Three Approaches to Health Care

developed by
Mel Dubnick
Loyola University of Chicago

Test Edition: Fall 1978

Prepared for the project on Instructional Innovation in Undergraduate Education, conducted by the American Political Science Association, supported by a grant from the National Science Foundation.

Student Manual

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The American Political Science Association
1527 New Hampshire Avenue, N.W.
Washington, D.C. 20036

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PREFACE

The Supplementary Analytical Units employ a curricular means to pursue a major intellectual end. A series of interactive teaching modules is being designed to clarify the intellectual content of political and social science by allowing students to apply analytical models from several partially competing traditions -- including the traditions of rational choice, information processing, and social structure. These curricular materials will be complemented by essays on the paradigmatic content of social science and by planned encounters of those skilled in the several competing traditions.

Donald E. Stokes
Chairman
Steering Committee

FOREWORD

The development of this unit, in the second series of Supplementary Analytical Units, interactive learning modules on topics of public policy analysis, was supported by Grant SED 77-18486 from the National Science Foundation to the American Political Science Association.

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I

The Problems of U.S. Health Care Delivery

A. The Personal Nature of the Problems

Everywhere you look in the mass media today, medical care is in the news. This is not unique to the present decade. The technological revolution characterizing our modern industrialized society has created many newsworthy events in medicine and public health, most taking the form of marvelous medical inventions and related major breakthroughs in humankind's quest for health. The conquest of smallpox, polio and other communicable diseases, the development of open-heart surgery techniques, organ transplants, kidney dialysis techniques -- all were immediate sensations among the general public, and all generated an optimism and hope for the future.

But hope no longer describes the tone of today's news stories about health care in America. Instead the media speaks of crises rather than improvements, of frustrating problems more than miracle cures. There are two reasons for this change in attitude. The first is medical and has evolved from an increasing awareness that achieving and maintaining a state of health has only a small relationship to the provision and quality of medical services. Dr. Leon R. Kass has made the point quite forcefully: "... medicine itself, understood as the treatment of disease, may contribute relatively little to our becoming and remaining healthy." In fact, according to at least one well known critic, Ivan Illich, the contemporary practice of medicine may actually be perpetuating an unhealthy condition for many people in modern society. Both Kass and Illich note that health ("the well working of the organism as a whole") is most closely associated with the way one lives, not the state of a medical science which continues to concentrate on "death prevention" rather than the attaining of a state of health. In Dr. Kass' words,

> " ... medicine _should_ be interested in preventing ... diseases or, failing that, in restoring their victims to as healthy a condition as possible. But it is primarily because they are the causes of _unhealth_, and only secondarily because they are killers, that we should be interested in preventing or combating them."

As awareness of the low relationship between current practices of medicine and health increases, so the positive attitude and optimism about health care declines.

However, this medical crisis is only half the story, for there is also a growing disenchantment with the delivery of available medical services. Despite debate over the value of current health care practices, the fact that available care is provided inequitably, inefficiently, and at costs which have climbed at annual rates much greater than other goods and services over the past decade, has created a more widespread crisis for health care in America. From this perspective, the problems of health care are not medical, per se, but _organizational and financial_. Such problems do not afflict American

medical science, but rather the health care delivery system which links the medical profession with the American public. In this module we will focus on this health care delivery crisis.

What makes this crisis very special is its personal nature -- it affects our lives, those of neighbors and friends, and those of our closest relations. No doubt it is a crisis impacting on classes of people, neighborhoods, races, etc. But when all is said and done, the crisis in health care is very personal. For example, consider the tragic story of Mr. Johnson of Chicago who sought care for his ten-year-old son, Carl, in a private hospital near their home. In testimony before a U.S. Senate subcommittee, Mr. Johnson relates what happens in a system where the delivery of medical services is closely linked to the patient's ability to pay.

> SENATOR KENNEDY: Tell us about what happened to your son.
> MR. JOHNSON: On December 15, 1969, he had a seizure at home and he passed out. I picked him up, rushed him to the nearest hospital, I went by a police station and was led to a hospital by the name of St. George's here in the neighborhood. I asked the police to carry me out to County Hospital and he said he couldn't go out of his district.
> The doctor didn't even look at him or put his hand on him at St. George's, but in the meantime I was in and they interviewed me to find out my history of my financial arrangements, my insurance and this and that. I had Traveler's Insurance at the time ...
> So we left this hospital and drove all the way from seventy-ninth over here to County Hospital, where my son died in a matter of an hour or so afterwards...
> SENATOR KENNEDY: You went to the emergency room of St. George's Hospital and you asked for service?
> MR. JOHNSON: Yes.
> SENATOR KENNEDY: That is, you asked for someone to take a look at your boy, is that right?
> MR. JOHNSON: Yes, but they interviewed me beforehand.
> SENATOR KENNEDY: When you did this, in effect your son was actually in the process of dying and they were asking you questions about where you lived?
> MR. JOHNSON: Yes.
> SENATOR KENNEDY: And about this kind of insurance you had?
> MR. JOHNSON: Yes sir -- "Do you own your own home?" and this and that, and "Who do you work for?" and "How long?" ... I asked them, if they needed further information and what not they could call out to County Hospital, that he had been a patient there and he was due to go in for a check-up which was that Friday, the nineteenth, and he didn't make it. They would have given them the information if they needed it, but they didn't even try to do anything. County Hospital had voluntarily told me also that if anything happens to Carl, even to have a tooth extracted or a tooth filled or anything, to call them and they would give the doctors the information that is necessary so it wouldn't be fatal to him.
> SENATOR KENNEDY: Then you took your son over to the other hospital, to County Hospital, is that right?
> MR. JOHNSON: Yes.

> SENATOR KENNEDY: Going by several other hospitals?
> MR. JOHNSON: Yes, because I was afraid to stop. I think the same thing would have happened if I had stopped at one of the other hospitals ... I might as well try to make it to the County. I drove down the expressway with my oldest son ... I had my oldest son with me, and my younger son was in pain and he was going into a coma, and he was hysterical and everything, and the older boy was holding him...
> SENATOR KENNEDY: As he was hysterical, the doctor at St. George's said, "If you don't like the service here, take him elsewhere?"
> MR. JOHNSON: Yes. He told me that "he couldn't be sick with a heart condition if he is able to scream and holler like that." That is what he said.
> SENATOR KENNEDY: So then you went to Cook County Hospital?
> MR. JOHNSON: Cook County Hospital, and they decided right away to put a pacemaker in and whatnot, but he went into a coma and passed away before they got a chance to insert it.
> SENATOR KENNEDY: Now, did you ever hear from St. George's again?
> MR. JOHNSON: Yes, I heard from them. I paid the emergency room bill...
> SENATOR KENNEDY: They sent you a bill after this?...
> MR. JOHNSON: Yes, one was a doctor's bill and one was the emergency room bill.
> SENATOR KENNEDY: How much were they?
> MR. JOHNSON: Twelve-fifty for the emergency room and seven dollars for the doctor's fee...*

The story of the Johnsons and others in their situation (i.e., mainly poor or ethnic minorities) are created by a health care system which is coming under increasingly heavy attack for what many critics perceive as its heartlessness -- its inability and (more tragically) unwillingness to contend with the basic medical needs of Americans. But these tragedies are not limited to those in lower income brackets. Even moderately affluent and well informed persons -- those who (one would think) "know better" than to leave themselves unprotected -- are susceptible to problems generated by the American health care delivery system. As evidence, take the case of Cotton, insurance executive:

> Even those with higher incomes can have their family finances shattered if they are caught in an insurance loophole. You would think an attorney and executive in an insurance company would be able to avoid getting caught in this. Mr. Sumner Cotton of Los Angeles was caught in such a situation, however, because he could not get coverage for his wife when he left a company with a group plan and applied for private coverage.

*Excerpted from Edward M. Kennedy, In Critical Condition: The Crisis in American Health Care (New York: Simon and Schuster, 1972), pp.80-83.

SENATOR KENNEDY: You work for an insurance company, is that right?
MR. SUMNER COTTON: I no longer do. I have been in the insurance business about twelve years. So I know the insurance industry quite well...

Just last year, my wife felt kind of ill. She was in and out of the hospital, I guess, five, six times. Had diagnostic studies done. At that time I did have group insurance, so it was marvelous. But they could find nothing specifically wrong with her. She kept complaining of some discomfort, some illness, but they couldn't come up with any particular diagnosis...

Anyway, she obviously had several claims, which were submitted to the private insurance carrier, the group carrier. Nineteen sixty-nine went by relatively well. And in June of 1970, while she was visiting back East, she was stricken with an aneurysm in the anterior-lobe section of the brain.

When I left employment in the insurance industry as an insurance executive I tried to convert the group coverage to some meaningful private coverage, and despite having known a number of good underwriters, it was impossible for me to obtain any meaningful coverage for her. The basis for that was that she had lodged claims five or six times in the preceding year. They said to me -- now, this is the personal kind of conversation I had with these gentlemen -- "Wait a couple of years, old friend, and if she has had no further claims and she is in good health, why, we will get her some health insurance."

Well, that's great, except before that period she came down with the aneurysm and at that point was not only uninsurable, she was not insured. There was no insurance available on the street, with Blue Cross or what-have-you. No one. Obviously, the financial burden that that event posed was quite substantial.

SENATOR KENNEDY: Now, as I understand, then, you did have some insurance and, as a matter of fact, even worked for an insurance company for ten to twelve years, and when you took another job you lost your health insurance. Is that correct?
MR. COTTON: Well, the group insurance -- you can convert a portion of it, but you can't convert the meaningful portion of it ...
SENATOR KENNEDY: But your wife was sick during this time, and you were trying to get some other insurance and were unable to do so?
MR. COTTON: Well, she was sick and she wasn't. They couldn't pinpoint what was wrong with her ... Insurance companies don't like to buy claims.
SENATOR KENNEDY: Why not?
MR. COTTON: It hurts their profit.
SENATOR KENNEDY: So she was hospitalized and you got the bills.... How much was the bill?
MR. COTTON: Oh, the total bill was in excess of thirteen thousand dollars.
SENATOR KENNEDY: Thirteen thousand dollars? And how much of that thirteen thousand was covered by any insurance that you had?
MR. COTTON: Zero....

SENATOR KENNEDY: Are you going to try and pay that off now?
MR. COTTON: Attempting to...*

These personal tragedies are often aggravated by the very mechanisms the government offers to alleviate the problems. A striking example was featured in the following news story about Howard and Ruth Thomas written for the St. Petersburg Evening Independent (January, 1973) by Judy McKnight. The headline: "Couple to Get Divorce to Gain Medicaid Help."

> A St. Petersburg man is divorcing his wife in a last ditch effort to get her the state aid she needs to stay alive.
>
> The 45-year-old woman, a multiple sclerosis victim confined to the Beverly Manor Convalescent Center, recently lost her Medicaid benefits because of financial ineligibility.
>
> Her husband, a steelworker in Tampa, takes home approximately $550 a month. The state's maximum for eligibility is $427 and is based on what it would cost to give nursing care in the home: $119 for basic personal hospital needs, $62 for shelter and $246 for nursing care.
>
> The man in tears yesterday told of his intensive search for help and funding. He has made several trips to Tallahassee only to be referred to local agencies that say they cannot help him.
>
> ... "I love my wife, and it won't make any difference to me that we are divorced. But, if that's the only way she can get care, then I'll have to accept it."
>
> ... "It's a sad day when a person has to get a divorce in order to receive care." said Boyd Hendrickson, administrator of the nursing home.
>
> But no one, other than the Legal Aid attorney the man was sent to, could come up with a solution.
>
> Because the woman has no income herself, a divorce would mean that she probably would become financially eligible for state aid. The Division of Family Services does not guarantee this but the husband already has asked a social worker to begin a new application, this time for his wife as a single individual.
>
> "We're all upset about this," said the attorney's secretary, "but we couldn't see any other way to help this man. I hope you can do something."
>
> ... "Why is it that the average man gets hurt?" asked the husband. "If I were real poor or real rich, I could take care of my wife. I work hard for a living and this is what happens, I just don't understand."
>
> The couple has two small children, aged 5 and 11, who are staying with married sisters. Until recently, the father was paying $30 a week for their care. He has discontinued those payments because he doesn't have the money.
>
> "I'm trying to pay off the nursing home bills, but I just can't do it alone."

---

*Excerpted from Kennedy, In Critical Condition ..., pp. 63-66.

His balance is $2,892.14. On February 1, however, he will receive another bill and the average monthly cost to care for his wife is about $800 to $1,000 a month.

A trust fund was established at the St. Petersburg Commercial Bank, 2100 - 34th St., S, with Mrs. Margaret Ryden. However, the donations have not been for more than $400.

"There is no other answer," the man said, "I'm going to get the divorce in order to help my wife, but I want to thank all of those who have thought and helped us during this unbelievable period."

****

Addendum: Wife Divorced to Qualify for Aid Dies
(St. Petersburg, Fla., Dec. 14, 1973) (AP)

Ruth Thomas, divorced by her husband 10 months ago so she could qualify for state medical aid, has died of multiple sclerosis.

Mrs. Thomas' seven-year battle with the debilitating disease ended Wednesday night at Welking Neurological Center in Chester, N.J.

"She suffered so long I guess it's for the best," said steelworker Howard Thomas. "She's better off now."*

To add to such grief is anything but humane and would obviously be contrary to the best traditions of the medical profession. Yet some of those involved in the delivery of health care conduct themselves in a manner not befitting the ethical standards set by Hippocrates and the generations of physicians (and related professionals) who follow that calling. In the following excerpt, Spencer Klaw describes what amounts to a "scandal" surrounding abuses of the U.S. government's health care delivery programs as it is manifest in poorer neighborhoods and nursing homes throughout the country.

> ...(S)upport for Medicaid had quickly been undermined by revelations that, in far too many instances, the program's chief beneficiaries had been doctors, dentists, podiatrists, and nursing-home proprietors. Within two years of the new law's enactment doctors all over the country were collecting huge sums from Medicaid by whisking the poor through their offices at a rate of one every two or three minutes. While some people were getting hasty and superficial care, other were getting care that they didn't need. Since 1965, thousands of group practices, of a kind known as Medicaid clinics, have been established in low-income city neighborhoods, and at some of these clinics it is standard procedure for a doctor to pass each new patient on to his associates for additional examination and treatment. This is called ping-ponging. "There was a group like that on 119th Street and First Avenue," Elma Harris, the East Harlem community worker, told me. "If you walked in that office, and you said you had a stomachache,

*Excerpted from Warren G. Magnuson and Elliot A. Segal, <u>How much For Health?</u> (Washington, D.C.: Robert B. Luce, Inc., 1974), pp.6-8.

> that meant you were going to see an M.D. After you saw the M.D., they sent you to the dentist. After you saw the dentist, then you had to see the podiatrist." Mrs. Harris conceded that this might have made good sense for some people, but that the podiatrist in the group seemed to find a remarkably large number of foot defects. "There were never so many shoes prescribed for children that were not needed," she said. "Because you know that <u>every</u> child that is born of a poor family does not have something wrong with his feet. But every child that went in that office got a prescription for shoes. My husband and I were paying fourteen dollars and seventy-five cents for Dr. Posners, and my little daughter refused to wear them. She said, 'Those are welfare shoes.' Because everybody was getting Dr. Posner shoes from the Medicaid."
>
> People who make a business of catering to Medicaid enrollees have found other ingenious and shoddy ways of exploiting them. Doctors have accepted kickbacks from laboratories to which they regularly refer patients for tests that they may or may not need. (In New York City, the Health Department has reported several instances in which tests for sickle cell anemia had been ordered for white persons, and one instance in which a man was sent to a laboratory for a pregnancy test). Pharmacists have kited Medicaid prescriptions by raising the number of pills called for on a prescription blank from, say, 100 to 200, and billing Medicaid for the larger amount. Dentists falsely claiming to have done work on one patient have supported their claim with x-rays of work done on another. Medicaid patients, as everyone knows, have also been shamelessly mistreated by greedy nursing-home proprietors. To give just one example, Senator Frank Moss of Utah called the Senate's attention in 1971 to the owner of a nursing home in Illinois who was feeding his patients on 54 cents a day each while realizing a pre-tax profit of $185,000 on the $400,000-a-year business he was doing with Medicaid. Moss went on to hint at exploitation of an even more shocking variety. In Illinois, he pointed out, the amount of money a nursing home could collect from Medicaid was determined by a point system based on the physical condition of the patients. "To my great dismay," he said, "I learned that large bedsores once developed by the patient are worth eight points, and at $6 a point the reimbursement to the nursing home increases $48 a month." Moss said he had been told that nursing home operators in Illinois commonly referred to bedsores as "being worth $48 a month."*

<u>ACTIVITY ONE</u>:

The personal tragedies which are linked to the American health care delivery system today are not found only in books or newspapers or Congressional hearings. They also affect people we know or have heard about through friends or relatives. Are there any experiences you have witnessed, heard of, or read about which reflect the personal tragedies generated by our health care system? Your course instructor will divide the class into small discussion groups. The purpose of these groups is for members of the class to share those experiences with each other and to generate a short list of "personal tragedies" that originate in the U.S. health care delivery system.

*Excerpted from Spencer Klaw, <u>The Great American Medicine Show: The Unhealthy State of U.S. Medical Care, and What Can Be Done About It</u> (New York: Viking Press, 1975) p. 190 to 192.

B. Understanding the Problems of Health Care Delivery

Each of the excerpts given above and the experiences discussed in your groups dramatizes the form our health care crisis is taking today, and each points to medical care problems which beg for solutions. Often we turn to government for such solutions, and its response takes the form of public policies indicating official objectives and goals in regard to a specific issue, and public programs describing the actions government will take (or avoid) to attain policy goals and objectives. But both policies and programs presuppose an understanding of the problems to be solved. This point is worth emphasizing in detail.

Problem-solving at its best is not a hit-or-miss proposition. Intuition and guesswork are important ingredients in any endeavor, but they are poor guides to action when we have specific objectives in mind. For example, think how much easier your commute to class is made by the fact that you understand what busses to take, what turns to make, or what building and floor to go to. To be a "stranger" in any town is to be ignorant -- not in the sense of being "stupid," but rather in not understanding the location of people, and places, and things. Once you overcome that "ignorance" -- once you understand the town and its layout -- then problem-solving (e.g., finding a store or bank or home), is made easier. Of course, all of us remain strangers to a certain extent. Even those who know a town in great detail may not "understand" it thoroughly or correctly.

Policymakers are often like "strangers" in the sense that they generally face issues they don't understand, fail to understand completely, or misunderstand. Most policies and programs are formulated and implemented on the basis of some assumed understanding of the problems to be solved. Relevant questions for students of public policy are what are those assumptions and are they correct?

U.S. poverty programs provide an example of how assumed understandings of issues influence public policies in both scope and direction. Until the Depression the dominant perspective on poverty considered the poor person as the "cause" of his or her situation. Under the capitalist work ethic, each individual was "self-made," whether poor or rich. If there was any blame to be set, it was on the head of those most victimized by poverty. This view was manifest in Elizabethan "poor laws" in England and resulted in a policy of incarcerating many debtors. While charity was supplied by some altruistic private citizens, the government's programs concentrated on the "poorhouse" and "debtor's prisons." Such programs were plainly logical extensions of the assumed explanation for poverty widely accepted at the time.

The Depression of the 1930's brought on mass impoverishment in such proportions that the Elizabethan view seemed both untenable and politically unpalatable. It was obvious that something was wrong with a system that allowed poverty to strike those who were unprotected. Such a tragedy would not have been as extensive, it was assumed, if the general public was "insured" against economic catastrophies. This approach and the assumptions underlying it brought about social security reforms in the U.S. and helped spread unemployment insurance and workman's compensation insurance nation-wide.

A more optimistic set of assumptions relative to poverty developed in the late 1950's and early 1960's. The belief that major causes of poverty were "structural" and could be pinpointed (and thus eliminated) became the underlying justification for the

War on Poverty. Once again, programs followed assumptions. From poorhouses to economic opportunity offices, poverty policies have been greatly effected by the assumptions policymakers had concerning the issues involved.

As it is with poverty policies, so it is with health care delivery. Government activity (or inactivity) takes many forms in this area. One study estimates that public sector expenditures on health care related activities amounted to $55 billion in 1975, or 46 percent of all health expenses for the American economy. These activities ranged in form from tax deductions and credits and direct subsidies to the provisions of medical services through federal, state, and local hospitals. Each of these programs reflect the policy assumptions of those who formulate and implement the activities, and while such assumptions may be as numerous as the problems they confront, most can be categorized as either demand-centered or supply-centered.

Demand-centered assumptions regard health care delivery problems as rooted in those forces which determine the claims made upon the limited resources of the American medical profession. As we will see, these assumptions lead policymakers to stress the financial nature of the health care delivery crisis. On the other side of the issue are those who see the problems as supply-centered, i.e., based in the organizational characteristics of those providing medical services to the American public.

To understand what difference these two general sets of assumptions can make, let us consider how Carl Johnson's death would be explained by each. From the demand-centered perspective, the problem was Mr. Johnson's inability to prove to the personnel at St. George's hospital that he had the financial resources or insurance coverage to warrant entrance for his son. From the supply-centered viewpoint, the problem (and therefore the blame for Carl's death) rested in a health care system which was incapable of delivering medical services to a patient in need of immediate care.

ACTIVITY TWO:

For this activity your class will be organized into small discussion groups. The task of each group will be to develop and discuss possible explanations for the pesonal tragedies described in the excerpts read in the introduction of this section. Following the example given in the case of the death of Carl Johnson, develop at least one explanation which is "demand-centered" and one which is "supply-centered." Specifically, apply these explanations to the following questions and discuss how valid you believe your explanations are: Why is Mr. Cotton burdened with such heavy medical bills despite the availability of insurance through private firms? Why were the Thomases forced to change their lives in order to receive medical care? How can we explain the treatment being received by those who use the "Medicaid clinics" described above?

Each group should select a spokesperson who will present a summary of the discussions before the entire class. That summary should not only present the explanations derived, but also how each applies to the tragedies that have been presented.

ACTIVITY THREE:

Once one identifies the cause of a problem, one also has insight into potential solutions! That is the key to policymaking and problem-solving in general. If one finds evidence, for instance, that poor health caused poverty, then a solution to impoverishment would be to make and keep everyone healthy. Of course, no social problem is so easily solved, but it can be assumed that the elimination or modification of some causal factor will have an impact on the problem. In Activity Two the group developed some reasons for each personal health care tragedy read earlier in the module. On an individual basis, you should attempt to develop policy suggestions (one for each) which will modify those causes or reasons in such a way as to improve the chances that those personal tragedies will not happen again. After writing these suggestions in brief form, share them with the group. Discuss these policy suggestions in terms of how effective they will be, how realistic, and how feasible. For instance, if someone had suggested ending poverty by keeping everyone healthy, you can ask whether the assumption (that ill health causes impoverishment) is correct; and, if so, whether the policy suggestion is realistic (can we even determine what is "healthy"); or even whether it is feasible (can we afford the financial and other costs of attaining the objective of "health").

After completing the discussion, each group should select a spokesperson to summarize the group's dialogue before the entire class. That summary should focus on whatever consensus group members reached regarding possible policy suggestions. If no such consensus was achieved, the spokesperson should emphasize the points of disagreement which arose.

Activities Two and Three demonstrate a process of problem-solving not completely unlike that applied by policymakers. Consciously or unconsciously, policymakers develop public policies and programs on the basis of beliefs and assumptions they hold regarding an issue being debated. The process is an extremely difficult one, especially when stakes are high and time is short. Ideally policymakers should be aware of the choices they are making when policies and programs are developed. That is, they should have knowledge of the options available to them, how these differ, and which among them will provide the "best" solution for the policy problem at the least cost.

This idealized policymaking model is reflected in the rational approach to decision-making which is advocated by many as a standard for evaluating policymaking activity. But obviously this ideal process is not feasible in real-world policymaking systems. Most of those charged with decision-making take several necessary "short-cuts" in making policy determinations by ignoring competing alternatives or disregarding the question of underlying assumptions altogether. The end result is not necessarily "bad" policies and programs, but rather actions based on limited information which are more likely to produce undesirable consequences than if informed by thorough and careful analysis and reflection.

The purpose of this module is to provide you (1) with an understanding of different approaches to problems of health care delivery in the U.S., and (2) with the capability to compare and analyze each. The approaches to be studied (Radical Reformist, Market Reformist, and Bureaucratic Reformist) are represented in three presentations offered in Section III of the module. Each is introduced with a brief discussion of the

position taken and followed by an exercise. In Section IV we will concentrate on developing your ability to specify and analyze the three approaches through various exercises. But before considering those general positions we will look (in Section II) at some of the specific proposals which have come before Congress in recent years and which manifest many of the arguments made by the authors of the three presentations studied later in the module.

II

Proposals for Health Care Delivery Reform

A. The Congressional Proposals

As noted previously, there are probably as many positions on health care delivery reform as there are reformers and analysts working on this issue. Following the classification presented above, the variety of positions can be categorized as either demand- or supply-centered. The arguments developed from these sets of assumptions have produced many specific reform proposals, some stressing financial changes, others emphasizing organizational adjustments, still others calling for a mixture of both. The ensuing debate has generated at least seven different proposals offered before the 93rd Congress (1973-74) and eight during the 94th (1975-76). In this section we will briefly consider some of the important features of several of those proposals and try to pinpoint the general demand and supply assumptions they are based upon.

Health Security Act. Also known as the Corman-Kennedy Bill, this act is by far the most comprehensive in coverage and most expensive in cost. Evolving from a similar bill presented in the 93rd Congress (Kennedy-Griffiths), this act would provide all U.S. residents with a broad range of medical care benefits at no direct cost. Financing of the plan would be through both payroll taxes and general revenue funds, and health care providers would be paid "reasonable costs" to be determined through administrative mechanisms within the Department of Health, Education, and Welfare. In addition to determining reasonable charges, the administrators of the program will work to create a more efficient and effective health care delivery system through comprehensive plans and utilization reviews as well as through setting specific standards for those who provide health care services.

The comprehensive nature of the Corman-Kennedy Bill attests to its broad view of the problems plaguing health care delivery in the U.S. today. Although placing greater emphasis on financial problems (the demand side), this proposal does not ignore the supply side. The strategy developed seems to rest on the assumption that besides not being able to afford medical care, many Americans are not being provided with efficient health care once they obtain sufficient funding. By attaching "strings" to participation in the program, the government will be able to reorganize the providers and determine how they will act if they wish to receive a "piece of the action." While participation by providers is voluntary, the incentives -- especially through financial controls -- are obviously too strong to ignore. In this sense, the Corman-Kennedy Bill is as comprehensive on the supply side as it is on the demand side.

National Health Care Services Financing and Reorganization Act. Sponsored by Oregon Representative Al Ullman (who happens to be chairperson of the powerful House Ways and Means Committee) and backed by the American Hospital Association (AHA), this bill is financially less generous than Corman-Kennedy but organizationally more demanding. Employers currently subject to Social Security taxes must offer their workers medical insurance underwritten by private carriers which meet specified minimum coverage levels.

If employees opt for the insurance, employers must pay 75% of the cost of the plan. The burdens thus imposed are offset through various tax credit and tax deduction mechanisms, although none of the resulting coverage is "free" of copayments* and deductibles.** Special provisions are made for the unemployed and self-employed, and low-income families and the aged receive 100 percent tax credits for the premiums they pay.

Organizationally, the bill would set up a Department of Health to administer the program and would strongly encourage states to implement state health plans and establish health care corporations (HCCs). HCCs would operate in geographic regions and act as coordinating centers for medical services in their area. Enrollment in HCCs would be encouraged by offering 10 percent tax credits on premiums paid to it by subscribers. Meanwhile, charges by providers would be determined by commissions set up to administer state health care plans. These commissions would also play a key role in regulating private insurance carriers and approving in advance proposed capital expenditures by all providers under their jurisdiction.

The Ullman Bill reflects the same dual emphasis on demand and supply reform as does the Corman-Kennedy Bill, but here the stress is on government actions which will improve the organization of providers. The support given this Act by the American Hospital Association is not surprising, since under the HCC concept medical services will become centered in large regional hospitals. This regional consolidation is regarded by the AHA as a necessary step in the improvement of the health care delivery system which they now regard as too fragmented and therefore highly inefficient.

National Health Care Act. Endorsed by the Health Insurance Industry of America, the Burleson-McIntyre Bill has the impact of maintaining the private provision of health care insurance and services while offering tax deduction incentives for the purchase of specified minimum benefits insurance plans. Most of these plans would involve a basic package of premiums and copayments, and only those at the extreme bottom of the income scale would be eligible for policies which involve neither. Most of the coverage would be through private carriers,+ while poor and uninsurable persons would be able to obtain policies through plans developed through cooperation between states and pools of private carriers. Providers would be able to charge what is reasonable, and that determination would be left to state commissions for hospitals and "prevailing rates" for physicians and other solo practitioners.

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*A "type of cost sharing whereby the insured or covered persons pay a specified flat amount per unit of service or unit of time..., their insurer paying the rest of the cost."

**A policy in which an amount of the expense must be incurred by an insured before an insurer will assume any liability.

+A "carrier" can be any commercial, public or non-profit (e.g., Blue-Cross/Blue Shield) organization which underwrites or administers programs of health insurance.

Organizationally, the Burleson-McIntyre Bill would increase funding to state and local health planning agencies, promote the availability of health maintenance organizations (HMOs)*, provide grants and low interest loans for the construction and operation of ambulatory health centers,** and increase loans and grants for medical students (especially those who will practice in areas of physician shortages). While these actions will influence the supply side of the health care delivery system, their impact is not that much different from programs currently financed through federal legislation. This reflects the proposal's emphasis on the financial aspects of the health care delivery crisis.

Comprehensive Health Care Insurance Act. Under a former title during the 93rd Congress, this proposal was backed by the American Medical Association (AMA). Known as the Fulton-Duncan Bill during the 94th Congress, it didn't carry an AMA endorsement but did represent the type of legislation that organization might favor. The basic rationale for the act was to facilitate the provision of health care to the poor or medically indigent*** within the framework of the current health care market. The program would involve tax incentives to promote the purchase of a specified minimum benefits policy. The lowest income groups would receive insurance through credit vouchers offered by the federal government based on filed tax returns. Thus, the strong emphasis is financial, and its impact is mainly among those at the lower end of the economic scale. The organizational dimension of health care delivery is ignored in the bill, reflecting an explicit premise that the current system is the best available.

