Social and Economic Attitudes Shaping American Health Policy*

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THESE LECTURES WILL EXPLORE THE SOCIAL AND economic dimensions of health care policy development, building upon the ideas of Henry Sigerist, who delivered the Heath Clark Lectures here at the London School of Hygiene and Tropical Medicine almost thirty years ago. Many of you will recall Sigerist's view that medicine is a social science. He wrote: "The tasks assigned [to the physician] are determined primarily by the social and economic structure of society and by the technical and scientific means available to medicine at the time" (Sigerist, 1941). If medicine and medical care delivery are affected by social and economic forces—and thus by the experiences, traditions, and values of a society—surely this is even more the case with the subject of these lectures, the formulation of health *policy*.

Health policy is part of social policy, and how nations choose to address matters of social policy, the questions they will ask, and the solutions they will elect, cannot derive from some technical model or set of multiple regression equations. These dynamic solutions will

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have to take into account the nature, history, and traditions of existing institutions and relationships, the attitudes and behavioral characteristics of key actors, the sector's organic development, the climate of opinion, the goals and values of a society and of its members. It is in that social and economic context that I shall discuss the development of health care policy.

Given that perspective and my own experience, my comments will be focused on United States events. Yet, in selecting the various topics I would explore in these lectures, I did choose those that seemed to me to be so basic to the economics of the health care sector that the probability of transatlantic relevance would be increased. For, while our problems surely are not identical, in some respects they may be (or become) similar. The months I have spent with you as the 1980 Heath Clark Lecturer have given me an opportunity to participate in the activities of the school and to learn more about Britain and British health care. Even so, I conclude that the relevance and applicability of the American experience to current debates in places other than the United States are best judged by insiders rather than by outsiders. The insider is more likely to appreciate the nature and importance of any differences; the outsider, eager to process new information and learn quickly, may be seduced by superficial variations or concentrate on apparent similarities.

Lecture I: American Health Care: Selected Policy Issues

In my first lecture, I begin with some observations about the United States, about our attitudes and views, about the context in which our social and health policies are formulated. I shall share my impressions of the American climate of opinion, particularly toward government, and shall discuss the growth of neoconservatism and some of its implications for the development of United States health policy. These remarks provide the frame of reference for my subsequent review of various health care cost-containment programs. I shall examine the impact of these several efforts and suggest the desirability of a more comprehensive approach to American health care problems.

Social and Economic Attitudes

System "Shocks"

The United States is a large country that has been buffeted by a series of significant "shocks" in recent years, "shocks" that have affected the national psyche and attitudes. While others may feel that the reality of some of these events is not as severe as America's perception of them, it is our perception of reality that impels us. We have experienced a high rate of inflation: in excess of 13 percent for the 1979 calendar year and now running at over 18 percent per annum. This is a new phenomenon and a matter of immense concern. It does not comfort us to be informed that our rate may be somewhat lower than yours, as it does not comfort you to be told that in the Argentine and in Israel the inflation rate is over 100 percent per annum. Thirteen percent affects attitudes when 1) few wages, salaries, or incomes, and no savings, are inflation-linked; 2) it is clear that the inflation rate will not be reduced appreciably in the near future (it is accelerating); 3) the inflation has come at a time when the economy is stagnant (real income dropped by almost 7 percent in the last year); and, most important, 4) we are told that a reduction in inflation will require an increase in unemployment.

Another "shock": energy costs. Again, the frame of reference for Americans is our own past. While it is true that energy prices in the United States remain lower than in many parts of the world—though considerably higher than in our two neighbors, Mexico and Canada—they have risen in the last year by large percentages, the cost of my home heating oil by over 80 percent, of my gasoline by over 50 percent (and both have risen by about 400 percent since 1973). Few of us have any confidence that these prices will stabilize, that alternative energy sources and supplies will come on-line in the next decade, or that we will find ways of sharing price increases and energy shortages equitably.

Inflation and energy costs are economic matters, but economics is not everything nor does it hold a monopoly on things "dismal." Other events have had profound effects on America: Vietnam, Watergate, and, more recently, Iranian hostages.

These various shocks are additive for they have a common characteristic: in one way or another, they involve a loss of confidence,

confidence in ourselves, in our political leadership, in our ability to solve problems and influence events. The development of United States social policy, thus, takes place in the context of an increasing disillusionment with the ability of government to govern and in an atmosphere characterized by an unhappy mixture of cynicism and skepticism. For many, the motto "can do" has been replaced by the phrase "nothing works." The optimistic attitudes expressed by the phrases "the New Frontier" and "the Great Society" have been replaced by such Malthusian terms as "scarce resources, constraints, and limits." We face the future gripped by a nostalgia for the past and we are hesitant. We are told that it is a time for incrementalism, not boldness; for realism, not idealism.

Realism has often come to be translated to mean that it is a time for the technician. Idealism is dead. The problems are complex. The call is for hard heads, not soft hearts, and, in the view of many, these are mutually exclusive organs of the body politic. If one reads a sampling of books, articles, and government reports, one can easily conclude that in the social policy arena we have entered the age of the tinkerer and technocrat. He is the kind of fellow who, with integrity and conviction, would have advised you to try a National Health Service scheme in one or two small boroughs so that the experiment could be monitored for the next twenty years, at which time there would be a report of inconclusive and ambiguous results, followed by a courageous call for more experiments, more research, and the refinement of methodological approaches.

That, however, is not the whole story. Harry Truman used to say, "Give me a one-armed economist. The trouble with the ones I have is that they spend all their time saying 'But, on the other hand.'" Aware of the genetic defect that pervades my discipline, I hope you will indulge a few "but, on the other hand" remarks.

It is true that we have increasingly turned to technicians to provide answers, and it is even true that the most able technicians soon advance to new responsibilities and begin to frame the questions and circumscribe the range of options. We have ignored Sir Richard Livingston's dictum that "a technician . . . can be defined as one who knows every aspect of his job—except its ultimate purpose and social consequences." It may appear, therefore, that United States social and health policy will now be characterized by battles over reorganization rather than by debates over ideas; by arguments about how to increase

the benefit-cost ratio rather than by questions concerning the meaning of benefit and the distribution of costs; by discussions about how to maximize rather than about what to maximize; about whether the trains run on time rather than about their destination.

It is out of fashion to debate the role of government in furthering distributive justice and equity. The Friedmans, after all, tell us that "unfairness can take many forms. It can take the form of the inheritance of property—bonds and stocks, houses, factories; it can also take the form of the inheritance of talent—musical ability, strength, mathematical genius" (Friedman and Friedman, 1980, 1979:136). We are admonished to accept inequality wherever it is found. The Friedmans state that, from an ethical point of view, there is no difference between the inheritance of property and talent. Aware of the difficulty of achieving equality in health outcomes and impressed by the Friedmans' argument and, thus, not certain of the desirability of the goal itself, many have given up the fight for equity in health-services access. Nevertheless, in a country as diverse and heterogeneous as the United States, not everyone has abandoned the battle of ideas. There still remain those who believe it is important to ask the question, What shall we do? not only, How shall we do it? Debates concerning the responsibilities of government and the appropriate place for collective and for individual action may be muted, but they have not been resolved.

Government Responsibilities

American political structure, party orientations, labor-movement traditions, and history do not lead us to frame our differences in ideologic terms. We shy away from such labels. This seems to be true not only among those who might be termed "liberals" but also among those who believe that Adam Smith's *Wealth of Nations* is the basis for a party platform and that a banner emblazoned with *the* answer "free market competition" is more compelling than one that, in a complex society with multiple goals, more appropriately calls for "a mixed economy with a little of this and a little of that, as seems appropriate to the problem and the time." But though, in general, we do not use ideologic *labels,* our differences are more than merely technical. There is a battle of ideas, ideas about the proper role of government and about its abilities. President Nixon could, and did, say, "We are all

Keynesians"; today, he might claim we are all monetarists. But I believe that both Adam Smith and Lord Keynes would have agreed (in a conversation on which many would have liked to eavesdrop) that they could distinguish between Richard Nixon and Hubert Humphrey.

