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Commentary

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BY WAY OF INTRODUCTION LET ME SAY that I found Dr. Daniel Fox's article an intriguing contribution to the contemporary history of social science in the United States. I am in substantial agreement with his basic thesis that a shift occurred from the earlier reformers to the later methodologists, and that what happened, what is happening, and what may happen as economists inundate the health arena is worthy of attention. I am pleased to add one "insider's" view of this development in the hope of providing some additional perspective.

My direct involvement, like that of Herbert Klarman, stems from World War II when we served respectively as director and assistant director of the Resources Analysis Division of the Surgeon General's Office, War Department, with responsibility for providing logistical advice on the allocation and utilization of manpower and facility resources. As a direct consequence of this wartime experience, we served together again in 1948–1949 on the Committee for the Future of Nursing[1] and the New York State Hospital study.[2]

Except for an occasional scholarly effort or consulting assignment, I had no further involvement with the health arena until the

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[1]The Committee for the Future of Nursing, Eli Ginzberg, chairman. 1948. *A Program for the Nursing Profession.* New York: Macmillan.

[2]Ginzberg, E. 1949. *A Pattern for Hospital Care.* New York: Columbia University Press.

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mid-1960s. Given my interest and experience, it was inevitable that I would be drawn back into the field with the enactment of Medicare and Medicaid and the recognition of their complex implications for policy. The lack of hospitality of the medical establishment to interloping economists was revealed to me by the career experiences of Klarman, who had remained in the field throughout the fifties and early sixties. Unlike most of the recent methodologists, Klarman and I brought to the health arena intimate knowledge of its institutional structure and mechanisms, always keeping that framework in mind in setting questions or looking for answers.

When Milton Friedman was finishing his study of professional incomes in the late 1930s, proving to all who would listen that organized medicine was a monopoly using controls over supply to raise physicians' earnings, I was not impressed by the cogency of his conclusions. Clearly, the model of a competitive market could not be used to determine entrance into the profession or earnings. I was struck at the time, and still am, that existing deviations in outcomes from the competitive model do not necessarily commend a public policy of more competition as Feldstein, Enthoven, Havighurst, and many other neoconservatives are advocating.

The large infusions of money into the health arena after World War II via health insurance, hospital construction, biomedical research and educational expansion took care of the most urgent problems. The fight over National Health Insurance was lost but the "old guard" from the 1930s remained and never conceded. As a consequence, few new policy issues emerged. The Eisenhower era was not conducive to public debate over unsolved problems.

By the early sixties at the first Conference on Health Economics at the University of Michigan (1962) the title of my presentation was a warning: "Medical Economics: More Than Curves and Computers."[3] The macroeconomists and econometricians were moving to the fore and I questioned their ability to "achieve understanding of or control over the economics of health and medical planning ... [because] of the lack of knowledge of economists concerning the structure and functioning of the relevant institutions."

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[3]Ginzberg, E. 1964. Medical Economics: More Than Curves and Computers. In *The Economics of Health and Medical Care*. Proceedings of the Conference on the Economics of Health and Medical Care, May 10–12, 1962, University of Michigan.

I did not see any easy way to reconcile the differences in orientation between the needs of the nation for policy guidance and the growing interest of economists in using the health arena for analytical exercises and methodological refinements. When Margaret Mahoney was still at the Carnegie Corporation, I advised her to finance the postgraduate training of a limited number of able young physicians in the social sciences with the aim of preparing the best of them to serve as professors of social medicine at leading medical schools. The Clinical Scholars Program at Carnegie and the R. W. Johnson Foundation shared this objective, but not for long.

Despite the rapidly growing numbers of social scientists who are now actively engaged with various aspects of the health care arena—economists, sociologists, political scientists, and still others—I have yet to see any substantial contribution to policy guidance. The barriers to such contributions are formidable and include the following:

1. An inadequate acquaintance with the structures and operations of the key provider groups—physicians, hospitals, the Blues [Blue Cross and Blue Shield], and government bureaucrats.

2. A selection of problems to investigate that fall within a single discipline. Most policy issues, however, are interdisciplinary and, as a result, much of the research outcome is lopsided, if not irrelevant.

3. The preference of economists to work with existing data that in many cases are not suitable for reaching judgments about alternative policy decisions.

4. The preoccupation of discipline-oriented investigators with the attempt to command the respect of their confreres by pursuing methodologically sophisticated approaches even if the results turn out to be nonsensical. Witness Uwe Reinhardt's amusing illustration of the researcher who found that the optimal admission flow to a hospital was "no patients"!

5. The reluctance of many academics to make the leap from research to policy.

6. The related belief that such an extension is a violation of the canons of scholarly behavior, which, in their naive view, requires them to pursue a value-free approach. Translated, this means an alignment with the status quo.

7. The shortcomings of economics in providing useful models for the study of the health care system, since the dominant conceptualization of competitive markets, profit-seeking or even "satisfying" enterprises, improved consumer choices, substitutability, and many other analytic tools is not only irrelevant but outright misleading.

Having called attention to these obstacles that stand in the way of intellectual progress and improved policy formulation, I must quickly add that the outlook is not entirely bleak. Among the young graduate students who are currently being trained by market economists, adherents of the human-capital school, econometricians and the others who stand in the forefront of the discipline, many will not stay in academic life, writing for their colleagues and instructing their pupils in the same tradition as they were taught. A growing number will move on to pursue careers in an industry that will reach the $200 billion mark this year. Here they will live and respond to the forces in the real world, adapting their theories and tools to the problems at hand. In my view, their analyses will be more pertinent. The open question is, Will they see themselves solely as technicians, coopted by the "system," or will at least a few of them look ahead and concern themselves with ways in which both the equity and efficiency of the health care system can be enhanced?

American society still has a considerable way to go before the hordes of professionals and managers[4] transcend their occupational environment and go beyond just practicing their skills to exercise their rights of citizenship and seek to improve that environment. But that may happen, possibly faster than even optimists would anticipate.

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[4]Ginzberg, E. 1979. The Professionalization of the U.S. Labor Force. *Scientific American* 240 (March): 48–53.

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