Catastrophic Health Insurance and Medical Assistance Reform Act. Better known as the Long-Ribicoff Bill, the proposal had two objectives, both demand oriented. The first objective was to promote the establishment and purchase of catastrophic expense insurance+ by offering a 100 percent tax credit for premiums (subject to the limitation that the credit not exceed tax obligation). The policies could be purchased (by individuals or employees) from private carriers or government, the latter plans being paid for by an additional percentage added to the Social Security tax. Coverage on a copayment basis begins when medical expenses for an illness reach $2,000 or hospitalization lasts for more than 60 consecutive days.

The second objective was to assist the poor, and this was done through a copayment system where low income patient pays a nominal portion of a reasonable charge made by health care providers. There is no premium for this policy, and while it has broad coverage, it is neither comprehensive nor unlimited in all respects.

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*An entity which provides health care within a geographic area for a voluntarily enrolled group of persons under a system of predetermined, fixed, and periodic prepayments. (See Garfield article at the end of the next Section.)

**Units which provide all types of outpatient health services (as opposed to home-based or inpatient services).

***Person too impoverished to meet medical expenses regardless of income level.

+Policies covering high cost of severe or lengthy illnesses.

The Long-Ribicoff bill also has provisions to promote the purchase of non-catastrophic expense insurance, but its efforts along these lines are not significant. Also included are provisions which promote the establishment of HMOs and the improvement of private carrier insurance by having them submit (voluntarily) their policies for H.E.W. certification (which they can then use in advertising their plans to the public). Certain provisions of antitrust laws would also be suspended, thus allowing insurance companies to "pool" their resources in order to develop better policies.

Like the Burleson-McIntyre and Fulton-Duncan Bills, Long-Ribicoff stresses the financial reform of health care delivery. The organizational dimension, however, is not ignored -- but neither is it substantially altered. The emphasis on demand is all too obvious.

While these five proposals do not exhaust the list of those given consideration in Congress, they do represent the wide range of alternatives and the various assumptions made in most plans. All recommend changes, and yet each has a uniqueness of its own rooted in the particular emphasis it places on the demand and supply problems of health care delivery in America today. Figure II.1 places each of the five along a continuum which has demand and supply assumptions at its polar extremes. At the demand extreme lies the Fulton-Duncan Bill which relies exclusively on financial changes and explicitly depends on current health market mechanisms to carry out the task of improving medical service delivery. At the other end (although not at the extreme) is the AHA endorsed Ullman proposal which emphasizes the need to reorganize the health care delivery system. Both the Burleson-McIntyre and Long-Ribicoff Bills fall to the left of center on the continuum, for both emphasize financial changes while not ignoring the need for some organizational modifications of the delivery system.

This leaves us with the anomalous Corman-Kennedy proposal -- a bill advocating major changes in both financing and organization, with emphasis on the former. The implied impact of the Health Security Act would be such that to locate it on the continuum would misrepresent the course it would mandate. For in combining a call for reform along both supply and demand dimensions, the Corman-Kennedy proposal seeks a substantial departure from present forms -- and thus its location in Figure II.1 off the continuum as a unique alternative to other programs.

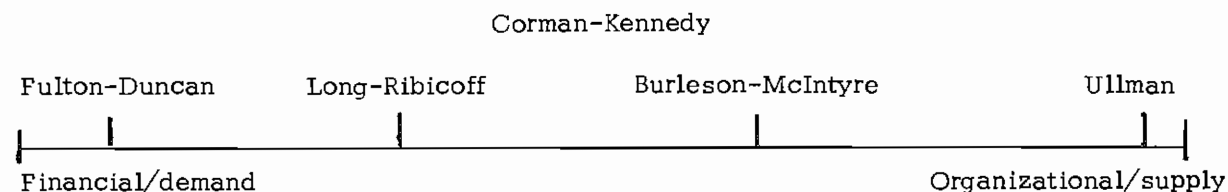

FIGURE II.1
The Assumptions of Health Care Delivery Reform Proposals

A different yet complementary way to perceive the differences among these proposals will become obvious after you have read Section III. In that section you will be introduced to three perspectives on health care delivery reform. First you will read about the "Radical Reformist" view which seeks to revamp both the financial and organizational mechanisms of health care delivery. The second, labelled "Market Reformist," would rely on financial reforms only, leaving the current pluralistic and fragmented structure of the health care system to carry out the efficient allocation of scarce resources. A third and final perspective, the "Bureaucratic Reformist," seeks to reorganize the health care delivery system through regional consolidations and centralization of administration. In Section III you will be presented with a more in-depth presentation of each position.

EXERCISE ONE:

The continuum in Figure II.2 reflects a modification of that presented above (Figure II.1). That is, it illustrates three policy choices rather than the two extremes of demand- and supply-centered only. Your task is to place the appropriate number for each of the reform proposals along the continuum provided below. Be prepared to explain your answers in class.

(1) Corman-Kennedy
(2) Ullman
(3) Burleson-McIntyre
(4) Fulton-Duncan
(5) Long-Ribicoff

Demand and Supply reforms	Demand/financial reforms	Supply/organizational reforms

FIGURE II.2
Health Care Reform Proposals and Reformist Perspectives

III

The Debate: Three Views on Health Care Delivery

Much has already been made of the fact that the choice of public policies depends on the assumptions made and accepted by policymakers. It has also been noted that the assumptions concerning health care delivery problems focus on financial/demand factors, organization/supply factors, or both. The result is three general perspectives on health care reform which stand out in policy debates on this issue. In this section we will look at each of those perspectives on health care reform which stand out in policy debates on this issue. In this section we will look at each of those perspectives as they are presented by specific authors in articles representing stands based on alternative sets of assumptions. Each position has been given a label here, but the use of a particular label does not imply a judgment about the position taken. For instance, the first part of Section III presents the "radical" perspective. It is "radical" in terms of the extensive changes it mandates for the current financial and organizational structure of the health care delivery system. Such a position is socialist to the extent that the current system is capitalist; it is Marxist to the extent that it attacks a class-based system of financing medical care. If the present system in the U.S. were similar to the nationalized health care found in eastern Europe and even some western and Scandinavian nations, then "radical" would be a label more appropriate to capitalist criticisms which sought to set up fragmented, market-like delivery mechanisms. Given the context within which it is found, the radical reformist perspective in the U.S. tends to be most clearly expressed in Marxist terms. The same can be said for the "market reformist" and "bureaucratic reformist" positions. To clarify what each reform perspective considers crucial, a brief introduction is included for each presentation. The labels should be understood in light of those introductions rather than any ideological stereotyping. For a more general discussion of these three views, the student is referred to Robert R. Alford's Health Care Politics: Ideological and Interest Group Barriers to Reform (Chicago: University of Chicago Press, 1975).

A. The Radical Reformist Position

The first selection is representative of a policy position which perceives health care delivery problems to be rooted in the financial and organizational structure mandated by capitalist society. The U.S. capitalist society is said to treat health care as a "commodity" bought and sold in a fragmented yet professionally monopolized market where the urge for profit overwhelms humanitarian concerns. "The most obvious function of the American medical system" notes a report of the Health Policy Advisory Center, "other than patient care, is profit-making. When it comes to making money, the health industry is an extraordinarily well-organized and efficient machine."

This position is a variant of what Alford terms the "institutional or class" perspective. The health care system, according to this view, involves three main groups of actors. First are "professional monopolists" who, located at the pinnacle of a health care system power structure, seek to maintain their dominant position. Composed of physicians and related medical service professionals, this group is represented by the American Medical Association and similar organizations. Through accumulated symbolic and legal controls at their disposal, professional monopolists promote the proliferation of projects, funding, and specialties upon which they continue to thrive. At the same time they fight to remain structurally decentralized and "un-bureaucratized," i.e., unhampered by governmental or similar bureaucratic controls.

Challenging this group are health planners and similar "corporate rationalizers" who seek to move the center of power from practicing physicians to hospitals, university training centers, and national research organizations. Represented by the American Hospital Association and similar administrator-centered organizations, this group is (according to Alford) more interested in wresting control and power from the professional monopolists than in improving medical services delivered to the community. Alford's description of their tactics and purpose is worth quoting:

> Sometimes corporate rationalizers ally themselves with professional monopolists within their own institutions as a way of gathering more financial resources and legitimacy, and also as a way of bringing more and more health care units into their domain, even if not under their control. But usually it is in the interests of the corporate rationalizers to attempt to control the conditions of work, the division of labor, and the salaries of their employees, in view of the exigencies of funding and the need to adopt technical and organizational innovations without the built-in resistances of professional (or union, for that matter) jurisdictions over tools and tasks. They therefore attempt to convert professionals, mainly physicians, into employees and in a variety of ways to circumscribe their power in the hospital.

A third group in the health care delivery system are regarded by Marxists as "true challengers" to the current domination of medical professionals and those seeking consolidation. Their position in the battle, as well as the potential they have for success, are summarized by the label Alford applies to them: the "repressed structural interests." Professional monopolists and corporate rationalizers usually confront each other on a stage where the community interests (i.e., "the varied interest groups of the white rural and urban poor, ghetto blacks, the lower middle class just above the Medicaid income maximum, the neighborhoods just poor enough that no doctor wants to establish his practice there, those middle class families rendered newly medically indigent by sharply escalating costs, those occupations affected by job-related diseases," etc.) are missing. On those infrequent occasions when the "repressed" enter the foray, monopolists, rationalizers, and the interests they represent coalesce into a "conservative force" which attempts (most often quite successfully) to maintain the status quo, especially current power relationships.

In other words, radicals like the Marxists regard the situation of most health care consumers to be doubly untenable. On the one hand, they face a delivery system which emphasizes how much you can afford. Under this system the medical professional dominates and the inequitable distribution of income in society determines the availability

and distribution of health care services. One's "right" to health care is thus precluded by a system which treats medical services as a commodity. On the other hand, those same groups must contend with powerful forces which are attempting to consolidate the market for the health care commodities, thus creating a monopoly situation which would do anything but help individuals obtain those services which should be theirs by right alone.

It is obvious that the Corman-Kennedy Bill is not Marxist in either origin or orientation. It is a plan which accepts the capitalist society Coontz criticizes. Thus, it should not be surprising that she does not endorse the proposal. Yet Corman-Kennedy does have in common with Coontz a belief that the problem is both demand and supply centered. It is radical in that specific sense.

In the following article ("You Can't Afford to Get Sick") Stephanie Coontz discusses health care delivery in the United States applying a view based on assumptions similar to those outlined by Alford and manifested in Corman-Kennedy. Coontz and other Marxist critics see the solution to current health care problems in a radical restructuring of the present system and the class relationships inherent to it. Health care, according to Coontz, must be a "right" rather than a "commodity," and that can be achieved only through the establishment of a "democratic socialist society."

YOU CAN'T AFFORD TO GET SICK
by Stephanie Coontz

According to legend the Chinese used to pay their doctors only when they were well. When people became ill they stopped paying because the doctor had failed to do a proper job of keeping them healthy. In the U. S., of course, the practice is the opposite; we pay when we get ill. And how we pay.

In 1950 medical care expenditures totaled $12 billion, 4.6 percent of the Gross National Product. By 1971 the figure had climbed to $75 billion, 7.4 percent of GNP, and in 1973 expenditures on health care reached $83 billion, 7.6 percent of GNP.[1] In other words, health care costs rose by almost 700 percent between 1950 and 1973, a staggering figure even by today's inflationary standards. On a per capita basis this translates into a yearly bill of nearly $400. The average American now works almost one month a year to cover the cost of doctors, hospitals, and health insurance for his or her family.

What do we get for all this money? Despite the unusually large percentage of GNP devoted to medical expenditures, American health care has deteriorated in relation to other industrialized countries. In 1950 the U. S. ranked fifth in the world in infant mortality

This article first appeared in the February 1974 issue of the *International Socialist Review*.

rates. In 1970 it ranked fifteenth, below all the industrialized nations of Europe. By 1971 the U. S. had dropped to twenty-third. Twenty-two countries have lower infant mortality rates than the wealthiest country in the world.*[2]

Within the U. S., probably the most startling fact about medical care is the contrast between the potential for expert care created by modern medical techniques and the unimpressive reality of everyday treatment. Only a tiny fraction of the vast sums of money channeled into medicine pays off in improved public care. In 1968, for example, community hospitals spent 16 percent more money than the year before but provided only 3.3 percent more days of inpatient care and 3.7 percent more outpatient visits.[3]

In some countries people die because of inadequate medical training or technology; in the U. S., every year thousands of people die or are permanently disabled by curable or preventable diseases and accidents. According to the National Society for the Prevention of Blindness, there are an estimated 1.5 million people in the U. S. with glaucoma, a degenerative eye disease that can cause blindness, but half of them don't even know it. Half of all American children reach age fifteen without ever having seen a dentist.[4]

These statistics only hint at the problem. Health

*Infant mortality rates are considered by most health experts to be a reliable indication of general health care quality. When world statistics showed that the U.S. was slipping, some people suggested that the rate was *not* related to deficiencies in health care. An analysis of all 1968 births in New York City, however, established an undeniable correlation between good health services and infant survival. The study, conducted by the Institute of Medicine at the National Academy of Sciences, concluded that if all pregnant women had received adequate care the 1968 infant death rate could have been reduced by one-third (*Scientific American*, September 1973).

authorities cannot gauge the true extent of U. S. health care deficiencies because so many problems remain undiagnosed. John H. Knowles, director of Massachusetts General Hospital in Boston, testified about a study he helped conduct in Charlestown and Roxbury, ghetto districts of Boston. The researchers found 50 percent of the children to have undiagnosed conditions that needed treatment and nearly 100 percent in need of dental care.[5]

America has no national preventive medicine program. In many states, welfare agencies are allowed to prescribe vitamins to treat but not to prevent rickets. Many welfare programs will care for children after they become blind but will not cover the cost of an operation to prevent blindness.[6]

The National Academy of Sciences, comparing U. S. emergency care to the sophisticated practices in Eastern Europe, charged in 1972 that thousands of lives are lost each year "through lack of systematic application of established principles of emergency care." A more recent estimate puts the toll at 175,000 a year.[7]

Even second-rate medical care is inaccessible to many Americans or imposes extreme financial burdens on them. A recent survey by the National Cancer Foundation reported that a major illness can reduce a middle-income family to bankruptcy in less than two years.[8] According to a 1972 study by the Department of Health, Education, and Welfare, of the 183 million non-institutionalized U. S. citizens under age sixty-five, 30 million people, 16.5 percent, had no health insurance whatsoever; 95.5 million, 52 percent, had no insurance for visits to physicians; and 164.2 million, 89.7 percent, had no dental insurance.

Even people with insurance are seldom fully covered. Many insurance policies have deductible and copayment schemes. Others do not pay above a set amount. Many insurance policies do not cover pregnancy and childbirth; among those that do, almost one-third do not cover an infant during the first fourteen days of life,

when the chance of complications is greatest. In fact, insurance pays only 36 percent of the average cost of sickness.[9] Although this percentage represents an increase from the 22 percent covered in 1966, costs of medical care have increased so much more rapidly that insured individuals still pay 25 percent *more* out of their own pockets than they did in 1966.[10] The cost of health insurance itself increased by 241 percent between 1950 and 1964, and since then the rate of increase has quickened.[11] As insurance costs continue to rise and real wages to fall, more and more families are likely to gamble their health against their immediate financial needs, and drop their insurance.

The gap left by private insurance has not been filled by the Medicare and Medicaid programs. Medicaid has reached only about 12 million of the poor, one-fourth its target goal of 40 million. More than one-third of the states have reduced services and cut recipients off the rolls, while the deadline for states to make services available to all those eligible has been postponed from 1975 to 1977, with the strong possibility that it may never take effect at all.[12]

As for Medicare, which is supposed to provide medical services for people over sixty-five, the numerous deductible and co-insurance expenses that must be paid by the patients mean that Medicare actually covers only 43 percent of their medical expenses. A 17 percent increase in the Medicare deductible and co-insurance costs took place on January 1, 1974. This means that the 23 million persons on Medicare will pay $103 million more of their own money for hospital care this year.[13] A HEW official called the rise a curb on frivolous medical spending: "It achieves a stop-and-look attitude: Do I need to be in the hospital an extra day? Do I need this test?"[14]

The upshot of all this is that health is a luxury in America today. Poor people have four times as much chronic illness, three times as much heart disease, and seven times as many eye defects as the affluent. Half

the children born to poor parents are not immunized against common childhood diseases, and a poor child has twice the average risk of dying before age thirty-five as the child of a family with an income over $10,000.[15]

The faults of American medicine do not lie primarily in inadequate medical technology but in the fact that health care is a commodity that must be purchased rather than a right free for the taking. Aristotle long ago enunciated the principle that American organized medicine has fought against for the last fifty years, that health care is a right and not a privilege: "If we believe men have any personal rights at all as human beings, they have an absolute right to such a measure of good health as society, and society alone, is able to give them."

Yet no capitalist society has ever started from the premise that medical care is a right. In some capitalist countries a strong labor movement has won the right of medical care. Thus the Labour Party in Britain established a national health care system, while in Germany and Canada bourgeois parties instituted national health reforms under pressure from organized labor. The American ruling class, however, has been able to impede the development of a labor party through a judicious blend of concessions, repression, and crumbs from the imperialist spoils. The oft-cited "paradox" of the richest country in the world having such backward social welfare programs is no paradox at all. Such is the logic of capitalism, and the American rulers have been strong enough to escape the concessions wrung from other capitalist nations by their working classes.

The American medical system remains relatively unmodified by concessions to the working class. As such, it can be viewed as the best example of the capitalist approach to health care. The overwhelming majority of medical services are for sale to the highest bidder. Most physicians operate on the "fee-for-service" princi-

ple. Rather than receiving a salary, they are paid for each individual service they perform. Each physician is in fact an independent entrepreneur. According to the 1971 *Statistical Abstract*, only 5 percent of all American physicians were employed full time by hospitals in 1969, and 7 percent were federally employed. Fifty percent worked in solo practice, while the remainder were involved in group practice, training programs, or some combination of private office and hospital practice.

The same private enterprise system prevails in the institutions of medical care. In fact, the American health care system is a classic example of what Marx called the anarachy of capitalist production. "We have some 7,000 hospitals, and they really act like 7,000 corner grocery stores," as the director of Mt. Zion Hospital put it.[16] There is no national planning for health needs or coordination of services, no uniform set of regulations for reviewing the competence of physicians or the quality of medical institutions and supplies. The federal regulation that does exist is hopelessly fragmented. Health programs are handled by twenty-four separate departments and agencies.[17]

This does not mean that the production of medical care is irrational from the capitalists' point of view. The medical industry, despite its occasional bureaucratic muddling, is highly efficient at achieving its primary goal—making money. As of 1969 the health industry was generating over $2.5 billion a year in after-tax profits.[18]

The American Medical Association was for years the most wealthy and powerful lobby in Washington, D. C., although it has been displaced by the oil lobby in the 1970s. Representing the nation's private practitioners, the AMA has been the front line of defense against even the most minor public health reforms that might infringe on the autonomy and profitability of the private practice of medicine. It has opposed vaccination programs, venereal-disease clinics, Red Cross blood banks, medical student loans, government maternity

care subsidies, and free cancer diagnostic centers. It has defeated every attempt to establish national health insurance since 1914.

Reporter Richard Harris has described the AMA's forty-five year, multimillion dollar fight against government-subsidized health care in his well-documented book, *A Sacred Trust*. He points out that in 1964 the AMA had an operating budget of $23 million and maintained twenty-three lobbyists in Washington, D. C.[19]

As it turned out, AMA's failure to block Medicare and Medicaid was a blessing in disguise for its membership, as billions of dollars have been channeled into medicine and many doctors have enriched themselves with government fees. Numerous cases have recently come to light revealing spectacular abuse of the federal programs by some physicians. Congress responded by establishing a review organization to oversee the administration of Medicare and Medicaid funds. The current AMA project is to repeal this legislation. Covering both sides of the street, however, the AMA has also applied for a $1.5 million contract to train the watchdog committee's personnel. As columnist Jack Anderson commented, that would be like hiring foxes to train the dogs that will guard the chicken coop.[20]

The medical industry has organized itself very efficiently indeed for the maximization of its profits, prerogatives, and fees. But what's good for the AMA is not necessarily good for the public.

Profit interest vs. public interest

A system of medicine based on the profit-motive organizes its health care delivery not according to what society needs but according to what pays. It goes where the money is. This means, most obviously, that people without money get inadequate treatment or no treatment at all, a fact reflected in the gap between the health of poor Americans and rich ones. But private enterprise affects medical care in other ways as well.

Because medicine goes where the money is, there

are tremendous imbalances in the availability of physicians and medical facilities in the U. S. In 1969 the distribution of physicians ranged from 78 per 100,000 residents in Mississippi and Alaska to 371 per 100,000 in Washington, D. C., with an average rate of 163. In one section of Brooklyn's Bedford-Stuyvesant slum area, there is only *one* practicing physician for a population of 100,000.[21]

The Connecticut Academy of Family Physicians has reported that as of February 1972, 33 of Connecticut's 169 towns were without doctors. Many extensive rural areas around the country face the same predicament. And a recent report issued by the American Geographers of Washington reveals that this regional imbalance has steadily increased over the last decade.[22]

The maldistribution is not just geographical. It also shows up as shortages in needed fields of work. Although the number of physicians has increased in recent years, the number engaged in primary care has dropped from 103 per 100,000 in 1950 to 90 in 1971, as students have headed for the more prestigious and higher paid specialist and research positions. In Connecticut, for instance, the number of general practitioners declined by 29 percent between 1963 and 1970. The Department of Health, Education, and Welfare estimates that there is a current shortage nationally of fifty thousand physicians, twenty thousand dentists, and one hundred and fifty thousand registered nurses.[23]

The profit system distorts not just the availability but also the type of medical care. It may discourage a doctor from referring a patient and thereby losing a fee. It tends to encourage unnecessary services and more expensive forms of care, thus raising insurance rates and prices in general. "Vitamin B-12 and estrogen shots alone pay the doctor's rent and put his kids through college," says Dr. George Williams of the San Joaquin Foundation for Medical Care. When the foundation began scrutinizing the need for such injections they fell off sharply, currently accounting for only 2 per-

cent of physicians' income in San Joaquin, compared to the 30 percent figure common in many areas.[24]

A 1964 study of the medical care given to Teamsters and their families concluded that one in five of the hospital admissions was unnecessary, that one in five of the hospitalized patients received poor care, and that another one in five of the hospitalized patients received only fair care. Twenty of the sixty hysterectomies performed were found to be unnecessary, and over half the caesarian sections were questionable.[25]

The other side of the coin is that those who cannot afford to pay receive too little care. Dr. Raymond Wheeler has testified before the Senate Subcommittee on Migratory Labor that almost every child in the migrant camps grows up with some preventable physical defect or disease because the family cannot afford medical care or because the care is simply inadequate.[26] Medical discoveries go unused because they are priced out of reach for the ordinary citizen. Thus, though a drug was developed over ten years ago to control the bleeding of hemophilia, only 4 percent of the nation's twenty-five thousand hemophiliacs can afford regular treatment with it.

During the 1971 Senate hearings on medical care, scores of witnesses told of being turned away from hospitals because they did not have $50 or $75 deposits. In Chicago, eighteen thousand emergency patients were refused admission to private hospitals in 1970. At least fifty died in the transfer to public hospitals.[27] But in Chicago there were at any rate public hospitals to receive the patients that survived; in many areas there are no such hospitals.

A graphic illustration of the effects of private profit on medicine is provided by the ethical drug industry. The adjective refers to the legality of prescription drugs, not to the business practices of an industry more concerned with sales and advertising than research and development. Drug companies spend twenty-five cents of every sales dollar on advertising and promotion and

only six cents on research. But this figure overstates the amount of research that is done. Approximately 70 percent of the research money in the pharmaceutical industry is spent to develop dosage changes and minor variants on already discovered drugs so that each company can patent its own version. Only seven hundred active compound drugs form the basis of modern pharmacology, but the drug companies have created over twenty thousand brand names.[28] Seventeen-year patents permit the drug firms to impose fantastic markups on their products.

The private profit system in the pharmaceutical business may cost the consumer more than money. One example of the effects of the industry's sales techniques first came to public attention in the 1951-52 Kefauver hearings on the drug business. It concerned the promotion of Chloromycetin, an antibiotic useful in the treatment of diseases like typhoid fever and Rocky Mountain spotted fever.

Unfortunately, the drug is also associated with blood dyscrasias (imbalances in the composition of blood), especially aplastic anemia, which has a fatality rate of over 50 percent. In 1952 the FDA suspended sales of Chloromycetin. It then allowed a resumption of sales, but required that a serious warning of the drug's dangers accompany each purchase. The warning was effective; sales dropped sharply. The manufacturer thereupon sent out letters to its salesmen instructing them not to mention the drug's toxicity unless the doctor raised the issue or was no longer prescribing the drug. In such cases the salesmen were to recite a standard speech declaring that the FDA had given "unqualified sanction of continued use of Chloromycetin" and dismissing the warning as "a sensible caution against indiscriminate use . . . an assurance that the full benefits of well-tolerated Chloromycetin will be available and free from misuse." Physicians were satisfied by this and began routinely prescribing the antibiotic for minor infections.

By 1963 sales of Chloromycetin had reached new levels.[29]

Senator Gaylord Nelson's 1967 hearings on Competitive Problems in the Drug Industry revealed that as of 1967 nearly 4 million Americans were still being dosed each year with the drug, although only ten thousand people would have received it if its use had been limited to those who specifically needed it. The hearings documented hundreds of cases of people who died from aplastic anemia following the use of Chloromycetin for minor infections.[30] Ralph Nader recently testified before a UN committee on multinational corporations that Park, Davis and Merck & Co. continue to sell Chloromycetin abroad without even the accompanying warning required in the United States.[31]

This example shows how the system of competitive drug sales, involving advertising expenditures by the drug industry as a whole of over $4,000 per physician per year, can make a mockery of governmental regulations and warnings. Even though not all cases involve such a serious threat to health, the production and promotion of drugs for private profit cuts across the ability of the most well-intentioned physician to provide the safest, most effective, and least expensive medication for the patient.

The American Medical Association's Council on Drugs once curtailed advertising excesses by the pharmaceutical industry, maintaining high standards for ads in AMA journals and even counteracting the power of drug patents by promoting the use of generic rather than brand names for drugs. But in the early 1950s the AMA hired Ben Goffin Associates, Inc., to study ways of increasing advertising revenues in AMA publications. The study indicated that AMA's strict advertising policies were an impediment to advertising sales. Following the logical implications of this, the AMA dismantled its apparatus for regulating ads. By 1957, the general manager of the AMA was able to assure a

drug manufacturers' convention that the Council on Drugs no longer exercised control over advertising in AMA publications.

The proud research company reported to other prospective clients how the AMA had profited from its efforts: "The utilization of the study findings netted the AMA a return of 3600% in increased pharmaceutical advertising for each dollar spent on the research." Following through on a good thing, the AMA wholly abolished the Council on Drugs in 1972, and in 1973 it decided to work both sides of the street and begin investing in the pharmaceutical industry, reversing a long-standing policy against it. Officials said they were also considering investment in the cigarette business as well.[32] After all, in addition to the immediate returns, consider the derived demand for oxygen respirators and heart and blood pressure treatment facilities.

The Kefauver hearings attracted much attention in the 1950s with their expose of false advertising, price-fixing, and profiteering in the drug business. Many people were shocked to learn that drug companies had a profit rate twice as high as the industrial average. Out of the hearings came the Kefauver-Harris amendments, which required that advertisements to physicians contain a drug's generic name in letters at least half the size of those in the brand name; that drug manufacturing establishments be inspected once every two years; and that drugs must be proved effective for the conditions they claim to treat.

The effects of this legislation were hardly spectacular. Today 90 percent of all prescriptions are still sold by brand name. There are four drug manufacturers among the ten U. S. companies with the largest profit margins in 1973. Profits in the drug industry as a whole are still twice the industrial average.[33]

Quality controls have significantly improved, yet on December 18, 1973, the Senate Subcommittee on Health heard charges that over one hundred Americans die

each day from adverse reactions to prescription and over-the-counter drugs! The General Accounting Office recently reported that drug companies regularly delay disclosures of side effects from forty days to nineteen months.[34]

An interesting sidelight on capitalist morality is what happens to drugs and foods that are recalled from the American market under the stricter regulations. These are often bought up by the U. S. government and given away as "foreign aid." After the FDA concluded that cyclamates in soft drinks could cause cancer, a large quantity of such beverages, banned in the U. S., was sent to South Vietnamese refugees.[35]

Recently there has been a trend toward consolidating and coordinating hospitals' and physicians' services. The number of physicians in solo practice has fallen, from 70 percent in 1950 to 50 percent in 1969. The AMA, which has traditionally represented the private practitioner, has seen its influence and membership drop, as the percentage of physicians it represents fell from 70 to about 60 percent between 1960 and 1970. There has been a corresponding growth in the organizations representing the new medical combines—the American Hospital Association, national Blue Cross, the American Association of Medical Colleges.

But the decline of the solo practitioner and the consolidation of medical care into large medical empires represent no more of a departure from production for private profit than did capitalism's concentration and centralization of many small enterprises into a few large corporations. And the establishment of a monopolist medical industry is hardly a victory for the public. Like any oligopoly, the modern medical combine can exercise economies of scale to decrease cost and increase efficiency, but it can also use its vast power to extend its private profit interests and dictate policies and prices to the public.

The medical industry is simply repeating a transformation that occurred long ago in the rest of the capitalist economy—the replacement of small entrepreneurs by large monopolies. If the medical industry has been slow to follow the overall pattern of monopolization, however, it has lost no time in reaping the benefits of the economic policies of modern monopoly capitalism—government support to private enterprise. Government research and welfare subsidies have pumped money into the medical industry, creating a virtually recession-proof sector of the economy.

Welfare for the poor always ties its small benefits to degrading restrictions and requirements; welfare for the rich has no strings attached. Section 1801 of the Medicare act succinctly summarizes the government's undemanding giveaway program to the medical establishment: "Nothing in this title shall be construed to authorize any federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided . . . or to exercise any supervision or control over the administration or operation of any such institution, agency or person."

Thus the U. S. government, in the name of public welfare, has heavily subsidized private medical interests. Medicaid was a giant shot in the arm for private medicine. In New York City, the private sector received 71 percent of all state and federal funds brought in by Medicaid. This radically changed the relationship of forces within the health care system: In 1966 less than 25 percent of the city's medical budget went to the private sector; by 1969 the private sector was getting 40 percent. In the opinion of the New York Health Policy Advisory Center, Medicaid caused "the wreckage of the city's forty-year-old public health and hospital system."[36]

Each medical reform that has been enacted in the U. S. has worked in the same way. Even when it has extended

health care benefits to larger sections of the population, its overwhelming effect has been to strengthen the private sector of the medical industry.

