitive market system will not automatically achieve the social optimum. In these circumstances, some form of governmental action may be justified—either regulation, taxation or subsidy.

An externality is a direct influence of a producer's or a consumer's activity on the activities of other producers and consumers that is not evaluated or accounted for by the market. The market system is characterized by general interdependence and interaction among producers and consumers, but their interacting influences

are exerted "indirectly" via relative prices within the market mechanism. Externality-generating influences, however, are exerted on producers and consumers "directly," outside the market mechanism (Mishan, 1971:2). They are not the deliberate outcome of a market relationship but rather an unintended or incidental result of legitimate but unrelated activity.

In the health field, national efforts historically have been directed primarily toward disease control and prevention in the area of public health (Chapman and Talmadge, 1970). From the outset, there has been little controversy about the propriety of some governmental role in combating epidemics; the government initiatives involved both prevention of communicable disease through immunization and control of epidemics through such measures as quarantines. The mandate for governmental intervention in public health, in traditional terms, arose from the very clearcut externalities involved in the spread of communicable disease. Understandably, and predictably, governmental initiatives in public health came early and drew widespread support.

The early federal emphasis on public health conforms to the traditional public finance criteria for government involvement since the private decision about prevention or cure does not reflect the total societal cost calculation. The United States Supreme Court has recognized the importance and constitutional legitimacy of governmental action, for example, in compelling smallpox vaccinations, even when the person involved claimed that his religion forbade the use of medicinal aids (*Jacobson v. Massachusetts*, 1905). Thus, governmental initiatives in public health have widely been recognized as justified in order to overcome the inadequacy of private decision making; this intervention, even by compulsion, has been sustained in the face of a constitutional challenge which pitted against governmental intervention the rights of free exercise of religion, a value whose special status is guaranteed by the First Amendment.

**Public Goods.** A second traditional basis for governmental involvement is the so-called public or social good. A public good is really an extreme example of an externality, a case in which benefits are entirely external (Musgrave, 1971:306). The decisive characteristic of a public good is that one individual's consumption does not interfere with anyone else's. In this sense, then, consumption of a public good is nonrival and contrasts with a pure private good from



whose consumption the particular consumer derives the entire benefit.

Frequently, public goods are characterized by an inability to exclude people from the benefits that accrue. For example, national defense is often used as the typical illustration of a public good; theoretically, all citizens alike benefit from construction, say, of an aircraft carrier, and it is impossible (or at least extremely difficult) to exclude people from benefiting. As a consequence, no individual has an incentive to reveal the true value of the benefit because he will gain regardless of how much he contributes. This is commonly referred to as the "free-rider" problem. Private choice, in the aggregate, may not be a satisfactory process of decision making for achieving a socially desired outcome because of the difficulties of accurately determining true values in the market.

In the health field, the results of a successful immunization program may be characterized as a public good. Consumption is nonrival, and all members of the community share in its benefits without exception. The individual decision about treatment for a communicable disease is an example of a private decision that has external effects, but the "production" of epidemic control warrants governmental intervention because it is a public good of which consumption is nonrival.

Monopoly. A third traditional basis for governmental involvement is the monopoly case, of which there are two forms. The first occurs when cost structure and market size make competition inefficient and unfeasible. If market size and production technology allow a single firm to operate in the decreasing cost portion of its long-run cost curve, with any additional output at lower marginal cost, then the economies of scale cannot be exhausted at any given level of market demand. This form of monopoly is called a "natural monopoly." The utility companies are often cited as the example of this form of monopoly. In the utility case, the economies of scale in production and distribution are so marked that if several companies were in competition, costs would be substantially higher and significant inconvenience and misallocation of resources would occur.

The second type of monopoly is an "unnatural monopoly." An unnatural monopoly has been able to create an artificial situation, in which a producer is supplying its market with a good for which there are no close substitutes. The monopolist, in order to maximize profits, will restrict output and charge higher prices.

The presence of a monopoly indicates a breakdown in the perfectly competitive market and therefore justifies governmental intervention. With respect to "unnatural monopoly," regulation is aimed at restoring the conditions of competition in the marketplace, thus assuring that the economic game is played according to the rules of the market. Antitrust is a policy tool designed to promote competition and to prevent monopolization. With respect to "natural monopolies," however, the maintenance or reestablishment of competitive conditions is not a desirable policy response. The public utility model has been used in these cases. Returns on capital are permitted, but, through price regulation, these returns are supposedly kept as close as possible to those earned in the competitive market.

Characteristics of both the "natural" and "unnatural" monopolistic situations exist in the hospital subsector. The hospital is apparently subject to significant economies of scale in its production process (Hefty, 1969). As a result, hospitals in many communities probably operate in the decreasing cost portion of their long-run cost curve, and many small communities cannot hope to have more than one hospital. These isolated rural hospitals are essentially natural monopolies in that they are providing a service for which there is no close substitute and in which additional entry is not economically feasible because of the high capital cost and economies of scale.

Some observers report that hospitals are also monopolies in terms of patient access. In general, patients do not have a free choice concerning the hospital to which they are admitted because certain traditional characteristics of the physician-hospital relationship and the physician-patient relationship have limited access. Since the patient's lack of knowledge forces him to rely upon the physician's decision whether or not to hospitalize, and since the physician in turn is limited to those hospitals in which he has privileges, patient choice is curtailed not only by the number and location of hospitals but also by the institutional relationships between doctor and patient and doctor and hospital. This form of institutional constraint can be addressed by government policy that promotes access; it is not a "natural" monopoly, and policy tools aimed at opening up the system would be appropriate under the traditional criteria.