It is clear that the terms of the debate over the role of government have changed markedly in the last decade and a half. 1980 is not 1965, the period of Medicare, Medicaid, civil rights, the Great Society; 1980 is not the year of the love affair with government. Rather, it is the year of the car sticker that reads, "If you like the U.S. Post Office, you'll love national health insurance." I should be frank: I saw that slogan as early as 1976, a year in which we elected a president who ran against government itself. By 1980, the slogan may be so self-evident that it is not needed.

This skepticism of and hostility to government is perhaps most evident in the social and economic spheres. Many Americans believe that government employment is inherently unproductive and wasteful. It is assumed that building a typewriter, designing a package for the "new and improved" breakfast cereal, and building a fourth bank or building society on the fourth corner of an intersection all strengthen the national economy, while typing a memorandum, designing an educational program, and building a park are wasteful. Since less waste is to be desired, so, too, is less government. Increasingly one hears many Americans saying:

—That government has grown more and more intrusive and "paternalistic." It knows better than we what is good and bad for us. Don't smoke; don't use saccharin; fasten your seat belt! Yesterday "they" warned us about asbestos; today "they" sit in Washington, sip their fine wine and tell us there are carcinogens in our beer. Enough!

—That government is impersonal and distant. Given the sheer size of the nation and its diversity, government programs simply cannot work well at the local level or for heterogeneous populations. If the programs ignore this diversity, they will miss their mark and fail the test of effectiveness. If they try to deal with heterogeneity, they will be complex, not easily administered, and will fail the test of efficiency.

—That government is large and cumbersome. Because of sheer size and the nature of the political process, it cannot respond quickly or adjust its programs and alter its rules and regulations to meet changing conditions. The view is of some supertanker that once under way

cannot easily be stopped. Government programs are difficult to enact but, once enacted, are seldom repealed. Like the Mississippi River, they just "go rolling along." After all, we still have a federal body that tests the quality of tea and this in the United States, not the United Kingdom.

—That governmental social *service*-entitlement programs are out of control, that they inevitably cost far more than originally estimated, are replete with fraud and abuse, fail to deliver the quality that had been promised, and often provide services to individuals not eligible. That government *cash*-entitlement programs share some of these deficiencies, do not work with equity, and often provide the wrong incentives, for example, rewarding leisure instead of work and profligacy instead of parsimony.

—That elected officials do not serve the public interest. They yield to the pressure of special interest groups and succumb to financial temptations. That government employees, "bureaucrats," are lazy and unresponsive.

In observing these points, I am acting as a reporter without judging their validity or consistency. A critical analysis would note, for example, that even as many Americans say that government is intrusive, we also react to almost every problem with the phrase, "There ought to be a law," or "Why doesn't government do something about that?" Such an analysis would point out that, even as many Americans want government to shrink, others feel that government is not doing enough. It would also note that, while many feel that government regulations cannot change, others believe government is too fickle to rely on, subject to whims in which it can take away as readily as it can give. Finally, it would point out that the impression of an ever-growing federal government is fallacious: the federal budget, as a percent of the gross national product (GNP), is declining, *not* increasing. Yet, even after I added these, and other, points, I would still be forced to return to the original assessment: the climate of opinion is one of skepticism of government's ability to perform its appropriate functions, combined with an inability to agree on what those functions are.

This general attitude reinforces, and is reinforced by, the growth of intellectual neoconservatism. Convinced that government's intentions, however beneficent, cannot yield desired outcomes and that, even if they did, they would have unexpected and undesirable "side

effects," neoconservatives offer an alternative: the economic marketplace, pure competition, the "invisible hand." Convinced that, at the macroeconomic level, government has proven not to be the master regulator (the "misery" index, the sum of the unemployment and inflation rate, has been rising), they would diminish government's discretionary role. Convinced that, at the microeconomic level, government policy and regulations have added to costs, retarded productivity, and reduced consumer sovereignty and welfare, they would give greater opportunity to market forces.

I am certain I need not elaborate on this point of view. I can leave that task to your American critic and sometime adviser, Milton Friedman. I note, however, the words of a great Englishman:

> Disease must be attacked in the poorest or in the richest, in the same way as the fire brigade will give its full assistance to the humble cottage as readily as to the most important mansion. Our policy is to create a National Health Service to ensure that everybody, irrespective of means, age, sex, or occupation, shall have equal opportunities to benefit from the best and most up-to-date medical and allied services available.

These words were spoken by Winston Churchill in 1944. I must say that, in regard to the choice between Churchill and Friedman, I do hope you decide to "Buy British." I should note, however, that whatever success Professor Friedman has in convincing *you* of the virtues of the invisible hand—that anatomical construct some of us think is all thumbs—the impact of his ideas on United States patterns of thought and attitudes should not be minimized. We do, after all, approach our inflation and energy problems with a mindset that opposes mandatory price and wage controls or gasoline rationing. We see our problems through a prism that tends to magnify the strength and virtue of the market.

We do seem to have moved from trust to skepticism, from feelings of community to individualism, from the belief in the need and power of government to help the disadvantaged to a belief that government is not the best instrument to achieve social justice. It is dangerous to describe social forces and climates of opinions, to write history without the advantages of distance, and especially so for the United States where the role of the individual, rather than the party, in quadrennial election campaigns makes possible rapid and large shifts in the defini-

tion of issues, in attitudes, and in policy direction. Yet, I feel that my assessment does describe reality, that it does describe our present mood. The mood may change but, if so, that is in the future.

Health Care Inflation

If all this be true, what then of health policy? Presumably, we would expect a policy of drift and inaction. In some extremely important respects, most evident in regard to national health insurance, that is what we have. In other respects, however, we are taking action and adopting new initiatives. The actions may be hesitant and sometimes at cross-purposes. The captain may have one course in mind, the crew another, and the passengers are not certain whether they prefer to stay in port or get under way, but the ship is moving nonetheless. No one is ready to unfurl the sails, but there is a growing feeling that the winds grow stronger and that the time to commit to a course grows nearer. What are these winds? What are the actions? True it may be that the United States does not have a unified health policy, but what are our various health policies? I should like to review some of them.

The strongest wind felt by the health sector is rising costs. The United States health sector, of course, is organized differently from that of the United Kingdom. Central federal government expenditures account for less than 30 percent of the $175 billion spent on personal health care (and total government expenditures—including federal, state, and local—account for less than 40 percent). Furthermore, the bulk of even those expenditures are for Medicare (a federal social health insurance program for the elderly) and Medicaid (a federal-state assistance scheme that pays for the health care of some of the poor), with payments under fee-for-service or equivalent arrangements in which government does not know what it will expend until the bills come in; that is, until those persons or institutions that have provided a service, ask to be paid for doing so. Thus, our national health expenditures are largely determined "after the fact," by totaling up what was spent. We do not spend within a budget. Let me stress that again, for it is perhaps the most basic descriptor of the United States health sector and of many of the issues it presents. Our national health expenditures are not budgeted. They are the outcome of individual provider and patient decisions. Absent the budget, there are no direct, and few indirect, expenditure-control mechanisms.

Health expenditures have grown. With some misgivings about the adequacy of translating dollars into pounds (at the current exchange rate of about $2.30 per £1), let me attempt to do so. In the three-year period, 1975 through 1978, United States total health expenditures rose by about 50 percent, from £57,000 million to £83,000 million, from £263 per capita to £375, from 8.5 percent of GNP to 9.1 percent. The health sector absorbs over one-twelfth of America's production. Put another way, the average American works over one month a year to pay for his or her health care.