One of the fastest growing trends in American medical care is the establishment of proprietary hospitals—hospitals owned by corporations and run directly for profit. From 1950 to 1969, such hospitals were on the decline. There were 849 of them in 1969. Since 1970, however, corporate chains have built or bought about 300 new proprietary hospitals. And private enterprise has only just begun. Jack Massey, director of Hospital Corporation of America, declares jubilantly: "the growth potential in hospitals is unlimited; it's even better than Kentucky Fried Chicken."[37] The comparison isn't fanciful—Massey was formerly chairman of Kentucky Fried Chicken. It is tempting to dwell on the qualifications he undoubtedly brings from this valuable business experience to the medical care industry.

Some proponents of the free market system have hailed the growth of proprietary hospitals as a step forward for modern medicine, arguing that profit maximization techniques will cut costs and increase efficiency. Certainly proprietary hospitals are more efficient—at making money. In 1970 their net income per patient per day was two-and-a-half times as great as that of the nonprofit hospitals. They have registered increases in earnings of 15 to 20 percent each year, and their estimated net returns for 1973 are $90 million on a gross of $1.8 billion.[38]

Efficient profit-making, however, does not always equal improved health care. As with supermarkets, the key to the profitability of proprietary hospitals is turnover. The average stay in a proprietary hospital is 6.8 days compared to 8.2 in a public hospital. The proprietary hospitals achieve this at the cost of full medical care, dumping their unprofitable services and patients on public institutions. A survey of 200 hospitals in Southern California revealed that the average

nonprofit hospital provided 13.1 services and charged $112.96 per day, while the average proprietary offered only 8.9 services and charged $128.05 per day.[39]

Another trend has been toward affiliating private nonprofit hospitals with public ones, generally to the detriment of the public hospitals. Both New York City's Bellevue Hospital and Boston's City Hospital, for example, have recently been reorganized to reflect the priorities of private institutions—New York University Medical Center at Bellevue and Boston University Medical Center at Boston City. Although such university medical centers are "nonprofit," they are invariably more expensive than public hospitals, and they are run in the interests of the university establishments.

The Health Policy Advisory Center of New York (Health/PAC) reports that this "privatization" of the public sector has resulted in the outright transfer of some public hospitals to private ownership and control. More often, the public hospital is simply subordinated to its private affiliate. The sharing of services in such relationships, for example, almost invariably works to the benefit of the private hospitals. Thus a service done at Bellevue for University Hospital patients is free, but the reverse does not hold true. Health/PAC concludes:

"The public system emerges as public in name and legal status only—in effect it has become an adjunct of the private system, partly performing functions the private sector prefers not to perform in its own facilities, partly providing a setting in which the private sector may carry out its own pet projects at public expense."[40]

The growth of monopoly in medicine has the same result as monopoly in any other industry—inflation. This is aggravated by government subsidies, which maintain a high-paying demand. Like the defense industry, medicine works on a cost-plus basis. The government reimburses it for its self-declared costs and adds a certain amount above, a policy scarcely designed to encourage cost-cutting. The inflationary re-

sults of the cost-plus system in the defense industry do not immediately affect the ordinary consumer, since most people aren't in the market for missiles. But consumers do purchase medical goods and services with their own money, and they find themselves in competition with the government, whose cost-plus practices help raise the price of medical care for everyone.

Government agencies and "nonprofit" organizations like Blue Cross-Blue Shield have done practically nothing to combat these rising costs. Blue Cross-Blue Shield —which covers 68 million Americans with hospital insurance, provides supplementary Medicare insurance to another 6 million, and administers many federal programs—has steadily raised its rates in recent years, claiming it is a helpless victim of rising hospital costs. But Blue Cross makes little objection to such costs when it negotiates its contracts with the hospitals, and for good reason—Blue Cross was created by the hospitals. Its trademark is owned by the American Hospital Association and its boards of trustees are packed with members of the hospital establishment. The hospital industry has found something even better than a sweetheart contract—a way of negotiating with itself. The fact is that organizations like Blue Cross-Blue Shield are essentially publicly-funded collection agencies for private medical interests.

Blue Cross has yet another reason to accept rising medical costs. It too is paid by the government on a cost-plus basis for its administration of the Medicaid-Medicare programs. On top of this, it collects from the government an annual "public interest charge" that is set at 1 percent of costs. This charge came to $5.1 million in 1971.[41]

The private profit system distorts the production and delivery of health care away from what is needed into what is profitable. While millions of Americans do without even the most elementary medical treatment, there is a proliferation of luxury items—hyperbaric chambers, electronic thermometers, plush administrative of-

fices, etc. Doctors eager for research grants are impatient with the mundane complaints of the poorer patient. There isn't much money or glory in curing pneumonia, malnutrition, vaginal infections, venereal disease, alcoholism. The dedicated physicians who do concern themselves with real illnesses of their patients run into the medical version of academia's "publish or perish." Grants and promotions don't go to good healers but to superstars and specialists in exotic and glamorous complaints.

Hospitals compete for endowments and government grants by emphasizing high-prestige and low-utilization items at the expense of vital but less profitable and showy services like intermediate and follow-up care. Over eight hundred hospitals maintain open-heart surgery units, but in one-third of them a year often goes by without a single operation.

America's medical institutions reflect the priorities and values of society as a whole. Police often outnumber doctors in emergency rooms. During the 1964 ghetto rebellion in Harlem the police made their headquarters in Harlem Hospital, which could hardly have encouraged victims of police brutality to seek treatment.

The medical industry is not immune to the racism in America. Many southern hospitals are still effectively segregated, while nonwhite patients in the North face humiliation and shoddy treatment. Teaching hospitals are usually located in ghetto areas—few wealthy patients would put up with the invasion of privacy involved—and young doctors learn to consider treatment of their nonwhite patients as practice; all but the most dedicated will "graduate" to the rich white suburbs.

Until recently, sickle cell anemia, which attacks few whites but afflicts many Black Americans, was practically ignored. Drug addition, a product of the socially-engendered despair in the predominantly Black and Puerto Rican ghettos, is usually punished rather than treated.

A particularly shocking example of racism in medicine

is the U.S. Public Health study begun in 1932 in Tuskegee, Alabama, and discontinued only in 1972 after it was exposed by reporters and became a national scandal. Four hundred Black men with syphilis were left untreated in an experiment to determine the progress of the disease. At least twenty-eight died directly from syphilis and 154 more died of its side effects.[42] Although the victims of this barbarity and their doctors lived in the South, this was a federal project with records available to the federal government during the whole "experiment."

The effects of American racism show up in the national statistics. A Black person in America has a life expectancy 10 percent less than that of a white. Native Americans have a life expectancy of forty-six years, twenty-three years less than the national average. Blacks and whites have roughly the same physical susceptibility to tuberculosis, diabetes, and cancer of the cervix, but Blacks have 800 percent more tuberculosis and 300 percent more diabetes and cancer of the cervix.[43] This health gap has widened, as improved medical techniques have been provided to affluent whites but remain inaccessible to the oppressed nationalities. The infant mortality rate was 9 percent higher for nonwhites than for whites in 1935; by 1965 it was 60 percent higher.[44]

The sexism of American society is also mirrored in its health care. Doctors, like mechanics, have tended to assume that every woman is an easy mark for unnecessary repairs and inflated bills. Ralph Nader's Health Research Group recently documented what poor and Black women have long charged—that many doctors have "cavalierly" high-pressured women into sterilization without explaining its hazards or discussing alternate birth control methods. The study cited examples of women being given sterilization forms to sign while in labor, even though they had indicated when entering the hospital that they did not want sterilization.[45] Nearly every woman has personally ex-

perienced the sexism of American medical care, whether in a gynecologist's brusque refusal to explain a simple yeast infection, a psychiatrist's admonition to adjust to her "feminine role," or an all-male medical board's review of her right to have an abortion.

Health reforms

The shortcomings of American medical care have created a significant public demand for health reform. A number of programs are now before Congress, all having to do with some form of national health insurance.

Of the three major plans under consideration, the Catastrophic Health Insurance Plan (CHIP), sponsored by Senators Long and Ribicoff, is the most blatantly inadequate. CHIP would not begin paying a person's medical bills until after sixty days in the hospital or an expenditure of $2,000. Senator Long considers it a high recommendation for his bill that only 2 percent of the American population would receive benefits under it in any one year. Predictably, this is the bill backed by the American Medical Association.

The Nixon administration has proposed a national insurance program with broader coverage. But the Nixon plan's "deductible" system would require people to pay the first $150 of medical expenses in a year, and under the "co-insurance" provision, only 75 percent of costs between $150 and $1,500 would be covered. The plan would channel billions of dollars into the hands of private insurance companies. Employers will pay 75 percent and employees 25 percent of premium costs, which the administration estimates will be about $320 a year per employee in 1975. This estimate, however, is almost undoubtedly too low.

In some cases the government will pay part or all of the premium and deductible costs for low-income families. But, although no accurate estimates are presently available, it seems unlikely that Nixon's plan will provide any more coverage—if as much—than

the Medicare-Medicaid programs it is intended to replace.

Nixon's plan has been coupled with the recently passed Health Maintenance Organization Act of 1973, which authorizes a five-year expenditure of $375 million to set up and evaluate prepaid group health facilities called Health Maintenance Organizations, or HMOs. These have been ballyhooed as a major landmark in medical reform. HMOs keep costs down because they get the same amount of money no matter how many services are performed. But this is not necessarily an advantage to the consumer. It gives the HMOs a financial incentive to hire less personnel and perform fewer services. They are certainly not likely to solve the problems of medical care for private profit, since corporations like Westinghouse, Equitable, and Connecticut General are rushing to get in on the HMO business. Additionally, HMOs will probably revise the administration's current projections of premium costs. Right now the typical HMO expense for a family ranges from $45 to $70 a month.[46]

The most sweeping health insurance proposal is the Health Security Act introduced by Senator Kennedy and backed by the AFL-CIO. This bill would require no deductible or co-insurance payments. Each covered service would be fully paid for. There would be some limitations on skilled nursing-home care, psychiatric consultations and hospitalization, and out-of-hospital prescription drugs. Taking these into consideration, it is estimated that the plan would cover 70 percent of all medical services in the nation.

The Kennedy plan is the most generous of the proposals before Congress and would extend benefits to thousands who do not now receive them. But even if passed—which seems unlikely without major concessions to the insurance industry—the national health insurance plan avoids or actually reinforces the basic problems of American medicine.

Introducing the bill on January 31, 1973, Senator

Kennedy offered "a series of guarantees to protect the fundamental principles important to American physicians." They are worth quoting in some detail:

"The first guarantee is that the Federal Government in this Nation must not own the hospitals or employ the physicians. . . . I do not want socialized medicine in America.

"I believe in maintaining the free enterprise system in this country and in American medicine. . . .

"My second guarantee is that we must not remove the freedom of every physician to choose where and how he provides health care. . . . I do not want to 'hijack' medical students into particular specialities or locations. . . .

"My third guarantee is that the Federal Government must not make medical judgments or interfere in the clinical decisions between a doctor and his patient. What we must do is encourage physicians to take the actions necessary to assure Americans they are receiving the finest possible care that American medicine can offer.

"My fourth guarantee is that we must not create an overarching Federal agency in Washington, telling every area and community in this Nation exactly how they must offer health care. What we must do is set national guidelines and standards, within which local agencies can develop the best possible health care programs for the doctors and patients in their areas."[47]

These are guarantees that the control of medical goods and services will remain entirely in the hands of private profit interests. Fee-for-service will continue, with its incentive for unnecessary expense and its incompatibility with preventive medicine. Private drug companies and medical supply houses will keep on producing what is profitable, paying more attention to sales and promotion than to improving their products. There will be no national planning to meet medical needs and no direction of the geographic or professional allocation of resources. And there will be no consumer control whatsoever over the delivery of health services.

Furthermore, the extension of benefits under Kennedy's bill is highly likely to be temporary. Aside from the fact that tremendous inequities in the availability and quality of medical care will remain, the Kennedy reforms are impractical in the long run. Because the bill does so little to control prices and profit-making, the proposed financing will in all probability quickly become inadequate, and the benefits will then have to be trimmed, just as Medicaid and Medicare benefits were cut back in the face of soaring costs.

To get at the source of America's "health crisis" we must do more than tamper with the distribution of existing medical treatment. We must reorganize the production of health care to establish preventive medicine and improve the quality of care. We need to establish a national, democratically controlled health program that abolishes the fee-for-service method of payment and wholly ends the involvement of the private sector in medical care.

The United Nations' International Labor Organization in Geneva conducted a detailed study of the health care delivery systems in eight countries — Belgium, Canada, Ecuador, West Germany, India, Poland, Tunisia, and the United Kingdom. The report clearly reveals that national health care systems divorced from the private sector of the economy are the best means for providing quality care to an entire population. Despite an attempt to be evenhanded in evaluating its findings, the most the study could bring itself to say for the private fee-for-service system was that it "meets the psychological needs of patients" in free market economies, although the quality of care "is certainly questionable," and it "satisfies the competitive entrepreneurial interests of doctors."[48]

Nationalized health systems, on the other hand, meet the *medical* needs of patients. The best nationalized

health systems are found in the workers' states, even those most hampered by the political machinations of a bureaucratic caste. Central planning enables a society to achieve the necessary supply and distribution of medical personnel. This is most evident in the workers' states, where there are no financial barriers to medical education, and planning for health needs can be integrated into national calculations.

In Poland after World War II, for instance, there were only 7,000 doctors for 24 million people, one per 3,400 persons. Today there are 42,000 doctors for 33 million people, one doctor per 800.[49] Similarly, the USSR more than doubled its supply of physicians between 1950 and 1965, while the number of physicians in the U.S. and Great Britain increased by one-third in the same period. In 1965 the USSR had twenty-one doctors per 10,000 people, the U.S. had fifteen, and Britain had eleven.[50]

National health systems, moreover, achieve a more equitable distribution of medical personnel. Dr. John Fry, who compared health care in the USSR, Britain, and the U.S., points out that national planning has enabled the Soviet Union to make medical care not only free but also accessible to its entire population, even in remote rural areas.[51]

National health organizations are also better equipped to ensure consistent quality of medical care. All aspects of health services may be integrated and coordinated, from education and training, to emergency care and hospital construction. More supervision over medical personnel is possible. Thus, while a medical certificate constitutes a lifetime license in all but two states in America, the USSR requires periodic postgraduate training for all practicing physicians.

The superiority of nationalized health systems is demonstrated most clearly in the field of preventive medicine. In a nationalized health system the responsibility for prevention of disease does not rest primarily on the individual; it is inextricably connected with all societal

medical services. In Poland, for instance, no distinction is made between the personnel involved in preventive and day-to-day medical care. In the Soviet Union all physicians are required to participate in public health education, and it is estimated that over half the adult working population has been through special health education courses.[52]

Some highly industrialized countries like West Germany and Great Britain have established effective national health care systems. Among the developing nations, however, only the workers' states have been able to do so. In Asia and Latin America the medical progress of the noncapitalist countries has far outstripped that of the colonial nations or even many of the industrial powers. Shanghai has an infant mortality rate half that of New York nonwhites and one-third lower than that of whites. Between 1959 and 1968 Cuba built 92 new hospitals, 260 polyclinics, 56 rural dispensaries, 20 public health laboratories, 40 stomatological clinics, 8 dental surgeries, and 14 blood banks. In addition, medical facilities were distributed more evenly around the country, as in the rural northern part of Oriente province, where there were 50 hospital beds before the revolution and there are now 3,500. North Vietnam had forty-seven hospitals, and one doctor per 180,000 people under French colonial rule; by 1971 there was one doctor per 7,000 persons or, if auxiliary personnel are included, one for every 1,600. The annual maternal mortality rate was reduced in this period from twenty per thousand births to 0.8 per thousand.[53]

Nationalized health care can be won within the framework of capitalism. It would provide better medical services for more people and would therefore be an important gain. But the most effective mobilization of health care resources can take place only within a national system of planned production for social use, where the development of health policies and facilities can mesh with national practices of economic planning.

As long as a private sector remains in the economy,

the private and public sectors will coexist in a constant state of tension. There are recurring conflicts between the needs of public health and the interests of various private industries that are affected by medical care decisions, such as hospital construction and supply companies or financing agencies. Which construction firms will get the lucrative hospital contracts? Which banks will take in the interest on government-guaranteed loans to health organizations? The answers to these questions are quite important for the economic interests of the private sector. In 1969 one New York City hospital alone paid $1.25 million for mortgage and other interest, an amount which represented $3.00 a day of every patient's bill and provided the banks with a tidy profit.[54] Clearly, the banks have a powerful incentive to attempt to influence the decisions of hospital boards, as do other private concerns that can profit greatly from particular decisions about hospital financing and construction.

As long as a private sector exists, it is almost inevitable that hospital boards will include people who have interests other than public health. People with the time and means to serve and the prominence (or influence) to be appointed are normally those who own or administer other businesses. Their outside interests affect their medical decisions, sometimes subtly, sometimes not.

Washington Post reporter Arnold Kessler recently analyzed Washington Hospital Center, a nonprofit "charitable" institution in the District of Columbia. He found that ten of the thirty-eight hospital trustees had engaged in "conflict of interest transactions" with the hospital. The treasurer, for instance, placed $1 million of hospital funds in a non-interest-earning account in a bank of which he was vice-president and treasurer. When the assistant administrator decided to reorganize the files he formed a computer company whose first customer promptly deposited $50,000 against future bills. The customer? Washington Hospital Center. The head

administrator raised no objection: He received free stock in the company and became one of its directors.[55]

Conflict of interest problems recur constantly in a capitalist economy, even in areas supposedly divorced from the private sector, as in the field of government regulation. Thus the chairman of the Drug Efficacy Review Committee of the National Academy of Science, whose job is to advise the FDA about various drugs, has admitted that he is on the payrolls of three drug firms as a "consultant." And the Senate Select Committee on Small Business found that at least twenty-four top officials of the FDA had graduated to high-paying jobs in the pharmaceutical industry in 1966, 1967, and 1968.[56]

In addition to conflicts of interest, another problem facing a national health care system operating within a capitalist economy is how to define the limits of the health care system in relation to the private sector. Where does health care end and private property right begin?

In America today many blood banks are privately owned. They buy blood to resell at a profit, and they get a large number of donors who need a quick buck—addicts, alcoholics, that section of the population most likely to have blood diseases such as hepatitis. Only seven states license blood banks and only five inspect them. Consequently, one in every 150 patients receiving transfusions is inoculated with hepatitis. This is no minor inconvenience for the recipients. The Center for Disease Control in Atlanta estimates that serum hepatitis causes 3,500 deaths a year; other physicians claim that the real total is closer to 35,000![57] Richard M. Titmuss has recounted the defeat of an attempt to coordinate and control bloodbanks: The courts ruled that it would infringe upon the property rights of private blood banks.[58]

Certainly even the most moderate advocates of a national health system would agree that blood banks and ambulance services should be taken out of private

hands and integrated into the national medical structure. But what about the medical supply houses? There are 1,100 companies making over 12,000 different medical devices, yet no federal agency presently regulates the efficacy or the safety of their products.[59] Would such regulation violate their "private property rights"? Should the medical supply industry be left in private hands at all?

Probably the best example of the encroachment of the private sector into national health systems is provided by the drug industry. This has remained in private hands in all countries except the workers' states. Only in the workers' states have drug prices and production been effectively controlled. In the capitalist nations, even the well-organized national health systems of West Germany and Great Britain have faced the problems of false advertising and profit gouging by international pharmaceutical combines.

The United Kingdom Monopolies Commission recently objected to the fact that Hoffman-LaRoche sells the active ingredients of its two tranquilizers, Librium and Valium, at $925 and $2,305 per kilogram respectively in Britain, when the cost of manufacture is $22 and $50 per kilogram. In the U.S., without even the partial protection of national health, the company sells Valium at four times and Librium at two-and-a-half times the already inflated British prices.[60]

Health and society

Good health care cannot be fit into a neat compartment that can be cleanly sliced off the private enterprise system and nationalized. Health care involves every aspect of life—where people sleep, what they eat, the water they drink, the jobs they work.

Only a seventeenth-century metaphysician with a rigorous training in hair splitting could conceive of an effective health care system that ignored the working conditions of a population. In the United States, a national health organization without authority over

U.S. industry would find itself in the frustrating position of medicating symptoms instead of treating the root causes of many diseases and injuries.

The United States has one of the ten highest death rates for job-related accidents in the world. Every working day 6,000 people are injured on the job and 50 people die. Self-regulation by private enterprise has not been effective; indeed, conditions have deteriorated. According to the Bureau of Labor Statistics, the injury frequency rate for manufacturing rose 29 percent between 1961 and 1970, from 11.8 disabling injuries per million manhours to 15.2. And the bureau admits that this is a conservative estimate.[61]

Over 100,000 miners have been killed in industrial accidents in the U.S. since the beginning of the century, almost 20,000 of them in West Virginia alone. Not until 1969 was the Mine Health and Safety Law passed, and it still has not been enforced. In 1969 the director of the Bureau of Mines was John O'Leary, who was asked to resign after he prepared stringent regulations to enforce the bill. His position remained vacant for a year and was then filled by a political appointee with no mining experience—a former lobbyist for the Iowa Association of Coin Operated Laundries. Today the bureau's files show 91,000 unpaid fines, with nearly $20 million outstanding. Following the Buffalo Creek disaster of 1972, when a dam burst and killed 125 people, West Virginia's governor promised to drain all similar dams. ABC camera crews flew over the dams in 1973 and found them still full, threatening the lives of thousands of people.[62]

The National Institute for Occupational Health and Safety estimated in 1972 that there are 390,000 cases of job-related illnesses and 100,000 deaths per year from industrial diseases. Over 100,000 American miners have "black lung," a chronic and disabling chest disease caused by the accumulation of coal dust particles in the lungs. The disease kills 1,000 miners a year in Pennsylvania alone.

Similar diseases are asbestosis, silicosis, and byssinosis. More than 3 million people in America work in industries where they are exposed to disease-producing dusts, but industry has taken almost no safety measures—even though some would be childishly simple, like mixing asbestos cement in plastic bags rather than in the open. Employers have either ignored the problem or flatly denied it. An editorial in the July 10, 1969, *American Textile Reporter* termed byssinosis, a lung disease common among cotton workers, "a thing thought up by venal doctors who attended last year's ILO [International Labor Organization] meeting in Africa, where inferior races are bound to be affected by new diseases more superior people defeated years ago."[63]

Industrial workers are not the only ones facing such conditions. In twenty-eight states agricultural workers have no legal protection at all against work hazards. This yields a harvest of over 2,500 deaths and 210,000 disabling injuries a year, not counting the long-range toxic effects of constant exposure to pesticides.[64]

The existence of poverty and unemployment is also a serious health problem. According to a Senate study published on May 6, 1973, more than 12 million Americans are malnourished, and the recent inflation of food prices may greatly increase this number.[65] Undernourishment causes several different illnesses, lowers general resistance to disease, and stunts both mental and physical growth.

Poverty produces most of the mental retardation in the U. S. Seventy-two percent of mental retardation occurs in poverty-stricken families—and not for the reasons cited by social Darwinists. Numerous studies have established the link between retardation and the quality of food available to the mother during pregnancy. After birth, poverty continues to destroy children's brains. Five percent of the children in this country are born retarded, but by age thirteen, 9 percent have become retarded.[66] One cause of brain damage is lead poisoning, which occurs when young children chew on the paint that peels from deteriorating walls and

ceilings. A 1973 government testing program found 30,000 children under age six—more than one out of every ten tested—to have potentially dangerous levels of lead in their bloodstreams.[67]

A national health system could reach maximum effectiveness only in conjunction with a program to wipe out poverty—a goal toward which American capitalism has made no progress. Although government figures set the poverty level so low as to define many of the poor out of existence, the percentage of the population admitted by the government to be poor has not substantially changed—14 percent in 1967, 13 percent in 1968, 12 percent in 1969, and 13 percent in 1970, the last date for which statistics are available.[68]

Nationalized health care would come far closer than national health insurance to closing the gap between America's great medical technology and the poor quality of everyday health care for the population. It is a reform that should be actively sought now. But the dependence of truly effective health care on the total social framework indicates that the most important preventive medicine program we could institute in the long run would be to construct a society run for people and not for profits. In such a system there would be no profit incentives to circumvent health regulations and no private interest groups with the power and money to override majority will.

A democratic socialist society will face new tasks that have hardly been defined under the present system. Techniques will have to be developed for combining efficient health care delivery with maximum flexibility and responsiveness to individual needs. Hospital administrations will have to consider thorny problems involving the boundary between technical-medical judgments and the desires of patients. Nonetheless, a system that has eliminated private profit as its motor force can consider such questions on their merits instead of on their opportunities for personal or corporate gain. In the process a whole new definition of health may emerge, a definition based not merely on the

absence of disease but on the extent to which an individual is able to fully develop his or her physical, intellectual, and emotional potential.

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ACTIVITY FOUR:

The Marxist position expounded by Coontz reflects many of the assumptions common to the radical reformist positions discussed above. Many of these assumptions are made explicitly in the article, others are hidden beneath the rhetorical nature of the presentation which hopes to convince the reader of its correctness. In Section IV of this module we will consider one means for drawing out such assumptions and presenting them as logical and coherent bodies of thought. For the present, however, let us see what our first reading of the Coontz article tells us about the radical reformist view of the American health care delivery system crisis.

You will be organized into small groups for purposes of this activity. The group's task is to discuss the position taken by Coontz relating to the following questions:

(1) What is the nature of the health care delivery crisis in the U.S. today? More specifically, what demand and supply features produce the type of health care now available to Americans?
(2) Is the health care thus delivered that which ought to be delivered? In other words, what is the quality of the services provided and how do they measure up to expectations of the group?
(3) What measures does Coontz believe are needed to improve the delivery of health care in the U.S.?
(4) Select a spokesperson to present a summary of the group's findings to the entire class.

EXERCISE TWO:

Following the group discussion in Activity Four and after a careful rereading of the Coontz article, write a short essay which explains the personal tragedies of the Johnsons, Cottons, and Thomases from the radical reformist perspective. (Does the position explain these tragedies to your satisfaction? If yes, how? If not, why not?)

B. Market Reformers

"Market reformers," according to Alford, "would expand the diversity of facilities available, the number of physicians, the competition between health facilities, and the quantity and quality of private insurance." They assume that the efficiency, effectiveness, and responsiveness of health care delivery is optimally maximized for all concerned individuals under a system of competitive exchange among many physicians (sellers) and clients (buyers). The pluralism and fragmentation of the system, with its overlapping organizations, duplication of effort, and seeming wastefulness, are considered "endemic and even healthy, because they guarantee diversity by maintaining competition between alternative modes of providing health care." While not advocating a "laissez-faire" approach for government in this field, market reformists do emphasize the need for any public or private actions to be complementary with market forces of supply and demand. Bureaucratic "interference and cumbersomeness," whether governmental or private, is to be eliminated where possible while government remains involved in steps to "patch up" the system's weak spots and "trouble areas" through minimal subsidies and similar programs which depend on the dynamics of the private sector. These reformers propose policies ranging from the elimination of artificially imposed restrictions on market forces to the creation of public and private mechanisms which facilitate rather than replace the influence of supply and demand in the health care industry.

To understand the market reformer's position, one must understand their assumptions about the operation of an ideal market. The ideal market mechanism is an exchange economy functioning under near perfect conditions; and though market reformers recognize that such conditions are rarely, if ever, encountered, they believe that to the extent real world conditions approximate them certain advantageous results follow in the allocation of scarce resources. They use a model similar to that first described by Adam Smith and since applied by economists to various private and public sector decisions. This model assumes the presence of several ideal conditions. First, there are buyers and sellers who come to the marketplace with resources each wishes to exchange with the other. Buyers come to the market with resources they have earned through selling their labor, renting their property, and lending their capital to commodity producers. They arrive with these resources seeking to maximize the satisfaction they can obtain from exchanging those earned resources for the sellers' produce. The sellers, in turn, seek to maximize the surplus value (i.e., profits) they can obtain from market transactions. Both buyer and seller face the dilemma of achieving those objectives in a world of limited resources -- a world of scarcity where desires always exceed potential.

Second, actors involved in ideal market transactions are rational in regard to what they need, desire, and are willing to exchange to achieve their specific ends. They enter the market with "schedules" of exchange ratios (i.e., prices) they are willing to apply in given transactions. Buyers have "demand schedules" reflecting the amount and combinations of seller goods and services being offered; and sellers come to the market with "supply schedules" indicating their willingness to sell their produce for given quantities of buyer resources.

A third essential condition for an ideal market system is perfect competition; that is, no actor or group of actors can have sufficient control of either demand or supply factors to permit the arbitrary determination of prices. Related to this is a fourth

condition: all production and consumption must be characterized by increasing costs. Under this condition, any increase in production or consumption will necessarily entail increasing costs for the producer or consumer. Were this not the case, perfect competition would be impossible since it would be easier for a large producer or consumer to grow larger and more difficult for smaller competitors to enter the field or generate more business.

The fifth and sixth conditions for the efficient functioning of the market place revolve around the need for what economists term the "exclusion principle." Put briefly, in the ideal market all transactions are complete. When one party sells a good or service to another party, the seller is giving up all benefits and costs of that product to the buyer; similarly, what is being obtained by the purchaser are the complete costs and benefits associated with the good or service. In other words, all other parties are excluded from obtaining the benefits or paying the costs of the products being exchanged in a given transaction. In terms of the conditions necessary for an ideal market exchange, the fifth holds that no product is to have spillover effects which would allow or impose upon a third party the benefits or costs of a transaction. As an example of spillover, consider the purchase of an automobile. As currently marketed, the automobile boosts the economy and creates jobs in various sectors of the economy not directly associated with G.M., Ford, Chrysler, or American Motors. When such sales drop, the consequences are felt throughout America within a matter of weeks. On the cost side, the purchase price of a car made by the big four manufacturers does not include the cost of environmental damage and energy resource depletion which is associated with internal combustion engines as they are currently manufactured. Were those costs included, the spillover effects of the automobile would be reduced.

The sixth condition can be regarded as an extreme form of the fifth, for there are some products which are "pure spillovers." The most frequently used example of this is the lighthouse. Perhaps some shipowner suffers substantial financial losses due to his ships constantly running aground at a specific location along a rocky coast. He figures his costs and benefits carefully and concludes that a lighthouse at that location will be to his benefit. He constructs the unit and it begins to function. The service performed by the lighthouse saves him money, but not him alone. All his competitors are using the lighthouse beacon as well -- but at absolutely no cost! In other words, there is a complete spillover benefit for the competitors who pay nothing while obtaining all the value they can possibly desire from the beacon which keeps their ships away from the shore. This type of product is a "public" good, and in the ideal market situation public goods and services would be entirely absent.

