Some Health Policy Issues: One Economist's View

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I SHOULD LIKE to attempt to convey some of my perspectives on a variety of broad health policy issues. In part these perspectives derive from my education as an economist. It is clear, however, that each of us has been molded by a variety of influences that go beyond his or her disciplinary training. No one is only an economist; he is a lot of other things as well. Given that observation and the fact—a fact that I regret to say is sometimes disputed—that economics and public policy are not merely technical affairs but relate to values, it becomes clear that I cannot claim to speak for all economists. The PhD is not a completely homogenizing force, as is abundantly evident from current dialog on economic issues facing the nation and from the diversity of opinion on these matters within the world of economics. The differences between economists should not come as a surprise. There is, after all, the story that when God made light, the devil made darkness; that when God made good, the devil made evil; and that when God created an economist, the devil made another economist.

Almost 13 years ago President John F. Kennedy received an honorary degree at Yale University. On that occasion he delivered an address in which he explored a number of economic myths. In introducing his subject he said *(1)*:

> For the great enemy of the truth is very often not the lie—deliberate, contrived and dishonest—but the myth—persistent, persuasive and unrealistic. Too often we hold fast to the cliches of our forebears. We subject all facts to a prefabricated set of interpretations. We enjoy the comfort of opinion without the discomfort of thought.

I should like to explore some of the myths that I believe are to be found in discussions concerning health care and health economics. In so doing, I hope to provide some illustrations of the interplay between health economics and public policy.

Most of the myths exist because, as President Kennedy put it, "We subject all facts to a prefabricated set of interpretations." The myths derive from an overriding mythical interpretation; namely, that,in its economic relationships, the health industry is like other industries and that the health care market is similar to competitive markets. It is that view—that we are really dealing with a market that we have met before in other areas of economic life—that leads to explanations of behavior that are incorrect, insufficient, and inappropriate—that, in a word, are myths.

Myths About Rising Health Care Expenditures

The first area that I should like to deal with relates to the increase in expenditures on health care in the United States. Explanations for the increase are often based on myths. As a consequence, the policies that are advocated to limit increases in the future often turn out to be inadequate or inefficient, that is, we get very little return for the amount of money or energy expended. The problem of rising expenditures is real, and the need to address the question is clear. Let us briefly explore some of its facets.

The first thing we must do, if we are to engage in an intelligent dialog in which words are given precise meaning and thus are understood by all parties, is that we distinguish between an increase in expenditures for health care and an increase in prices of health services. Both prices and expenditures are important, but they

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are not synonymous. In recent years a great deal of confusion has resulted from the use of the term "inflation"—a term which has a technical meaning—to describe both an increase in prices and an increase in expenditures. Thus, the Bureau of Labor Statistics (BLS) reports that we have witnessed periods of rapid increases in medical care prices. Similarly, the Office of Research and Statistics (ORS) in the Social Security Administration tells us that we have witnessed significant increases in medical care expenditures. The perspectives of BLS and the Office of Management and Budget (OMB) (or ORS) and the two phenomena they report are different. The movement of prices need not be parallel to and need not proceed at the same rate as the movement of expenditures which are determined by quantity as well as prices. Solutions that would attempt to restrain price or expenditure increases are not necessarily the same. To suggest that controlling prices necessarily controls expenditures or vice versa is really a simplification that borders on mythology.

Indeed, it is not at all difficult to imagine a set of policy measures that would limit increases in expenditures but stimulate more rapid increases in prices, and vice versa. Thus, for example, an effective program to reduce dollar inflows into the hospital sector by early discharge and by limiting care only to those who absolutely need it might turn out to be effective in reducing the amount of money expended in that sector and thus in the total health care bill for the nation. The Office of Management and Budget would be pleased. Yet, if only the most sick were in hospital, per diem costs of hospital care would rise. The Bureau of Labor Statistics would be distressed.