Monopoly elements also exist in the physician market through restriction on entry. The artificial shortage of physicians has result-

ed primarily from federal and state legislation concerning licensure requirements and from the educational requirements established by the American Medical Association. It has been argued that supply has been limited in order to restrict competition and thus allow physicians to set their own (higher) prices (Kessel, 1970; Kessel, 1958; Friedman and Kuznets, 1954:137); thus, the physician's monopolistic position must be classified as an "unnatural monopoly." This implies that government should modify those regulations restricting supply or impeding factor substitution.

**Other Market Imperfections.** There are situations in which the conditions of the competitive system do not obtain but which do not conform to the specific criteria for intervention already discussed. One of the foremost assumptions of the competitive model is that there is perfect knowledge in the market. The concept of "consumer sovereignty" cannot operate when the consumer is unable to make an informed choice. In the medical sector, consumers often lack the expertise required to make informed judgments. Because of this, the patient must delegate to the physician much of his freedom of choice. Consequently, although the traditional competitive model assumes that demand and supply are independent, demand in the medical sector depends largely on the judgment of the physician-suppliers (the "dependence effect"). The number of visits to the physician, the kinds of laboratory tests called for, the decision to hospitalize or not and for how long, and even the need for surgical operations are normally based on the judgment of the physician-supplier (Feldstein, 1968).

The perfect knowledge assumption of the competitive model also implies that there is no uncertainty within the market concerning future events. The unpredictable incidence of illness and accidents creates difficulties for the individual. Statistical indices can be worked out for large groups, but the incidence of sickness for an individual is largely random. Moreover, it is unlikely that a consumer is able to assess accurately the probability of illness and the costs involved should disability or catastrophe strike (Calabresi, 1970). In addition, dislocation may result from catastrophic or debilitating illness or accidents; this often means prolonged recuperation and absence from work. Consequently, exacerbating the unpredictability of illness are the severe consequences of dislocation.

Another problem in analyzing the medical sector is the unde-

finable nature of the output produced. Since each medical service is difficult to define or standardize, the medical sector does not produce a clearly defined unit. But until a single definition of health has been accepted, the concept of output cannot be clarified, and even if "health" could be defined precisely, it would still be difficult to measure. Researchers have suggested the use of proxy variables to represent the product. Some of these are the number of patient visits, the number of patients for outpatient services, the number of cases, patient days, bed days, or gross measures such as morbidity or mortality rates. These measures have proved useful in the development of certain internal management control procedures, but, in the context of a broader conceptual perspective, the measures lack both comprehensive and adequate focus on the rationale behind the provision of medical services. Consequently, changes in the medical delivery system which increase the number of hospital days or patient visits may or may not result in an improvement in the population's health. The problems associated with defining output and measuring productivity simply emphasize the nonhomogeneous nature of the product involved. Without a measure for productivity, comparisons between programs or the evaluation of a single program in terms of quality of care and the efficiency of production are difficult. What is needed is an evaluation methodology which, instead of focusing separately on inputs or proxy output measures, would combine both the input and output concepts into one methodology.

The process of defining output for the health sector is made even more difficult because most health services represent a combination of both consumption and investment aspects which are difficult to separate.<sup>3</sup> Many services are considered investments because they increase the productivity and extend the working life of the employed members of society. Other services provide temporary relief from pain and suffering and yield immediate benefits to the individual only in the current time period. Since outlays for medical services have both consumption and investment components, and

<sup>3</sup> This same problem exists in measuring the output of education (Becker, 1964; Schultz, 1963, 1970). The problem of identifying output is further complicated because medical services are often produced jointly with medical education.

since such classification is difficult and imprecise, output measures for the health industry are speculative at best.

The important role played by the nonprofit institutions in the medical care sector poses more difficulties in relation to the workings of the competitive model. The profit motive encourages technical efficiency and low-cost production. The marketplace disciplines firms that become overly inefficient. Nonprofit producers do not have the same pressures for efficient production nor the same incentive to adjust output in order to achieve higher profit (Newhouse, 1970; Lee, 1971). This problem is exacerbated by the form of third-party cost-plus payment that characterizes existing medical insurance plans (Pauly and Drake, 1970; Havighurst, 1970). Such a system of reimbursement provides few incentives for either the hospital or the physician to achieve greater efficiency, and leads to higher consumer costs.

In short, many of the distinctive characteristics of health and medical services satisfy the traditional grounds for government intervention. The irregular, uncertain, and sometimes communicable nature of illness, the unusual characteristics of the inputs and outputs, and the unusual forms of organization utilized to deliver health and medical care indicate that some form of government involvement is called for.

*Merit Goods.* Traditional public finance criteria for governmental intervention do not challenge the underlying assumption of consumer sovereignty. Governmental action is necessary to achieve the result that, but for various imperfections, would have been achieved through operation of the market. But the objectives of government policy in the traditional scheme of things must be quite limited, paralleling as closely as possible the outcome of the market and deviating from the market system itself as little as feasible.

In recognition of the fact that government often acts in ways which do not conform to the traditional public finance criteria, economists have developed a concept of a "merit good" as a basis for governmental involvement. The satisfaction of merit wants is provided for through the public budget, apart from what is purchased by private consumers. "The satisfaction of merit wants, by its very nature, involves interference with consumer preferences" (Musgrave, 1959:13; Musgrave, 1971:312-313).

