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Commentary

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DANIEL FOX HAS PRODUCED an interesting document that attempts to explore and explain a change in the economists' views on health care, one that holds little promise for reforms in medical care delivery or financing in the near future. The early reformers who felt compulsory health insurance was inevitable and worked toward its enactment into law have, in his opinion, been replaced by academicians who make continuation of the status quo inevitable. I would not have described my role as a "reformer"; rather, I felt I was a gatherer of data that others could use to depict the reasons why revisions in our medical care delivery system were needed.

Dr. Fox dismisses the period from 1920 to circa 1950 as one in which there was no interest in the subject of health economics. One cannot help recalling that World War II might well have interrupted a great many normal interests and scientific pursuits. In this period Governor Earl Warren came close to passing a health program for California. A great number of physicians and trained researchers were involved from 1927 through 1933 in the activities of the Committee on the Costs of Medical Care; the committee's work very nearly resulted in the enactment of a program of compulsory health insurance as part of the Social Security package in 1938.

Historian Fox has made no mention of the "Clark Report" ("Health Insurance Plans in the U.S."), prepared by Dr. Dean Clark after intensive research by the Senate's Committee on Labor and

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Public Welfare.[1] Both this report and the five or six volumes of *The Health Needs of the Nation* provided substantial background material demonstrating a lively interest in improving supply and understanding demand in the medical care arena. These reports showed that good medical care was affordable in the United States, given the right economic base.

My own view is that, stimulated by the work of the Committee on the Costs of Medical Care, when peace returned after World War II, economists as well as others realized the need for definitive data to back up their sense of the inherent correctness of their pressure for policy changes. They began to employ tools either not widely used before World War II or newly created during the war. I well remember explaining to the doctors in the Public Health Service that cost-benefit analysis was really just a new "buzz word" for the activities that went into preparing the department's yearly budget. How often I have wished that the techniques refined in cost-effectiveness analysis had been applied when Salk first came up with polio vaccine. We could easily have paid for universal vaccination of all the children in the country with the savings enjoyed from hospital beds emptied by the ending of this crippling disease. (Canada went ahead and did have a public program, without refined cost-benefit analysis.) Other developments that aided the economist were refinements in the cost-of-living index, to reflect medical care costs more accurately, and revisions in life tables that made calculations of the value of a man's life of toil more accurate.

Furthermore, medicine, neither very effective nor very costly in times past, began to make medical care a worthwhile, but increasingly expensive, service. When I entered this field, a day of hospital care cost less than $15.00 and physicians' charges were manageable. Knowledge of how much the nation was spending for each item of care, and the mounting infusion of public monies into this market, made statistics on the size and distribution of services and their costs increasingly necessary.

True, the concentration on studies, and more studies, and still more studies served a dual purpose: 1) research keeps funds flowing into universities to maintain their staffs of researchers; and 2) studies

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[1]1951. Report no. 359, part I, 82nd Congress, 1st session. Washington, D.C.: Government Printing Office.

postpone making any decisions until "the facts are all in." This is a popular tactic of medical societies and, one has to admit, of Congress. As an example, data have demonstrated all too many times that fewer days of hospital care are used by the enrollment in prepaid group practice plans than under Blue Cross, so that the cost of this segment of care is less. Scitovsky's studies of the Palo Alto group practice clinic have shown that care provided by specialists has a better outcome (even if more expensive) than care by less well-trained practitioners, restoring the patient to the labor force sooner and adding to the nation's productivity and wealth.

More and more popular journals have contained articles on medical economic subjects. I still recall the day when *Business Week* was preparing to run its first definitive piece. Leonard Silk reached me from New York while I was at the hairdresser's in Washington, and we verified the text for an hour via long distance! My hunch is that laymen have had a lot of exposure to the subject and this grass-roots awareness—including labor union educational efforts and congressional airing of the problems of the aged in obtaining and paying for health care—makes the posture of academic economists less important.

Another clue to the improved chances for change lies in the sphere of professional associations. For instance, membership in the Medical Care Section of the American Public Health Association (APHA), in these same "lean years," had been growing rapidly. The section became the largest in the APHA. If one adds the Health Officers' Section to that of the Medical Care Section, and members of state affiliates as well, there would be a sizable number of people concerned with the economics of medical care and their numbers continue to expand.

While my long-continuing interest (from 1929 onwards) in prepaid group practice has been disparagingly referred to by some physicians as a "do-gooder" activity, it really stems from the patently logical economics of this form of delivery of medical care. As an oldster, who should be getting to a stage of resisting change, I still have high hopes for a system of equity and justice in medical care.

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