Similarly, a program designed to double, triple, or quadruple the number of physicians or hospital beds in order to reduce price per unit of service, even were it to succeed in reducing price markedly and thus reduce inflation in price—pleasing BLS—would nevertheless increase the total number of dollars flowing into the health sector (and thus increase Government expenditures)—distressing OMB. The design of policy must take account of the differences between prices and expenditures, and the designers must decide which of these two variables to address. We should not use the word "inflation" to mean both an increase in prices and an increase in expenditures. We must be more precise than that unless we, purposefully, want to confuse things. From this semantic imprecision derives the view that price constraint is our first order of priority if we are to limit increases in expenditures. That view may be fallacious.

As we speak about precision in the use of language, it is also worth noting the tremendous confusion that results from the vague use of the term, "cost of medical care." We often find references to the "soaring costs of medical care." Sometimes "costs" mean prices and sometimes expenditures. Surely we know that we mean price when we say that the cost of sugar is going up. Yet, we mean expenditures when we say the costs of police protection are rising. When we turn to medical care, however, we are unclear about out meanings or—at best—leave the reader or listener unclear. This lack of precision contributes to confusion. We have enough disagreements about matters when we do understand each other, not to need the additional disagreements caused by the use of the same words to mean different things.

Together with this inaccuracy and confusion, growing out of it and supporting it, we find the myth that the bulk of the increase that we have witnessed in total expenditures is due to increases in health care prices and that few additional explanatory variables are required. Thus, one finds sentences such as: "Largely as a result of inflation, from 1965 to 1972 alone the nation's health care expenditures rose from $39 billion to $83 billion." This rise is termed a "massive inflationary tide." The fact of the matter is that the Social Security Administration estimates that "about 52 percent of the $38.4 billion increase from fiscal year 1965 to fiscal year 1972 reflected the rise in prices, 10 percent ($3.8 billion) was the result of population growth, and the remaining 38 percent ($14.7 billion) was attributable to greater utilization of services and the introduction of new medical techniques" (2). In analyzing the increase in expenditures, it is surely necessary to take account of the fact that inflation alone leaves 48 percent of the increase unexplained.

In the almost 2 years of Federal price controls (Phases I, II, and III), medical care prices rose by less than 4 percent per annum and yet medical care expenditures rose at about 12 percent per annum. Medical care expenditures rose by $18 billion in the period fiscal year 1960 through fiscal 1966, that is, more than 11 percent per annum. During that same period, medical care prices increased by less than 3 percent per annum. If prices alone are not equal to expenditures, then price movements alone do not necessarily explain expenditure movements, and we oversimplify if we equate them—we perpetuate a myth.

Myths About the Influence of Demand on Price

All of us would agree that the level of medical care prices is important and particularly so under the existing financing patterns which do not relate a person's medical care expenditures to his income or ability to pay. Yet, I am sure that we would also agree that ultimately the factor that should receive highest attention is the total bill, that is, total expenditures. I should, therefore, like to explore the myths that surround the determinants of the price of medical services and of the demand for medical services, since these are the two variables that together determine total expenditures. Let me first turn to price.

It is alleged that inflation in prices is the direct consequence of increases in demand pressing upon a supply that, in the short run, does not and cannot respond sufficiently. It is often suggested that the implementation of Medicare and Medicaid, in particular, expand-

ed demand and that this expansion of demand lies at the heart of the inflationary pressures that ensued. None of us would deny the importance of supply and demand considerations. After all, in the introduction to chapter 4 of Paul Samuelson's text, "Economics," one finds the quotation: "You can make even a parrot into a learned political economist—all he must learn are the words, 'supply' and 'demand.' " To say that supply and demand are important, however, is not to say that they are everything or that the quotation describes reality. One does not become a learned political economist or even that lesser category, a learned medical economist, if all one knows and incants are the words "supply" and "demand." There is a difference between a parrot and a wise owl.

However important supply and demand are in the medical economy, the organization of this particular market, the nature of an equilibrium price, the impact of alternative payment mechanisms, and funding sources—all of these and more suggest the need for a much deeper and richer analysis than the myth implies. If we fail to undertake the analysis, if we perpetuate the myth, we are likely to focus on inappropriate solutions and likely to constrain public policy. As President Kennedy said in his address *(1)*:

> The stereotypes that I have been discussing distract our attention and divide our effort. These stereotypes do our nation a disservice, not just because they are exhausted and irrelevant, but above all because they are misleading—because they stand in the way of the solution of hard and complicated problems.