The final two conditions for an ideal market are total knowledge and complete mobility of all resources. All those involved in the market should have information on all factors relevant to the exchange: costs of production; demand and supply schedules, etc. In addition, buyers and sellers should be capable of mobilizing their resources whenever changing market conditions make moves necessary.

Market reformers assume that, were these conditions present, the market would automatically produce and distribute the right goods and services both efficiently and equitably. Those in need of health care, for example, would get it in just the right amount and at a just price. However, it is obvious that these eight conditions are never present in the real world market place for any type of commodity. What is even more obvious is that the health care "market" does not fit this picture. Health care,

by its very nature, seems to violate all the conditions to some degree. Its unique characteristics produce a situation quite different from that predicted by the ideal market model. The special role of physicians as both consumer consultants and service suppliers places them in a unique and awkward position. Consumer ignorance is another inherent feature of the health care market which creates an imperfect exchange system, as do the numerous "spillover" benefits and costs which cannot be attributed to any consumer or producer through a normal price mechanism. For example, how does one exclude others from the failure of a physician to diagnose and cure a contagious disease. Or how does one distribute the costs of a vaccine which will reduce the probability that an epidemic will take place or benefit one portion of the population but not another. To a certain extent, health care is a public good just like the lighthouse. If nothing else, it violates the exclusion property to a great extent -- enough, at least, to render the market for health care services imperfect at best. In addition, the uncertainty of available cures (none has proven 100 percent effective -- even with great advances in technology) is matched only by the unpredictability of the illnesses which plague humankind. Add to this the great number of suppliers who supposedly function on a "not-for-profit" basis, and you have some idea of the many complexities of health care delivery in the U.S. which render the market for medical services imperfect.

Market reformists do not ignore such imperfections. Instead they seek to develop a health care system which will function as closely as possible to the market ideal given the fact that such imperfections exist and cause numerous problems. They realize that such characteristics lead to inefficiencies and often produce poor health care, but they also feel it is possible to correct or adjust the system to at least partly make amends for these distortions. Where these changes should occur in the system depends, of course, on its present state. In a system where the supply of medical services is consolidated and centralized, market reformers would suggest creating a pluralistic market which is highly decentralized. Where the demand for medical services is distorted through government or insurance carrier payment arrangements, the market reformist position would stress adjustments of those to better "fit" the open market ideal they so strongly believe in.

Given this view of the health care system, it is not surprising that market reformers in the U.S. concentrate on the demand side of the health care delivery problem. The U.S. health care market is highly fragmented and decentralized already -- a situation market reformers believe is very desirable. Consider, for example, the fact that there are 7,000 hospitals in the U.S., including private and public, voluntary and proprietary, specialized and general. There are over 325,000 active physicians, most of whom are working on a fee-for-service basis in solo practices. Add to this the fact that there are 20,000 nursing homes, 40,000 retail drugstore outlets, 100,000 dentists, and so on, and you have some picture of the dispersion of the current system. If the market reformer seeks fragmentation, it is something already present in the U.S. If there is a problem with health care delivery, it is on the demand side, not the supply.

It is that point of view which we find reflected in the following article by Mark V. Pauly in his analysis of the relationship between health insurance and hospital behavior. Notice, if you will, the almost exclusive concern for the financial problems of health care delivery, especially as these are manifest in current hospitalization insurance plans.

FIVE

HEALTH INSURANCE AND HOSPITAL BEHAVIOR

MARK V. PAULY
Professor of Economics, Northwestern University

INTRODUCTION

More than 90 percent of hospital costs are paid for by sources other than the person who receives the care—primarily by private insurance and two federal government programs, Medicare and Medicaid. The percentage is substantial (though not so high) for many other kinds of medical care. The growth of these "third-party payments" is shown in Table 1. This system of payment has had a profound and fundamental influence on how both consumers and providers (hospitals and physicians who treat patients in them) behave. This behavior has caused inflation in both prices and expenditures per capita far exceeding the general increases in the cost of living. A comparison between hospital prices and the consumer price index for the period 1945–1975 appears in Figure 1. Many other problems in the hospital and medical sectors are really only symptoms caused by the extent and form of insurance.

In order to change this undesirable behavior, one of two things must happen. Either the level of coverage will have to be changed, or the "third-party payers" will have to react in very

TABLE 1 Percentage Distribution of Hospital Care Expenditures by Source of Funds, Selected Fiscal Years 1950–74*

Total Public	Year	Direct Payment	Insurance Benefits	Other	Total Private
45.7	1950	34.2	16.5	3.6	54.3
45.9	1955	23.6	27.4	3.0	54.1
42.0	1960	18.6	36.8	2.6	58.0
37.5	1965	18.5	41.7	2.3	62.5
51.9	1970	12.3	35.5	1.4	49.2
52.9	1974	10.4	35.4	1.3	47.2

*Source: Nancy Worthington, "National Health Expenditures, 1929–74," *Social Security Bulletin*, vol. 38, no. 2 (February 1975):18.

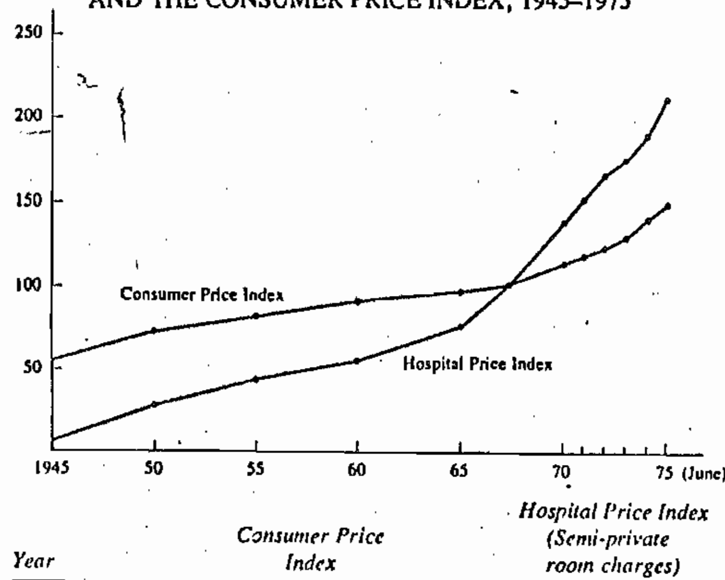
different ways than they do at present. Reducing coverage is not in prospect in most national health insurance schemes. Significant changes in third-party behavior will also be difficult to effect.

This chapter will attempt to distinguish fundamental from apparent causes of the problem and consider solutions which, though probably effective, are not likely to attract much support because of difficulties in their implementation. I shall also discuss other remedies which, though ineffective, will attract much support because they are easy to implement. I will concentrate on hospital care and hospital insurance, both because hospital insurance is the most widespread form of medical insurance and because hospital expenditures are the largest single component of medical spending.

WHO HAS INSURANCE COVERAGE, AND WHAT DOES IT PAY FOR?

When people come home from a hospital stay, a sheaf of bills usually follows. Some will be from the hospital as an institution, others from the physicians who performed treatment in the hospital. Most people do not have to pay all these bills themselves. Whether they are elderly or not, many have private health insurance; almost all over 65 have insurance provided free or at heavily subsidized rates under the Medicare program,

FIGURE 1
AN INDEXED COMPARISON OF HOSPITAL PRICES AND THE CONSUMER PRICE INDEX, 1945–1975



Year	Consumer Price Index	Hospital Price Index (Semi-private room charges)
1945	53.0	16.2
1950	72.1	28.9
1955	80.2	41.5
1960	88.7	56.3
1965	94.5	76.6
1967	100.0	100.0
1970	116.3	145.4
1971	121.3	163.1
1972	125.3	173.9
1973	133.1	182.1
1974	147.7	201.5
1975 (June)	160.0	232.8

while the Medicaid program provides coverage for persons in low-income families. Finally there are some—not yet very many—who receive all their care with only nominal out-of-pocket payments. They are enrolled in health maintenance organizations (HMOs). For other kinds of health care, insurance is not as extensive but is still widespread.

Let us concentrate first on persons under 65 who are not eligible for Medicare. About 80 percent of them have some private hospital insurance. Of the remaining 20 percent, many have what amounts to free insurance coverage under the Medicaid program (i.e., the program will pay their medical bills). How many is difficult to say, since not all eligible persons actually receive Medicaid payments of any sort in a given year, and even fewer receive payments for hospital care. But the number of non-aged, blind, or disabled persons actually receiving Medicaid in 1973 was equal to about 10 percent of the population. So, in total, about 90 percent of the under-65 population has some third-party coverage for bills incurred in nonfederal hospitals. Another 1 or 2 percent of the population may also be receiving government-provided medical care from the armed forces or from the Indian Health Service. Almost all persons over 65 have Medicare coverage.

Coverage for types of care other than as a hospital inpatient is less extensive. While about half of the under-65 population has coverage for physician services not received as hospital inpatients, much of this is major medical, involving deductibles before coverage begins and copayments once it does. Because major medical typically covers all kinds of care in hospital or home, once the deductible is exceeded, again about half of the population is covered for prescribed drugs, private-duty nursing, and visiting nurse service. But less than 10 percent have coverage for dental care, and about one-fifth for nursing-home care.[1]

The first questions one might want to ask is whether there is any rationale for this pattern. In part, the answer is yes. Those kinds of care tend to be covered which are likely to occur when expenses are large, as one might expect. It is, after all, the purpose of insurance to reduce risk by covering large but uncertain losses in exchange for a smaller but certain premium. Types of care which one might regard as more discretionary and less a matter of life-and-death, such as dental and nursing-home care, are generally not covered.

But there are some peculiarities. Coverage—especially for

hospital care—is often "upside down," in the sense that many people channel funds through the insurance plan for relatively small, predictable expenses while they leave themselves uncovered for large "catastrophic" expenses which could seriously injure their financial—in addition to their physical—health. This is a topic I shall discuss in more detail below.

The people who do not have third-party coverage are generally either those who are unwilling to buy insurance or those whom insurance companies are unwilling to accept. People in the first group do not buy insurance because the price is too high relative to the benefits they expect to get. For most of these people, the price is high because they have been unable or unwilling to take advantage of a device which substantially lowers the price for the bulk of the population. That device is group health insurance as a fringe benefit of employment.

The price of insurance to a person is the ratio of insurance premiums to expected or average dollar benefits he might receive. The difference between premiums and benefits represents the selling and administrative costs of the insurance firm. When insurance is provided to employees as a group, rather than to each one individually, there is a substantial saving on selling and administrative costs and consequently substantially lower premiums. The premium per insured for group insurance is generally 50 to 80 percent less than the premium for identical benefits if the insurance were purchased individually. The advantage of group purchasing also increases with firm or group size. While there are potentially some disadvantages to group insurance—the individual may not be able to get exactly the insurance he wants—it is clear that on balance the unavailability of group insurance is an important deterrent to purchase.

In addition to the group size effect, that part of the insurance premium which is paid by the employer is not taxed as income. Yet the person clearly gets the same insurance policy whether the employer buys it for him or whether the employer pays him the equivalent amount of cash and then the worker uses the cash to buy the policy. But if the employee receives the cash as wages, he is liable for income and payroll tax; whereas if the

employer pays, the cost of the policy is not counted as income and not taxed. Here again there is a substantial incentive for purchasing insurance. Indeed, the tax advantages are so great that, for all workers but those with incomes below $3,000, it is actually less costly on average to buy medical care via insurance than to purchase it outright.[2] Thus, the tax savings from having medical care paid for by an untaxed employer-paid insurance rather than paying for the care out of after-tax income *exceed* the costs of administering insurance and processing claims. While this saving is positive for almost all workers, it obviously is greater according to the relative tax on the worker's income and the increase in his medical expenses. Since both the tax rate and medical expenses increase with income, the incentive to buy insurance increases with income.

These influences have precisely the expected effect: people are more likely to have health insurance for themselves and their families the larger the group they belong to and the higher their income. Even at the low income level of $3–5,000 per year, nearly three-fourths of all workers are enrolled in a health insurance plan. In firms where labor force size is small, such as construction, or where income is low, such as agriculture, they are much less likely to have group insurance. The fraction of full-time workers with group health insurance is 43.5 percent in agriculture and mining, and 62.7 percent in construction, while in manufacturing and transportation, where incomes are high and firm size large, the percentages are 82.0 and 83.0 respectively.[3]

These are, of course, not the only influences. Part of insurance premiums are deductible on the federal income tax with tax-incentive effects similar to those already described. If a firm has a strong union, group health insurance is more likely to be provided. Why this happens is uncertain; it may be the result of dominance of the union by older members with larger families and higher incomes who have more to gain from health insurance.[4]

Insurance also performs a budgeting function; it permits people to save for medical expenses in a regular and often

tax-free way; the alternative of borrowing at reasonable interest to pay medical bills is usually not available.

Young workers are also less likely to be insured, and they are more likely to be employed part-time than older workers. The likelihood of hospitalization for a young person is less than that for a middle-aged person, and yet insurance premiums are almost always the same for both. For the young person, then, insurance is much less advantageous, so it's not surprising that relatively fewer of them are covered.

Finally, there are those persons whom insurance companies will not accept because their health is poor, the "bad risks." Some of these people have been picked up by the extension of Medicare to the disabled, and many family-member bad risks are covered under group plans, although there are often exclusions of preexisting conditions. But bad risks often cannot work and so are not eligible for group insurance, but cannot buy individual insurance at the same rates as others. It is, of course, not clear that these persons would be willing to buy insurance if it were offered at the very high premium that would cover their risk of expense. The absence of insurance for the chronically ill may reflect absence of demand at the price that would be charged. Pooling of good risks and bad risks would lower the rates to the latter, but would raise them for good risks; the bad risks would be more likely to buy insurance, and the good risks less. And it is possible to purchase policies with guaranteed renewal.

In summary, only a tiny fraction—less than 10 percent—of the population is at present without any insurance to cover hospital bills. Many of those persons who lack coverage have low incomes; they are the households just near the poverty line. Many of them would be eligible for Medicaid, especially if their incomes fall because of illness. For such persons health insurance may not be very worthwhile, given its relatively high premium cost and given the low tax subsidy they face. Many more have probably chosen not to seek coverage because the likelihood of hospitalization for them is so low relative to the premium cost of insurance. In addition, some of those who now

obtain insurance may have been induced to do so only because of the tax subsidy to purchasers.

Not all persons with insurance receive the same benefits. For persons with group hospitalization insurance (about 80 percent of all of those with private insurance), an average of 17 percent or $14 per capita had to be paid out-of-pocket for hospital care. For those with non-group insurance, the figures are 30 percent and $24. While some persons may have very shallow coverage, this is not common. Of all persons with total medical expenses over $1,500 with group insurance coverage, insurance paid 76 percent. It is true that there are some persons who are left with large bills. Of the persons with expenses over $3,000, one in eight had to pay more than half out-of-pocket and one in three more than one-quarter out-of-pocket. But expenses which are large and uncovered by insurance are extremely rare.

The relationship between low income and coverage may be influenced by the existence of the Medicaid plan. For even a presently employed person may become eligible for Medicaid assistance if he loses his job because of ill health or if his expenditures are sufficiently large. Thus for such persons health insurance may not be worthwhile, given its relatively high premium cost and low tax subsidy.

The following picture, then, emerges: insurance coverage is high for most persons and for most hospital bills. In general, people tend to have coverage for large, non-discretionary medical expenses. Those expenses which are not covered are usually small, and often highly discretionary. "Usually," of course, is not "always"; there are some, but not many, people who happen to fall in uncovered categories (such as prescription drugs) or whose expenses become so large that they exceed the limits on coverage. Some persons also fall completely between the cracks of this social structure and have little or no coverage. Most such persons are in low or lower-middle income classes. Often this voluntary insurance is just not worth the cost. While these individual situations may be serious, they are rare; among upper and middle income Americans, there really is no lack of insurance coverage for medium-sized expenses. Even at this point, and even granting that health insurance is a good thing,

there is a question of the extent to which the social fabric should be stretched to cover these exceptional cases. The harm done to the great bulk of the population may more than offset the benefit to a few atypical individuals.

A question that has been touched upon at several points now needs to be treated explicitly. In reviewing the pattern of coverage, we noted that usually it tends to be reasonable; there are reasons why a person typically will want the insurance plan to pay for his gallbladder operation and hospital stay but not for his child's camp physical. But why, especially for hospital expenses, is coverage sometimes "upside down"? Why do people often have first-dollar coverage for short hospital stays, but not for very large catastrophic expenses? No one knows for sure, but there are some reasonable explanations.

First, almost everyone already has some kind of catastrophic coverage provided by government at some level. Because medical expenses are deductible in the federal (and some state) income taxes beyond some limit, there is a "tax subsidy" to very large expenses. For people further down in the income distribution, catastrophic expense can usually be counted on to generate eligibility for public or private charity, while private insurance benefits, if available, must be used first. This is not a very pleasant kind of deductible, to be sure. Second, on the supply side, hospitalization insurance via the Blue Cross approach was originally created by hospitals to help the hospitals collect their bills during the depression. Many more of a hospital's bills involve first-dollar than catastrophic coverage. So Blue Cross has not pushed major medical type insurance.

Except possibly for the absence of catastrophic coverage, consumers do appear to be rational in choosing their insurance coverage, comparing the advantages and disadvantages. That high-risk persons generally do not buy coverage is because of the high premium that they would have to pay; if people (or groups) wish to do so, it is possible to obtain (for a price) a "guaranteed renewability." Persons who are not eligible for group insurance are less likely to buy coverage because of the high premiums they would have to pay for individual coverage. It is a bit more conjectural, but there is reason to suspect that

coverage of ambulatory care and lower-cost substitutes for hospitilization would not reduce total costs; it might not even reduce hospital cost. Consequently, the total premium for a comprehensive package might be too high for most persons. There is some evidence for this, in the sense that comprehensive coverage is now available from ordinary insurance plans, and it has not so far swept the market.

To argue that individuals make what are, by and large, rational choices is not, of course, to say that the result is *socially* rational. Probably the most important source of inefficiency is the tax subsidy to health insurance, which may cause most people to take *too much* health insurance. In most cases, the subsidy is so large as to cause people to ignore the substantial administrative costs of running their medical bills through an insurance plan, and possibly to ignore some of the excess and inefficient usage that insurance causes.

Whether or not the lack of coverage for the very small fraction of the population who are bad risks is socially inefficient is not known, since we do not know whether such people would in fact take insurance if they had to pay a premium that covered their expected benefits and administrative costs. If there is inefficiency, it is small. Similarly, it is not clear whether the comparative absence of insurance for people who are not in large groups is inefficient or not. Obviously, it is not efficient for all firms to be large, so not all groups can easily be made large. It might be possible to combine individuals into groups larger than the firm for insurance purposes, but then the individual has much less control over the kind or amount of insurance he gets. It may also be that an open enrollment group would attract bad risks. Most workers have the option of taking a job in a firm that does offer insurance, though there may be a cost in lower money wages or a less desirable job. So it is likely that people have in general sorted themselves out; those who work for firms without insurance or with less insurance, or those who, insofar as insurance matters at all, would prefer the fringe benefit package they receive. Of course, matching of preferences is not perfect, and persons may choose a given firm for reasons other than health insurance. But if a worker placed a high value on medical insur-

ance, he could in general find a job in a firm that offers it. If he does not select such a job, perhaps health insurance is not something that, comparing benefits and costs, he would rationally choose.

In summary, if the present pattern of coverage is socially irrational, that irrationality generally takes the form of too much insurance coverage. There is a small number, surely less than 1 percent of the population, who may be bad risks and who *may* not be getting coverage they should have. There is possibly a similarly small number who are involuntarily denied the advantages of group purchasing. For these and other reasons, we may want to broaden the scope of Medicaid, or of insurance coverage for the poor. But for the bulk of the population, hospitalization insurance is not inadequate; it is too expensive.

THE EFFECT OF NATIONAL HEALTH INSURANCE ON THE HOSPITAL SECTOR

As noted above, most bills for hospital care and in-hospital physicians' services are already covered by third-party payments. So one intuitively would expect that the small increase involved in moving to full coverage under national health insurance would have a modest effect. Precisely this point has been made by Newhouse et al., who predicted only a 15 percent rise in inpatient expenses compared to a much larger increase for ambulatory services.[5]

Unfortunately, this prediction may be wrong. The predictions are based on estimates of how much an individual increases his demand when his coverage is increased. But the crucial question is *whether the response of the system as a whole will equal some composite of these individual responses.* The crucial fact is that at present uninsured persons, even though few in number, may be the only constraint on what costly procedures are done in hospitals. Remove this constraint and costs may float ever upward, and at an increasing rate. Remove the basis of comparison and no cost may seem unreasonable.

The insurance coverage described above seriously influences

the way patients (and doctors) use hospitals. For the patient or the physician acting in his behalf, there are two relevant aspects of insurance. First, the insurance only pays if he uses the hospital; and the higher the hospital bill, the more it pays. Thus the patient has an incentive (or at least less disincentive) to use the hospital than if he had no insurance. He is more likely to use the hospital than potentially cheaper home or ambulatory care, and he may agree to procedures he would have declined if he had to pay the full cost. This same incentive is probably even greater for physicians' services; insurance helps the patient pay the doctor's bill to a much greater extent if the procedure is done in hospital. Not only is the doctor understandably interested in collecting his bill, but he generally can charge a larger fee for procedures done in hospital. So both the patient and his doctor have incentives to "overuse" hospitals.

Second, insurance coverage makes the patient less resistant to and responsive to differences in cost. If one hospital has a $50-per-day room rate and another a $100 rate, but the patient has insurance which pays 90 percent of the cost, he pays only $5 less if he chooses the cheaper hospital. So even a slight preference for the more expensive hospital will lead him to choose it. From the physician's viewpoint, even if the extra cost means only a slight improvement in the quality of care, he would not be acting in his patients' own best interests if he were not to suggest the higher cost and quality hospital.

The response of the hospital as an institution is more difficult to judge. Most hospitals are not profit-seeking firms, but are either not-for-profit or (especially in the rural south and west) operated by local governments. Although nominal hospital control may be in the hands of a board of trustees (usually major donors or other civic bigwigs) or elected or appointed bureaucrats, there is little evidence that these groups control either substantive policy decisions or important aspects of day-do-day operations.

In large part it is the physicians on the hospital's medical staff who make the important decisions. They decide which patients

to admit and when to discharge, what types of medicine and diet to order, and how intensively nurses ought to care for the patient. While physicians do not directly control the decision to hire more nurses or buy more equipment, they can have a strong influence by overworking an existing staff of nurses, by threatening to take their patients elsewhere, and by intimidating administration and trustees with reliance on their aura of expertise on medicine and quality of care.

The hospital's lay administrators, while in a somewhat less powerful position, still have some power. They can control the "hotel" aspects of hospital operations, and they may be able to play off different factions in the medical staff against each other. If there is a shortage of hospital appointments for doctors in the area or if the hospital is especially desirable, the administrators may be able to give less credence to threats to resign from the medical staff. The balance of power between staff and administration is likely to vary across hospitals; so the response of the hospital as an institution will likely combine the goals of both groups.

What do physicians want "their" hospital to do for them? There are a number of possible goals. It should permit them to earn the high incomes they expect, possibly with sufficient annual increases to keep discreetly ahead of inflation. It should allow them sufficient uninterrupted leisure time, both in the weeks they work intensively and during the possibly extensive vacations they take to enjoy their high incomes. It should give them the satisfaction of providing "high quality care" to patients, where quality is usually defined by the latest and most sophisticated equipment and by interest of colleagues. It should give them facilities to do all the procedures they wish, including the newest that their colleagues in other hospitals can do. This is a caricature, of course; there must be tradeoffs between income, leisure, and technical quality, and not all hospitals, particularly those in rural areas, reach the forefront of technology.

Hospital administrators are presumably concerned about their own incomes, which appear to depend primarily on the

size and complexity of the physical plant they manage—not on how efficient or frugal they are, as long as they can keep the hospital from incurring losses in excess of those contributors are willing to make up. So administrators want growth and technical sophistication both to increase their money incomes and probably for nonmonetary prestige as well. Finally, they do want to avoid excessively large deficits. Technical sophistication usually pleases the medical staff, but growth may or may not be desirable, depending on the form it takes. More beds may be fine, but more ambulatory care facilities or mergers with other hospitals (and their medical staffs) may not be so agreeable. The administrator is likely to be more concerned with a deficit in the only hospital which employs him than are physicians who can shift their patients to other hospitals if this one is forced to curtail operations.

What kinds of incentives govern this uneasy bipartite arrangement? For the most part, hospital insurance is intended to pay hospital bills, not control hospital costs. Some insurances pay charges and others pay costs, but there is usually little inquiry into the reasonableness or rationale for costs or charges. What arguing does occur usually concerns the distribution of costs among multiple insurers, not arguments about the total. Since Blue Cross plans were begun by hospitals and are still largely controlled by them, it is not surprising that except when prodded by government officials or consumer advocates, or when the financial wolf is at the door, they have not been aggressively concerned about costs. But commercial insurers have not been much more intensively concerned. After all, they profit from selling more insurance at higher premiums (as long as the premiums keep enough ahead of benefits), not from reductions in premium volume. And the efforts of any single insurer to control member costs will likely benefit all insurers, regardless of the carrier. It is not surprising, therefore, that no single insurer will embark on a crusade, nor is it in insurers' group interests to do so.

For all practical purposes, then, hospitalization insurance pays hospital costs plus possibly a little profit for expansion.

whatever those costs are. As a broad generalization, this means that it is only the 10 percent uninsured "tail" that keeps the 90 percent third-party "tiger" from getting away altogether. As it is, high and rising hospital costs result from the fact that the bulk of hospital care is paid for on a "cost-plus" basis: if the firm bears only a small fraction of increased costs, Memorial Hospital is just as likely to have a cost overrun as Lockheed Aircraft. And though the size of any single firm is small, the total inflation in health may be comparable to that in defense.

To be sure, these additional costs represent payments for something—people, machines, supplies. These inputs do not, by and large, sit around idle. At the same time, although the specifications for a C-5A aircraft are usually precise and detailed so that one can tell when higher costs do not mean more output, the situation is not so fortunate in health. The hospital or physician in the health field can always assert that in return for higher costs the consumer is getting higher "quality." Analysis thus becomes difficult, because it is usually the hospital or physician who defines what higher quality is. Some improvements in quality may not improve patient health, peace of mind, comfort, or knowledge at all. Others may produce improvements which are so slight as not to be worth the extra costs. "Objective" indexes such as mortality rates are not strongly related to anything that goes on in hospitals, so they are not much help.

The most important point, however, and about all we have to go on, is the theoretical presumption that these quality improvements are worth *less* to consumers than the extra costs they bear, primarily in insurance premiums. The reason for this presumption was suggested above: because consumers pay only a tiny fraction of the total cost of each increase in quality at the point of purchase, they will demand (or be willing to accept) improvements in quality which they would reject if they had to pay their full cost. So the opportunity clearly exists for hospitals and doctors to push quality increases.

As also suggested above, both administration and medical staff are likely to take advantage of this opportunity. For the

administrator, both his salary and his prestige can depend on the complexity and the sophistication of his hospital. For the physician staff, in addition to the prestige factor, fancier equipment and more skilled personnel are apt to mean that physicians can perform new and more profitable procedures and, because of their association with a high-quality hospital, charge more for those they usually perform. The availability of more highly trained personnel—physician residents and trained nurses—means they can delegate more tasks and spend less time at the hospital (without necessarily reducing their fees)—which will get them more leisure. Attracting more physicians to the hospital may also be a source of referrals and of coverage during nonworking hours. Finally, there is the fascination of new technology itself; a new machine in the hospital may be more exciting than a new machine on the highway, and planned obsolescence may be more important for the former than for the latter. The critical point to note, however, is that higher quality and new technology are not the *causes* of inflation—for in almost any industry there is always some new and fancier machine on the drawing boards and there are many cases of innovations that are unsuccessful because they are ahead of their time. In the medical industry the form of insurance coverage encourages this indulgence. Indeed, in the limit, the only constraint on hospital costs would be the rate at which biomedical engineers could turn out new devices which are marginally better or more attractive than existing ones.

If additional use pushes up insurance premiums, why don't people stop using care that is worth less to them than its cost? Don't they recognize that their behavior pushes up the premiums they have to pay? By its nature, insurance pools the expenses or losses of many persons. The consequences of a given individual's "overuse" are spread over all insureds, but he alone gets the benefit from the medical care he receives. For all practical purposes, then, any single individual is likely to ignore the consequences of his own actions on premiums, because their effect on his premium is miniscule.[6]

There is some evidence that the self-pay constraint, even though mightily eroded by the spread of third-party payments, is still operative. First, we note that the level of coverage is an important influence on demand. It is fortunate for society if not for the individuals concerned that some persons do not have complete third-party coverage. But as Martin Feldstein has noted, there is a vicious circle which tends to reduce the number of such persons. Higher medical care prices induce people to buy more insurance coverage, but the additional coverage pushes prices still higher.[7]

Second, the antipathy of many not-for-profit hospitals toward profit-seeking or proprietary ones can only be explained if there is still a role for price. For if all hospital care were paid for at cost, a for-profit firm would probably behave rather the same as a not-for-profit one. It might try to hide profits, labeling them as costs; and it might strive more vigorously for the plus. But in general it would behave in the same way any industry whose price or rate of return is regulated behaves—and that is not very different from our stylized description of the not-for-profit firm.

But—at least the not-for-profit hospitals argue—proprietary hospitals are different. The difference is not based, ostensibly at least, on the presumption from economic theory that profit-seeking firms should be efficient. After all, there is no received theory that tells us that not-for-profit firms should not—faced with the same environment—be as efficient in the short run as for-profit firms. When much of output is sold on a cost-plus basis, this level of efficiency may of course not be very high for either kind of firm. For-profit firms may push up costs to some extent to maximize the size of the "plus," or may engage in too much capital investment. Not-for-profit firms, in turn, may take their "profits" not as entries in the net income column for the institution, but rather as higher real incomes for the dominant group or groups—in the case of hospitals, physicians and administrators. Indeed what empirical evidence we have suggests that, adjusted for size, one cannot say that proprietaries have lower costs, even considering tax advantages.

But the charge is not that proprietaries are more efficient in general, but rather that they engage in attracting certain profitable kinds of cases, leaving a large burden of unprofitable activities to the voluntaries. Clearly, if all activities were reimbursed at cost, plus some fixed percentage, no one activity could be more profitable than any other and this so-called "cream-skimming" would not be feasible. It must be, then, that for some activities prices *are* important.

There is very little hard evidence on this problem, and so we will be forced to look at it theoretically. First, it is hard to believe that only proprietaries engage in cream-skimming. Not all voluntary hospitals provide a full range of services we know, and not all voluntaries treat the same kinds of cases. While cream-skimming may be more likely, other things equal, from a proprietary hospital, we should not suppose that it is wholly determined by the type of hospital control.