Increases in health sector prices (at rates that outstrip that of general inflation) combine with growth in population and increases in use and/or kinds of services and supplies to yield even higher rates of increase in health expenditures. These rising prices and rising expenditures affect all payers for care: individuals, both for insurance premiums and out-of-pocket costs; firms, for the fringe benefits they provide their employees by paying part or all of the cost of health insurance premiums (General Motors pays more per annum to Michigan Blue Cross/Blue Shield than it does to U.S. Steel); and government—the 1981 federal budget for health rises, in largest measure, because of the anticipated inexorable increase in Medicare and Medicaid payments. At a time when real incomes are strained, when wage increases are not keeping pace with inflation, when the thrust is to eliminate government deficits, there is an understandable desire to try to control the uncontrollable. This is especially so if the uncontrollable represents a considerable proportion of expenditures, as is true in the case of health care. As a consequence, those who govern have been forced to consider what they might do *now* to try to contain rising costs. There is little question that it is cost-control problems that are the driving force behind many of the bits and pieces of health policy. No proposal in the health sphere can be considered without attention to what has become the overriding question, Will it assist in controlling costs?

The Impact of Health Cost-Containment Policies

Given the absence of significant ways of directly affecting costs, we are forced to proposals that attempt to deal with aspects of the problem

indirectly, if not actually insidiously. Thus, we adopt measures that appear to be medical care proposals but whose genesis was really cost control. They are not called cost control; they do not look like cost control; often they are legislated under the guise of improving quality (and, in fact, may do that); but they were conceived in an effort to save money.

This indirection should not surprise us; two factors can help to explain it. First, one man's cost is another man's income. In spite of all the hustle and bustle over costs, the fact remains that some people like things the way they are and do not relish, or even feel neutral about, a reduction in *their* incomes or in *their* budgets. When they agree that costs must be reduced, they refer to other parts of the sector: my CAT scanner saves costs, the next fellow's is cost-generating; my hospital's 75 percent occupancy rate reflects "readiness to serve," the other fellow's represents "overbedding." Thus, one would hardly expect an overt, specific cost-cutting proposal to be greeted with universal enthusiasm. Far better to call it by another name, to "sell" it in another way.

But there is yet a second reason for the indirect approach. Consider the few tools at the disposal of the administration and the Congress. Government cannot use budgets; cannot set prices; cannot fix fees; cannot determine wages, salaries, or incomes; cannot close hospitals or reduce beds; cannot determine utilization. It is difficult to contain expenditures without control of both prices and quantity, and even more difficult if you cannot effectively control either one.

Thus far, none of the measures we have undertaken, individually or their sum collectively, has had a significant impact on prices or expenditures. Nor is this simply a matter of time, i.e., that the measures have not yet taken hold. Some of us feel that the problems are inherent in the absence of a control mechanism, of budgets, in the fragmented nature of our health care financing schemes and structure of our health care delivery system, and, given our present mood, in our inability to develop and implement a comprehensive health care (not just a health care costs) policy. Even so, it would be incorrect to dismiss the programs we have attempted as being entirely without value. They have had educational value, a benefit that none of us takes lightly. They have had, or can be expected to have, some positive impact on costs, not dramatic but not entirely to be ignored. They have often improved the quality of health care, and the purpose of the

health sector, after all, is not only to minimize costs. And, on occasion, they have put into place an infrastructure that the United States health care system sorely lacks.

Lessons Learned

First, educational value. We have come a long way in the last decade and have significantly increased our understanding of the nature of our health economy. Ten years ago, I had the opportunity to meet with a small group of senior officials (including economic advisers) in the executive branch of our government. Even then they were concerned about health care inflation. They felt (incorrectly, in my view) that price increases were the result of a surge in demand stimulated by Medicare and Medicaid pressing upon a constrained supply of health resources. Since these financing programs were not likely to be repealed, attention was directed to expanding the supply of beds and the number of physicians as a way of relieving price and expenditure pressures. Today it is inconceivable that a serious discussion of the economics of the health sector would be based on this most simplistic supply/demand proposition. It has been an expensive lesson, but we have learned that expanding total supply *does not* solve our maldistribution problems nor does it reduce prices; but it *does* increase total expenditures. Supply creates its own demand and having an unnecessary operation will be harmful to one's budget, as well as to one's health.

To some of us in the field of medical care, these lessons may appear obvious. I suggest that they are not so at all. There is nothing obvious, and surely nothing trivial, in recognizing the fact that simple economic models do not describe the real world in which people have memories, hopes, passions, and ambitions. When this is recognized by cabinet officers and their aides, and even by economists, we have a consummation devoutly to be wished.

Controlling Capital

So it is that the United States has put into place various laws and regulations designed to slow capital formation in the health sector, and various standards and guidelines designed to reduce existing bed capacity. In spite of the belief in free enterprise, it *is* required that

hospitals, though not physicians, obtain approval from state authorities for capital expenditures that exceed $150,000 (£65,000). Absent such approval, the costs of the investment cannot be passed on for government reimbursement through Medicare and Medicaid. However, state authorities have little incentive to deny an application, especially when the capital investment involves private funds and the presumed potential benefits of more plant and equipment arouse much emotional support. There is, as yet, no capital budget or ceiling at local, state, or national level. Similarly, it is hard to close a hospital, especially a small, local hospital close to the people and physicians it serves, and those hospitals, rather than the large, teaching hospitals, are the ones in jeopardy. Authorities and their constituencies recognize that hospitals do more than provide health care—they provide jobs as well. In the United States, almost 7 million persons are employed in the medical care sector, and well over half of that number, including many members of minority groups, work in hospitals. Thus, it is to be expected that closing a hospital is as difficult, say, as closing a local post office.

It is not surprising, therefore, that I cannot report conspicuous success on the hospital closure or even on the capital-expansion front. Nevertheless, there has been some progress in some areas of the country. Although construction is at about the same dollar volume of $5 billion (£2,200 million) per annum as was the case three years ago, it is declining in real terms because of inflation. Furthermore, even when efforts to contain expansion fail, there may still be some gains: the review processes may help in rationalizing the mix of services and in structuring better interhospital relationships with favorable impacts on quality.

Improving Quality of Care

We would all agree that quality is difficult to assess and especially so for services rendered in the physician's office. We lack consensus on expectations, criteria, data, and adequate information on outcomes. Most efforts at quality control have been directed at hospital services, which do account for 45 percent of all personal health care expenditures. In this arena, we find a number of quality improvement, cost-control measures.

First, we are actively trying, through various mechanisms, to elimi-

nate unnecessary duplication of services, especially ones involving expensive technology. It is a source of embarrassment that 30 percent of the 800 hospitals equipped for open-heart surgery in the United States had no cases at all over a one-year period, though I am sure we would be even more embarrassed and concerned if they had each had one case. There simply is no question that, in the United States, the health care sector does offer a number of opportunities to have the best of all worlds—to improve quality *and* to save money at the same time. In fields like obstetric units, open-heart surgery, and other highly sophisticated care, we are trying to grasp those opportunities.

We are also engaged in strenuous (and costly) efforts to monitor and affect the utilization of hospital services through utilization review committees and professional standards review organizations. Although observers are agreed that the wide variation in physician behavior and in utilization of certain services (surgical interventions and diagnostic tests, for example) cannot be explained by variation in patient needs, we lack accepted norms of what is and what is not appropriate. On the one hand, there are journal articles noting that the United States has more surgeons and, thus, more surgery than does Britain. On the other hand, there are responses that this is further evidence that Britain has too few surgeons rather than that the United States has too many. The widely held, though tacit, assumption is that better norms, if known and applied, would reduce use and would save money.

Absent the norms and aware of the difficulty of intervening with individual physician decisions, we have been limited to reviewing the unusual and abnormal, defined as the significant departures from prevailing patterns. By definition, there are relatively few such cases and especially so if, in a cost-control environment, we place stress only on cases where "too much" care was given and ignore the cases where "too little" care was offered, only on the cases that fall far above—forgetting those that fall far below—the mean. Potential savings and quality improvement are, therefore, limited. Nevertheless, they are real. Nor should one completely discount the hope that physician awareness of the review mechanisms and physician education about, and discussion of, these matters will, over a period of time, affect general behavior, reducing variation and perhaps shifting the mean itself. Obviously this will not come easily in a system in which some individuals can pay for care while others cannot. Nor are we aided by

monetary incentives that work at cross-purposes. (Both physicians and hospitals benefit from increased utilization, and one does not have to be a sophisticated economist to conclude that it is an odd world indeed in which we ask the workman to produce fewer pieces while continuing to pay him for each piece he does produce.) Clearly, the whole review process, largely administered by physicians, resembles a situation in which the fox is guarding the chicken coop. Yet, the development of the review structure, the monitoring of performance, the analysis of variation, and the investigation of unusual behavior, all have value. The important thing is that we not expect more from this activity than it can deliver.