The theoretical underpinning for the merit good concept, however, is rather flabby at this point. Clearly there are very significant redistributive aspects to the substitution of collective consumer decision making for the market. But more is at stake than redistribution. Since the provision of services is defined categorically, as in some of the proposed compulsory national health insurance programs, the eligibility criteria may not impose any means test.

At least two explanations are offered for the presence of merit goods. The first is a basic rejection, for a spectrum of items, of the notion that people know what is in their own best interests. No matter how this argument is sliced it is paternalistic. Basically, the rationale is that in certain cases there is inadequate consumer information or insufficient consumer expertise to evaluate options. Either through misleading advertising or through lack of expertise, consumers may not have sufficient information or competence to make intelligent consumer purchases. Some see this as a justification for governmental imposition of collective consumer choice through the political system.

But another link in the analytical chain is necessary before this conclusion is warranted. Lack of information can be remedied by governmental regulation which requires producers to make available accurate data on their products. The "Truth in Lending" statute and the various labeling statutes are attempts to improve the information at the disposal of the consumer so as to approach the competitive ideal of perfect knowledge. Only if providing this information is unacceptably expensive is the alternative of collective purchase justified. It is, of course, possible that in some cases information costs are so prohibitive that other action is necessary. But imposition of collective consumer choice in such a situation would, presumably, still attempt to mirror the outcome of the marketplace as closely as possible. Consequently, this basis for intervention does not explain why provision of a "merit good" rests on a different theoretical foundation from more traditional forms of intervention, such as labeling. Nor does it explain why, if the redistribution element is put aside, medical care should be supplied through the federal budget. Provision of medical services through the federal budget will not enhance the ability of the average citizen to understand the factors involved. If an explanation is to be found for the political mood that medical services should be provided to all as a right, we must look elsewhere than the lack of information or expertise.

A second explanation of the merit good phenomenon is that it is a case of disguised (or at least controlled) redistribution (Musgrave, 1971:315): "What seems to be a case of merit goods may, in fact, reflect interdependence of utilities and their provision may be an instrument of redistribution." Seen this way, the merit good label turns out to be applicable to any categorical program of assistance. These programs have been roundly criticized by many welfare economists who claim that transferring nonnegotiable commodities is a less efficient method of redistribution than substituting money for in-kind transfers. In effect, the market economists argue that transfers in kind deprive the recipients of the right to choose freely their own marketbasket of goods, and that this creates waste at a net cost in welfare.

The merit good construct seems like an attempt to explain why, despite constant academic criticism, politicians continue to advocate categorical assistance programs. Redistribution may be in the nature of a social good with interdependent utilities so that A derives satisfaction from B's consumption, especially if B's income is low relative to that of A. From this perspective, a merit good may be an example of a voluntary redistribution, and the donor may gain more satisfaction if the donee consumes medical care rather than whisky. For this reason, it may be easier to muster a political consensus for provision of medical care as a right than for a redistribution of a similar amount of income through a direct grant.

The public reaction of alarm and indignation to the demogrant proposal of Senator McGovern in the 1972 presidential campaign is evidence that the political phenomenon exists. The explanation may be that the price exacted by these voluntary donors is control of the way the redistributed funds are spent. Thus, we come full circle. Again, we have a paternalistic reason for this type of control, although with a different motivation for the paternalism. The condition on which the redistribution is given is the loss of consumer sovereignty for the donee.

One further word for the theoretical discussion in the medical care context is now appropriate. The political decision to provide categorical assistance through the federal budget for personal medical services was made in 1965 with the enactment of Medicare and Medicaid. From a pragmatic point of view, therefore, it is only reasonable to acknowledge that medical services have been defined as a merit good, at least for the medically indigent and the aged. This

poses a troublesome conceptual question about the current debate over compulsory national health insurance for everyone. Since the medically indigent already are the beneficiaries of Medicaid assistance, what is the argument for compulsory universal national health insurance? If the redistribution goal is largely inconsequential, we are left with the information-competence argument. But those who are not medically indigent could assume the burden voluntarily of insuring against the risks of illness. Moreover, if government took steps to assure a competitive market for insurance, consumers would be able to choose from among a variety of packages instead of being confined to a single, government-imposed medical market-basket.

An argument can be made that individuals rationally might vote to tax themselves for medical insurance as a means of forced savings. This would apply especially to those unable to discipline themselves to invest in medical insurance if left with money which could be spent on more immediate pleasures. The argument has some superficial appeal: let the weak-willed, who recognize their own infirmity, pull the magic political lever once and assure themselves of adequate savings to purchase medical insurance. But why should the political system be used by a majority (by assumption) to impose on an unwilling minority a consumer good which (by hypothesis and by definition) the minority chooses not to consume (at least not in the form presented in the compulsory system)? As long as the only actor involved is the individual voter who is in the majority, there is no problem. But when the minority voters are brought in, the issue of an imposed choice must be faced. In some cases, failure to impose the majority will could result in deprivation for the majority because the good cannot reasonably be purchased or produced in any other way. But in the case of medical insurance, a private market exists. If a consumer is afraid of himself, there is a means of privately forcing saving—through contractual arrangement in which an individual can bind himself to save by creating legally enforceable obligations. Through this system of private ordering with the force of law, individuals can effectively limit their own freedom but at the same time not impose their consumer choices on an unwilling minority because of their own frailties. So long as adequate alternatives exist—e.g., private ordering through contract and governmental action to promote greater consumer choice among in-



insurance packages—it is difficult to justify compulsory medical insurance on the basis of the forced-saving argument.