Given that cream-skimming does occur, and given that it makes things more difficult for not-for-profit hospitals, this does not mean that it is necessarily bad for the community as a whole. If there is a cross-subsidization within the hospital's price structure, and this cross-subsidization is hindered by the presence of proprietaries, we need to ask whether this cross-subsidization is justifiable. Even without looking at what kinds of care are "taxed," there is a presumption that it is not. Some gain and some lose, and even if we prefer the gainers, they would be better off with the cash. One may argue that the community may be interested in fostering some kinds of care as opposed to others. Perhaps; but the private not-for-profit hospital would not appear to be the most legitimate vehicle for these expressions of community concern, if they do exist.

Which kinds of care are subsidized? Generally, emergency rooms and out-patient departments, obstetrical departments, and, to a lesser extent, kinds of cases which make more intensive use of hospital facilities. It is of interest to note that insurance coverage is typically less extensive for the first two kinds of care. If insurance makes demand less responsive to price, the

criminating monopolist. But the erosion of monopoly power is not usually something the community as a whole would be interested in avoiding.

To be concrete, outpatients and emergency departments tend to be priced below cost because they compete with physicians' offices for ambulatory care. To the extent that they serve as a safety valve for demand when the private physician is not available, there may be some scope for a payment for standby capacity. Obstetrical departments handle a kind of care for which there is typically a nine-month advance notice, and which is not wholly a random event. Here again competition is likely to be sharper.

If in fact not-for-profit hospitals are run for their physicians and administrators, there is little reason to be concerned about cream-skimming. Indeed, there is little reason to give tax advantages to the voluntaries. Proprietaries can operate successfully only because of gaps in insurance coverage. That they exist and flourish is an indication that even though we are close to full coverage, the uninsured minimum still can play a vital role in allocating cases and keeping not-for-profit costs and prices down.

In summary, extensive third-party coverages had an important role in pushing up hospital costs. Only a small part of total hospital expenses, and only a small part of the population are presently not covered by such financing. While this may imply that the complete coverage contained in most NHI schemes would add little more damage to that already done, there are reasons to be concerned that even this prediction may be too optimistic.

HOW CAN WE CONTROL HOSPITAL EXPENSES?

During the past ten years, expenditures per capita for hospital care can have grown twice as rapidly as service expenditures per capita, and three or four times more rapidly than general input prices. A third or less of this increase was due to an increase in

the acceleration in the rate of increase in this decade as compared to the previous one, has come from increasing expenses per day of stay or per admission. As it turns out, it is easier to think of ways of reducing admissions per capita or length of stay than it is to think of ways to push down unit costs, or stop them from rising.

It is impossible to continue to provide the same kind of insurance benefits for hospital and in-hospital physician services and at the same time reinstate incentives for consumers and providers. For consumers the only way to give an incentive to seek out lower-cost sources is to put the consumer at risk of a larger out-of-pocket outlay. Indemnity insurance, for instance, which would pay a fixed dollar amount per illness or per unit of care would provide incentives, but would also penalize the consumer who ends up with a high-cost source of care. If we want to have lower hospital costs through better incentives for consumers, we must be prepared to give up some security, not add more.

For providers it would appear to be easier to combine full coverage and incentives. For it would seem that one could retain full coverage for consumers but change the incentives facing providers. And since the doctor ostensibly makes the decision, while the consumer is usually thought of as passive, it might seem better to concentrate incentives on the relevant decision-maker.

There are in fact many discussions of incentive reimbursement schemes for hospitals. Almost all of them rely on putting the hospital at risk for some costs, for those costs which cannot be related to a set of legitimate causes or influences. The presumption is that this will cause the hospital to behave efficiently.

But will it? Or will it just select those kinds of cases which make it appear to be efficient, and if costs are denied, might it not just bill patients for the excess?

The difficulty here is that although we think we know of some devices to get physicians to reduce use or costs, there is no sure way of telling whether the reductions that will actually occur will be the ones which provide benefits to consumers (in the form of lower expenditures) which exceed the costs (in the form

of *de facto* reduction in the quantity and quality of care people get). Because there is a presumption under orthodox insurance that people use care which is worth less to them than it costs, there is a *presumption* that, on balance, reductions in use will mean positive net benefits. But what is missing is a link between what providers (physicians and hospitals) decide not to provide and the value that consumers would place on the services they no longer receive. When we change only the incentives to providers, we cannot be sure that physicians will cut out those things which consumers value least. The strongest evidence that admission rates could be reduced comes from the prepaid group practice plans. The hospital admission rate for subscribers of prepaid group practices is generally only a half to three-fourths of that of otherwise ostensibly similar people with traditional insurance coverage. While there are some studies that do not show this, and while there may be some out-of-plan use by members, the preponderance of evidence is that there is an effect.

This difference is generally attributed to the incentive structure. The plan as a whole makes a larger profit if it can keep use down. But more important, the salaried individual physician gains no extra income from hospitalizing a patient, whereas under fee-for-service he generally does. Length of stay and expense per stay are generally the same as in fee-for-service practice, which suggests it is the incentive to the physician, rather than to the plan as a whole, that is most important. For fee-for-service physicians also do not generally gain much *directly* from longer patient stays or higher hospital costs, though there may be substantial indirect gains. The unanswered question is whether the money saved is worth the reduction in use.

The most obvious observation is that the physician in the prepaid group is not in an especially good position to determine what care would have been worth to his patient; for the same reasons as given above, he has little incentive to obtain this information or to act on it. A less obvious implication is that some physicians are not acting in the best interest of their own

patients. Either fee-for-service physicians are overrepresenting the benefits of hospitalization, or the group-practice physician is not acting in the best interest of his patient by underrepresenting the benefits. The latter may feel that he is acting in the best interest of all subscribers to the plan, but how can he determine those relative benefits and how can he weight them?

If people are free to accept or reject the group plan, then the presumption is that for those who choose the group plan, the change in expected hospital care is offset by lower costs or some other benefits. But where such plans are available, they have not been overwhelmingly popular. This would suggest that for the bulk of the population the reductions in use are not "worth it."

Whether the differences in results are really due to differences in incentives is under substantial question. Even among fee-for-service physicians, propensity to hospitalize varies markedly. The sensible manager of a prepaid practice will naturally hire those physicians with lower propensities. But it does not follow that those who remain in fee-for-service practice would alter their behavior much if the incentives confronting them were changed.

The biggest dollar gains might be made in the area of costs per admission; here at least is where the biggest cost increases have occurred. Here again we have the problem of relating what producers do to what consumers value. Even putting this aside, however, little is known about the consequences of incentives. Yet Victor Fuchs has noted:

> The person who is in the best position to exert intelligent restraints on hospital costs is the physician. He knows better than anyone which patients need to be admitted, which one could go home a day early, which tests are really superfluous. The physician is also best situated to appraise the excess capacity now appearing in many hospital care markets.[8]

But if the physician is the culprit, why make the hospital administrator worry about deficits? The administrator may, as Fuchs goes on to argue, be able to get physicians to do what they alone can do best by pleading poverty. The existence of finan-

cial disaster may give him more bargaining power. But it may also only mean a shift of even a larger share of the hospital's now more-limited resources to things physicians want. If the medical staff wants a new piece of equipment, the administrator may be compelled to scrap his community outreach program in order to get the funds to pay for it. At some point, of course, there will be nothing else left to cut, but a lot can happen before then.

It would seem far better to put the medical staff at risk for the cost of the care it orders. HMOs do this, of course, but there must be a way to provide this incentive without going all the way to prepayment.

For initial consideration, one may think of a scheme in which the individual physician or the hospital's physician staff as a group bear part of the risk of higher hospital costs. That is, costs in excess of some target amount would, fully or in part, be charged to the physician or physicians. The target could be fixed by statistical determination of appropriate or average charges for the unit of output, or the indemnity character of this arrangement could be made explicit, and consumers could be permitted to choose their preferred level of indemnity. After the excess charges or costs are billed to the physician, he may in turn wish to bill the patients for them. This will surely make the patients more cost-conscious and more concerned about the usefulness of the care provided. The critical point is that the physician not be permitted to claim insurance reimbursement in *his* charge for these costs.

There are two other strategies for controlling hospital use. One relies on the obvious fact that inputs are needed to produce outputs. By restricting the amount of inputs, one may restrict output and thereby control use. Do hospitals produce too many bed days of care? Then reduce the number of beds, or at least do not add to it. Do surgeons do too much surgery? Then reduce the number of surgeons being trained, and prohibit some of those who are already physicians from performing surgery.

The reduced amount of care will have to be rationed among eager demanders in some way, and this is a topic of a later

chapter. For the moment we should note that, theoretically at least *compared to the present system of excess open-ended insurance*, collective decisions on resources may result in a level of use which is at least partly rational and is preferable to the current situation. Rather than satisfy demand at insurance-subsidized prices, it may be better to control it via collective control on resources. This is not to say that this is the best strategy, or even that there are not many better ones.

There are reasons to worry, however, that such restrictions on supply as are feasible may be largely unproductive anyway. The excess capacity in beds was doubtless fostered by the federal government's Hill-Burton program to subsidize construction in rural areas, but again insurance would appear to be the main culprit. For as long as insurance pays the cost, why should administrator or physician not favor a new building or at least a nice new wing for "their" hospital. It is probably also true that since hospitals overreacted to the surge in demand that accompanied Medicare in 1966, they were unprepared for the demand decline that has come with rising hospital prices, *de facto* increases in Medicare out-of-pocket charges, reductions in population growth, and economic downturn. The evidence of excess capacity is in the AHA statistics; many hospitals operate at less than 70 percent occupancy rates.

What is less clear is what this evidence means. One might suppose that, at a minimum, excess capacity should mean no new beds and an attempt to get rid of those expensive and unused old ones. Indeed, the American Hospital Association has been successful in getting many states to pass certificate-of-need laws which regulate hospital investment, and even incentives to hospitals to close down empty beds, merge, or shut down entirely are now being voiced.

There are reasons to be skeptical of both of these "obvious" solutions. A study by David Salkever of Johns Hopkins University suggests that certificate-of-need laws have had little effect on investment rates; they have only influenced the composition of investment.[9] And there is a question as to how much could be saved by closing down beds that are not expected to be used anyway. Merger, especially of small hospitals, might make

more sense, though even here economies of scale are often more a matter of faith than fact. An increase in hospital size is usually accompanied by an increase in services. While a large hospital can often produce that batch of services more cheaply than a small one, the unanswered question is whether the extra services are worth the cost. Rather than try to control a hospital's response to warped incentives, it may be better to change the incentives.

For the surplus of surgeons, again there is some statistical evidence: a typical community practice was found to have average surgical workloads of three to four operations per week of the complexity of a hernia repair. Average work weeks are less than forty hours.[10] Here again there is an obvious solution: If there are too many surgeons, do not train additional ones and perhaps try to convert some of those existing into primary care physicians. But again the direct approach fails to deal with the cause of the problem. A surgeon can make a very good income even doing a small number of surgical procedures because he receives a good price for each service. How can prices be high in the midst of excess capacity? Why don't surgeons bid down the price of surgical services, just as oil refiners cut gasoline prices when there is an excess of gasoline? Surgery is one of the most heavily insured physician specialities. If a surgeon lowered his going rate for a hernia from $300 to $200 it would make little difference to most of his patients; for them, insurance pays the bill no matter what it is. Even for those who have, say, 20 percent coinsurance, the price change is only $20—a small fraction of the total cost of a surgical procedure, and we must often buy the surgeon to buy this hospital. As long as the financial incentive exists to perform surgery, either there will be surplus surgeons or some surgeons will have to have their monopoly strengthened.

CONCLUSION

As far as hospital care is concerned, the general problem is not too little insurance coverage; it is that there is too much insurance of the wrong kind. Most NHI plans will just add the last

increments of the same kind of coverage. While this step may only make things slightly worse, it may have an even more severe effect by removing the last effective constraint on hospital costs. Substituting government restrictions on supply or controls via planning would obviously be necessary once market forces are eliminated. But this is not the only possible scenario and it is not even likely to be the best alternative.

While full third-party coverage necessarily requires government control and regulation of supply, the regulations and controls which are desirable do not require full third-party coverage. It is possible to have a judicious mixture of copayments, indemnities, catastrophic coverage, and controls on the worst abuses. While there have been some discussions in the NHI debate of insurance with large deductibles and copayments, the outline of a package of compatible user charges, indemnities, consumer information, low interest-rate financing, and controls on excess supply has never been provided. Of course, design of such a package is not easy as the primary support for NHI has not come from groups interested in such an approach.

Rather than attempting to check by bureaucratic decree the inappropriate consumer and producer incentives that arise from the way care is paid for, it may be better to attempt to provide financial incentives to reinforce the regulatory intent. Then even if the regulation is like most other government regulations (that is, largely ineffective), at least there will still be some control. For regulation to function at all, it will be necessary to identify appropriate use of hospitals, or appropriate lengths of stay, or appropriate levels of hospital costs. Rather than simply mandate a solution, a system of indemnity-like insurances should be established to provide the largest payments for precisely those "appropriate" levels of service. Such a system would be both feasible and desirable. And although it may expose consumers, producers, and most especially physicians to some financial risk, that risk need not be too large to provide a necessary accompaniment to incentive.

One final point: most NHI schemes have as ostensible goals both removing barriers to needed care and controlling costs.

Most plans are likely to be more effective in removing barriers to care of all types, whether needed or not, than in controlling costs. I have argued that there is no reason to increase coverage for hospital care for the great bulk of the population. Moreover, effective control of costs may require an *increase* to the height of those financial barriers. This is not to say there are not some poor and near-poor persons who do in some sense need greater access. But this may be accomplished much more effectively by keeping general prices and expenditures down than by packaging coverage for the few who need it with coverage for everyone else. Society's willingness to pay for care for the poor and near-poor likely depends upon the price it has to pay. Providing more coverage where it is not necessary, and continuing to subsidize via the tax system such excess coverage, may only result in higher prices—which would discourage society from buying care for those who truly need it.

Mark V. Pauly: "Health Insurance and Hospital Behavior"

[1]See Marjorie S. Mueller, "Private Health Insurance in 1970: Population Coverage, Enrollment, and Financial Experience," *Social Security Bulletin*, vol. 35 (February 1972):5.

[2]Bridger Mitchell and Charles Phelps, "Employer-Paid Group Health Insurance and the Costs of Mandated National Coverage," *Report R-1509-NC/OEO* (Santa Monica, California: The Rand Corporation, December 1974).

[3]Ibid.

[4]For a discussion of the determinants of group insurance, see G. S. Goldstein and M. V. Pauly, "Group Health Insurance: A Local Public Good," in Richard Rosett, ed., *The Role of Health Insurance in the Health Services Sector* (n.p.: National Bureau of Economic Research, 1976); Charles Phelps, "The Demand for Health Insurance," *Report R-1054-OEO* (Santa Monica, California: The Rand Corporation, July 1973).

[5]Joseph Newhouse, Charles Phelps, and William Schwartz, "Policy Options and the Impact of National Health Insurance," *New England Journal of Medicine*, vol. 290 (June 13, 1974):1345–59.

[6]A more extensive discussion of this point can be found in Mark V. Pauly, "The Economics of Moral Hazard," *American Economic Review*, vol. 58 (June 1968): 531–37.

[7]M. S. Feldstein, "The Welfare Loss of Excess Health Insurance," *Journal of Political Economy*, vol. 81 (March/April 1973):252.

[8]Victor Fuchs, *Who Shall Live?* (New York: Basic Books, 1975), p. 104.

[9]David Salkever, "Certificate of Need Laws and Hospital Investment" (unpublished paper, John Hopkins University, 1975).

[10]E. F. X. Hughes et al., "Surgical Work Loads in a Community Practice," *Surgery*, vol 71 (March 1972):315–27.

ACTIVITY FIVE:

The market reformist position used by Pauly brings into focus a set of assumptions quite different from those of the radicals. It also reflects assumptions upon which several of the proposals before Congress are based, especially the Fulton-Duncan Bill. In your discussion groups consider the following questions about the market reform perspective as represented by Pauly:

(1) What is the health care delivery crisis from Pauly's point of view? What specific features of the current system seem to produce it?
(2) What measures does Pauly believe necessary to improve the health care delivery system, and what do these suggestions tell us about Pauly's understanding of the current system?
(3) How does Pauly's position differ from Coontz's? In what way are they similar? Can the two be compromised? If so, how? If not, why?
(4) Select a spokesperson to summarize your group's position before the entire class.

EXERCISE THREE:

Write a short essay using Pauly's argument to explain the situation of the Johnsons, Cottons, and Thomases. Is Pauly's presentation relevant to the problems of all three families? If yes, how? If not, why?

C. Bureaucratic Reformers

The third position reflecting policy assumptions common among health care delivery system reformers focuses attention on the organization of medical service supply. For these analysts, the primary problem is the fragmentation and pluralization of the medical profession into an unlinked, uncoordinated hodge-podge of solo practitioners who use facilities which are wasteful and inefficient in their duplication of equipment and related services. They blame the market-like competition which occurs in this fragmented health care system for creating and perpetuating many of the problems which now plague consumers of medical services. They believe these problems cannot be solved by merely "patching-up" the imperfect market; nor do they regard government intervention on a major scale as a solution, whether through national health insurance or the nationalization of health care facilities. From their perspective, contemporary problems of health care delivery are solvable only through the local and regional reorganization of the system into a form which will rationally allocate and distribute needed services.

The strategy is labelled "bureaucratic" due to its emphasis on organizational form and administrative solutions to health care delivery problems. Anne R. Somers has termed this approach the "rationalization" of health services, and has noted elsewhere that this position is currently finding wide application in most of Western Europe. Her observation on this point is quite insightful, for it emphasizes the fact that those nations now undertaking bureaucratic reforms first attacked the financial problems of health care delivery but found the results of those efforts less than completely satisfying. Accordingly, there is a lesson here for the U.S.

> This is a sobering thought for both proponents and opponents of national compulsory health insurance in the United States. Public financing has not proved a panacea in Europe. It has solved some problems and created or exacerbated others. Clearly, also, our health problems and theirs are basically similar despite certain historical variations and differences in timing.
>
> . . . .
>
> Effective rationalization implies imagination, innovation, experimentation. It also implies decision-making, discipline, and control. As we inevitably move in this direction -- hopefully democratically, but in any case inevitably -- it would be the height of folly to disregard the wealth of valuable trial-and-error experience offered us by our European cousins.

While one might challenge Somers' belief in the "inevitability" of bureaucratic reform, one cannot deny its possibility. Of the major proposals before Congress, one (Ullman's) places heavy emphasis on the rationalization of health services, while two others made efforts in this direction despite greater stress on financial arrangements (Burleson-McIntyre and Long-Ribicoff). Underlying these and similar proposals is a set of assumptions which holds that, unless consciously directed and coordinated through appropriate structures (public and private, with emphasis on the latter), the delivery of health care in the U.S. will lack the singleness of purpose and integration of resources which facilitate efficient and effective medical care.

The following article by Sidney R. Garfield is seen by many as a classic presentation of the bureaucratic reform approach. Taken from a 1970 issue of Scientific American, this piece not only reflects a supply centered analysis of problems in U.S. health care delivery, but also suggests a system which Garfield believes will rationally offer the American public what they should expect from American medicine -- and perhaps more. The thrust of Garfield's suggestions come down to this: attempts to improve the access of health care through financial means will end in frustration unless the current organization of health care providers is made more rational.

SCIENTIFIC AMERICAN
Established 1845 April 1970 Volume 222 Number 4

The Delivery of Medical Care

Medical care in the U.S. is expensive and poorly distributed, and national health insurance will make things worse. What is needed is an innovative system in which the sick are separated from the well

by Sidney R. Garfield

The U.S. system of high-quality but expensive and poorly distributed medical care is in trouble. Dramatic advances in medical knowledge and new techniques, combined with soaring demands created by growing public awareness, by hospital and medical insurance and by Medicare and Medicaid, are swamping the system by which medical care is delivered. As the disparity between the capabilities of medical care and its availability increases, and as costs rise beyond the ability of most Americans to pay them, pressures build up for action. High on the list of suggested remedies are national health insurance and a new medical-care delivery system.

National health insurance, an attractive idea to many Americans, can only make things worse. Medicare and Medicaid- equivalents of national health insurance for segments of our population—have largely failed because the surge of demand they created only dramatized and exacerbated the inadequacies of the existing delivery system and its painful shortages of manpower and facilities. It is folly to believe that compounding this demand by extending health insurance to the entire population will improve matters. On the contrary, it is certain that further overtaxing of our inadequate medical resources will result in serious deterioration in the quality and availability of service for the sick. If this country has learned anything from experience with Medicare and Medicaid, it is that a rational delivery system should have been prepared for projects of such scope.

The question then becomes: What are the necessary elements of a rational medical-care delivery system? Many have proposed that prepaid group practice patterned after the Kaiser-Permanente program, a private system centered on the West Coast, may be a solution. We at Kaiser-Permanente, who have had more than 30 years' experience working with health-care problems, believe that prepaid group practice is a step in the right direction but that it is far from being the entire answer. Lessons we have learned lead us to believe there is a broader solution that is applicable both to the Kaiser-Permanente system and to the system of private practice that prevails today.

The heart of the traditional medical-care delivery system is the physician. Whether he practices alone or in a group, he is still directly involved in the care of the patient at every important stage, from the initial interview to the final discharge. Any realistic solution to the medical-care problem must therefore begin by facing up to the facts about the supply of physicians.

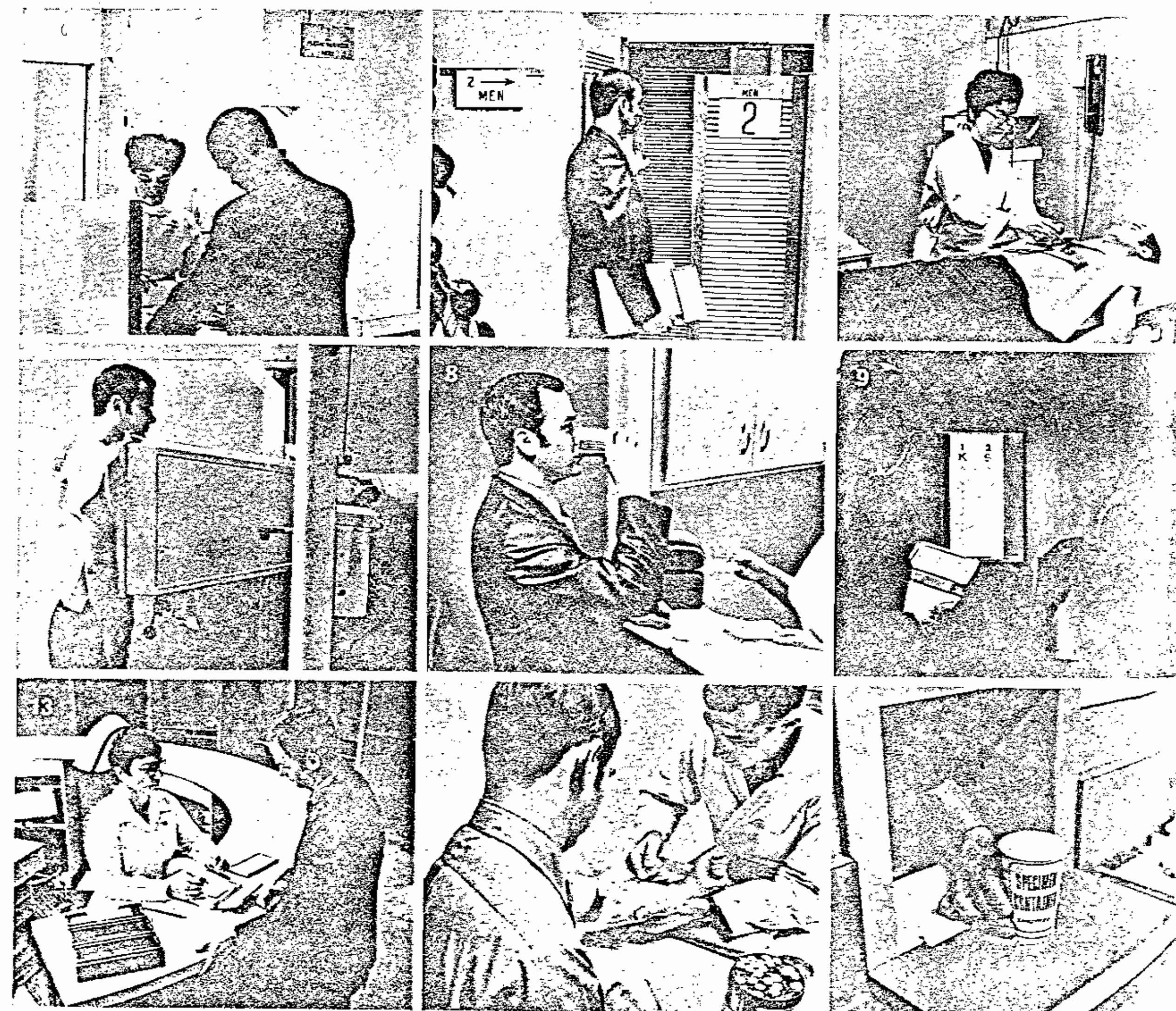
Of the active doctors in the U.S. a great many are engaged in research, teaching and administration. Those actually giving patient care, in practice and on hospital staffs, number about 275,000 (approximately 135 per 100,000 of population), and they are far from evenly distributed throughout the population. A preponderance are in urban areas, and within those areas they tend to be concentrated where people can best afford their services. Increasing specialization accentuates the shortage of doctors. If we were to augment the output of our medical schools from the present level (fewer than 9,000 doctors a year) to twice that number (which is scarcely possible), we would barely affect this supply in 20 years, considering the natural attrition in our existing physician complement. The necessity of living with a limited supply of physicians in the face of increasing demand forces us to focus on the need for a medical-care delivery system that utilizes scarce and costly medical manpower properly.

The traditional medical-care delivery system has evolved over the years with little deliberate planning. At the end of the 19th century medical care was still relatively primitive: there was the doctor and his black bag and there were hospitals—places to die. People generally stayed away from the doctor unless they were very ill. In this century expanding medical knowledge soon became too much for any one man to master, and specialties began developing. Laboratories, X-ray facilities and hospitals became important adjuncts to the individual physician in his care of sick people. Since World War II a chain reaction of accelerated research, expanding knowledge, important discoveries and new technology has brought medical care to the level of a sophisticated discipline, offering much hope in the treatment of illness, yet requiring the precise and costly teamwork of specialists operating in expensively equipped and highly organized facilities [*see illustrations on pages 20 and 21*].

Throughout these years of remarkable medical achievement the delivery system has remained relatively unchanged, as though oblivious to the great need for new forms of organization equal to the task of applying new techniques and knowledge. Physicians have clung to individualism and old traditions. Their individual hospitals have continued on their individual ways, striving to be all things to their doctors and patients, creating their own private domains, largely ignoring the tremendous need to merge their highly specialized services and facilities. It is only in comparatively recent years that group practice by doctors has been considered respectable (and as yet only some 12 percent of all physicians practice in groups) and that regional-facility planning boards have appeared to force some semblance of cooperation on hospital construction.

It is amazing that the traditional delivery system functioned as well as it did for so long, considering the stresses between old methods and new technology. Much of its inefficiency was absorbed by dedicated physicians working long hours and donating additional hours; much was absorbed by office and hospital personnel working for extremely low pay. Only recently, under the joint impact of soaring demands for service and demands for competitive wages, has the system begun to break down, but it has been faltering for some time. In 1967 the National Advisory Commission on Health Manpower reported that "medical care in the U.S. is more a collection of bits and pieces (with overlapping, duplication, great gaps, high costs and wasted effort) than an integrated system in which need and efforts are closely related."

Let us look at another medical-care delivery system: the Kaiser-Permanente plan. This program had its origin in southern California in the depression years from 1933 to 1938. I was then in private practice, and I became involved in providing medical and hospital services and facilities for several thousand



HEALTH TESTING is depicted at the Kaiser-Permanente Multitest Laboratory in Oakland. After registering (*1*), the patient is assigned to a dressing room (*2*), where he partially undresses and puts on a paper gown. An electrocardiogram is made and his pulse and blood pressure are measured (*3*). Height and weight are recorded (*4*). a skin-fold test measures body fat (*5*) and a tendon reflex is checked (*6*). The chest is X-ray'd (*7*). (Women have a breast X-ray examination.) After dressing, the patient drinks a

construction workers. Unable to make ends meet by depending for remuneration on the usual fee for service, I finally tried prepayment and thus happened on our basic concepts of health care. Prepayment to a group of physicians in integrated clinic and hospital facilities proved to be a remarkably effective system for providing comprehensive care to workers on a completely self-sustaining basis. At the Grand Coulee Dam from 1938 to 1942, with the warm interest and counsel of Henry J. Kaiser and his son Edgar, these basic concepts were further developed, tested and broadened into a complete family plan for the entire temporary community built around that construction job.

World War II expanded our health-plan concept into care for 90,000 workers of the Kaiser wartime shipyards in the San Francisco Bay area and a similar number of workers in the Portland and Vancouver area. At the end of the war these workers returned to their homes, leaving us with facilities and medical and hospital organizations. We decided to make our services available to the community at large. Since 1945 the plan has grown of its own impetus, without advertising, to its present size: more than two million subscribers served by outpatient centers, 51 clinics and 22 hospitals in California, Oregon, Washington and Hawaii and in Cleveland and Denver. The plan provides comprehensive care at an annual cost of $100 per capita, which is approximately two-thirds the cost of comparable care in most parts of the country.

The plan is completely self-sustaining. Physical facilities and equipment worth $267 million have been financed by health-plan income and bank loans (except for gifts and loans to the extent of about 2 percent). The plan income provides funds for teaching, training and research and pays competitive incomes to 2,000 physicians and 13,000 nonphysician employees.