Other actions, although indirectly impelled by cost concerns, have a long-term potential for benefiting both health status and cost containment. Some of the beginnings include: a greater emphasis on preventive care and on health promotion; a shift toward primary care and family practice; and an increased emphasis on ambulatory rather than in-hospital care.

Building Infrastructure

Finally, the various measures thus far taken have helped in developing an infrastructure for the United States health care system. Let me mention two of its aspects. The first is the network of over 200 health systems agencies (HSAs). Though, in general, these planning organizations are weak—they are merely advisory, they do not control budgets and, under our financing system, local imperatives are not likely to fit with national goals—they have opened up a dialogue and are a first step toward planning. Today, the powers of the HSAs are few and the problems are many: the articulation of guidelines; the relations between federal, state, local governments and voluntary associations; and the mechanisms for effective consumer representation. Some HSAs are working well and are having an impact (especially so where effective state support is present). Perhaps of even greater significance is the fact that they exist at all. They, or organizations like them, will be necessary when we move, as I believe we should and hope we will, to a national health insurance program that, under new budgeting and financing arrangements, tries to contain costs even as it increases access. But we must guard against the danger of unrealistic expectations. In the United States political system, which requires

"overselling" a program to enable its enactment, that danger is real. Health systems agencies might be destroyed for "underdelivering" and, in some future period, the United States will have to reinvent them.

The second step toward an infrastructure, useful in its own right and important in a restructured health care delivery system, is the health maintenance organization (HMO), and especially the prepaid group practice. Offering comprehensive care for a predetermined monthly payment, prepaid group practices represent a significant departure from open-ended, fee-for-service, solo medicine. Both the prepayment and group practice features are important. The method of payment means that the organization operates on a budget and on a set of economic incentives completely different from those influencing the rest of the health sector—incentives to conserve resources, to minimize hospital utilization, and to economize. The group practice form of organization can offer comprehensive services and peer review activities that are seldom found in solo ambulatory care. Peer review, as well as medical ethics and the fact that prepaid group practices coexist with the rest of medicine, helps in insuring that the incentive to do less does not lead to failure to do enough, that the economic incentives are acted upon in a responsible fashion. There is no doubt that prepaid group practices offer clear *economic* advantages over our more traditional organization and, some of us believe, clear *medical* advantages as well. Though their market share is limited and will remain so for quite some time, their effect is already discernible. We are fortunate that they exist, for if they were not already in place, a national health insurance program, oriented to traditional fee-for-service arrangements, could make it impossible to invent them. If they were not already strong, the United States could, through inadvertence, make it impossible to sustain them.

Conclusion

American health care policies involve approaches that are discontinuous and, to some degree, inconsistent. Often the various laws and programs are administered by different sections of the Department of Health, Education, and Welfare (HEW). Each of these units is responsible for the effective administration of *its* program, not for the

development or implementation of a coherent national health policy. Thus we can find that Medicare, administered by one branch of HEW, pays higher fees to urban physicians than to those practicing in rural areas while, at the same time, other sections of HEW administer programs designed to induce physicians to move to rural areas. Some divisions of HEW emphasize the importance of prevention, while others are not permitted to pay for preventive services. Consider that, in the early HMO days, prepaid group practices were called upon to meet the market test of competition but were required to offer such an all-inclusive and comprehensive set of health care services that many of them were priced out of the market. We build categorical programs serving particular populations, or addressed to particular diseases, even as we proclaim the virtues of universality and of comprehensive care. Perhaps the enactment of Medicare (a social-insurance program for "beneficiaries") and of Medicaid (a welfare-oriented program for "recipients") in the same year and, in many cases, helping the very same people, best illustrates our fragmentation and inconsistency.

Many of our problems derive from the multiplicity of our financing arrangements. We are inhibited from using even the large sums that flow through Medicare and Medicaid to influence events by the legislative imperative in the Medicare Act prohibiting the federal government from exercising supervision or control over the practice of medicine or the manner in which medical services are provided. Furthermore, there are limits even beyond those of legislation to the use of the Medicare-Medicaid purse. Those payments are significant but, nonetheless, are outweighed by the dollars that flow through the rest of the system. Unless the levels of payment in the rest of the system are met—and in an effort to save money, they seldom are—the Medicare beneficiary and the Medicaid recipient are at risk. The danger is inherent in a system in which government is able to set standards only for the minority of patients it pays for and only for the dollars it spends. It is especially inherent in programs that, like Medicaid, have a target population limited to the poor and that fail to generate the political support that accompanies universality.

Public interventions into what once were felt to be purely professional, medical affairs grow more numerous and the attempts to achieve public control grow stronger. In my view, these efforts requiring the expenditure of great energy and monetary resources and the

erection of cumbersome administrative structures will have only limited success. I reach that conclusion because I doubt the efficacy of ad hoc measures that attempt to deal with cost problems in the absence of a comprehensive attempt to solve health care delivery problems, albeit in the context of economic realities. Yet there is even more. I doubt the efficacy of small and modest steps (call it incrementalism) directed at a $200 billion industry with the structure, organization, financing, incentives, and priorities that characterize our health care system. John Stuart Mill put it, "When the object is to raise the permanent condition of a people, small means do not merely produce small effects, they produce no effect at all." Churchill was more succinct and dramatic: "You don't leap over a chasm in two steps." So much for incrementalism.

But if bold and large steps are needed, what might they be? In the next lecture, I shall explore that question.

Lecture II: Efficiency and Equity in Medicine: The Role of the Economist

In my previous lecture, I suggested that health policy is a part of social policy; that, at present, the United States economy is beset with difficulties; that, in such a context, social policy bends to economic realities and perceptions; that the new conservatism found among intellectuals and the "man in the street" provides a hostile environment for the development of new public programs. I discussed the limits of existing health policies that attempt to contain health care costs, and concluded that a more comprehensive health policy is necessary. In this lecture, I should like to explore the economic characteristics and equity/efficiency dimensions of such a policy.

I shall contrast two views. The first places priority on the achievement of health sector efficiency. It calls for a greater emphasis on the market as the ultimate allocator and stresses the benefits to be gained from competition. The second places priority on the need to achieve greater equity in health care access and outcomes. It calls for a strengthened role for government both in financing and in planning. I shall discuss the nature of these two alternative approaches and shall comment on the role of the economist in examining the efficiency/equity choice before us.

Attitudes Toward Medical Care

I begin with attitudes toward medical care, since discussions about financing health care inevitably are heavily influenced by prevailing attitudes toward medicine and ways of looking at and formulating medical/economic issues.

Investing in Human Capital

The National Portrait Gallery in London displays a portrait of Edwin Chadwick. Next to it, there is a card that reads, "Chadwick's view was a cold financial one: if you were ill you could not work, therefore poverty and disease meant lower production." There, in one brief sentence, is summarized a point of view, an idea with which we must reckon.

The idea began with Sir William Petty who, over 300 years ago, attempted to quantify the value of human life, using as the measure of value an average individual's contribution to the productive process. Petty employed these monetary estimates to assess the costs of plague and war and the benefits of various expenditures or investments designed to alter the human condition. He argued that removing people from London during the plague, and thus increasing their probability of survival, was an excellent financial investment (each £1 invested would yield a return of £84); that the nation's human capital and productive resources would be increased by the provision of lying-in hospitals for illegitimate births; that better medicine could save 200,000 lives a year and thus represented a sensible state expenditure. "Wherefore it is not in the Interest of the State to leave Phisitians and Patients (as now) to their own shifts" (Petty, 1676:176). (In a curious note, he also advocated migration from Ireland to England since, in terms of their productive contribution, Irishmen were calculated to be worth only £70 while Englishmen were worth £90.)