One might also argue that without compulsory national health insurance a dual system of medical services will be perpetuated, one for the relatively affluent and one for the poor. The argument proceeds as follows: because of its importance, nonindigents have a duty to supply adequate medical care to indigents; but a system that does not include governmental financing for the nonpoor may allow for inferior care for the poor, and so equality demands that universal government financing be made compulsory so as to eliminate a dual system. This argument is weak on at least two grounds. First, conceptually, the merit good approach would seem to warrant redistribution in kind of medical services that could be characterized as basic or necessary (Michelman, 1969). Once the duty of society to provide adequate care is met, however, inequality in provision of additional services is no more (and no less) of a societal problem than any other inequality in access to goods or services. The “specialness” of medical care exists only up to a certain threshold; beyond that it becomes just another consumer item. Implicit in the argument that nonindigents have a duty to provide access to care to those who could not otherwise afford such access is an understanding that inequalities in total consumption may continue to exist as they do in other sectors of the economy. Indeed, it is unlikely that any system of compulsory national health insurance would bar consumers from spending supplementary private funds for additional medical care, and if this option is left open, a “dual” system will develop in any case.

Second, even if unequal consumption of medical services is admitted, a proponent of compulsory national health insurance could point to the access to quality-care problems that have faced Medicaid patients. But if indigents have command of sufficient resources to purchase an adequate level or package of care in the marketplace, only imperfections in the market would inhibit their purchase of mainstream medicine. This is not to deny the problems the poor have had in gaining access to first-rate physician services or in having as broad a scope of choice as those who pay fees out of their own pockets (and who are likely to have socioeconomic, cultural, or racial backgrounds more akin to a physician's other patients) (Zubkoff, 1973). It is to state that a remedy for that problem

could and should be fashioned that more precisely deals with the access-to-quality-care problem. The imposition of a compulsory, universal national health insurance program is not a policy instrument tailored to deal with the problem identified and may not even contribute to its amelioration.

It could also be argued that compulsory health insurance—that is, health insurance as a universal merit good—is necessary because individuals cannot assess correctly the probability of incidence of debilitating illness (Calabresi, 1970:55–58). The information cost associated with fully educating consumers of the dangers of disability might well be exorbitant. Moreover, as with Social Security, there may be serious secondary effects upon third parties when a person is disabled and, in the case of medical care, society (either through government or charitable agency) would likely come to the aid of an unfortunate disabled person. In such a case, a consumer might be likely to purchase less disability insurance than he might otherwise, relying on society to bail him out if something goes wrong. For this reason, the political process might be the only way to achieve an optimal solution. However, the lack-of-knowledge–extreme-side-effects argument can be stretched only so far; it does not cover nondisability or nonemergency situations and, moreover, conforms to the traditional criteria for intervention. The merit good theory is not needed to deal with this situation.

The political decision about the scope of the merit good in medical services is important for policy determination. If the merit good concept is applied, then policy makers must think in terms of substantive policy objectives and priorities, not only of remedial procedural tinkering. The result of such a governmental decision is increased governmental (and most likely centralized) control over the allocation process in the health field, and the types of policies formulated and programs developed would have markedly different objectives.

### The Range of Choice for Governmental Intervention

Any discussion of the strategy for governmental intervention in the health field must first take stock of the tools available to the government. The selection of tools will depend in large measure upon what resolution the political process reaches on the merit good issue. If government continues to treat medical services as a federal

program of categorical assistance for the poor and the aged, an assumption made here, then such issues as adequate access (both financial and geographical), determining the precise scope of the benefit package, and defining the class of people to whom the package will be provided will receive highest priority. If government intervention is based more on the criteria reflected in the traditional model, then the primary focus of policy will be restoration of the market as a functioning institution.

Determination of the breadth and depth of the benefit package is the major demand-side issue, and the problem arises once the decision is made to provide medical care through the budget to categorically defined groups. On the supply side, various tools are available both in cases where traditional criteria govern and where the merit good concept prevails. At one extreme, government could do nothing at all if the market mechanism is functioning well. At the other extreme, government could supply directly all medical services, in effect expanding the VA hospitals to provide care to the entire civilian population. In between these extremes are the following forms of intervention: (1) piecemeal dynamic intervention aimed at restoring the market mechanism; for example, reducing the barriers to entry by modifying licensure requirements and reducing the monopoly power of voluntary medical associations; (2) ad hoc static regulation aimed at short-run symptomatic remedies; for example, utilization review and wage and price controls; (3) regulation of output by a regulatory body such as a public utility commission with control of such things as product, pricing, investment, and cost standards (Posner, 1971).

At present, government policy primarily reflects a heavy reliance on such short-run symptomatic remedies as price controls. The outcome of the political debate about the basis for involvement will largely determine the shape of future federal programs in the health field.

Two illustrations will help indicate the differences in concern that can arise from differences in the orientation of federal policy. The supply of providers has not kept pace with the rapid increase in demand for medical services. There may be many reasons for this gap, but the longer the lag time between increased demand and ultimate supply response, the greater the impact of increased demand on the economy. Diminishing the length of the supply-response lag is an example of a market-perfecting policy for government. Con-

sistent with such a goal would be encouraging medical schools to increase their output of new physicians by reducing the required training from four to three years. Similarly, government could reduce the institutional barriers to entry (as reflected in the various licensure laws) by relaxing the formal educational requirements for medical manpower. Again, by altering the institutional requirements, government would be fostering increased supply by "dynamic" regulation.<sup>4</sup>

Intervention on the supply side through subsidy would have to be justified by the presence, say, of externalities. Otherwise, government policy based on traditional criteria must be limited to the function of facilitating market accommodation, without regard to substantive outcome. Along these lines, if the outcome of the market's functioning were to mean that certain geographic areas would not have sufficient medical care, then the traditional model would adopt a "so be it" response. However, it is now clear that the political judgment has been made that adequate access to medical services is a major policy objective of the federal government (U.S. Congress, 1971).