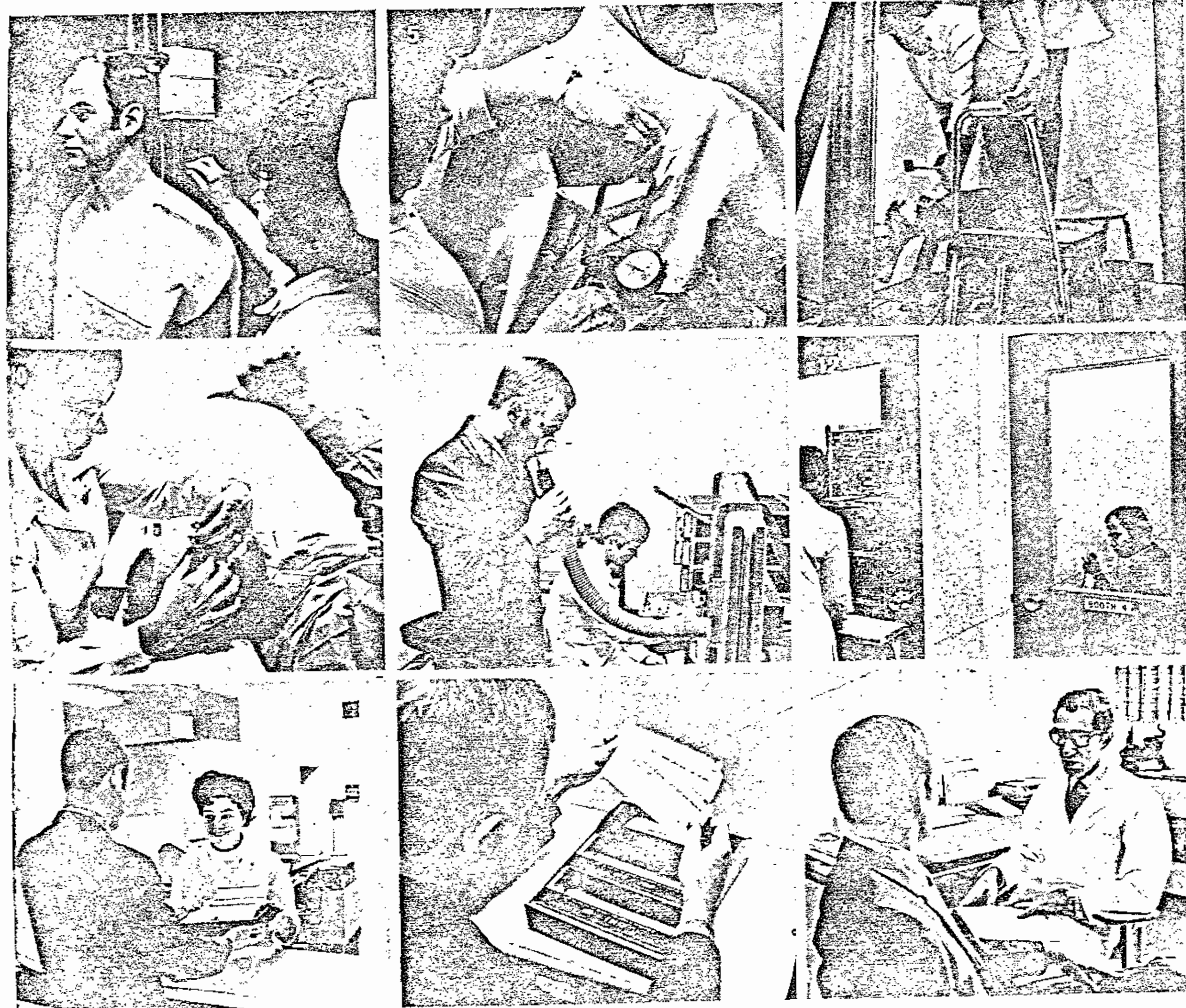
The health plan and the hospitals are organized as nonprofit operations and the medical groups in each area are autonomous partnerships. This organization gives our physicians essentially the same incentives as physicians in private practice have; they are motivated, in addition, by their belief in the rightness of this way of practicing medicine.

In addition to prepayment, group practice and the integration of hospital and clinic facilities, we can identify three other principles that are essential to the plan's success. One is the institution of what is in effect a new medical economics, which flows simply from the fact that the total health-plan income is turned over to the physicians and hospitals not as a fee for specific services but as a total sum. This reverses the usual economics of medicine: our doctors are better off if our subscribers stay well and our hospitals better off if their beds are empty. Another principle is freedom of choice. We require any group that wants to enroll its members in our program to offer them at least one alternative choice of medical plan, be it Blue Cross or a medical-society plan or something else. Finally, we consider it a fundamental principle that the physicians must be involved in responsibility for administrative and operational decisions that affect the quality of the care they provide.

We believe any group of physicians, or a foundation working with physicians, can easily duplicate the Kaiser-Permanente success. It only requires a dedicated group of physicians with reasonably well-organized facilities, a membership desiring their services on a prepaid basis and strict adherence to all these principles.

All of this is not to say that U.S. medicine should change over to the Kaiser-Permanente pattern. On the contrary, freedom of choice is important; we believe the choice of alternate systems, including solo practice, is preferable for both the public and physicians. Any change to prepaid group practice should be evolutionary, not revolutionary. Physicians in general have too much time and effort invested in their practice to discard them overnight. It will probably be the younger men, starting out in practice, who will innovate. Medical school faculties should point out the advantages and disadvantages of all methods of practice to these young men so that they can choose wisely.

Let us examine the functioning of these two systems—the traditional system and the Kaiser-Permanente one. In the



glucose solution (8) in preparation for a blood test an hour later. His visual acuity is tested (9) and his eyes are checked for glaucoma (10). Lung capacity is measured (11) and hearing is tested electronically (12). The patient is given punched cards (13) for a self-administered medical questionnaire. A blood sample is taken (14) for analysis, as is a urine specimen (15). After returning his question cards (16) the patient gets another set for a psychological test (17) and later finishes with a talk with a doctor (18).

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TEST, PATIENT                                         DR. SMITH
M.R. NO. 2256590        BIRTHDATE   7-18      FEMALE       S.F.     31

LAST MHC  6/16/68. RANGES ARE LOW-HIGH VALUES FOR PATIENT MHC EXAMS, 1967-68
```

	(TEST)	(NORMAL)	(VALUE)	(1968)	(1967-1968)
	HEIGHT: IN.		63.8	64.0	63.5- 63.9
	WEIGHT: LB.		133.5	132.0	131.5- 133.5
	TRICEPS SKINFOLD: MM.	UNDER 43	23.0	18.0	19.0- 20.0
	CIRCULATORY:				
**	B.P. SUPINE:	90-159/50-89	164/100	154/104	135-144/ 96-098
	RAD. PULSE SUPINE:	60-95	68	76	66 - 74
	RESPIROMETRY:				
	FEV 1 SEC: L.	OVER 1.2	2.1	2.0	1.9- 2.2
	FEV 2 SEC: L.		2.4	2.5	2.2- 2.6
	TOTAL FEV: L.	OVER 2.1	2.8	2.7	2.5- 2.9
	PEAK FLOW: L.		4.1	4.0	3.9- 4.4
	ACHILLES REFLEX: MS.	250.0 -400.0	290	270	280 - 310
	PAIN RESPONSE:	8.0 - 35.0	18	22	20 - 37
	BLOOD:				
	WHITE CELL COUNT:	3,500-12,000	7,700	6,600	5,500 - 7,700
	RED CELLS (MILLIONS):	4.0 - 5.5	4.5	NOT DONE	NOT DONE
**	HEMOGLOBIN GM:	12.0 - 16.0	9.2	11.2	13.1- 13.9
	HEMATOCRIT:	35.0 - 49.0	36.0	NOT DONE	NOT DONE
	MEAN CORP VOL:	80 -100	80	NOT DONE	NOT DONE
**	MEAN CORP HG:	26.0 - 34.0	20.6	NOT DONE	NOT DONE
**	MCH CONC:	32.0 - 38.0	25.6	NOT DONE	NOT DONE
	SODIUM MEQ/L:	133 -145	140	NOT DONE	NOT DONE
	POTASSIUM MEQ/L:	3.0 - 5.0	3.7	NOT DONE	NOT DONE
	CALCIUM MG%:	8.0 - 10.5	9.9	9.5	9.0- 10.5
	PHOSPHORUS MG%:	1.5 - 4.5	3.2	NOT DONE	NOT DONE
**	GLUCOSE 1 HR: MG.	UNDER 263	232.0	234.0	212.0- 247.0
**	GLUCOSE 2 HR: MG.	UNDER 150	164.0	NOT DONE	NOT DONE
	BUN MG%:	UNDER- 22.0	15.2	NOT DONE	NOT DONE
	CREATININE MG%:	UNDER- 1.4	.9	.8	.8- [illegible]
	URIC ACID MG%:	2.0 - 7.3	3.5	NOT DONE	NOT DONE
	BILIRUBIN TOT MG%:	UNDER- 1.5	.9	NOT DONE	NOT DONE
	BILIRUBIN DIR MG%:	UNDER- .6	.1	NOT DONE	NOT DONE
	ALK PHOSPHATASE UNITS:	UNDER- 15.0	6.0	NOT DONE	NOT DONE
	SGOT UNITS:	UNDER- 40	36	25	23 - 38
	SGPT UNITS:	UNDER- 50	25	NOT DONE	NOT DONE
	PROTEIN TOTAL GM%:	6.0 - 8.0	7.5	7.6	7.6- 8.0
	ALBUMIN GM%:	OVER - 3.0	4.0	4.1	3.9- 4.2
	LIPIDS TOTAL GM%:	.3 - 2.0	.7	NOT DONE	NOT DONE
	BETA-LIPOPROT UNITS:	UNDER- 47.0	17.0	NOT DONE	NOT DONE
	CHOLESTEROL MG%:	90 -330	275	200	195 - 220
-	IRON MCG%:	50 -180	NOT DONE	NOT DONE	NOT DONE
-	FE BIND CAP MCG%:	190 -425	NOT DONE	NOT DONE	NOT DONE
	LATEX AGGLUT.R.F.:	NEG.	NEG.	NEG.	NEG.-NEG.
**	VDRL:	NEG.	POS.	NEG.	NEG.-NEG.
**	QUANTITATIVE VDRL:		[illegible]		
	BLOOD GROUP:		O	O	O - O
	URINE:				
	PH:		6.0	7.0	7.0- 7.0
**	GLUCOSE:	NEG.	MED.	NEG.	NEG.-NEG.
**	CLINITEST:	NEG.	3+		
**	ACETONE:	NEG.	+		
	PROTEIN:	NEG.	NEG.	NEG.	NEG.-NEG.
	BLOOD:	NEG.	NEG.	NEG.	NEG.-NEG.
	URINE BACILLI:	NEG.	NEG.	NEG.	NEG.-NEG.

```
   CHEST X-RAY:     NO SIGNIFICANT CHANGE FROM PRIOR X-RAY
     1968: NO SIGNIFICANT CHANGE FROM PRIOR X-RAY
     1967: NO SIGNIFICANT CHANGE FROM PRIOR X-RAY
** BREAST X-RAY:    FIBROCYSTIC DIFFUSE CHANGES
     1968: NO SIGNIFICANT CHANGE FROM PRIOR X-RAY
     1967: NSA
   ECG:             NO SIGNIFICANT CHANGE FROM PRIOR ELECTROCARDIOGRAM
     1968: NO SIGNIFICANT CHANGE FROM PRIOR ELECTROCARDIOGRAM
     1967: NSA
** HEARING:         CLINICALLY IMPAIRED HEARING IN LEFT EAR.
**   1968: CLINICALLY IMPAIRED HEARING IN LEFT EAR.
**   1967: CLINICALLY IMPAIRED HEARING IN LEFT EAR.
   VISUAL ACUITY:  L.E. 20/40 OR BETTER.    R.E. 20/40 OR BETTER.
     1968: L.E. 20/40 OR BETTER.    R.E. 20/40 OR BETTER.
     1967: L.E. 20/40 OR BETTER.    R.E. 20/40 OR BETTER.
   OCULAR TENSION: L.E. NORMAL.     R.E. NORMAL.
     1968: L.E. NORMAL.     R.E. NORMAL.
-    1967: TEST_NOT_DONE RIGHT
-          TEST_NOT_DONE LEFT
-          L.E. NO VALUE.    R.E. NO VALUE.
   PUPIL. ESCAPE:  NO ESCAPE
     1968: NO ESCAPE
     1967: NO ESCAPE
** RETINAL PHOTO:  SUGGESTS ACTIVE OCULAR DISEASE
-    1968: TEST_NOT_INDICATED
-    1967: TEST_NOT_INDICATED

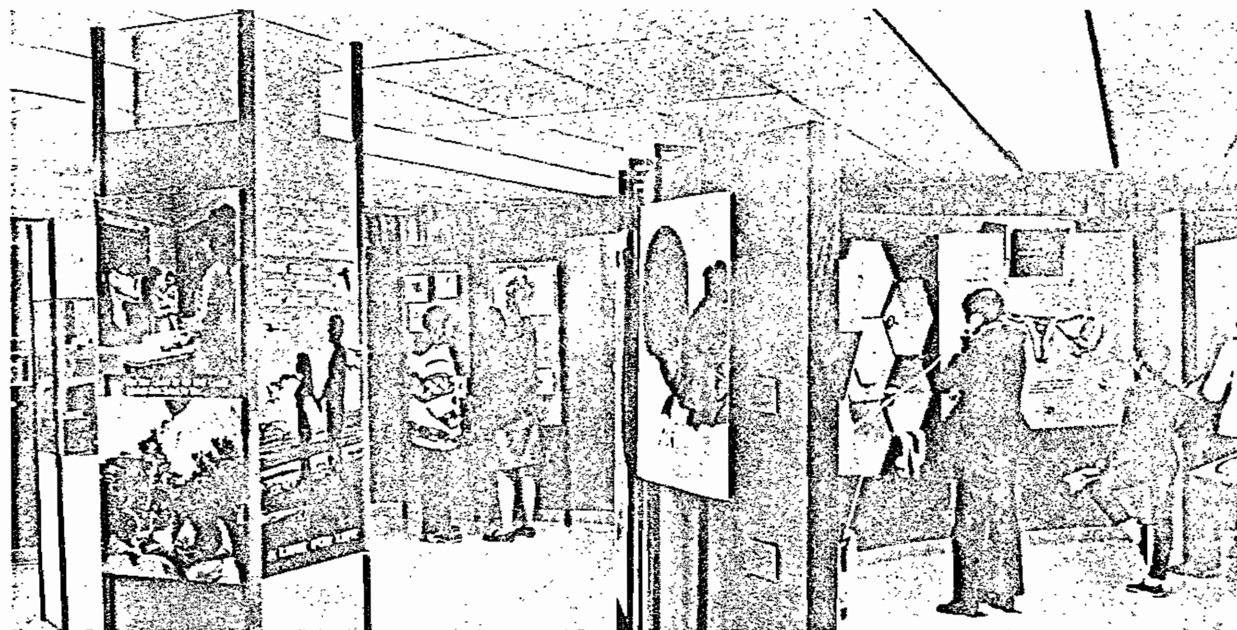
-  PATIENT RECEIVED FOLLOWING (ADVICE RULE) DIRECTIONS:
   700-REQUEST PT RETURN AMS LAB FOR 2 HR SERUM SUGAR.
   901-REFER DROP-IN CLINIC - URINE SUGAR,ACETONE,SERUM GLUCOSE.
   801-ROUTINE, PHYSICIAN WILL CONSIDER EARLY APPINT.

-  CONSIDER REFER TO ASYMPTOMATIC DIABETES RESEARCH STUDY
    IF FOLLOW-UP CONFIRMS DIABETES.
PATIENT ANSWERED YES TO THESE QUESTIONS ON THE MHC 1968 FORM:
   HAD BAD REACTION OR SENSITIVITY TO ASPIRIN OR SALICYLATES
   HAD BAD REACTION OR SENSITIVITY TO SULFA DRUGS
-  IN PAST YEAR, USUALLY HAD 6 OR MORE ALCOHOLIC DRINKS A DAY
-  IN PAST 6 MONTHS HAD HEADACHES NOT HELPED BY ASPIRIN, EMPIRIN, ETC
   IN PAST YEAR SPELLS OF WEAKNESS OR PARALYSIS OF ARMS OR LEGS
-  IN PAST YEAR BLURRING OF EYESIGHT LASTING OVER A FEW MINUTES
-  IN PAST YEAR ANY TIMES WHEN YOU WERE CROSS-EYED OR WALL-EYED
   IN PAST YEAR ANY LOSS OF HEARING WHICH IS STILL PRESENT
   IN PAST 6 MONTHS OFTEN HAD PAIN IN THE EAR
-  IN PAST 6 MONTHS 2 OR MORE NOSE BLEEDS NOT FROM INJURY OR A COLD
-  IN PAST YEAR COUGHED UP ANY BLOOD
   IN PAST YEAR HAD ANY ASTHMA
   HAS VARICOSE VEINS IN LEGS
-  NEEDS MORE CLOTHES IN COLD WEATHER

-  TO THESE QUESTIONS, ANSWERED YES ON THIS MHC AND NO ON LAST MHC.