Medical care prices were increasing even prior to the enactment and subsequent implementation of titles XVIII and XIX. During the period fiscal 1960–66, as I have already indicated, medical care prices increased at 2.8 percent per annum. The Consumer Price Index (CPI), in those most happy days, increased by only 1.5 percent per annum. In contrast, from fiscal 1966 through fiscal 1969, medical care prices increased by 6.7 percent per annum (2.4 times more rapidly than in the earlier period), but it should also be noted that the CPI increased by 4.1 percent per annum (2.7 times more rapidly than in the earlier period). Interestingly, too, in the prefreeze period, fiscal 1969 through fiscal 1971, medical care prices continued to increase at an annual rate of 6.7 percent, even as the CPI increased at an annual rate of 5.6 percent. The gap between increases in the CPI and the medical care index has narrowed.

I cite these numbers not to suggest some mechanistic relationship between the medical care price index and the CPI, for surely that cannot be supported either by the data or by any theoretical contruct. Rather, the numbers are cited to suggest that if one desired to invoke a simple supply-demand explanation of price movement, such as is often suggested, one would be left with a large number of unanswered questions. The movements of prices are simply too complex to be explained entirely by shifts in a demand curve.

I must digress for a moment to note the uneasiness that I feel and that I am sure you share as a result of my reference to "medical care prices"—a conglomerate that encompasses so many different goods, services, and procedures each with its own characteristics, pressures, funding patterns, and institutional framework. In the types of analyses that are required if we are to advance our understanding, we simply cannot mix physicians' and dentists' fees, hospital service charges, and drugs and prescriptions. For many purposes the medical care price index is extremely useful, but as with many other agendas for economic research, we are required to go beyond the index number to its constituent components. It is time that we did more micro work. Our macro fetish is to be deplored. Nowhere, it can be added, is this more needed than in distinguishing between physicians' fees and hospital daily service charges.

It is not at all difficult to develop a classical economic model that assumes that the medical care market has the same characteristics that competitive markets, described so comprehensively in our textbooks, possess. I leave to the Council of Economic Advisors the question of how many markets for various goods and services in fact have those competitive characteristics. An answer to that question is required if we are to succeed in developing policies that effectively combat inflation without strangling the economy. We do not need the Council, however, to tell us that the medical care market is not adequately described in our elementary economics textbooks.

A hospital, for example, can hardly be considered competitive. It exists as a not-for-profit institution whose behavior patterns are guided by various actors who are trying to maximize a number of nonmonetary performance characteristics, whose accounting systems are constructs that, in part, reflect the characteristics of payors and third parties in particular, whose incentives to economy and efficiency in the light of payment mechanisms are often weak. The physician, too, is motivated by goals other than maximization of profit or of income. It is, for example, sometimes suggested that the concept of target income is important in understanding physician-price behavior. While it is not my intention to review the literature that sets forth different models of hospital-or physician-pricing policy, I do suggest that the real world is much richer and, indeed, much more interesting than is the mythical world in which price is equal to that number at which demand equals supply.

The implementation of Medicare and Medicaid was followed by a more rapid increase in price than we had previously witnessed. It is convenient to ascribe this increase to the two programs and, in particular, to the increase in demand they generated. One of the most distinguished economists on the American scene has written *(3)*:

> I must express my unabashed admiration for the accomplishments of the neoclassical viewpoint. In its most formal statement, we simply

use for analysis the equilibrium conditions of the individual agent and of the market, without inquiry as to how they come to hold. Yet even these statements turn out to yield revealing insights in the workings of resource allocation. Why have medical costs risen so rapidly relative to other prices since 1967? The upward shift in demand due to Medicare and Medicaid with a price-inelastic supply of physicians and hospitals provides a simple straightforward answer. . . .