Almost two centuries later, Chadwick summarized this train of thought when he wrote:

> As the artist for his purpose views the human being as a subject for the cultivation of the beautiful—as the physiologist for the cultivation of his art views him solely as a material organism, so the economist for the advancement of his science may well treat the

> human being simply as an investment of capital, in productive force. (Chadwick, 1862:503)

He used this view in arguing for better sanitation "as an economical question of production." He adapted the pecuniary and preventive perspective to tie education and sanitation together:

> It is well to subscribe to reformatories as to hospitals for the treatment of the sick, but giving exclusive attention to them is like giving exclusive attention to the foundation and maintenance of hospitals for the alleviation of marsh and foul air diseases, without regard to the drainage of the marshes, or the removal of the sources of the foul air whence the diseases arise. (Chadwick, 1862:522)

The human capital approach spread to various countries and was applied to various fields: the cost of war; migration studies; education; and health care, with particular reference to specific diseases such as tuberculosis and typhoid. Though the main body of economics did not incorporate human capital theory until the 1950s, the basic views of Petty and of Chadwick (as well as Farr and others) did take root.

I refer to these matters because of the importance they have had in the development of patterns of thought and in the history of ideas. These ideas are familiar to us because, in no small measure, they are the way we think about things, including health activities ("benefits and costs" or "health and medical care as an investment"). Indeed, the economist's language and frame of reference has now found its way into the daily discourse of physician-researchers. No self-respecting editor of a medical journal feels entirely comfortable without an article on the economics of particular interventions or techniques, and the analysis and measurement of economic benefits and costs of screening have kept many an economist from entering the reserve army of the unemployed.

I prefer employment to unemployment; on those grounds, if on no other, I welcome these articles. But there, of course, are other grounds as well. Surely all of us, not just economists, are entitled to seek "value for money" and that is what much of the new burst of activity in the economics of health care is about. That is what Petty was about and what the National Portrait Gallery ascribes to Chadwick. What distinguishes economists is not the particular tools we use in our analyses—though there is some of that, given our facility in mul-

tivariate analysis—but the pattern of thought, how we approach a problem. And our approach, our automatic approach, is to think in terms of value for money, benefits, and costs. Clearly, then, I am predisposed to the kinds of analyses that now find their way into even the medical journals.

But we must be careful to recognize that it is not as simple as all that. A pattern of thought, a way of looking at a question, is not neutral. It has side-effects. To say that medical care is an investment, to ask whether a particular medical procedure is a good investment in comparison, presumably, with other investments (and that evaluation is a slippery task, indeed) is in fact to say something very powerful, yet incomplete.

My own reading of Chadwick suggests that the card next to his portrait does him a disservice. Let us suppose that Chadwick had determined that sanitation would save lives and create a healthier and more pleasant environment but, nonetheless, was not a good investment. Perhaps, given its cost, it would not have saved enough lives. Perhaps it would have saved only the old or the unemployed. What would Chadwick have advocated under those conditions? I find a number of statements to suggest that—like his predecessors and many of his successors—Chadwick did not consider that question because he saw these economic calculations not as the final arbiter on government expenditure but as tools that might support what he and others advocated on moral grounds. For Chadwick (1862:509) also wrote, "When the sentimentalist and the moralist fails, he will have as a last resource to call in the aid of the economist, who has in some instances proved the power of his art to draw iron tears from the cheeks of a city Plutus." Thus, the economist in the service of the moralist; thus, the economist allied with the sentimentalist against the city Plutus. Is this only a "cold financial" point of view?

There was a time, indeed, until quite recently, when many economists felt there was a happy cojoining of their scientific, quantitative approach with that of the nonscientific, nonquantitative social reformer. Both together in the service of a better, not just a richer, society. But these times have changed. Having developed the benefit-cost approach and used it, we now find that 1) there are interventions whose monetary benefits (as measured) are not equal to their monetary costs (as measured); and 2) that there are interventions whose benefit-cost ratio is greater than 1.0 but, nevertheless, is

not as high as that of alternative interventions. Under such conditions, the wise economist might say that this is useful information but that its importance and its weight must be determined by the ultimate decision maker. For the wise economist would know that statistics are not a substitute for judgment.

All well and good, but let us recognize the dangers. There is something very seductive about quantification, and many of us are especially awed by numbers that emerge from computers and are generated by statistical techniques we do not understand. Even when unconvinced by the results, we are disarmed: to question is to reveal ignorance, to criticize is to be a Luddite. There is a second danger as well. Earlier I said the *wise* economist will know the limits to which the information should be pushed. He or she will know that there is more to life and to a society than is revealed by economic analysis. I hesitate to reveal the fact but I feel I must: though all economists are intelligent, not all of us are wise. Even more disappointing are those, sometimes found in high government positions, who are not economists but who behave as they believe economists would, preferring to rely more on their understanding of economic laws that "cannot be repealed" than to exercise judgments that are open to dispute.

So, from a world in which the economics of investment in medical care and public health was one more arrow in the decision maker's quiver, we have come to a situation in which, often, it is the only arrow. It is necessary to balance the monetary and nonmonetary, the economic and the social, but if that be done, the limits of the economic in measuring benefits must be understood. Those limits are severe, and I shall return to them later. For the moment, I simply note that, once the benefit-cost methodology is used, the fact is that, just as we can discover that some things pay, we can also discover that some things (at least as measured in the absence of theologians, philosophers, humanists, and students of society) do not pay. Once we have classified health care as simply another investment, like other investments and to be compared with them, we cannot easily declassify it. We are trapped by language and language affects attitudes.

Assessing Health Benefits

In the United States, other forces are also at work in molding attitudes toward medical care. Let me turn to the problem engendered by the

increased frequency with which we are all confronted by the statement that medical care does little to improve health. This view is one that is not limited to some small fringe group that has discovered some nontechnological alternatives. Rather, it is heard at various meetings and conferences of the most learned and able clinicians. (Often, these meetings are held in Washington, thus reducing the travel time required to go from conference to government officials to plead for more money with which to do more of this unnecessary work.) It may seem peculiar for an economist to try to defend medicine from the onslaught of academic physicians, but because I am not only an economist but also a potential patient, let me try to do so.

Because of the need to evaluate and the difficulty of quantifying such things as comfort, concern, lack of pain, and functional ability (as well as for historic reasons), mortality and morbidity statistics are used to measure health. I am not an expert on how to operationalize other indicators, but surely at a time when so many health problems are of a geriatric and chronic nature, I am entitled to the view that morbidity and mortality data are insufficient indicators of health status. Yet these are the criteria used in examining the contribution that medical care makes to health. If the conclusion reached were that a higher priority should be attached to chronic care, that would be good, but what is heard is not that at all. What seems to be heard is that health will be measured by morbidity and mortality, and since medicine does relatively little to affect these indicators, medicine does little for health.

The behavior of patients hardly suggests that this view is accepted by those who are ill, at least in relation to *their* care. Yet, it has pervaded the academic community and governmental circles. It is a view that seems to fit our national mood. Skeptical of government and antibureaucratic, we search for failure, fraud, incompetence. Investigative reporters—unimpeded by an Official Secrets Act—demonstrate that the Nuclear Regulatory Agency's and Federal Aviation Agency's inspection standards have been inadequate and that the CIA and FBI have engaged in "dirty tricks." The danger does not lie in the reports and in the search for truth but in our response. At first saddened by the failure of prevailing institutions and of expertise, many Americans have grown to accept that as the norm. We expect to learn that our belief in institutions (and in individuals) is ill-founded and relish the most recent validation of our expectations. It is in a climate in which curiosity is replaced by suspicion, that the question,

Do the best and the brightest in medical care serve us well? is asked.

I am not arguing that *all* of medicine does good, and surely not that, in allocating its resources, medicine has arrived at a distribution that maximizes the amount of good it does do. What I suggest is that, in the United States, various factors have played a role in making medicine a defendant who is guilty until proven innocent, guilty of a conspiracy to defraud the body politic and the public. Young social scientists who, I suspect, have not known sickness and who have not walked hospital corridors, tend to view medical care as a sector dominated by practitioners serving their own needs, desires, and interests by demanding more and more high technology, more "toys," that cost a lot of money. In that climate, the academic economist or planner who is concerned about increasing access and who would allocate more resources to medical care is viewed as having been taken in and is dismissed as an inexpert witness. Conversely, he who would contain resources is adjudged as tough-minded and objective.