**  CONSIDER POSSIBLE ABNORMAL.
-   NOTE.
NSA NO SIGNIFICANT ABNORMALITY.
```

TEST RESULTS are compiled by a computer and are printed out as in this sample. The computer compares measurements with those from previous tests and with appropriate norms and calls attention to "possible abnormal" results. It also flags any other noteworthy items, orders additional tests and appointments and advises on diagnoses to be considered—in this case one of diabetes.



HEALTH-CARE CENTER is a special building that houses educational exhibits (*above*) as well as clinics, lecture rooms and audio-visual and other facilities. It would be the site of the health-care service to which well people would be referred after health testing.

language of systems analysis, the traditional medical-care system has an input (the patient), a processing unit of discrete medical resources (individual doctors and individual hospitals) and an output (one hopes the cured or improved patient). Customarily the patient decides when he needs care. This more or less educated decision by the patient creates a variable entry mix into medical care consisting of (1) the well, (2) the "worried well," (3) the "early sick" and (4) the sick. This entry mix has markedly increased in quantity and changed in character over the years as medical-care resources have grown in complexity and specialization. One constant throughout this evolution has been the point of entry into the system, which is and always has been the appointment with the doctor. Moreover, in traditional practice the patient enters with a fee.

The Kaiser-Permanente program alters the traditional medical-care delivery system in only two ways. It eliminates the fee for service, substituting prepayment, and it organizes the many units of medical-care resources into a coordinated group practice in integrated clinic and hospital facilities. We have come to realize that ironically the elimination of the fee has created a new set of problems. The lessons we have learned in seeking to solve these problems have a direct bearing on the difficulties besetting the country's faltering medical-care system.

The obvious purpose of the fee is remuneration of the physician. It has a less obvious but very significant side effect: it is a potent regulator of flow into the delivery system. Since nobody wants to pay for unneeded medical care, one tends to put off seeing the doctor until one is really sick. This limits the number of people seeking entry, particularly the number of well and early-sick people. Conversely, the sicker a person is, the earlier he seeks help—regardless of fee. Thus the fee-for-service regulator tends to limit overall quantity, to decrease the number of the healthy and early sick and to increase the number of the really sick in the entry mix.

Elimination of the fee has always been a must in our thinking, since it is a barrier to early entry into sick care. Early entry is essential for early treatment and for preventing serious illness and complications. Only after years of costly experience did we discover that the elimination of the fee is practically as much of a barrier to early sick care as the fee itself. The reason is that when we removed the fee, we removed the regulator of flow into the system and put nothing in its place. The result is an uncontrolled flood of well, worried-well, early-sick and sick people into our point of entry—the doctor's appointment—on a first-come, first-served basis that has little relation to priority of need. The impact of this demand overloads the system and, since the well and worried-well people are a considerable proportion of our entry mix, the usurping of available doctors' time by healthy people actually interferes with the care of the sick.

The same thing has happened at the broad national level. The traditional medical-care delivery system, which has evolved rather loosely over the years subject to the checks and balances of the open market, is being overwhelmed because of the elimination of personally paid fees through the spread of health insurance, Medicare and Medicaid. This floods the system not only with increased numbers of people but also with a changed entry mix characterized by an increasing proportion of relatively well people. For this considerable segment of patients the old methods of examining and diagnosing used by the doctor become very inefficient. He spends a large portion of his time trying to find something wrong with healthy people by applying the techniques he was taught for diagnosing illness. This reverse use of sick-care technology for healthy and comparatively symptomless people is wasteful of the doctor's time and boring and frustrating for him.

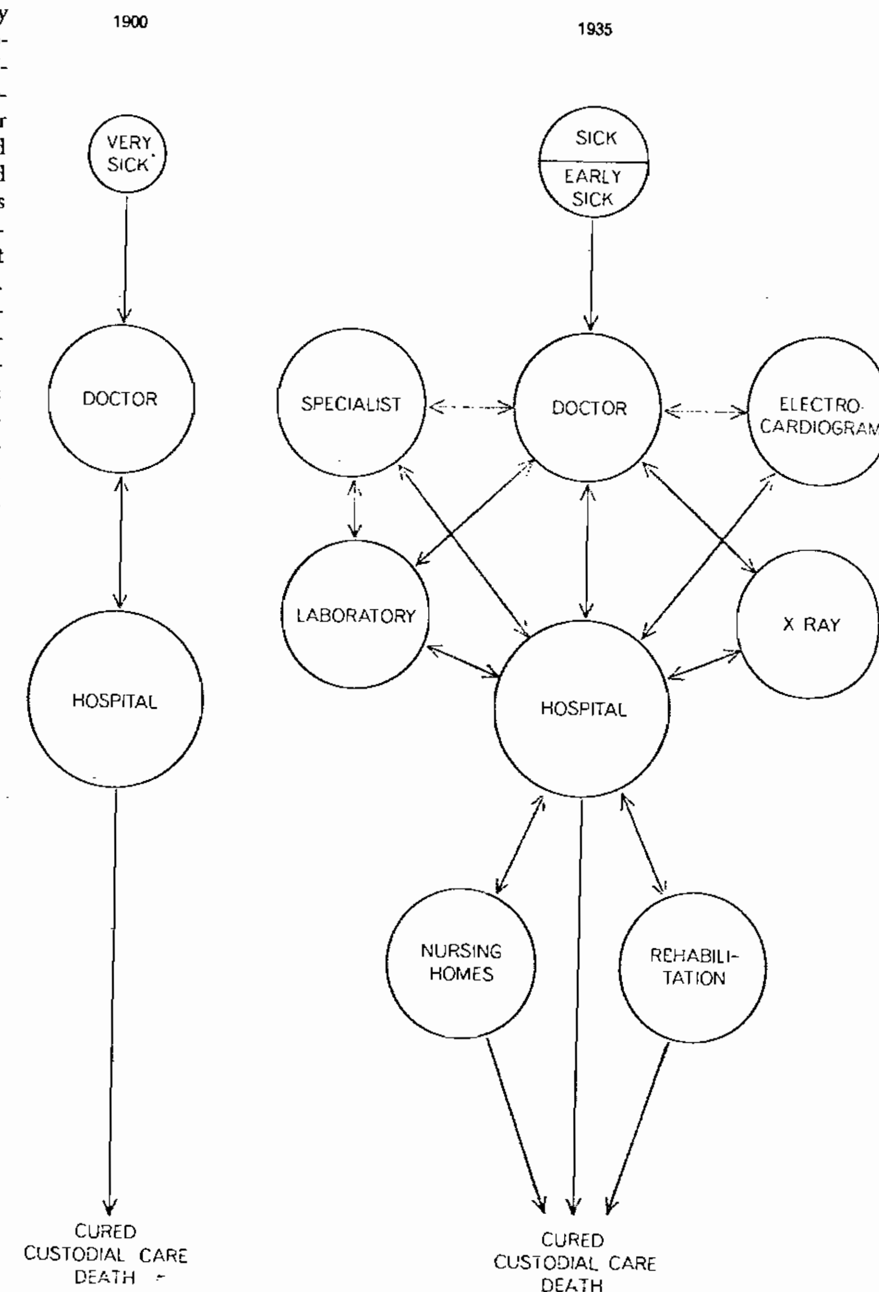
The obvious solution is to find a new regulator to replace the eliminated fee at the point of entry, one that is more sensitive to real medical need than to ability to pay and that can help to separate the well from the sick and establish entry priorities for the sick. We believe we have developed just such a regulator. Our Medical Methods Research Department, headed by Morris F. Collen, who is an electrical engineer as well as a physician, has successfully developed and tested techniques for evaluating the health of our members. The system that has been developed, which is variously called multiphasic screening, health evaluation or simply health testing, promises to solve the problem of a new regulator of flow into our medical-care delivery system.

Originally designed to meet our ever increasing demand for periodic health checkups, health testing combines a detailed computerized medical history with a comprehensive panel of physiological tests administered by paramedical personnel. Tests record the function of the heart, thyroid, neuromuscular system, respiratory system, vision and hearing. Other tests record height and weight, blood pressure, a urine analysis and a series of 20 blood-chemistry measurements plus hematology. The chest and (in women) the breasts are X-ray'd. By the time the entire process is completed the computerized results generate "advice" rules that recommend further tests when needed or, depending on the urgency of any significant abnormalities, an immediate or routine appointment with a physician. The entire record is stored by the computer as a health profile for future reference.

This health-testing procedure is ideally suited to be a regulator of entry into medical care. Certainly it is more sophisticated than the usual fee for service or our present first-come, first-served method. As a new entry regulator, health testing serves to separate the well from the sick and to establish entry priorities. In addition it detects symptomless and early illness, provides a preliminary survey for the doctors, aids in the diagnostic process, provides a basic health profile for future reference, saves the doctor (and patient) time and visits, saves hospital days for diagnostic work and makes possible the maximum utilization of paramedical personnel. Most important of all, it falls into place as the heart of a new and rational medical-care delivery system [*see illustration on page 22*].

As I have indicated, much of the trouble with the existing delivery system derives from the impact of an unstructured entry mix on scarce and valuable doctor time. Health testing can effectively separate this entry mix into its basic components: the healthy, the symptomless early sick and the sick. This clear separation is the key to the rational allocation of needed medical resources to each group. With health testing as the heart of the system, the entry mix is sorted into its components, which fan out to each of three distinct divisions of service: a health-care service, a preventive-maintenance service and a sick-care service. Compare this with the existing process, where the entire heterogeneous entry mix empties into the doctor's appointment, a sick-care service.

Health-care service is a new division of medicine that does not exist in this country or in any other country. Medical planners have long dreamed of the day when resources and funds could be channeled into keeping people healthy, in contrast to our present overwhelming preoccupation with curing sickness. Yet health care has been an elusive concept, and understandably so: well people entering medical care have been hopelessly mixed into and submerged in sick care, the primary concern of doctors. Doctors trained and oriented to sick care have been much too busy to be involved in the

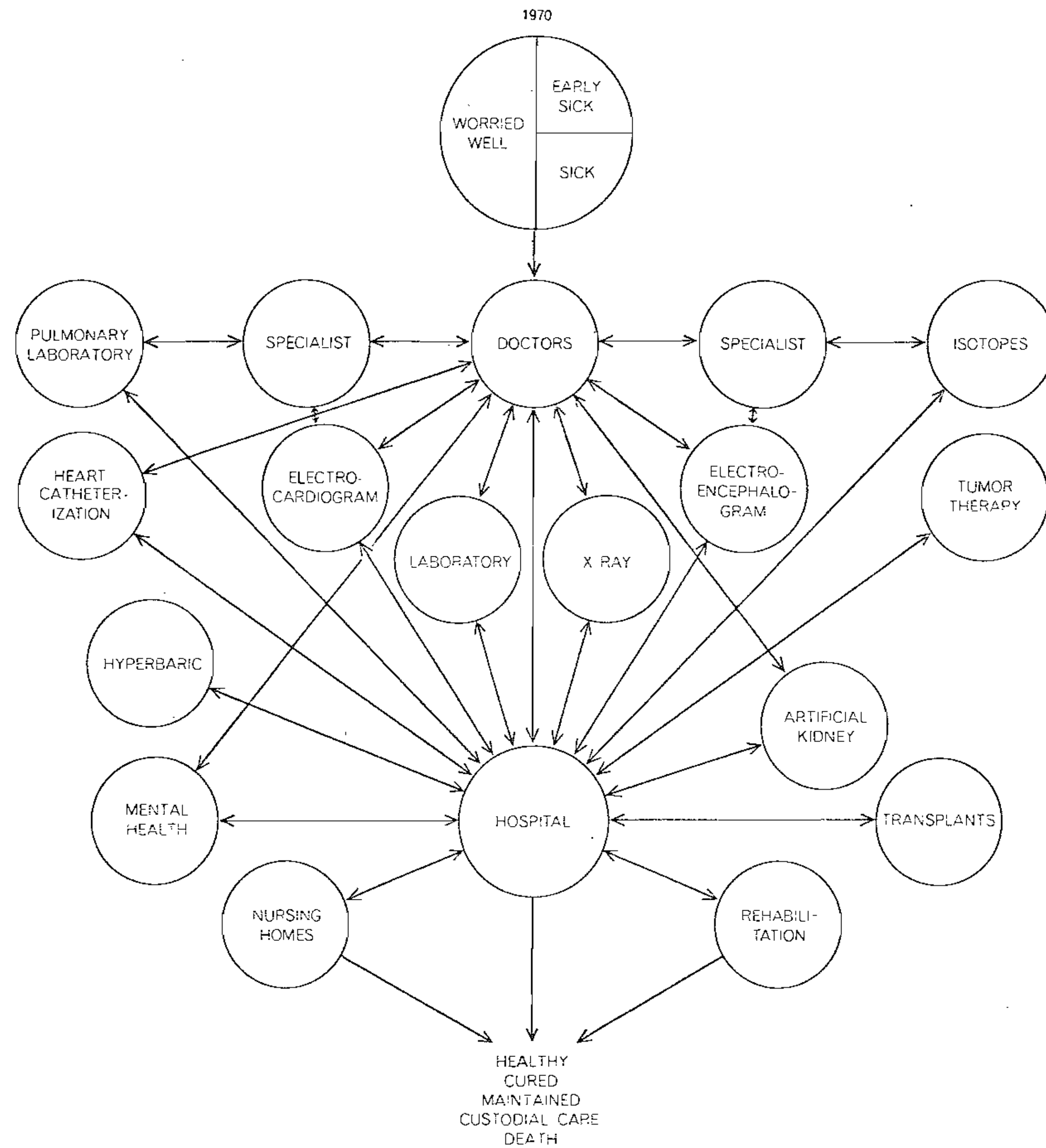


MEDICAL CARE has become more complex in this century and as it has become more effective the entry mix of people has changed significantly. Yet the entry point is still the doctor's appointment. Before 1900 (*left*) medicine had little to offer and only sick people

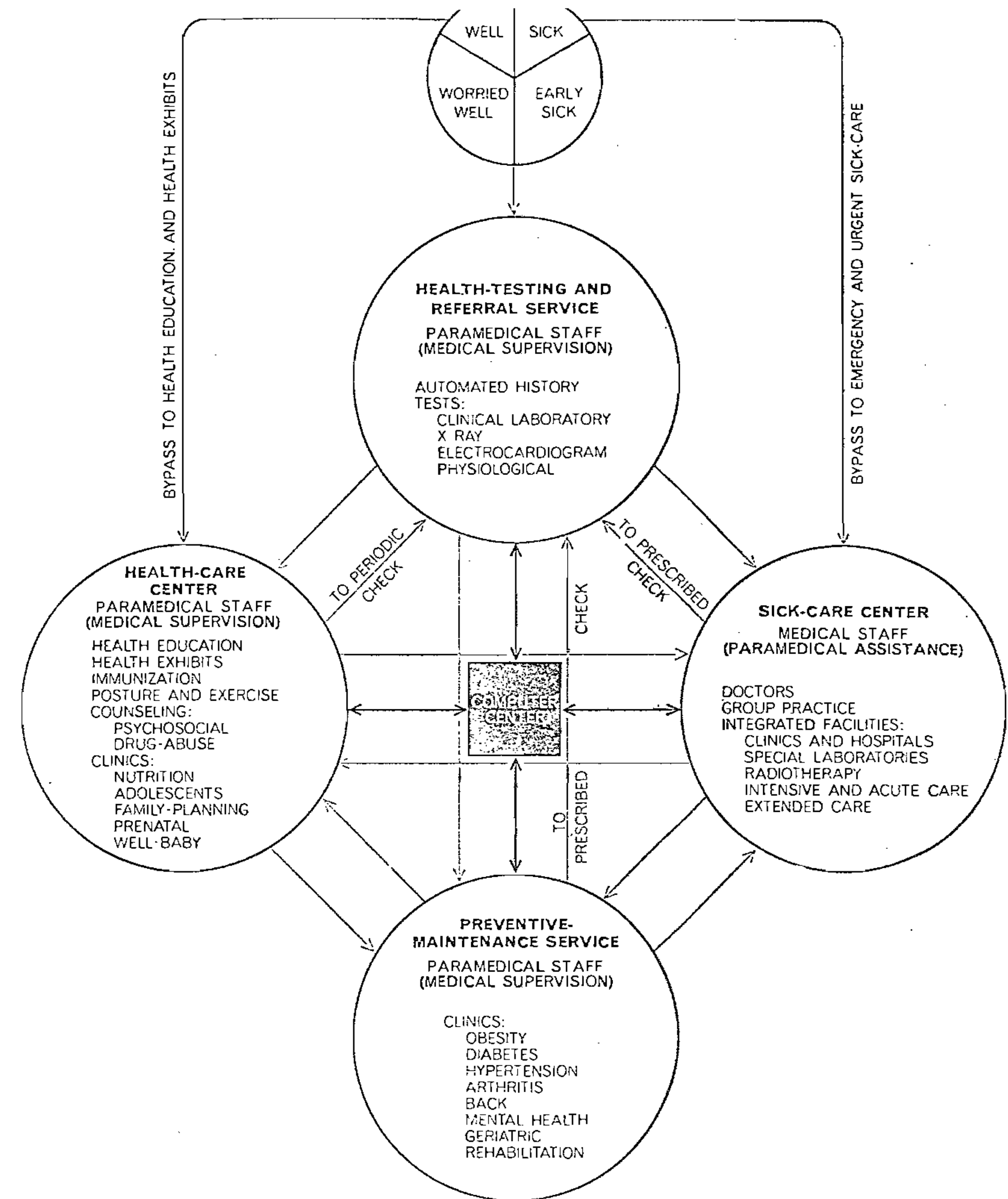
care of well people. True health care never had a chance to develop in that environment. In fact, not even the highly socialized governments with socialized medicine have created any significant services for the healthy other than sanitation and immunization. These governments swamp the doctor with the entire entry mix of well and sick and thus are unable to provide adequate care for either.

The clear definition of a health-care service, made possible by health testing, is a basic first step toward a positive program for keeping people well. It should be housed in a new type of health facility where in pleasant surroundings lectures, health exhibits, audio-visual tapes and films, counseling and other services would be available. Whether or not one believes in the possibility of actually keeping people well, however, is now beside the point; this new health-care service is absolutely essential in order to meet the increasing demand for just this kind of service and to keep people from overloading sick-care resources.

Preventive-maintenance service, like health-care service, has been submerged in sick care. Essentially it is a service for high-incidence chronic illness that requires routine treatment, moni-



entered medical care. By 1935, as medicine began to have more to offer and as insurance plans appeared, some "early sick" people were entering the system (*middle*). Since World War II medical technology has proliferated, as indicated by the partial display of treatment components (*right*), and well people enter, largely because of prepayment, insurance plans, Medicare and Medicaid.



NEW DELIVERY SYSTEM proposed by the author would separate the sick from the well. It would do this by establishing a new method of entry, the health-testing service, to perform the regulating function that was performed, more crudely, by the fee for service. After health testing the patient would be referred for sick care, health care or preventive maintenance as required and would be transferred among the services as his condition changed. The computer center would regulate the flow of patients and information among the units, coordinating the entire system, which would depend heavily on paramedical personnel to save doctors' time.

toring and follow-up; its object is to improve the patient's condition or prevent progression of the illness, if possible, and to guard against complications. This type of care, performed by paramedical personnel reporting to the patient's doctor, can save a great deal of the doctor's time and (because it allows more frequent visits) provide closer and better surveillance.

The use of paramedical personnel with limited knowledge and limited but precise skills to relieve the physician of minor routine and repetitious tasks reqoires that such tasks be clearly defined and well supervised. Procedures are automatically defined and structured in the new system by the clear separation of services. Three of the four divisions of the proposed system—health-testing service, health-care service and preventive-maintenance service—are primarily areas for paramedical personnel. Supervising physicians will be involved in varying degrees: least in health testing and most in preventive maintenance. This leaves sick care, with its judgments on diagnosis and treatment, clearly in the physician's realm. Even here, however, he will be aided by the three other services: in diagnosis, by health testing; in follow-up care, by preventive maintenance; in repetitive explanations and instructions to patients and relatives, by the audio-visual library of the health-care service. We believe, incidentally, that the doctor-patient relationship, which is suffering from the pressure of crowded schedules today, would gain under this system. Giving the doctor more time for care of the sick can help to preserve the relationship at the stage where it counts most.

Implementing the new delivery system should be relatively simple in the Kaiser-Permanente program, since there are no basic conflicts. The subscribers will benefit from better and prompter service to both the well and the sick; the doctors will have more time for their sick patients and their work will be more interesting and stimulating. Although the complete system remains to be tested and evaluated at each step, our hypothesis, on the basis of our research to date, is that we can save at least 50 percent of our general practitioners', internists' and pediatricians' time. This should greatly enhance our service for the sick and improve our services for the well.

Implementing this new medical-care delivery system in the world of traditional medical practice will be more difficult, but it still makes sense. Many forward-looking physicians will see in these new methods an opportunity to improve their services to patients. Most doctors these days have more work than they can handle and begrudge the time they must spend on well people. The assistance they could get from health-testing and health-care services will be welcome to many of them if such services are carefully designed and planned to help them. The sponsorship of health-testing and health-care services for private practice logically falls to the local medical societies. Some have already moved in the direction of health evaluation. A few local medical societies in northern California have for several years been operating a mobile unit evaluating the health of cannery workers. Some leaders of other medical societies have expressed interest in health testing as an entry into medical care. They realize that improvement of the delivery system is essential for the preservation of the private enterprise of medicine in this country.

The proposed delivery system may offer a solution to the hitherto insoluble problem of poverty medical care in many areas. The need is to make health services accessible to poor people. To this end neighborhood clinics are established, but staffing these clinics with physicians has proved virtually impossible. Physicians in general want to be in a stimulating medical environment; they like to associate with well-trained colleagues in good medical centers and tend to avoid isolated clinics.

In the system being proposed a central medical center, well staffed and equipped, would provide sick care. It could have four or five "outreach" neighborhood clinics, each providing the three primarily paramedical services: health testing, health care and preventive maintenance. Staffing these services with paramedical personnel should be much less difficult than staffing clinics with doctors; many of the workers could be recruited from the neighborhood itself. Such outreach clinics, coordinated with the sick-care center, could provide high-quality, personal service—better service, perhaps, than is available to the affluent today—at a cost probably lower than the cost of the inferior service poor people now receive.

The concept of medical care as a right is an excellent principle that both the public and the medical world have now accepted. Yet the words mean very little, since we have no system capable of delivering quality medical care as a right. This is hardly surprising. Picture what would happen to, say, transportation service if fares were suddenly eliminated and travel became a right. What would happen to our already overtaxed airports and what chance would anyone have of getting anywhere if he really needed to? National health insurance, if it were legislated today, would have the same effect. It would create turmoil. Even if sick care were superbly organized today, with group practice in well-integrated facilities, the change from "fee" to "free" would stagger the system.

Quality medical care as a right cannot be achieved unless we can establish need, separate the well from the sick and do that without wasting physicians' time. It follows that to make medical care a right, or national health insurance possible, it is mandatory that we first make available health testing and health-care services throughout the country. It is our conviction that these services should be provided or arranged for by the physicians themselves in order to be responsive to their needs and not just a commercial operation.

A basic cause-and-effect relationship is directly responsible for much of today's medical-care problems. The cause is the elimination of a personally paid fee for medical service. The effect is a changed, unstructured entry mix into the delivery system that wastes scarce medical manpower. The suggested solution, a new method of entry through health testing, serves as the heart of a new medical-care delivery system for the future.

The entry of healthy people into the medical-care system should not be considered undesirable. It opens the door to a great opportunity for American medicine: If these well people are guided away from sick care into a new, meaningful health-care service, there is hope that we can develop an effective preventive-care program for the future. The concomitant release of misused doctors' time can significantly slow the trend toward the inflation of costs and the maldistribution and unavailability of service. There should be little shortage of manpower if manpower is utilized properly.

Medical care stands at a critical point. One choice would be to adopt rash legislation that can only depreciate the quality of care for both the sick and the well. The better choice is to create a rational new medical-care delivery system that will make it genuinely possible to achieve the principle of quality medical care as a right. Matching the superb technology of present-day medicine with an effective delivery system can raise U.S. medical care to a level unparalleled in the world.

ACTIVITY SIX:

The bureaucratic reform perspective provides an alternative to both the radical and market positions which has found favor among those who believe the future of health care delivery is to be found in the regionalization of medical services or other forms of consolidation. Rejoining your groups once again, aim your discussions at the following topics:

(1) Given Garfield's point of view, how would you describe the crisis of health care delivery in the U.S. today?
(2) To what extent does Garfield seem to regard the problems as financial rather than organizational?
(3) How does Garfield's position differ from Pauly's? From Coontz's? Can either or both of these be compromised with Garfield's bureaucratic perspective? If yes, how? If not, why?
(4) Select a spokesperson to present a summary of your group's discussion to the entire class.

EXERCISE FOUR:

Write a short essay using Garfield's argument to explain the situation of the Johnsons, Cottons, and Thomases. Is the perspective thus applied relevant to the problems faced by the families? If yes, how? If not, why?

IV

Analyzing Competing Policy Alternatives

A. The Problem of Choice

We have now considered the two dimensions of health care delivery crisis, several proposals intended to meet these problems, and three general perspectives which reflect basic assumptions made by those who propose reforms for the system. As should be evident, the result of all this is a problem of choice for those who intend to take action regarding the delivery of medical services in the U.S. Public policymakers (and those depending on their actions) face a dilemma built upon the foundation of insightful presentations made by reformers who advocate competing policy alternatives. While there are certain points of agreement between these proposals and perspectives (e.g., radicals agree with market reformers that a major problem is financial, and with bureaucratic reformers that it is also organizational), the positions taken lead to policy proposals which are basically irreconcilable. Compare, for instance, the Corman-Kennedy Bill with either Ullman's, Long-Ribicoff, or any of the others. To adopt a position backing any one of those alternatives means adopting assumptions which might seem unnacceptable to those who back the others. Compromises among the proponents might pay off politically, but only at the cost of compromising basic assumptions and beliefs associated with each proposal. Disregarding for the moment the desirability or feasibility of compromise, we can see that policymakers must choose positions on this issue which they feel best reflect current problems plaguing American health care delivery and thus seem to present the best set of potential solutions to the crisis. The question to be answered is, on what basis should their choice be made?

This problem of choice can be solved in one of two ways. The first (and most desirable) way would be for the policymaker to compare the program alternatives (e.g., Corman-Kennedy, Ullman, Long-Ribicoff, etc.) suggested by each reform perspective, and to choose that one which best accomplishes the policy goals that have been set. From previous discussions we have come to regard three policy objectives as primary: the achievement of health care delivery <u>efficiency</u>; the <u>equitable treatment</u> of all those who make use of the health care system; and the minimization of health care <u>costs</u> and cost increases. We will discuss the comparison of policy program alternatives specifically -- and its feasibility -- in the first portion of this section of the module.

A second means for comparison accepts the fact that the evaluation of program alternatives may not be feasible, thus leaving the policymaker's problem of choice intact and unresolved. This second approach assumes that if one's premises are incorrect, one's conclusions are likely to be highly questionable. Extending this to the comparison of policy alternatives, if the assumptions and premises of a policy perspective lack credibility, then the actions and programs it generates may not warrant support. Extended to the problem of choice, this approach holds that where one is faced with competing programs based on competing policy perspectives, it is possible to make a viable

choice among the alternatives by comparing the credibility of the assumptions and premises found in the rival perspectives. We will concentrate on this approach in the second part of this section.

There are any number of grounds for making choices. One may choose an alternative because it "feels right." Another individual may select from among a variety of options on the basis of some expert advice given by accepted authority. Still a third person might choose in accordance with some rationale, such as "which alternative will provide the most satisfaction to my constituency?" or "which will do the most good for me at election time?" Regardless of the basis for choice, the selection of one course of action from among several is a difficult problem which is inherent to the task of policymakers. Thus, we must remain constantly aware of the grounds for choice as well as the alternatives available. For present purposes, let us define choice in a formal way: the consideration of alternatives and the selection of that which is most likely to achieve the objectives one is attempting to achieve. A process of choice based on that definition will involve two basic steps: first, it necessitates the specification and clarification of alternatives; and second, it calls for the application of choice criteria. We will use those two steps as a means for organizing our discussion in the next two parts of this section.

B. Comparing Policy Programs

As noted earlier in this module, there is a difference between a government's public policies (stating official objectives and goals) and its public programs (actions taken or avoided in achieving those objectives and goals). We have also noted that one means for comparing alternative policy proposals is to focus on the programs advocated by each. The objective of such a comparison would be to discover which alternative program will best achieve the objectives sought by the policymaker.

Regarding our topic of health care delivery reform, this approach would compare proposals reflecting the basic choices posited by the radical, market, and bureaucratic reformers. Borrowing from the list of major proposals before Congress in recent years (Section II), this would mean comparing programs such as those manifest in the Corman-Kennedy (radical), Fulton-Duncan (market), and Ullman (bureaucratic) bills. (Of course, none of these is ideally representative of the three perspectives. Nevertheless, each comes as close to the ideal as can be expected while still maintaining a degree of acceptability -- enough, in other words, to get serious consideration in the U.S. Congress.) The Corman-Kennedy proposal would essentially nationalize the financing of health care delivery in the U.S. while also promoting the extensive reorganization of the various mechanisms which supply medical services today. The Fulton-Duncan Bill would bring about reforms in the financial mechanisms of American health care delivery, but would otherwise leave the supply mechanisms intact. Meanwhile, the Ullman proposal would bring about many organizational changes in the supply mechanisms of the delivery system, making only indirect and relatively minor efforts on the financial side. Three alternative programs reflecting three alternative perspectives focusing on the same basic problems of health care delivery: inefficiency, inequity, and cost inflation.

The comparison of program choices has become a topic of concern for professional policy analysts in recent years. The evaluation of on-going programs became a major part of public sector management after World War Two, and lessons learned from that endeavor have led many to call for the evaluation of policy choices (proposals as opposed to on-going programs) as a means of cutting back on the chances of waste and enhancing returns gathered from the investment of public funds. Thus, instead of taking a "chance" on one of the policy alternatives for health care reform, the effective comparison of the available choices would facilitate the likelihood of future program success.

The crucial ingredients in the comparison of programs are (1) the choice of alternatives to compare, (2) the determination of what will be compared, and (3) how the comparisons are made. The first of those problems has already been partly solved for us by noting that there are specific proposals before Congress, each representing a basic reform position. What will be compared, however, is a bit more difficult to specify. For present purposes let us focus on four basic criteria which might be used to compare the programs: their feasibility, effectiveness, efficiency, and fairness.

All policy programs are doomed unless they are feasible, so perhaps it is most important to consider first whether the program being advocated can be authorized and implemented. Feasibility takes three forms in regard to policy choices: technical, financial, and political. First, any policy choice which cannot be carried out because those charged with its implementation do not have access to the necessary knowledge or the technology should not be chosen. If, for example, a health care reform program called for the eradication of the common cold by 1984, one would have to say that (given the current state of medical science) the technical possibility of achieving that objective would be low. It is not a matter of having the knowledge or technology at the moment of a policy's adoption, but rather knowing that an effort to obtain such things is even possible. John F. Kennedy's mandate to NASA that we be on the moon by 1980 was not possible at the moment it was issued, but it has proven technically feasible. In this sense we must ask of all health care delivery reform proposals, are they technically within our grasp?

A second form of feasibility is financial. Put briefly, we may have the technical capacity, the know-how, to carry out a program, but do we have the resources to invest in the actions needed. We had the resources to send a man to the moon by 1980, but only because we expended funds for that effort which would have gone elsewhere -- toward fighting the "War on Poverty," to rebuilding our cities, to defense, etc. Our financial capabilities are limited by a variety of factors, and the question is, given those limits can we finance the alternative programs for health care reform. Financial feasibility (like technical feasibility) will vary from proposal to proposal. For example, some estimates show that the Corman-Kennedy Bill would cost $137.3 billion in federal funds for Fiscal Year 1978 and $180.4 in Fiscal Year 1982. This compares with federal expenditures of $38.7 billion for FY 1978 and 60.4 billion for FY 1982 without any program, or $53.2 billion (FY 1978) and $83.0 billion (FY 1982) for a program similar to the Fulton-Duncan Bill. The question of financing these various amounts is political to the extent that Congress must be willing to raise revenues where necessary, but it is also strictly financial if we focus only on the capacity of the government to generate the needed funds. Thus, it is important to consider the financial feasibility of alternative programs.

Finally there is the question of political feasibility -- what is the likelihood of the alternative proposals receiving the support necessary for passage. Proposals will vary on this point from place to place, year to year, and so on. If health care delivery costs were to continue to rise by leaps and bounds as they have in the recent past, the political feasibility of passage for programs which might otherwise never stand a chance in Congress will be increased. Specifically, as the health care delivery crisis intensifies, so will the chances that a radical proposal like Corman-Kennedy will be seriously considered. As the crisis eases, so will the likelihood for passage of the Health Security Act. These considerations must be taken into account when comparing alternative program proposals.

But a program which is feasible may not be effective, and so a second major comparative criterion for evaluating competing choices is the likelihood that the policies will be <u>effective</u>. Effectiveness in this sense, means the likelihood that the programs will achieve their objectives. In our issue area, this involves investigating which of the three programs being analyzed is more likely to increase the health care delivery system's efficiency and equity of treatment while maintaining or even decreasing costs for medical services. The programs are not likely to be equally effective in attaining all three goals, and it is the difference of achievement potential which the comparison must seek to uncover.

The third major basis for comparison is related to the last -- the <u>cost efficiency</u> of competing programs. While policy program X may be more feasible and prove highly effective, it may do so at a cost which indicates that there is much waste of resources and misuse of technology. Program Y, an alternative, may not be as feasible or as highly effective, but prove more cost efficient than X and therefore more desirable to a policymaker who values the minimization of waste over maximization of goal achievement. One of the arguments made for Corman-Kennedy is that, despite its high initial cost to the federal government, the program will prove <u>more cost efficient</u> and just as effective over time for the entire society as would the alternatives. According to supporters of that proposal, total expenditures for health care by Americans will rise from $142.3 billion in FY 1978 to $222.2 billion in FY 1982 without any reforms, and from $151.1 billion to $235.9 billion with a market reform like that represented by the Fulton-Duncan Bill. But with Corman-Kennedy, they estimate those same expenditures will increase only from $160.2 billion to $210.4 billion -- a more cost efficient result according to these figures.

Last among the comparative criteria to be reviewed here is the equity of competing proposals, i.e., the <u>fairness</u> of the health care delivery system which will be produced by each reform. Equity of treatment is something valued by most Americans, and it is likely that our choice from among alternative programs will include this factor. A system of health care delivery which is cost efficient but fails to provide medical services for low income families or the medically indigent is not likely to be as desirable as one which might be less efficient but more equitable.

Knowing our choices and some of the critical criteria which will guide our comparisons among them, we now come to the most difficult part of our effort -- the application of those criteria to the alternatives in question. It is possible that we can logically speculate as to the relative feasibility, effectiveness, efficiency and fairness

of our program alternatives, especially if we had relevant data at our disposal. Nevertheless, there are limits to the value of comparisons based solely on reason and sophisticated critical analysis. The comparisons involved present us not with questions of logic, but with empirical questions. We want to know <u>empirically</u> which alternative is most feasible; <u>empirically</u> which is more effective and cost efficient; <u>empirically</u> which is most equitable. Our problem is that the design and use of empirical studies which will effectively answer these questions is not likely.

According to one well known analyst of social policies, Alice M. Rivlin, there are three ways of gathering empirical answers to these questions: random innovation, natural experiments, and systematic experimentation. Random innovation occurs when some unit of government is asked to try a particular reform. After the reform program is implemented and enforced for a period of time, analysts can attempt to make their assessments. Natural experiments are applied to situations where the analyst finds a system similar to that which the reform program would produce. That similar system is studied and the findings used as a basis for empirical comparisons.

While random innovations and natural experiments have proven useful and feasible for comparing policy alternatives in some issue areas (e.g., educational methods reform, community action program changes, metropolitan reorganization, and so on), they are not likely to help us compare our alternative health care delivery reforms. For example, the nationalization of health care financing has no equivalent among governments in the U.S. and the practices of private medical insurance carriers is generally the same throughout the country. These conditions make it difficult (if not impossible) to study innovations (since they cannot be easily instituted) or natural situations (since they do not exist). We could, of course, carry on natural experiments by comparing recent reforms in other countries (e.g., United Kingdom, Sweden, Canada), but such comparisons leave much to be desired. In short, studies through random innovation and natural experiments are limited in value for our purposes.

An alternative would be systematic experimentation whereby the "innovation should be tried in enough places to establish its capacity to make a difference and the conditions under which it works best." It would be a study in which "the conditions of scientific experiments should be realized as nearly as possible." Since we are looking at three competing programs, it would involve structuring systematic experiments for each under similar circumstances which will produce the evidence we need to answer the empirical questions demanded by our comparisons. Almost necessarily, notes Rivlin, the use of systematic experiments in health care delivery reform "calls for strong central leadership in the design of a coordinated series of experiments, along with funds or other incentives to reward cooperation." This can be accomplished by few organizations, and will probably have to be done by the federal government.

This raises the question of the feasibility of systematic experimentation. There are any number of problems which lead us to doubt the value of this approach as a basis for making program comparisons, the most obvious being the time and expense involved. Other concerns are reflected in ethical and technical considerations which we will not deal with here, other than to note that systematic experimentation is not likely to be undertaken. There are too many restrictions, too many doubts about this approach, just as there are problems with random innovation and natural experiments. We are led to conclude that finding answers to the empirical questions asked in the comparison of