What I am arguing, however, is not that Medicare and Medicaid did not contribute to the inflationary pressures but that much more was involved than the increase in demand. We might, in fact, remind ourselves and others that Medicare and Medicaid were not programs whose only rationale was to increase demand, that is, to make medical care available to people who could not afford it. In no small measure, however, the programs were also justified as a way to prevent financial catastrophe from being visited upon those who needed medical care and purchased it and as a way of easing the financial pressures for institutions that were already providing medical care to people who could not pay for it. All of this is to say that we would have to look closely and carefully to the question—how much did demand really increase? Even beyond that, however, we might remind ourselves and others that Medicare and Medicaid paid providers in particular ways that many would argue encouraged inflation. I find much to agree with in former Secretary Elliot Richardson's more comprehensive explanation than is provided by the neoclassical model *(4)*:

Incentives that have led to inflationary medical costs are not too difficult to discern. When Medicare was introduced, it provided that physicians would be paid their customary fees. Some had been giving care free of charge or at prices below what they considered to be their value, and hardly customary. Hence, there was a rather rapid jump in the cost of physicians' services after the birth of Medicare.

Medicare and Medicaid, as well as private health insurance companies, have been willing to reimburse hospitals at cost, which has become a euphemism for a blank check. There has been little incentive to hold down costs, to search for means of increasing the productivity of health manpower and facilities, or to substitute capital for labor.

Many observers, for example, argue that physicians' services were traditionally priced below the equilibrium price that would equilibrate supply and demand. If this argument is true, Medicare and Medicaid may have contributed to price increases more significantly through the development of new funding mechanisms than through demand increases. It may be that the key factor was a change in the climate of opinion and the culture of American medicine, a change that encouraged physicians to narrow the gap between the equilibrium price and the market price.

The true explanation for price increases is important. Mythical explanations lead to fallacious public policy implications. It is not sufficient to direct attention to how one might go about increasing "S" or cutting "D." I can think of few more important areas that bear careful examination than the question of prices—how they are set and what they represent.

Myths About Consumers' Effect on Utilization

I should now like to turn to another myth, this one related to demand for care—to the utilization component in the definition of expenditures. In "Determinants of Expenditures for Physicians' Services in the United States, 1948–1968" Fuchs and Kramer wrote that there is a "widely held belief that utilization and expenditures are determined by the patient, and that information about income, insurance coverage, and price is sufficient to explain and predict changes in demand" *(5)*. They went on to say that that belief stands in sharp contrast to their findings; namely, that supply factors, technology, and number of physicians appear to be of decisive importance in determining the utilization of and expenditures for physicians' services. "Indeed, we find that the elasticities of demand with respect to income, price, and insurance are all small relative to the direct effect of the number of physicians on demand." Total expenditures, then, are the product of prices which are, to some extent, administered and utilization which is, in large measure, also administered; that is, determined by the physician.

This, indeed, makes for a fascinating world since if to this we add the concept of target income, we may conclude that policies that are designed to affect or control one variable simply lead to compensating changes in the other variable—control prices and quantity increases; reduce quantity and prices go up. The myth that the consumer determines demand has as its chief attraction the fact that the myth is much simpler than the real world. The danger lies in the fact that the beguiling myth has a host of public policy implications which, in the real world, are tenuous indeed. Let me mention a few.

From the myth, for example, derives a good deal of the rationale for deductibles and coinsurance. I recognize, of course, that there are those who favor such cost sharing for reasons other than its presumed impact on utilization. Nevertheless, we can agree that one of the major thrusts for such cost sharing stems from the view that it would constrain demand, thus both utilization and price increases and, as a consequence, total expenditures. None of us would argue that utilization would be totally unaffected by cost sharing; yet, if Fuchs and Kramer are correct, are we not entitled to ask whether in the light of the determinants of utilization, cost sharing is the most efficient way to restrain demand? I think it can be argued with cogency, and I believe with support from the data that Fuchs and Kramer present, that the level of cost sharing required to have a significant impact on utilization—by "significant" I suppose I mean a reduction in utilization sufficient to yield monetary savings that exceed administrative costs—would itself he high; high enough to re-enter the world of inequity; high enough to affect the utilization of necessary as well as unnecessary care. One might also add that, at those kinds of high levels, large parts of the population would be likely to insure

themselves against the cost sharing, with consequences of both high utilization and inequity.