A second illustration of the influence on policy orientation of one's theory of intervention arises in the context of hospitals. There have been some suggestions that increased emphasis be placed on hospitals which operate on a for-profit basis. Proponents of this approach argue that proprietary hospitals have financial incentives to keep costs in line and that efficiency has been better in the for-profit

<sup>4</sup>The approaches to supply shortages mentioned above assume that the market adequately performs the allocative function but that structural and institutional rigidities operate so as to impede its proper performance. In such situations, government action, under traditional theory, must strive to restore competitive conditions. It is important, however, to underscore what assumptions underlie the traditional response. As prices in the health sector rise in response to the excess demand, the expectation is that increased incomes to health professionals will induce more people to become members of the health professions. As these new workers take their place in the profession, one would expect the imbalance of demand and supply to disappear and the extranormal increase in prices to dissipate. Therefore, it is appropriate within the traditional framework to smooth the path of supply response or to act affirmatively to shorten the period of lag. It would be inappropriate, however, for government through subsidy to induce more people to pursue careers in the health professions in the absence of externalities or other public finance justifications. This allocation function is one for the market; if its functioning is restored, the results would follow rationally without explicit governmental inducement.

hospitals. But one of the strongest counterarguments is that reliance on for-profit hospitals would mean that certain kinds of less profitable medical services would either be less available or would strain the financial resources of the voluntary hospitals. In essence, the critics of the for-profit hospitals argue that the hospital is a major focus of modern medical service delivery and that it must continue to afford comprehensive treatment for reasons of health policy. If a hospital were to cut back in areas in which profit levels were not high, there might be a concomitant deterioration in the quality of overall medical service. The solution to this problem adopted by the voluntary hospitals is that profitable medical services subsidize the less profitable.

Those with a market orientation would rebut the critics of the proprietary hospitals by arguing that since a subsidy is being paid for reasons of health policy, a more rational approach would be to determine on whose shoulders the subsidy should fall and then to subsidize openly either the voluntaries or the proprietaries on that basis. It may be difficult to justify a system which covertly taxes patients with profitable illnesses to support those with less profitable ones. So long as health policy dictates that less profitable illnesses need to be treated, these same policy considerations should be brought out into the open to determine who should pay for this subsidy and at what level. It seems doubtful that one class of the sick should support another class without regard to such factors as income. Nevertheless, the less affluent afflicted with profitable diseases now subsidize the more affluent with unprofitable illnesses. The market-oriented would argue that health policy goals should be subsidized through the budget, and that the rest of the hospital's operations should face market competition.

The purpose of the discussion of manpower and hospitals has not been to advocate one approach over another but rather to illustrate the consequences for policy of adopting one orientation or another toward the appropriate basis of governmental action. The next sections address the question of whether the market mechanism or the regulatory mechanism should serve as the basis for future governmental involvement in certain areas of the health field.

### *Modes of Intervention: The Utility Approach*

Since much of the impetus for review of the governmental role in medical care derives from the recent increases in costs to consum-

ers, it might seem logical for the government to grab the bull by the horns and focus policy directly on the stabilization of prices. The outcome of such a policy determination would be to choose the regulatory model as the best means of keeping down prices in the medical care sector. There have been some suggestions, for example, that a public utility approach be used for regulation of hospitals. The American Hospital Association embraced this concept in February, 1972 (Priest, 1970; American Hospital Association, 1972).

Adoption of the utility concept amounts to a wholesale recognition that competition and the marketplace cannot function effectively in the medical sector. For two reasons, we reject the avenue of total regulation, at least at this time. First, the history of utility-style regulation in this country has been anything but encouraging; any argument for complete rejection of the market must bear a heavy burden in showing that the proposed solution is desirable and workable, and also that the alternatives are doomed to failure. We believe this showing has not been made. Second, a good case can be made that the market system itself has not been given a chance to operate in the medical sector in light of the special restrictions which have been imposed by government. For this reason, further reliance on the market as a mechanism for social ordering may still be an available option.

Recent criticism of public utility regulation has focused on three points (Donahue, Jr., 1971; Posner, 1971). First is the difficulty that a regulatory agency inevitably has in determining the legitimate costs of the regulated firms. The agency cannot rely on the regulated firm's own calculations but must attempt to determine acceptable costs independently. This is an extremely difficult task involving highly complex accounting, and the consequence of error may be either inadequate capital for the regulated industry or excess monopoly profits. The stakes are high whereas the mechanism is rather imprecise.

Second, price regulation may distort the incentives of the regulated firm. For example, a firm that sells both regulated and unregulated products may seek to subsidize the competitive enterprise by allocating costs to the unregulated portion of its business. Also a regulated firm may attempt to take out nonmonetary profits in the way of prestige items like thicker carpets, bigger offices, a shorter work week, etc. The result of this is higher but less visible costs not easily susceptible to regulatory control.

Third, public utility regulation is a political as well as an economic process. Experience with regulatory agencies since the New Deal Era indicates that the regulated industries frequently exercise a great deal of control over their own regulation. This phenomenon is often more acute at the state level, and much of the regulatory activity in the medical care sector would most likely occur at this level. The proposal by the American Hospital Association for utility regulation by a state body is evidence that the industry feels that its interests will be well protected through state utility-type regulation.

