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Commentary

C. RUFUS OREM

Health Care Economist (Retired),
New York City

EARLY IN THE YEAR 1928 a national Committee on the Costs of Medical Care began a study to develop recommendations for changes in the production and financing of health care for Americans. It was a period of high employment and low prices, but there was a general feeling that adequate medical services were not available to the average man, who was defined as a "person of moderate means." Six philanthropic foundations contributed a total of about one million dollars to support the project. Two others refused to help finance the venture, on the grounds that research was unnecessary and that the time had come for action.

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Health care is an economic commodity in the sense that the costs of production and consumption can be, and are, measured in terms of money. But health care differs sharply from other commodities; these differences must be considered in any economic analysis.

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Modern society decrees that access to health care is a human right, regardless of a person's ability to pay. This policy is defended on the principle that health is wealth, and unattended sickness or injury is a public danger and inconvenience.

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Coinsurance and deductible provisions are often used to limit the amount of care to which an insured person will be entitled. The purpose is declared to be the avoidance of unnecessary care, the conservation of providers' time and resources, and the containment of total costs to beneficiaries of a health care program. Undoubtedly coinsurance and deductibles accomplish these objectives. But their enforcement constitutes the control of medicine by arithmetic rather than by professional judgment. These procedures are an offense to honest consumers, and an implied insult to the integrity of ethical practitioners and responsible management.

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Legislators have shown great interest in programs that would provide payments to providers when the total amounts reach catastrophic proportions that might consume a person's total wealth or drive him into bankruptcy. Such instances face about one percent of the population annually. But a person supporting a family on an annual income of $25,000 is more interested in the first $1,000 for an episode of sickness or disability than the last $100,000 that may be paid practitioners and institutions when he is broke.

Care of catastrophic or terminal illness is a proper feature of a national or state-wide program, but it should not precede or be substituted for the many services that are required in smaller amounts by more than half the population every year.

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Relativism in health care is a term used to characterize incremental or minor changes in some aspects of production or financing. Examples are voluntary health insurance programs, money reimbursement of interns and resident physicians at hospitals, private group practice by doctors and dentists, increased ambulatory care and emergency care at hospitals, and government programs of medical care for the aged and indigent. These changes were not developed as alternatives to complete "reform." They were alternatives to the previous status quo, compromises in a class struggle between providers and consumers of health care.

Address correspondence to: C. Rufus Rorem, Ph.D., C.P.A., 15 Charles Street, Apt. 4A, New York, New York 10014.