A willingness to put up with the "discomfort of thought," a willingness to depart from myth would, I believe, necessarily lead us to focus attention on policies designed to affect physician behavior rather than on the simplistic device of erecting price barriers.

Also stemming from the myth about utilization and from the myth about the role of competitive market forces is the view that an increase in the number of physicians will result in significant improvements in the maldistribution of physicians, both in terms of specialty and geography. If one believes that it is the patient who determines the demand for medical care, there is much less room in the analysis for the phenomenon described as "overdoctoring." If "overdoctoring" could not occur, we could anticipate that the forces of competition acting upon an increased supply of physicians, would reduce prices and relative incomes in specialties and in geographic areas of oversupply and thus lead to a redistribution of physician resources. We would be fully justified in expanding the number of physicians in general and relying on market forces to yield appropriate distribution patterns. But "overdoctoring" can occur, and maldistributions can continue even in the face of larger numbers of MDs.

There may be those who feel that I erect a straw man and that I exaggerate the importance of the myth, offering as evidence the increased public policy concern with family and primary care residencies and with service in physician-short areas. I would note, however, that this legislative concern is relatively new, that for many years it was believed that the solution was simply to expand enrollment in medical schools. There still exist large and strong bodies of opinion that believe that intervention that would deal in a more direct fashion with physician maldistribution is uncalled for and that the market (and some unspecified form of voluntary action) is not only our best tool but that it makes all other tools unnecessary. Increasing the number of physicians may be justified on various grounds, but the argument that such increases will reduce prices and redistribute physicians is not one of them.

It would be possible to develop further myths that surround the manpower area and to explore their implications. I shall not do so, however, for two reasons. The first is that, to some degree, the myths that I would cite are repetitions, in that they again reflect the underlying myth that I have already alluded to; namely, that the medical care market is really like many other markets. The second is that I should like to depart from that particular myth in order to mention, if not fully discuss, two other significant areas.

The Myth That Government Programs Do Not Work

The first question that I should like to discuss is of singular importance in the development of public policy. I would ask you to note how often we hear the comments that nothing works and, above all, that Government programs do not work. I am sure I need not discuss the history that has led to the development of this point of view—a point of view that I would label a myth. As with other myths, there is an element of truth, but we should not let that kernel of truth dominate the larger error. We are all aware of the history: the development of the Great Society, OEO, the War on Poverty, the recognition that things were much more complex than we had imagined, the appearance on the scene of an escalated Vietnam conflict and its consequent budgetary implications, the drying up of dollars for social programs (except for cash transfers), and the drying up of energy and sustained effort, the development of credibility gaps and of a cynicism about government leaders as individuals and the role of Government as an institution. These have been difficult times, and there is reason to believe that even more difficulty lies ahead. Nevertheless, it does not seem to me entirely accurate to describe the 1960's as a period in which we engaged in a great effort and learned out of that engagement that we cannot improve things. The effort was not all that great, at least in terms of resources devoted to it, and we did have some successes. I think it behooves us to reject simplistic notions at the two polar positions: the one that says that nothing has changed and that we have not learned how to change things; the second that says that everything is either already good or proceeding on that trajectory. It is perhaps fairer to argue that we have made some progress, but not as much as is required; that we have devoted some resources to change, but not as many as we should; that in recent years we have been adrift, and that this national drift has been reflected in the attitude, culture, and perspectives of the citizenry, and perhaps even in the research findings of social scientists. I cannot easily imagine that it could be otherwise.

We have been thwarted in impacting on a complex situation because, often, we had only individual, discrete programs not linked in a meaningful way to sets of other activities. Furthermore, on a number of occasions when linkages did exist—that is, when some general conceptual model was developed—the programs were massively underfunded. Thus, it is undoubtedly the case that a number of social programs have not worked as effectively as we might like or even as we might have imagined they would. Yet, Medicare has worked—even if its impacts are being eroded under heavily inflationary pressures. Yet, Medicaid has accomplished much, and so have manpower development and training efforts and elementary and secondary education aid, and food stamp programs, and so forth. We have done far less in some basic areas than was required—housing and mass transportation being prime examples—but the cynicism that we hear is simply not warranted. That "nothing works" is simply a myth.