Given the track record of utility regulation, government should hesitate to commit itself wholesale to the regulatory path in the medical sector. A much heavier burden of justification would be necessary before commitment to such a total system could be justified. Not only is the history of public utility regulation undistinguished, but, in the context of the medical care field, special considerations suggest that its extension would be unwise (Posner, 1971:8-10).

One special problem is product specification. If a regulatory commission were to attempt to establish appropriate rates for physician's services, the problem would arise as to define what the good or service involved was. Unless this was defined with precision, a regulated firm could substitute an inferior product for the one which was the basis of the rate established by the regulatory commission. Both the physician's and the hospital's service are much more amorphous products than typical products of regulated firms like electrical energy or telephone service. The technology of measuring output in health is in its infancy right now, and there is widespread disagreement about what output measures are appropriate. The real difficulty here is that the ultimate product—good health—is very difficult to measure of itself. Consequently, surrogate measures such as days off the job or days in the hospital are used, but these are at best only inadequate measures of output.

Another special concern in the medical care sector is cost control, but utility regulation is extremely weak in imposing cost consciousness. Regulated prices are derived after determination by the regulatory body of a fair and reasonable rate of return. This procedure provides an incentive for padding expenses on which a return can be earned and has the defects that inhere in cost-plus pricing. Consequently, utility regulation might very well exacerbate the in-

flationary pressures that already exist within the medical care sector.

Finally, organized medicine has time and time again shown its political clout.<sup>5</sup> Since the history of utility regulation shows that the regulated often control the regulators, the prognosis in the medical sector is not good. If anything, the extraordinary political influence of organized medicine should signal a pause before acceptance of a wholesale regulatory takeover.

### *Modes of Intervention:*

#### *Countervailing Market-Oriented Mechanisms*

This discussion suggests, then, that in the medical care sector a dose of competition might be what the doctor ordered (Havighurst, 1970). For example, the introduction of health maintenance organizations (HMOs) may encourage greater cost consciousness in the hospital sector. At present, third-party reimbursement on a cost-plus basis is the general rule for hospitals. Moreover, most of the third-party payment schemes do not reimburse patients for ambulatory care but require hospitalization before reimbursement is permitted. This structural bias toward hospitalization increases the cost of medical care because hospital care is the most expensive form of medical treatment. The HMO, through the prepayment device, will have an incentive to keep hospital costs down since incomes come from capitation fee, not fee for service. Reduced expenditures will result in increased income, so the prepaid HMOs will have an interest both in bargaining with hospitals to keep costs down and in emphasizing ambulatory and other less expensive forms of care.

Furthermore, the HMOs will be in a position to deal effectively in the marketplace. While consumers may not have the expertise to make medical decisions, and physicians may now have no incentive to serve the role of intermediary on behalf of the patient, the reward system for the HMO will encourage it to act on the consum-

<sup>5</sup> One must wonder why there is much a push for regulation *now* on the part of hospitals. Possibly this desire to be regulated is a response to the increased public pressure on hospitals to contain costs and at the same time meet community needs. A regulatory commission may serve the hospitals—e.g., by keeping out low-service competition, or by protecting the hospitals from the public—but it seems unlikely to serve the public (Chapman and Talmadge, 1970).



er's behalf in keeping costs down. Moreover, because of its professional expertise, it will be better able to deal effectively with hospitals and other providers (Wolfe and Zubkoff, 1973).

Of course, the introduction of HMOs will be no panacea for the problem of consumer ignorance or hospital inefficiency. Especially in areas where there may be inadequate choice among health maintenance organizations, there may be a similar problem with respect to fees set or quality of services offered by the HMO itself. We do not suggest that regulation has no place but rather that competition does have an important role to play. The introduction of new institutions and new devices for consumer participation might well make the market a more viable institution for social ordering in the medical context than anyone has thought.

In the past, government has responded to the distinctive traits of the medical sector by imposing restrictions on the providers. The detailed licensure statutes, the comprehensive regulation and planning of facilities construction, and medical education are examples of the minute piece-meal manner in which the medical sector is now regulated. It might be time, however, to look toward the more traditional role of government in attempting to make the market work. If consumer ignorance is a major problem—and it is—then government could become involved in more intensive health education programs.

One approach might be to establish roles such as health advocates to whom consumers could turn for advice and who could serve as intermediaries on behalf of consumers in dealing with providers. Moreover, greater responsibility could be imposed on doctors to disclose the mysteries of their practice. Too many doctors assume a role of aloofness so that patients feel inhibited from inquiring about what is going on. It is possible that legal institutions could have an effect “so as to compel the doctor to share critical decision-making power with the patient and to encourage the development of a partnership mode in doctor-patient relations to replace the prevalent authoritarian pattern” (Yale Law Journal, 1970:1534).

In addition to helping foster a more open doctor-patient relationship, the legal system can limit the extraordinary dominance by the physician of the entire health profession. Current statutes frequently preclude anyone but licensed physicians from providing certain care, even though there is far from clear evidence that such

a requirement is necessary for quality care (Carlson, 1970). Modifications in licensure laws could therefore permit other health professionals to assume broader responsibility<sup>6</sup> and could perhaps reduce the individual's medical care bill by allowing for a different, less expensive "production technology" for good health. Many states have recently liberalized their licensure laws in recognition of the expanded roles that can be played by allied health professionals.

### *Other Modes of Consumer Influence*

There are other mechanisms which can also be used to foster more effective use of the market. To the extent that health maintenance organizations themselves suffer from lack of effective competition, consumer participation in the organization and management of the group could help alleviate some of the consumer complaints that currently exist while affording the providers insight into consumer attitudes and desires.