At a time when budgets are tight and the economy is characterized by rapid inflation and negative growth in real output, the joy with which a budget decision maker welcomes the latest report that medical care not only is not the best social investment but, in fact, does not do much for health—that joy must be quite indescribable. Budgeteers, after all, are honorable men and surely do not enjoy the budget surgery they feel they must perform. How much easier if they believe that that which they would cut serves no real function.

Preventing Illness

A third factor affecting attitudes toward health care and its public support relates to preventive care and lifestyle. I must tread very carefully in these waters for I know only too well that in discussing this matter the choice of words is critical. To some, "prevention" is a new religion, generating emotions and passions that inhibit rational dialogue. The problem is not with prevention and with those who advocate it in its proper place. Rather, it is that valid prevention efforts have occasionally been used to help shape negative attitudes to the broader corpus of health care. How does this occur?

The United States has always valued private decision-making over public choice. We have prized the freedom of the individual to act as he sees fit (insofar as his actions do not intrude on the rights of others).

Many Americans resist rules concerning the wearing of crash helmets or the fastening of seat belts on just those grounds. The freedom to have one's own lifestyle, to make one's own "mistakes" is part of our and, as your recent parliamentary debate on seat-belt legislation has demonstrated, part of your, value system.

Thus, prevention is seen by many to be a private matter, something that should involve individual assessment of risk and costs and individual decision-making rather than collective choice. We hesitate to compel prevention, and especially so if the preventive effort would require major changes in behavior and in lifestyle. The arguments about prevention, however, have not been limited to the role of government. I believe that, in the United States, even that part that involves private behavior, rather than government control, has been seized upon as a weapon in an ideologic battle. The libertarian seems to argue that, if prevention is possible and yet illness or injury is present, then people have voluntarily chosen to assume risks (and they have lost). He then explains this preference for risk by the presence of insurance, which reduces the private costs of care and thus makes illness less undesirable (dare I say more desirable?) than it otherwise would be. If one would not pay for broken eyeglasses because people were not careful, why pay to set broken limbs caused by carelessness on ski slopes or to treat lung cancer caused by the voluntary decision to smoke? It is argued that the structure of financing induces private behavioral responses that lead to misallocation of resources and waste. Rather than seek "prevention," we should privatize the costs of illness, accident, disease and, thus, affect the "voluntary" choices that are made.

The links in this chain of reasoning are many, and the assumptions are tenuous: for example, does the citizen have the requisite information on risks? Are we able to exercise free choice? How can we distinguish between assumed risk and imposed risk? Are there sufficient familial, cultural, and other supports to assist those who want to change behavior, say, to lose weight or give up smoking? Are healthy products as available and affordable as others? What of the influence of advertising? The British data on social class differences in health behavior suggest the important role played by differences in social class (which may be a proxy for education, housing, and other variables). We are reminded that income is important and that many (though not all) prevention and health promotion actions, e.g., use of

health foods and exercise, are expensive. Furthermore, the policy implications in regard to financing of health care are unclear: prevention may reduce but not eliminate disease, and, in any case, what penalty would society exact from those who "foolishly" (or unknowingly) take risks? Nevertheless, the libertarian argument is cast as a principle and, as has been said, "A conservative is one who in defense of principles he considers imperative, can bear with equanimity the suffering of others" (Heilbrun, 1976). The argument, the principle, may fail to meet standards of cogency or validity, but these are not prerequisites for influence.

The emphasis on prevention entails other difficulties as well. Often the preventive argument is cast in economic terms: prevention will save money. I appreciate the temptation, especially at a time when money is scarce, to call upon the Chadwick imperative, but the argument may hurt more than it helps. The issue is not whether the calculus is valid (perhaps it is) but whether it is believed, ***and it is not.*** Nor is that surprising. For two decades or more, every sector has been telling us how it could save money in the long run by spending more money now, and few of us are convinced this has occurred. We are asked to support prevention, not because it will reduce human misery but because it makes economic sense, and we are skeptical. That skepticism sometimes carries over to the whole health enterprise. It is as if we do not believe what those who favor prevention say about prevention, but do believe what we think we hear them saying about medicine's inability to offer cure. Many conclude that cure is a bad way to spend money, even while rejecting the notion that government expenditures on prevention are a good way.

Please note that I am not criticizing prevention or minimizing its importance. What I am suggesting is that the prevention argument has been misused by those who have chosen to imply that it is an argument for individualism and an argument against health insurance. Much of the prevention strategy requires intervention by the public sector: health education, food standards, environmental controls, to cite but a few examples. But the rugged-individualist argument has taken a different tack, that of blaming the victim: we bring it on ourselves; more correctly, each of us brings it on himself. We hear Milton Friedman state that workers in Hong Kong who labor under trying conditions have voluntarily chosen these conditions; presum-

ably, as at an earlier time, young children opted for collieries and 18-hour days. That argument leads some to call for the abolition of health, safety, and child labor legislation. Similarly, we are told that people "choose" the consequences of smoking, drinking, driving, and living in an unhealthy environment; in turn, we hear the call for fewer resources to deal with the consequences of these presumed preferences.

Let me summarize:

1. There is a bias in the United States against embarking on new ventures, against undertaking major changes in existing relationships, and against the introduction of new federal programs.

2. The health community, once captivated by the utility of the economic-investment model and of the monetary benefit-cost approach, now finds itself in difficulty: the old rules may no longer serve it well, and yet it cannot very well accept the rules only when it is certain it will win, and call for new ones when it loses. Having called upon the economic model, it can no longer free itself from the embrace of that which it once loved.

3. The nature of illness has changed and the priorities of medicine as well; yet we remain fixed upon the criteria by which we once measured success, mortality and morbidity rates. The problem, therefore, is not the value-for-money formulation but the need for a broader definition and more comprehensive measurement of value. That is difficult, and in the absence of adequate measures of what could be termed the consumption (in contrast with investment) aspects of medical care, the health advocate sounds intuitive and moralistic, the antithesis of scientific and in a scientific age at that. The health sector stands indicted: it cannot document what it does and whether it does it well. Too often its defense is that the data that do exist are not really relevant but that the relevant data, unfortunately, do not exist.

4. Prevention and health-promotion activities, once highly valued, find themselves under attack. Some argue that prevention is a matter of individual choice; still others contend that preventable illnesses occur because insurance programs encourage risk-taking behavior. The call for additional resources for preventive efforts is viewed as simply another case in which the medical community wants to serve its own, rather than the patient's, interests.

Financing Care and Market Discipline

Small wonder that the government decision maker is suspicious of a program for universal and comprehensive national health insurance. The temper of the times, and the attitudes toward medical care services and those who provide them, both call for limiting resources, for cutbacks rather than expansion, for parsimony rather than profligacy. Into the fray leaps the free-market economist. He not only offers an explanation for the current state of affairs but, undaunted by the special characteristics of medical care, provides an agenda for future actions.

Insurance and Expenditures

Existing financing and reimbursement arrangements provide incentives for the public to seek and providers to deliver more care than knowledgeable physicians deem appropriate or necessary; for hospitals to be overbuilt; for technology to run rampant; and for costs, prices, and expenditures to keep escalating. In spite of rules and regulations, the incentives create a situation in which the health care system appears out of control. The free-marketeer suggests that this is the inevitable outcome of a set of policies that have interfered with the market by introducing government funding for health care and resource development and by encouraging the expansion of health insurance coverage. He attaches special blame to health insurance that eliminates, or significantly reduces, the patient's monetary payment at the time that the particular service is sought. Given the absence of a price barrier, we find more physician visits, hospital days, and drugs than patients need or would choose in a nondistorted market. Given federal and state regulations, licensing practices, and reimbursement and payment arrangements, prices and expenditures inevitably rise.