Surely this is not the time to try to develop a bibliography on evaluation of various kinds of social in-

tervention and social programs. It is the time, however, to suggest that we should not subscribe as easily as some would have us do to the view that, because we have not been entirely successful, we should turn things back to the market and then sit back and watch the success stories unfold. The market as an arbitrator has many advantages. There is a certain impersonal mechanism involved, and we are not called upon to act. The market acts for us. But we did not depart from market solutions because of some devious plot by former Presidents, elected officials, and political appointees. If Government intervened into the market, it was in response to the failings of the market. It is not that we thirst for regulation and intervention but that we need regulation and intervention because we find the market solutions inadequate in a humane and just society.

What is required is not a walking away from problems but a commitment to solving them. That degree of commitment requires more than dollars which may be in short supply and more than knowledge which is also in short supply, but a willingness to do battle with special interest groups and others whose concerns are with their own status rather than with something bigger, say, society. To mobilize such commitment is not easy but is nonetheless required.

I realize, of course, that all of this may be considered rhetoric and, though I could, I prefer not to continue on this theme. Suffice it to say that we have no choice but to reject the myth, for even if it could be demonstrated that it adequately describes the past, and I do not think that it does, we have to assume that it will not adequately describe the future. To behave as if the myth is correct, that is, to behave as if nothing works or will work, is to give up.

The Myth That We Do Not Know Any Answers

Related to but somewhat different from that myth is the final one that I would mention. That is the myth that we do not know any answers and that we live in a virtually complete state of ignorance. This myth also has its policy implications, for many believe that in this state of ignorance we had best fund experiments and demonstration projects in order to discover what the real world looks like before we implement any legislation that would induce changes. A belief in the myth at times becomes a prescription for paralysis. There are two separate questions that bear upon this issue. The first I should like to mention but not pursue in any detail. That relates to the question whether, even were it true that we know very little with certainty, we would be correct in assigning the highest priority to experimentation and demonstration projects rather than to action. It could well be, after all, that these research tools would not significantly increase our knowledge or that the many years required before more certain answers were available would impel us to take actions today not based on certainty but on reasonable guesses.

That, however, is not what I should like to discuss, for that is not really the first issue. The first question to be asked is whether it is accurate that we know little. Isn't it a myth to say that we are really that ignorant?

As one who comes from a university in which research is an important activity, I surely would agree that there is much more that we would like to know and much more that we should know. Nevertheless, we already do know much. We will never know it all, and we cannot permit ourselves the luxury of waiting to act until we do. Those involved in policymaking make policy just as much when they fail to act as when they do.

This is no call for thrashing about, but I would suggest that, on the basis of all that we have learned in the past 10 years and on the basis of experience in the health field in other countries, we already know a good deal. Take, for example, various issues in national health insurance. We behave in our dialog as if we are discussing that which no other country has attempted and as if we will be taking the first strides known to man into a brave new world, and yet just across the border lies not a Scandinavian country with a cultural tradition and a health system vastly different from ours but Canada, with a tradition and a system rather similar to ours. Neither we nor Canadians should want to consider Canada our laboratory, but on a variety of issues in national health insurance, it can be so considered. Yet, except for a handful of people who have studied the Canadian developments, the mass of us are quite uninterested in our neighbor to the north. We do know or could learn with relative ease much more than we imagine. And this is true of any number of issues. Studies have been done, papers have been written—but they have not entered into the stream of public dialog. If this be defined as ignorance, it is of a special kind. No, in my view, the problem is really one of the willingness to apply knowledge, and I consider it a myth to argue, as some do, that we are so ignorant that we dare not act.

The agenda, then, is a large one: to define terms more carefully, to debate more cogently, to experiment, to analyze, to study, and to move in the policy arena. Such an agenda will leave few of us unemployed.

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