In an engaging recent book, Professor Hirschman (1970) discusses the problems associated with the deterioration of the quality of output of an organization. His discussion and analysis have relevance for our discussion of nonregulatory mechanisms for promoting operating efficiency and responsiveness in the medical sector. Hirschman notes that competition is a mechanism for restoring organizational efficiency and, in his terms, promoting recuperation. Hirschman points out that the process of recovery can be spurred by two different though interrelated phenomena which he calls exit and voice.

In response to an absolute or comparative decline in quality, some customers stop purchasing a firm's product or some members leave an organization. "[T]his is the exit option. As a result, revenues drop, membership declines, and management is impelled to search for ways and means to correct whatever faults have led to exit" (Hirschman, 1970:4). This process of exit is the one normally associated with the competitive market system; the discipline of the marketplace is imposed on a firm through the opportunity of consumers to go elsewhere.

However, there is another way in which consumers can seek improvement in the functioning of a firm or an organization. They

<sup>6</sup> See, e.g., New York's new definition of nursing, Education Law §§6901, 6902, McKinney's Consolidated Laws of N.Y. (1972 supp.).

can express their dissatisfaction directly to its management or through general protest. This is what Hirschman calls the voice option. This also causes management to seek possible remedies for the expressed dissatisfaction. Hirschman's work offers a theoretical basis for such things as consumer activities which focus on corporate responsibility.<sup>7</sup>

In terms of the medical care sector, Hirschman's analysis suggests another private mechanism by which consumers can attempt to exercise a greater measure of influence, if not sovereignty. Without resorting to the traditional regulatory framework, government can foster private institutions and mechanisms through which consumers can enhance their ability to deal effectively in the marketplace. If HMOs prove to be monopolistic, for example, then government can institutionalize voice by consumers as a means of promoting continued operational vitality. In any case, the possibility of influencing organizational effectiveness in situations in which traditional modes of competition may be inadequate offers an alternative that should be explored further before wholesale regulatory takeover is pressed.

## Illustrative Programmatic Intervention

To say that nongovernmental institutions that retain private ordering should be promoted is not to deny that some governmental intervention in the health field may be warranted, even under the traditional criteria. Of course, market-perfecting policies are appropriate under the traditional criteria; so are such activities as public health and biomedical research, the first areas of comprehensive federal involvement. But persuasive argument can be made that the traditional criteria justify government involvement in at least three other areas. The types of intervention discussed in this section are illustrative of the kinds of programs that can be supported on the traditional theoretical foundation.

### *Emergency*

The market for medical services is actually composed of several submarkets; an important submarket is that for emergency care.

<sup>7</sup> For a discussion of a specific attempt to influence the corporate management of General Motors, see Donald E. Schwartz (1971).

Defining the precise boundaries of what constitutes emergency care surely is an uncertain venture, but hospital emergency rooms now typically break down their visits according to emergency and non-emergency classifications (Zubkoff, 1971:120-134). Similarly, under Medicare, hospitals that are not eligible for federal reimbursement for general patient services are eligible for payment for emergency services. The Medicare regulations establish guidelines describing the kinds of services and the circumstances that qualify as emergencies within the Medicare statute. Questions of definition and categorization still persist and sometimes necessitate adjudication (*Carey v. Finch*, 1970), but, nevertheless, it does make sense to think of emergency care as a somewhat distinct submarket of the medical services market.

The market for emergency care is characterized by highly inelastic demand elasticity so that an increase in price has only a minimal effect in reducing demand (Campbell, 1971:53-54). In the normal nonemergency case, a patient may rely heavily on the physician's judgment to determine the quantity of medical services consumed, but a patient can shop around for several opinions and even compare prices. As the Medicare legislation acknowledges, a patient confronted with a medical emergency faces a situation of non-choice where even the limited options open to a patient with a non-emergency medical problem are not available. The free choice of the marketplace does not realistically exist for a person with a medical emergency.

Recognizing the distinctive characteristics of medical emergencies, some courts have imposed a requirement on hospital emergency rooms to treat all comers without respect to ability to pay, even though those same hospitals may have no duty to provide nonemergency care to indigents (*Stanturf v. Sipes*, 1969). This approach reflects the attitudes with which medical providers and society at large respond to medical emergencies. Providers historically have given free emergency care more readily than nonemergency care. Also, society is more likely to respond charitably to an emergency than to a nonemergency situation.

On the one hand, emergencies are highly unpredictable, and services must be purchased as an indivisible package with the concomitant discontinuities of supply. On the other hand, providers and society are likely to feel an obligation to treat a patient in an emergency situation. In such a case, a strong analogy exists to So-

cial Security, in which compulsory insurance is justified on the ground that if an individual chooses not to insure himself privately, society will bear the onus of any mistaken private decision out of a sense that the elderly should not be permitted to go destitute.

In any case of emergency medical care, there is a strong argument that consumers will undervalue this insurance because of a calculation that if things get really bad, someone will bail them out. In this way, private decision making would permit a beggar-thy-neighbor private choice. Thus, this is a case in which an externality may be involved, since the detriment resulting from a poor private choice does not fall on the individual himself but on others (society at large or at least on the providers of care). Such an analysis makes it possible to draw a parallel with the compulsory liability insurance that many states impose on automobile drivers. Since the burden of harm wrought by a reckless and impecunious driver falls not on that driver but on his victims, government can justifiably impose mandatory insurance on the driver as a cost of operating his automobile. From the perspective outlined here, government financing of emergency medical care may be warranted on similar grounds. In those areas where competition among providers of emergency services is nonexistent or infeasible, some form of regulation could also be supported under the traditional criterion of natural monopoly.