Overbedding and other excesses thus are partly explained by the surge of demand for care. Insurance makes it possible to translate the consumer's presumed taste for medical care, for physician visits, hospital days, CAT scans into effective demand. Nor is it surprising that supply increases to meet that demand. Physicians, hospital administrators, equipment manufacturers, all find expansion rewarding in monetary and prestige terms and sometimes in both. The normal

constraints, the ability to sell wares or services or fill beds, are no longer present. Absent the market, there is an explosive expansion.

True, each of us is aware that our own behavior contributes to the escalation of premiums. But each of us is also aware that our individual contribution is negligible and that premiums would not be different if we "behaved" ourselves while others did not—and why should we assume *they* would? Indeed, if we assume that others would take advantage of the system, we feel encouraged to do so ourselves. In a society that is preoccupied with "feeling well"—Boston has a radio station that weekly summarizes the leading, current articles from the *New England Journal of Medicine* (I fear and tremble that the news editor will come to Britain on holiday and discover the *Lancet*)—in such a society, overuse will prevail.

The argument sounds powerful; yet, there is even more. How is it that, knowing the outcome, we purchase the insurance nonetheless, and purchase it though it covers events many of us could finance out-of-pocket. Why should we form voluntary association with those who will abuse the system? Ignoring the psychological security provided by insurance and our willingness to pay for risk aversion, the explanation for our behavior is sought in government tax policy, which, in the United States, encourages the purchase of insurance by reducing its true price. The process is simple: if I buy insurance for myself, I do so with after-tax dollars. If I am in a 40 percent tax bracket, I must earn $1,000 to be able to purchase $600 worth of insurance. If, however, my employer buys insurance for me, the cost of the insurance (the price paid by the employer) is *not* considered as taxable income to me—the insurance is a tax-free, fringe benefit (analogous to a middle-management car). Thus, the employer can purchase $1,000 worth of insurance on my behalf, 67 percent more than I could buy, at no cost to him (if he reduces my wages accordingly) and with no drop in after-tax income for me. Indeed, if he purchases $800 worth of insurance for me, I end up with $200 worth of extra insurance and $120 more disposable income. The employer is just as well off, and I am better off in all respects. The loser is the public purse. It loses tax revenue because of the tax subsidy provided for the purchase of insurance, and an inequitable subsidy at that, for the more income I have, the higher my tax bracket and the greater the subsidy.

Obviously, the numbers are not the key to the example. The key is the distortion of market price and the consequences thereof. We end up in a world in which we buy insurance at a subsidized price. But, ultimately, we are the losers. The government deficit (the subsidy) must be financed, and it is we who do so.

This argument, though captivating, is incomplete or, perhaps because it is incomplete, it appears simple and captivating. It ignores the externalities, the social benefits of insurance, the welfare gains associated with security, the unequal distribution of income and of purchasing power. It assumes that insurance pays the full fee without deductibles or coinsurance and overlooks the fact that the physician's fee is only one part of the cost of care. Some people lose wages when they visit a physician; for others, transport costs may represent a barrier. It ignores the fact that, even in the presence of insurance or "free care," it is often necessary to have outreach programs to achieve greater utilization, that some people are afraid to visit their physician lest he confirm their worst fears or cause them pain, and that others have no ready source of care. It ignores the fact that our attitudes and behavior toward medical care are not the same as, say, toward ice cream cones. The argument defines the free-market allocation of resources as optimal and assumes that except for insurance we would, in fact, have a free market. It says that voting with dollars is somehow more appropriate than voting with ballots and that being "free to choose" in the market will yield better outcomes than being "free to choose" in the political sphere, as if, for example, each of us should buy clean air and not collectively legislate about it.

Fostering the Market

Many economists in the United States find the previous arguments about tax subsidies, the expansion of insurance, and the increase in demand compelling. Nor do they stop with the analysis. They use the analysis as a basis for policy prescriptions and that set of prescriptions is, of course, fairly obvious: eliminate government tax incentives that stimulate the purchase of insurance by distorting its real price, and make certain that insurance policies require significant cost-sharing by the consumer. Some proposals suggest utilizing a high deductible in which the patient might pay for his medical expenses on his own up to, say, 5 percent of family income (an average annual deductible, in

1978, of $750 or £325). Above that, he would face a coinsurance rate of 50 percent for the next 10 percent of income; thus, an additional payment of $750 or £325. The maximum risk, therefore, would be a full 10 percent of income. Above that figure, catastrophic insurance would take over, providing the financial protection that is "really" needed. The various cost-sharing devices, it is assumed, would lead to more responsible behavior on the part of patients and on the part of physicians, acting as the patients' agents. The fact that most care would be paid for by the patient would deter the use of services, bring price consciousness, induce price competition, and lead to greater efficiency. Though we have different health care needs and different incomes, the proposals rely on price rationing to supply the discipline, the control mechanisms, that the health care system lacks.

I am reminded, as I consider the approach, of the salesman who came to our door shortly after the birth of our first child. He had a product that could serve as a feeding table and, with adjustments and additions of various parts, could be converted to a play table, blackboard, bassinet, car seat, and countless other uses. I purchased it and soon found it was difficult to change from one use to another. The fact that the piece of furniture was multipurpose meant it could not do anything very well. It did not serve our needs. So, too, with this pure economic nostrum designed to bring responsible behavior on the part of patients, cost awareness to physicians, increased tax receipts to government, a reduction in national health expenditures, an increase in general welfare and equity, and to do so by the simple expedient of relying on prices to affect the behavior of the imaginary *homo economicus*.

Neglected Issues

Wherein lies the fallacy? What is at error in the proposed solution? Let me try to answer that question in two ways. First, I should like to mention some matters that, I believe, call into question the idea that the answer to the economic problems of the United States health sector, to resource misallocation, and to rising expenditures lies in increasing cost-sharing or charges and in reducing government support for, and provision of, insurance. I question the notion that these devices would maximize "efficiency." But I shall not leave it at that, for I should also like to raise a more basic question that relates to the

question of equity, the needs that health services address, and the role of health activities.

The more technical questions that can be raised can be listed:

1. Does a proposal that erects a substantial economic barrier to the receipt of noncatastrophic medical care respond to the area of prevention and early treatment, on the one hand, or to the financial impact of chronic illness, on the other? Does such an approach represent good medicine? If the flow of resources does follow the flow of dollars, does this approach adequately reflect the real priorities of health care?

2. Does the emphasis on cost sharing meet the clear desire expressed by individuals in their voting and personal behavior and in union-management collective-bargaining agreements for a budgeting device that reduces the impact of the nonforeseeable illness? Everything we observe suggests that individuals who can afford it rush to buy insurance to fill in the uncovered bits and pieces (and do so at rates that, because of the costs of administration, often are actuarially unsound). They are looking for security, predictability, budgeting devices. Is this irrational? If we do believe in individual choice, why rule out these choices, why rule out individual choices collectively expressed?

3. Can economic deterrents work with equal impact on families and individuals with unequal economic resources? Will not the poor face barriers that will impede access to early treatment? Can we really expect that the only care that will be affected is that which really was "unnecessary"?

4. If we conceive of a program that is income-related or means-tested, we will need to know income and to pay the costs of ascertaining and monitoring the requisite data. We will also have to pay the costs of keeping track of the deductibles and other elements of cost-sharing. These costs will be substantial. Each program refinement that is added in order to deal with equity adds to these costs. Too often the economist who designs a policy that fits his principles ignores the questions, Will it work? What will I have to do to make it work? What will it cost to administer? There is a difference between a policy and a functioning program.

5. The assumption of competitive behavior on the part of providers and price shopping on the part of consumers in seeking care is questionable at best and foolish at worst. Can we really expect the benefits of price competition? Collusion does exist in 1980 as it did in 1776

when Smith wrote, "People of the same trade seldom meet together for merriment and diversion, but [that] the conversation ends in a conspiracy against the public or in some contrivance to raise price." The golf courses of suburbia are not unlike the coffee houses of Glasgow. Furthermore, consumers, confronted by illness, are hardly in a position to shop, are not privy to the information required, and might (as all of us do so often) assume that higher price means higher quality. If so, they are hardly likely to feel comfortable about seeking low-cost care for themselves or their dependents.