### *Dislocation*

A second area in which government involvement may be appropriate is dislocation—that is, illness or accidents that result in catastrophe or disability and therefore substantially disrupt the functioning of a person as a social and economic being. Like emergency, dislocation may elicit charity from society; individuals' perception of this likelihood might result in an understated revealed preference by consumers for insurance to deal with emergency situations.

The concern with dislocation reflects the functional approach to health discussed at the outset (Mechanic, 1968; Wilson, 1970). People unable to work may face a loss of income at the same time that medical bills impose a direct financial burden. To be sure, individuals can insure privately against many forms of dislocation, but the impact of a mistaken choice by a head of a household can have

major secondary effects on others who are dependent. It is unrealistic, for example, to expect children, given their subordinate role within the family unit, their lack of independent funds, and their limited access to information and limited experience, to make an informed private choice weighing risks about catastrophe or disability. Similarly, there is little reason to impose parental risk preferences on children, especially since society normally assumes a special responsibility to care for children whose parents are incapacitated.

Of course, the protection-of-children argument runs the danger of proving too much, justifying potentially disruptive governmental intrusion into the constitutionally protected realm of family rearing (*Pierce v. Society of Sisters*, 1925; *Meyer v. Nebraska*, 1923). But the decision of a parent to forgo dislocation insurance in favor of some other form of consumption significantly affects those members of the family unit whom society frequently feels obliged in other contexts to protect, even against their own parents. Compulsory education laws and prohibitions on child labor are illustrations of governmental intervention to safeguard the interests of children. Since the burden of private error in the instance of dislocation falls on others besides the chooser, traditional criteria for government intervention would permit compulsory insurance. Whether this type of program would unduly interfere with countervailing values of family control of child rearing is the kind of analysis that goes into constitutional decision making; suffice it to say that taxation of this type has not typically been considered a significant infringement of parental prerogatives nor a substantial intrusion of government into intrafamily life.

By government action, losses that result from dislocation can be spread among many people (interpersonal loss spreading) and over time (intertemporal loss spreading) (Calabresi, 1970:39-42). In this way, the impact of functional dislocation on any individual or family would be reduced. The question then must be faced of why a system of total compensation for dislocation should not be established in the form of a comprehensive social insurance scheme. It is true that the current health policy debate has largely taken place in isolation from the simultaneous controversy over the no-fault concept of automobile insurance, yet the issues that arise in determining the scope of governmental involvement in the health field must also be addressed in policy terms in the accident law

field. One of the difficulties with adopting a governmental system of total insurance for dislocation is that it would very likely lead to an increase in disbursements for at least two reasons. First is that without strict administrative limitations, such a reimbursement system would attract attempted freeloaders and promote overuse. Second, provision for comprehensive coverage for dislocation might reduce the incentives for people to exercise caution in their daily lives. To be sure, the problem of reducing the incidence of dislocation is more acute in the context of accidents than in the context of disease; nevertheless, the complexity of the "production function" of health does indicate that there may be significant ways to reduce the incidence of illness which causes dislocation. Thus, any system devised must balance the need for encouraging personal health maintenance with the need to ameliorate the problems brought on by dislocation.

### *Prevention*

This leads to a third area of government involvement: prevention. To the extent that some form of social insurance for dislocation is implemented, an obligation falls on government to minimize, to the degree feasible, the incidence of dislocation. In the accident law field, reduction in the incidence and severity of accidents—primary cost avoidance in the parlance of Professor Calabresi—is achieved in part through rules of legal liability. From a health perspective, government can move broadly to help cut down on dislocation. Examples of government movement in this direction are such measures as mine safety and general occupational health legislation. Similarly, environmental programs that lower the incidence of debilitating respiratory illness also fall within this category, as do such social programs as sanitation, food inspection, and nutrition which help lower risks of serious disease. The government initiative in broad prevention programs is essentially a form of technological intervention so as to minimize the amount of dislocation with which it must cope. If a governmental response in cases of dislocation is warranted, an aggressive governmental role in preventive measures is also justified to keep the costs down—the counterpart of the objective of accident law to keep the primary costs of accidents down.

In addition, government emphasis on preventive measures may

often be justified on the basis of the public-good features of many preventive programs and the externalities associated with such measures. For example, an improved water supply or cleaner air will benefit members of the community without consumption being rival (at least to the point of overutilization). Similarly, public health measures that seek to eradicate communicable diseases benefit those who are not directly immunized. Consequently, government support of preventive measures can be justified under the traditional criteria both because they may contribute to a lower incidence of dislocation and also because delivery of preventive services is often characterized by public-good and externality-generating features (Zubkoff and Dunlop, 1973).

## Conclusion

The dialogue about national health policy is bound to continue into the foreseeable future. In this paper, we have attempted to put the issues of health policy into an analytical framework that will be useful for those involved in policy formulation and implementation. It is our belief that insufficient attention has been paid to first principles of policy analysis; as a consequence, some previous and proposed policy instruments have not and would not successfully address the problems identified. More particularly, it is our view that policy must accommodate itself to the realities of the economic market and that additional attention should be given to governmental initiatives that promote increased effectiveness of the market as a device of social ordering. Of course, regulation will have a place in any comprehensive national health strategy, but intervention should follow from theoretical analysis and should encourage market perfection wherever feasible and appropriate.

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