6. Given the administrative costs, the insurance purchased to fill in the gaps, the use of price as proxy for quality, will the nation's total health expenditures stabilize or will expenditures continue to escalate? Is the control mechanism of price sufficient unto the task?

It seems to me we solve little in the American health care problem by adopting a solution that assumes unreal conditions: that consumers have, or could acquire, perfect knowledge; that providers could compete; and that cost-sharing and income data would spew out of the computer at little cost. If one is searching for a frame of reference, some understanding of how the system would behave, that frame of reference is not to be found in textbook descriptions of pure competition, which are useful for didactic purposes only because they abstract from reality. Instead, look to an examination of the behavior of real markets populated by real people, people with fears, emotions, and passions. Regrettably, our understanding of these markets and of the people in them, their goals, desires, and behavior, leaves much to be desired. So, too, with our understanding of the dynamic purposes that create the situations, the imperfections, that subsequently are deplored. Nonetheless, imperfect as our understanding is, I would suggest that, in the health arena, the market solution would neither serve us well nor be stable.

The Importance of Equity

In my view, the problems of the health sector do require action but action of another kind. We suffer from inefficiency both at the macro and the micro levels, but inefficiency problems cannot be solved without first attacking existing inequities.

None of us lives in an economy. We live in a society. That society is

something bigger than the economy, prices, balance of payments, and exchange rates. A society's goals and aspirations, the way it works, what it calls forth from us, the way we see ourselves and others, how we behave, all these are more than economics. Surely economic arrangements influence those matters, and that is just the point. Since economic arrangements do have an impact on the fabric of the society, we dare not evaluate those economic arrangements solely on the basis of their presumed *economic* benefits, on what they might do to investment or to production. We must consider what impact they might have on the social fabric. Does it avail us to have a higher gross national product if the cost is hostility and alienation? Indeed, in the long run, can we have that higher GNP if each of us behaves as an island unto one's self?

If the problem of equity is not addressed, we shall continue to ration health care services by price. The impersonal market, the interplay of prices and unequal incomes, will distribute resources as it distributes cars, phonograph records, books, and fine wine. Researchers may suggest that medical care is not as helpful as the public thinks, that it does not offer value for money, but both patients and physicians are unlikely to accept that argument. Those with low income and inadequate care, observing the behavior of those with money, will be more impressed by the behavior of the rich in seeking care than by the words of those who say the rich are wasting their money in doing so. They will conclude, and rightly so, that budget cuts and new constraints will not affect the provision of care and cure for the individual who can pay the price, but will affect *their* opportunities. They will conclude that the social benefit-cost criteria will apply to them but not to others. They will wonder why, if efficiency is really so desirable, it should not be sought everywhere, not solely in the publicly supported programs. They will wonder how a society can proclaim the right to a decent existence and yet permit—in Arthur Okun's words—"dollars to transgress on rights."

Thus, efforts to contain health care costs and to develop a more efficient health care system will meet resistance. In the American health care system, one that is built on private insurance for many, government assistance for others, and that leaves many millions without any protection, the impact of budget cuts and of reductions in resource input will not fall with equal force on the citizenry. Even if one is interested only in efficiency, the proper strategy requires that

the first step involve equity, for only in a society that has set equity as a goal worth seeking, and thus in a context of the fair sharing of both benefits and burdens, can one call for sacrifices and restraints and hope they will be accepted.

To develop a national health insurance system that is universal and comprehensive, in which budget allocations rather than market forces are the expenditure-control mechanism, is not easy. The United States political system, the present economic situation, our preferences for avoiding the explicit and hard allocative decisions by relying on "invisible" price rationing, all these stand in our way. Yet, it seems to me that such a system is necessary.

For the alternative seems clear. The perpetuation of our existing financial structures and arrangements implies the continued acceptance of dual systems of health care and of gross inequities in access to health services. Mixed financing, payment, and delivery systems also mean the further wastage of private and public funds in the purchase of administrative services rather than of medical care, and lead to ever-rising prices and expenditures. Neither equity nor cost-containment goals are furthered in the presence of dual markets. This observation is as valid for the United Kingdom (where some call for privatization and the creation of multiple systems) as for the United States (where these features already exist and some call for their retention).

The desire for dual markets is understandable. Government tends to focus on its expenditures for health rather than on national health expenditures. It is tempted to view private insurance and private payments as devices that might ease the pressure on the government purse and thus help stem inflation, increase private investment, and raise productivity. That, however, is not a likely outcome. If the private sector sets the pace and standard, government must either keep up to that standard (and what would that do to government expenditures and to total health expenditures for the nation in subsequent time periods?) or it must lower public standards (and what would that do to the *society* in subsequent time periods?). Most governments would do a little of both, thus managing to have the worst of both worlds: rising expenditures and the perception of inequality. Or should I say the worst of three worlds, for the desired reduction in inflation and increase in private investment and productivity would also not be realized. True, the government budget would no longer

have to meet the expenses of the new privately insured individual, but those expenses would still be there, to be met by the individual himself. Calling them private does not make them more productive; reducing government budgets but increasing private ones does not free resources for investment or contain inflation. Only the reduction of total health expenditures, not just governmental, would help (though at what cost), and the additional administrative costs required to run dual systems of insurance and, ultimately, perhaps of care will only add to costs, not reduce them.

Conclusion

The critical issue for economic policy is the amount spent for health care in the society, just as the critical issue for social policy is the way that amount is shared. Certainly, there is an interplay between the two perspectives, and each is strengthened when account is taken of the other. That is why, among other reasons, economists have a role to play. There are things we economists know and problems we can analyze. But there are other areas, questions of distribution and of equity, on which we are weaker. That is why economists have a role to play but not the only role.

We have come full circle. You will recall that I opened this lecture with a cautionary note about the danger of calling on Chadwick's economic rationale. I suggested that, in doing so, we run the risk of implying that investment criteria are deemed "superior" and compelling. Yet I, too, being an economist and pressed by those who would contain expenditures, have argued for national health insurance, at least in part, on economic grounds. I referred to the strategic and tactical importance of striving for equity if we want to attain efficiency and control costs.

But equity has merits beyond those of strategy. In a civilized society, there are times when we should do things that are right and decent even if they should turn out to be poor economic investments. Not by accident, my lecture was entitled "Efficiency *and* Equity." In health delivery, we can have both. Even if the real world were harsher and we were forced to a new title "Efficiency vs Equity" (or, dare I say, "A Richer *Economy* vs a More Human *Society*"?), the choice would still be ours. No one can make that choice for us unless we let that happen

by assuming that some one or some discipline has superior wisdom. To say "vs" is to say there is a trade-off, and to say there is a trade-off is to say that we must choose. And we are free to choose, to choose between passively accepting the fact that life is unfair and actively seeking to reduce the consequences of the unfairness.

Even if economists sang with one voice, and we do not, the tune we would sing needs blending and balancing with other voices. None of us would find life comfortable in a society that never, or in one that always, listened to its economists, though our discomforts would be of a different kind. If progress is to occur, and it will, it will come when more of the people and their leaders are wise enough to know when, and to whom, to listen, and are confident enough to debate about what they believe they have heard.

References

Chadwick, E. 1862. Opening address as president of Section F (Economic Sciences and Statistics) of the British Association for the Advancement of Science. *Journal of the Statistical Society of London* 25:502–524.

Friedman, M., and Friedman, R. 1980, 1979. *Free to Choose: A Personal Statement.* New York: Harcourt Brace Jovanovich.

Heilbrun, C. 1976. *Chronicle of Higher Education,* 15 November.

Petty, William. 1927. Anatomy Lecture. In Lansdowne, Marquis of, ed., *The Petty Papers: Some Unpublished Writings of Sir William Petty, from the Bowood Papers, 1676.* London: Constable.

Sigerist, H.E. 1941. *Medicine and Human Welfare.* New Haven: Yale University Press.

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