policy program alternatives is not something we can or ought to rely on -- at least not now. Although it would be beneficial to compare competing programs before committing resources to one, the realities indicate that we should consider another path to solving our problem of choice.

ACTIVITY SEVEN: (optional)

In your discussion groups:

(1) Apply your "speculative" capacities and informally compare the Corman-Kennedy, Ullman, and Fulton-Duncan proposals. In the process, be sure to specify what standards or criteria you are using. (Each member of the group can prepare for the discussion by doing research on the bills in question.)
(2) Assume you have been given a blank check to carry out systematic experiments for purposes of comparing the effectiveness, efficiency, and fairness of the three proposals noted above. Discuss what you would do -- how you would structure and carry out the experiments. (Again you might wish to prepare by finding more detailed information on the alternative programs.)

C. Comparing Policy Assumptions

All reform policy positions reflect sets of assumptions about the world they are meant to change. That is the premise for the second approach to the comparison of competing policy alternatives. To an extent, this is a "second best" approach, for it would obviously be better for us to compare and choose from among the actual programs. But we have seen that such comparisons are limited, and rather than throw our arms in the air and walk away from the challenge we ought to consider this alternative.

To review what has been stated earlier, this second approach is built upon the idea that in any series of statements making an assertion (drawing a conclusion), the validity of the premises will determine the probable validity of the conclusion. From this perspective, a policy program can be seen as being as credible as the assumptions and empirical assertions upon which it is based; and where one is faced with several alternatives, an effort can and should be made to compare them and determine which set is more credible.

This approach does have its drawbacks, of course, for while we might assume that valid conclusions follow from credible premises, that might not necessarily be the case. As any student of logic knows, empirically credible conclusions can be drawn from invalid premises. Similarly, one may begin with valid premises and have a conclusion with a low degree of empirical credibility. Thus, while the approach we use here can prove useful, it is far from infallible. This should be kept in mind as we consider the steps one takes in carrying out a comparison of policy premises using this approach.

What should be stressed here is a critical distinction between empirical assertions and simplifying assumptions. An empirical assertion is a contention which is testable. That is, it represents any statement of fact which is put forth as valid. Such statements, when used as the basis for a policy proposal, can be regarded as hypotheses which can be used to test the credibility of a reform program. This second approach is based upon comparisons of empirical assertions made by competing reform positions. Such assertions are different from simplifying assumptions which are often used to help develop useful theories despite the possibility that they may lack empirical credibility. For example, scientists and engineers often find themselves dealing with "useful fictions" which help make their work easier. It is much easier to work with the concept of a solar system in dealing with the structure of atoms than with a more complex model of reality. Atomic structure may not in fact resemble the solar system, but that model has proven useful in answering some of the basic questions posed by physicists. In a similar fashion, it is possible that a policy proposal may be based on simplifying assumptions which are not intended to be empirically valid. This is the case when we see proposals which use analogies. To say that the health care delivery system acts like a greedy individual is an analogy which can be used to explain much of what has happened in recent years. However, such a statement is not meant as a testable assertion. It is not the same as a statement which holds that individuals in the health care delivery system are driven by a desire for profit. That kind of assertion is empirical and open to test. The point is that in this approach we are interested in comparing alternative assumptions that take the form of empirical assertions rather than simplifying assumptions.

There is nothing new or unique about this approach. In fact, it is reflected in what scientists call the "method of multiple working hypotheses." As described in 1897 by geologist T.C. Chamberlin and more recently by biophysicist John R. Platt, this method involves an "effort ... to bring up into view every rational explanation of new phenomena, and to develop every tenable hypothesis respecting their causes and history." Having done this, the investigator has "tentatively neutralized the partialities" which would otherwise accompany the adoption of particular orientations. Thus, with neutrality established and alternative hypotheses arrayed against each other, the scientist conducts what has become known as "critical" tests or "crucial" experiments. These tests focus on points of contention between the competing sets of hypotheses. For example, if one set of hypotheses states that the relationship between phenomena X and Y is positive, while another notes it to be negative, then the critical test would attempt to establish which view is "right" -- or more correctly, which is more credible. If the experiment or test demonstrates the relationship is positive, then the hypotheses from which that proposition is derived can be regarded as more credible than the set which noted it to be negative. Following this, another point of contention between the two sets is found, a test conducted once again to measure the credibility of one against the other, and so on -- until the investigator believes there is enough evidence to warrant a conclusion that one set of hypotheses is more credible than the other.

The logic of this approach is enhanced by its value as an efficient means for selecting among alternatives. As Arthur L. Stinchcombe has noted,

> If we can specify the most important of alternative theories, then it is very inefficient to test our theory by picking empirical consequences at random, with the hope that some of them will be inconsistent with the main alternative theories. The rational thing to do is to look for those consequences of our theory whose negation is implied by the alternatives.... By eliminating the most likely alternative theory, we increase the credibility of our theory much more than we do by eliminating alternatives at random by checking consequences of our theory without thinking.

Choosing from among competing policy alternatives is not quite the same experience as comparing contending sets of hypotheses in the "hard" sciences. Nevertheless, there is something to be gained from adapting the method of multiple working hypotheses to our problem of choice. We begin by perceiving the alternative policy perspectives as sets of hypotheses which might explain the world the policymaker wishes to influence. To facilitate this, we break down each of the perspectives into sets of assumptions (i.e., hypotheses) relevant to our task. These assumptions, once made explicit, can then be compared to each other, differences and similarities among them being noted. The next step would involve developing critical tests or crucial experiments which can tell us something about the credibility of the alternative assumptions. Accumulating this knowledge for many policy assumptions, we will eventually (it is hoped) be able to render an informed judgment regarding the relative credibility of the competing perspectives. It would follow that we can then make a more informed choice among the policy proposals before us.

All this is easier said than done, of course, and in the balance of this section we will work several exercises which will help you begin the comparison process.

The first task is a careful and systematic explication of the assumptions upon which each policy perspective is based. While uncovering those assumptions, you will simultaneously construct diagrams indicating the relationships involved in the premises of each perspective. All this will provide us with some basis for discussing how a choice among policy alternatives can be made using these basic assumptions and a modified version of the method of multiple working hypotheses.

Let us start by returning to the problem of health care delivery discussed at the beginning of the module. The reform proposals we have been looking at and the perspectives they represent are relevant for us because each addresses the health care delivery crisis being faced by the U.S. That crisis in turn, has three basic dimensions.*

First, there is the problem of efficiency. One of the major complaints heard from critics of America's health care delivery system is that it is inefficient, i.e., medical services are provided ineffectively and at costs which reflect the wastefulness of the system. Such waste not only leads to a misallocation of scarce health care resources, but also the poor application of those services which are provided.

Second is the problem of equity. There are critics who focus on the fact that what health care we do have is delivered inequitably to the American population, and that such maldistributions are not justified given both our technical capabilities as a civilization and our values as a community. While some receive quality care, others receive none; while some obtain the benefits of the latest advances in medical science, others must settle for relatively crude treatment at the hands of practitioners who are frequently overburdened and sometimes unqualified.

Finally, there is the problem of cost. As you already have seen in the articles read for Section III, the cost of medical services has increased by leaps and bounds in recent years, oftentimes far outdistancing normal inflationary trends. This situation further aggravates the problems of efficiency and equity of health care delivery; but in addition it has a status all its own given the fact that it has implications not only for the health of Americans, but also their economic well-being. After all, a dollar spent on health care is a dollar not spent on some other consumable.

While each of these factors (efficiency, equity, and cost) are central to the crisis of health care delivery in the U.S., it is noteworthy how differently each is defined by the three authors representing the alternative reform perspectives. For example, while efficiency is a matter of the effective use of resources for all three, each has a

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*Note should be taken here of the fact that all three dimensions -- efficiency, equity, and cost -- are lacking in an explicit reference to the quality of care received. One can have medical services provided efficiently, equitably, and at a reasonable cost and still receive poor care. This problem is not approached by many reformers of health care delivery who regard the key issue to be more a matter of quantitative service provision rather than qualitative. In fact, a careful reading of two of the articles in Section III (Pauly and Garfield) demonstrates the implicit assumption that the real problem is getting any kind of health care delivered, not guaranteeing that what is delivered is of high quality. Only Coontz seems to speak to this when she defines "efficiency" in terms of available resources being used to their full potential and "cost being tied into the qualitative improvement

distinct view of that effectiveness. For Coontz, efficiency exists when available resources in society are applied to their full potential. In this sense, inefficiency is reflected in the gap between the promise and performance of American health care. For Pauly, efficiency is the proper allocation of available yet scarce resources to where they are most valued. Inefficiency for him and other market reformers exists when the wrong services or treatments are produced and distributed wastefully. Garfield perceives efficiency as the proper use of the resources once they have been allocated to a particular sector of the health care system, e.g., physician, hospital, clinic, etc. Inefficiency for Garfield is not so much an overabundance of certain resources as it is the irrational application of them to health care needs.

A similar set of differences among the authors can be found in regard to equity. To Coontz, a system is equitable if it delivers the same treatment to all regardless of individual status or ability to pay. Everyone deserves (i.e., has a "right" to) the same sufficient treatment from the system. Thus she uses a standard for the system which can only be compared to "absolute equity" for all with the same needs. Pauly, stressing the scarcity of resources, fears the inequities which would result for the entire community if an absolute equity standard was used. Instead he seems to view equity as a modification of that condition which would exist under an efficient health care system. Efficiency of the market would, according to market advocates, produce and distribute medical services as they should be produced and distributed. Thus under conditions of efficiency, equity would pose no problems. But Pauly's modification assumes that the market will be imperfect and that some individuals -- specifically, the medically indigent -- must be given special protection. They should be supplied with at least minimal insurance coverage. Having met this need, the workings of the market should be permitted to take care of equity. Compare this to Garfield's view that any system which helps only the very sick or early sick is not giving the total population its just due -- that is, it is an inequitable system of health care delivery. From Garfield's perspective (and, in part, from Coontz's view) the system would be equitable only if it provided each consumer appropriate services regardless of condition. The well would receive what they need through education and counseling; the worried well would be satisfied through x-rays and examinations; the early sick and sick would continue to get sufficient treatment for their malaise.

These differences carry over into the "cost" dimension of the health care crisis, for again each author has a different focus and concern. For Coontz, costs must be seen relative to the improvement in care obtained. If costs rise while care provided deteriorates, then costs are too high; if costs rise while services improve in quality and quantity, then the cost is really not going up. Pauly has a view of cost which is not tied to the care that is provided, but rather the general trend among all costs in an economy. Thus he compares the recent rise in medical costs to the rise in the consumer price index, the implication being that if medical costs had risen proportionately with all other costs, then it would not have been "too high" an increase. For Garfield, costliness is evaluated in terms of the patient's ability to pay. When individuals cannot afford the health care they need, then costs are too high from his point of view.

(continued) of care received. With this exception, the matter of quality is generally ignored and will not prove a major concern in the analysis undertaken in the balance of this module -- though it is obviously of concern in the area of health care policy.

These different views have been only briefly summarized here. Figure IV.1 illustrates those differences in an even more condensed form, but one you can refer to while completing Exercise Five.

	EFFICIENCY as resources	EQUITY as:	COST as measured relative to:
COONTZ	being used to full potential	equal treatment for all	improvement in care provided
PAULY	allocated to appropriate and valued uses	the guarantee of minimal care for the medically indigent	general costs in the market place
GARFIELD	being applied rationally	appropriate care for all of the population	patient's ability to pay

FIGURE IV.1
Three Views of Health Care Delivery
Efficiency, Equity and Cost

EXERCISE FIVE:

There are certain characteristics of health care delivery systems which remain relatively stable over time and space while there are others which change from situation to situation, from time X to time Y, and so on. The first are called constants and may include known illnesses, common treatments, available technology, and similar factors of the system which hold at certain levels or change only very infrequently during a short time span. Those factors which tend to change or vary with frequency are called variables, and they include items such as the number of patients seeking appointments with physicians each day, the types of surgery performed in a major community hospital during a given week, the cost of treating a patient for an ailment from year to year, etc. Among the significant variables in the American health care delivery system are the three which concern us here: efficiency, equity, and cost. All three will vary over a given period of time, and each will differ from place to place throughout the country.

In this exercise we will be concerned with two types of variables. First, we will be looking at variables which are influenced by factors external to themselves.

In other words, we will be looking at variables which are caused, conditioned, or otherwise changed. These are called dependent variables because they are viewed in terms of a dependency relationship. Variables considered to be the causes, conditions, or influences in such relationships are called independent. Graphically, the relationship involved between the two types resembles that pictured in Figure IV.2. The arrow in the figure represents the direction of influence.

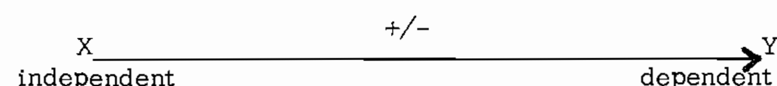


FIGURE IV.2
Relationship Between Variables

On the arrow are two designations, one positive (+), the other negative (-). The positive sign indicates that the independent variable in the relationship is associated with the dependent in such a way that when X increases (or decreases) so will Y. Thus, what happens to X will happen to Y under a positive relationship, although not necessarily to the same extent. For example, the Surgeon General of the United States has found there to be a positive relationship between cigarette smoking (the independent variable) and the incidence of lung cancer (the dependent variable). It follows that if this relationship is correct, the more one smokes cigarettes, the more likely one is to fall victim to lung cancer. Were the relationship negative, the more one smoked, the less likely one would come down with the dread disease.

The reason for this explanation is that in this exercise we are going to treat the three qualities of the health care delivery system (efficiency, equity, and cost) as dependent variables. Our intent in treating them in this way is to provide a common basis for analyzing the specifying similarities and differences among the three reform perspectives represented by the Coontz, Pauly, and Garfield articles reprinted in Section III. Briefly, our purpose is to find out what each author regards as causal, conditioning, or influencing (i.e., independent) factors for each of the three key qualities which most concern us about health care delivery.

The method is a relatively simple one. It involves a careful reading of each article in which you will find those specific factors which the author says has an impact on any or all of the three dependent variables in question. Let us consider at least one example from each of the three articles.

Coontz opens her article with a sweeping description of the cost inflation, poor service (i.e., inefficiency), and maldistribution of care which characterizes American health care today. Her first explicit attempt to specify cause for any of these is made on (her) page 73 where she provides a very general explanation: "The faults of American medicine do not lie primarily in inadequate medical technology," she states, "but in the fact that health care is a commodity that must be purchased rather than a right free for the taking." Thus, Coontz has established a relationship between "treatment of health care as a commodity" and the three dependent variables of efficiency, equity, and cost. The nature of the relationship between health care's status as a commodity

and efficiency is obviously negative; between that commodity status and equity, also negative; and between commodity status and cost, positive. These relationships are represented graphically in Figure IV.3.

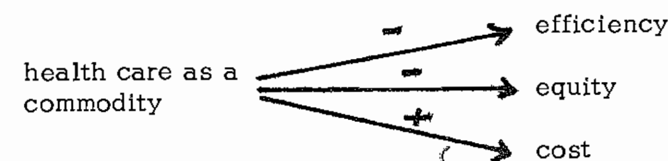


FIGURE IV.3
Example of Coontz's Relationships

The first relationship noted by Pauly is much more limited in scope and is found in the opening sentences of his article where he notes that the third-party payment system characteristic of most insurance plans has been a major cause of cost inflation. The resulting relationship is diagrammed in Figure IV.4.

FIGURE IV.4
Example of Pauly Relationship

A second factor Pauly concentrates on is the amount of insurance coverage held by Americans. Briefly stated, he posits that the fact that 90 percent of the American public is covered by health insurance is associated with both the high cost of hospitalization and the social inefficiency of health care delivery. This is shown in Figure IV.5.

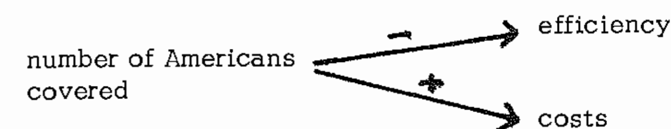


FIGURE IV.5
Example of Pauly Relationship

Finally, in the Garfield article representing the bureaucratic reform perspective, the first relationship influencing either of the three dependent variables is implied almost immediately. In the second sentence of the work Garfield notes that the combination of "dramatic advances" in medical knowledge and technology and the "soaring demands" brought on by Medicare and Medicaid "are swamping the system by which medical care is delivered." The system is facing an ever increasing gap between capabilities and the availability of care, and this is accompanied by large cost increases. Thus, Garfield writes of the system's inefficiency in being unable "to deliver" medical services and the massive price inflation which has accompanied and further aggravated the situation. Interpreting this statement for this exercise, we see that the two dependent variables

involved (efficiency and cost) are influenced by two independent variables (advances in medical knowledge/technology and high demand for services). Figure IV.6 illustrates the relationships derived from that reading.

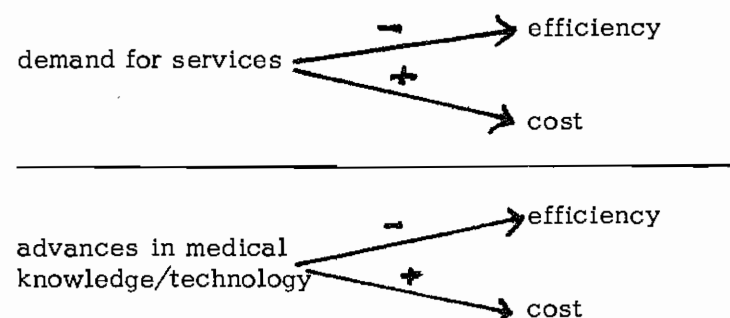


FIGURE IV.6
Examples of Garfield's Relationships

Before you continue with the task at hand, three comments are in order. First, care must be taken in looking for what each author considers to be "efficiency," "equity," or "cost." As was noted earlier, these qualities are not identically defined for each author. Nor does each author bother to call efficiency by its appropriate term. You will have to look for either obvious synonyms for each concept (e.g., "poor service" for inefficiency; "maldistribution" for inequity; and so on) or some indicator used by the author which is an obvious relevance to the variable in question (e.g., high infant mortality rates represent an indicator of inefficiency for Coontz; the consumer price index for medical services is an indicator of costs for Pauly; etc.). As an aid to carrying out the exercise, you may wish to write a list of relevant synonyms and indicators of these concepts for each article as you reread each. You will find such a list extremely valuable.

Second, that the crisis in health care delivery deals with matters of efficiency, equity, and cost does not mean that each perspective and each reformer who uses a specific perspective will address all three dependent variables. In fact, some reformers may believe that the system is efficient as it now stands, and that they basic problems are cost inflationary trends and/or the equitable treatment of those in need of medical care. Others may see the system as basically equitable or not extremely costly -- in short, they may focus on one of the problems of health care delivery to the exclusion of others. Therefore, don't be disturbed if you begin to see that an author's presentation concentrates on only one or two of the three factors we have decided to focus on for this exercise.

The third and final matter to be noted is that this exercise will demand that you apply your interpretive abilities in making explicit what might be obscured by an author. In other words, you sometimes have to trust what you believe the author is stating rather than searching for only explicit statements of relationships. You must do this with care; the point is, you must do it where necessary. In the Garfield example provided above you see such an interpretive effort.

Having provided you with these warnings and instructions, it is now up to you to complete the exercise. Forms for listing the various independent variables are provided on the following pages, with the examples already included. Note how each form is arranged and how each noted independent variable is listed along with the positive or negative direction of the relationship. Your job is to carefully reread each of the articles assigned in the previous section for the purpose of finding those variables which are posited as directly related to the three dependent factors of efficiency, equity, and cost. Examples are provided on the sheets. The question to ask while you are examining each article is what does the author consider to be important and directly relevant to each of the primary dependent variables. Having answered that question, determine whether that important and relevant factor (i.e., the discovered independent variable) is positively or negatively related to the dependent variable. As demonstrated in the examples provided, state the independent variable and the relationship you have found. Use additional sheets of paper if necessary.

1. Stephanie Coontz, "You Can't Afford To Get Sick"

a. Efficiency:

-health care as a commodity; negative

b. Equity:

-health care as a commodity; negative

c. Cost:

-health care as a commodity; positive

2. Mark V. Pauly, "Health Insurance and Hospital Behavior"

a. Efficiency:

-number of Americans covered; negative

b. Equity:

c. Cost:

-third-party payment system; positive
-number of Americans covered; positive

3. Sidney R. Garfield, "The Delivery of Medical Care"

a. Efficiency:

-demand for services; negative

-advances in medical knowledge/technology; negative

b. Equity:

c. Cost:

-demand for services; positive

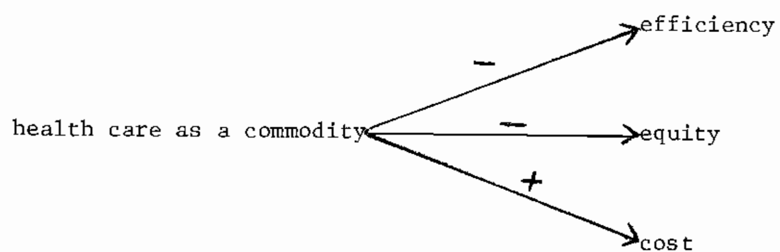
-advances in medical knowledge/technology; positive

EXERCISE SIX:

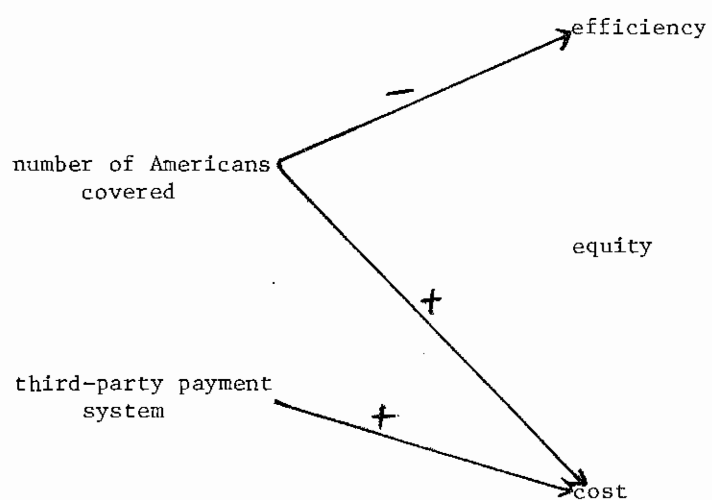
In the previous exercise you listed for each article the independent variables directly associated with health care delivery system efficiency, equity and cost variations. In the examples demonstrating how the exercise was to be carried out, each of the relationships uncovered was diagrammed. Graphics such as those are useful as a means of facilitating our understanding of what reformers are saying and how various aspects of their discussions relate to one another. As will be shown in a later exercise, the diagrams also help us compare alternative perspectives and thereby facilitate further analysis. Before moving on to a more detailed clarification of the arguments presented by each of the three authors we are studying, let us take time to produce diagrams which summarize what was uncovered in Exercise Five.

Each of the following pages provides space for the illustration of relationships uncovered in parts 1, 2, and 3 of the previous exercise. If there are any independent variables which might represent duplications of others, be sure to condense where possible. Also use this opportunity to check your reading and interpretation of the articles to see if you left any relationships off or included some which were really not stated. The examples from the previous exercise are entered where appropriate as a demonstration of what should be accomplished on these pages.

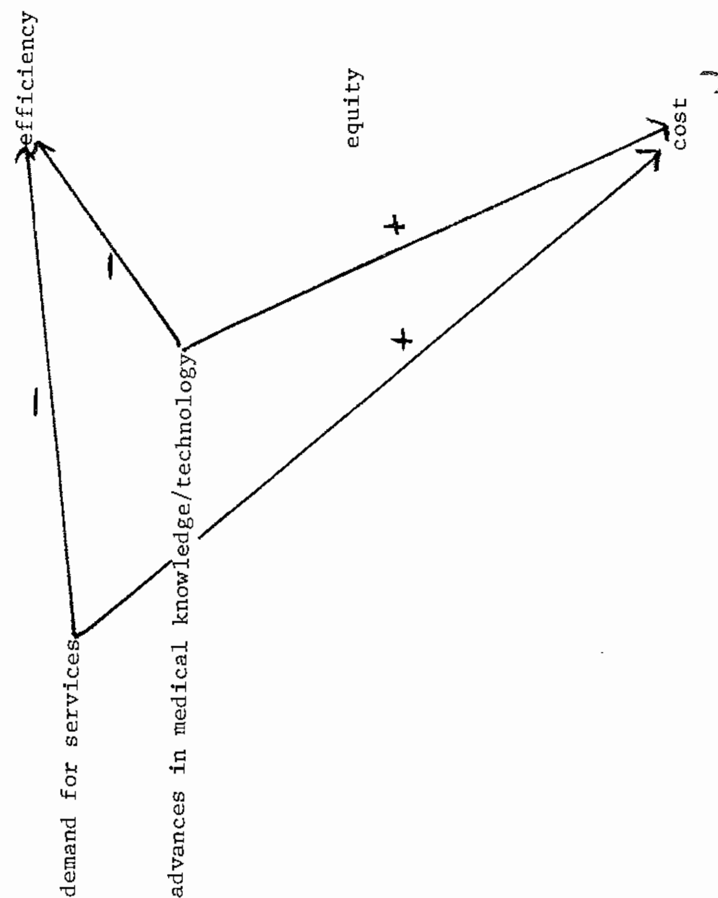
1. Stephanie Coontz, "You Can't Afford To Get Sick"



2. Mark V. Pauly, "Health Insurance and Hospital Behavior"



3. Sidney R. Garfield, "The Delivery of Medical Care"



EXERCISE SEVEN:

Up to this point we have focused on what each of the three authors has to say concerning the factors which bring about the health care delivery system's inefficiencies, inequities, or price inflation. Our concern has been for those independent variables which are directly related to the three key dependent variables. But we can, and in this exercise we shall, extend the analysis by finding those variables (if any) which each author regards as factors causing, conditioning, or otherwise influencing what we regarded as independent variables in Exercises Five and Six.

Operationally, what we will do here is shift our focus and consider those variables we previously called "independent" to now be dependent. Our objective is to find those factors which are regarded as independent in their relationship to the new dependent variables. This can be clarified by looking once again at our examples from Exercise Five. For instance, while the treatment of health care as a commodity was the independent variable noted in our example, if we shift our focus we find Coontz noting that the commodity status was positively related to the fact that American society is "capitalist." She even becomes more specific in her statement by noting that the commodity status of health care in the U.S. is even more likely since there exists no strong labor movement to push for the right to medical services. All this is summarized in Figure IV.7.

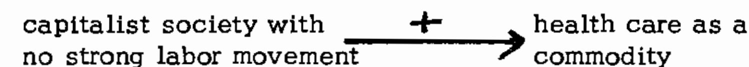


FIGURE IV.7
Example of Coontz's Relationship

This is, of course, just one way of picturing Coontz's statement. Another view is reflected in Figure IV.8 where the "capitalist society with no strong labor movement" is treated as two independent variables having an influence on "health care as a commodity."

FIGURE IV.8
Example of Coontz's Relationship

In Pauly's article, one of several explanations for the high number of American's covered by health insurance policies is noted as the tax advantages inherent in obtaining coverage. This is reflected in Figure IV.9.

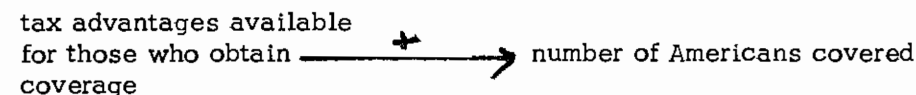


FIGURE IV.9
Example of Pauly's Relationship

And finally, in Garfield there is an explicit locus of blame for the great increase in demand for medical services: the passage and implementation of Medicare and Medicaid legislation. This is diagrammed in Figure IV.10.

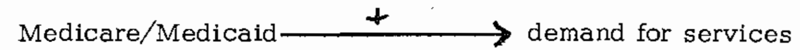
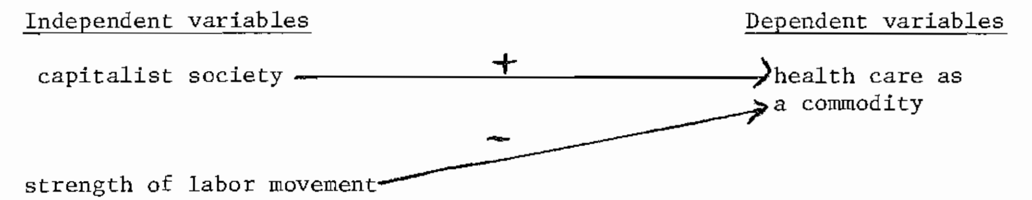


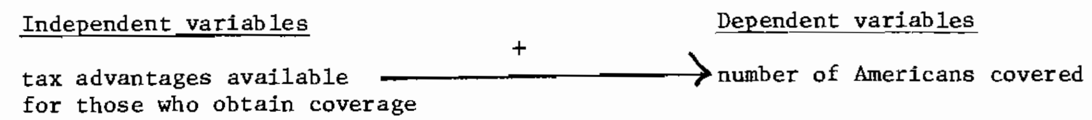
FIGURE IV.10
Example of Garfield's Relationship

The following pages can be used in accomplishing the analysis suggested here, and the examples given above are filled in where appropriate. Please note that the format of the exercise is such as to facilitate the direct use of diagrams in expressing the relationships.

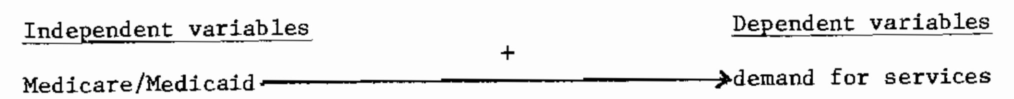
1. Stephanie Coontz, "You Can't Afford To Get Sick"



2. Mark V. Pauly, "Health Insurance and Hospital Behavior"



3. Sidney R. Garfield, "The Delivery of Medical Care"



EXERCISE EIGHT:

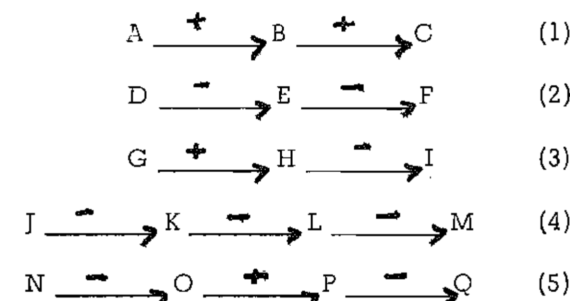
It should be evident by now that what might be a dependent variable one moment can become an independent the next and vice versa. In a very real sense, it all depends on the questions you ask and the focus of your analysis. Basic to all this is the fact that the real social world is extremely complex. This does not mean that the world is incomprehensible, but rather that it is much too complicated to be pictured as simply the relationship between two variables, one a cause and the other a result. It would be an easier world to work in for both social scientists and reformers if this were the case.

In this exercise you are asked to combine the work you have done to this point by bringing together the diagrams drawn to reflect the specific relationships found in the work of the three authors. In this process of combining relationships derived from Exercises Five, Six, and Seven, you will no doubt notice the complex interrelationships which develop. Here we are dealing with more than dependent and independent variables. If you examine the examples presented on the following pages, you will note that some of the relationships are modified. For example, combining the diagrams relevant to Coontz's presentation shows there is a relationship between "capitalist society" (the dependent variable in this case) and "equity" (an independent variable for this example). Yet the relationship is not direct; it is mediated by a third variable, "health care as a commodity." Such a mediating variable is called <u>intervening</u>. Notice that the labels "dependent," "independent," and "intervening" are applied to variables on the basis of their relative position in a relationship. The same is true for the label "<u>alternative</u> variable" which is applicable to both "capitalist society" and "strength of labor movement" in the example using the Coontz article. These are both independent variables which can be used to explain the dependent variable identified with both. Alternative variables are not necessarily mutually exclusive; they can both be regarded as explanations of the dependent variable at a given point in time.

Examples of the combining process you are to undertake in this exercise are provided on the following pages. Your task is to finish each of the diagrams using the charts developed for previous exercises.

Before attempting the combination exercise, we should consider how one reads the resulting flow chart. To this point we have been dealing with relationships between two variables, independent and dependent. Such relationships were easy to read, for they were merely positive or negative as stated. But now we face situations where there are more than two variables and one linkage involved at some points. So rather than having a situation as simple as X---+--->Y, our flow chart will reflect a more complex situation such as X---+--->Y ---−--->Z. If we wish to know the relationship between X and Y in the multiple variable relationship, the determination is both easy and obvious -- it is positive. Similarly, if we wish to find the relationship between Y and Z, that is easily noted -- it is negative. But what is the relationship between X and Z? To read these extended relationships involving intervening variables, you need to become familiar with the "sign rule."

To understand the sign rule, let us consider the following examples:



According to the sign rule,

- if all signs on links between two variables (A and C in example 1) is positive, the relationship between them is positive;
- if all signs between two variables are negative, the direction of the relationship between them depends on the number of variable linkages involved; thus
  - if the number of links are even (as between D and F in 2), then the relationship is positive;
  - if the number of links are odd (as between J and M in 4), then the relationship is negative.
- if the signs on links between two variables are mixed, then the direction of the relationship between them depends on the number of negative signs involved; thus
  - if the number of negative signs is odd (as in 3), the relationship (in this case between G and I) is negative;
  - if the number of negative signs is even (as in 5), the relationship between them (e.g., N and Q) is positive.

As a preliminary exercise, take some time to read the examples from all three articles. The purpose of this reading is to help you understand the meaning of the diagrams. Using the sign rule, see whether the following statements make sense to you:

<u>For Coontz</u>:

the relationship between . . .	and . . .	is . . .
capitalist society	efficiency	negative
capitalist society	equity	negative
capitalist society	cost	positive
strength of labor movement	efficiency	positive
strength of labor movement	equity	positive
strength of labor movement	cost	negative

For Pauly:

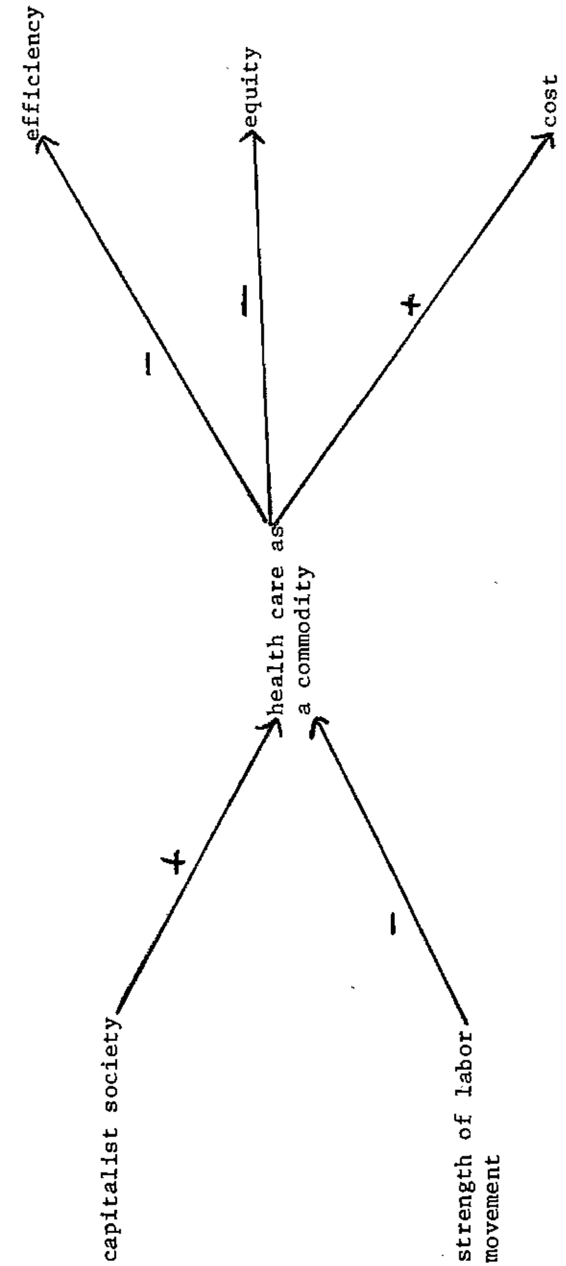
the relationship between ...	and ...	is...
tax advantages for those who obtain coverage	efficiency	negative
	cost	positive

For Garfield:

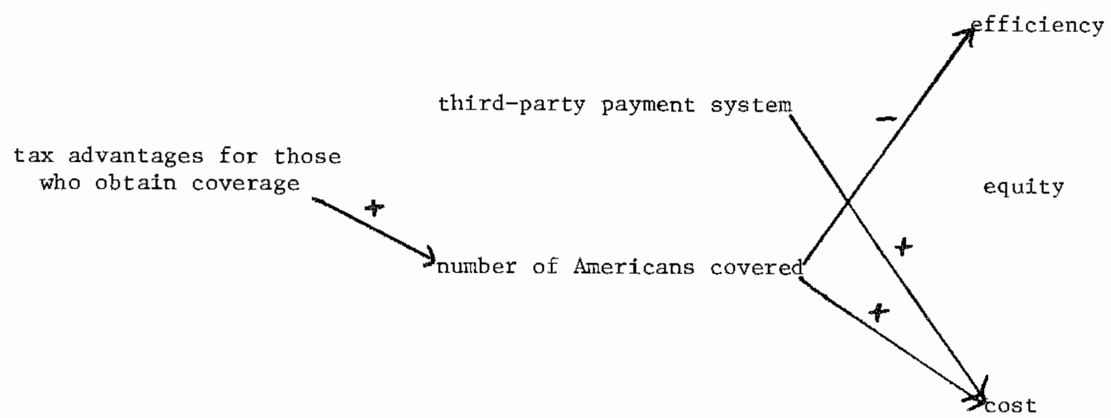
the relationship between ...	and ...	is ...
Medicare/Medicaid	efficiency	negative
Medicare/Medicaid	cost	positive

On the pages that follow, bring together the answers (i.e., flow charts) from the previous exercises into a single diagram. Be sure to apply the appropriate signs for each relationship you have uncovered. Use additional or separate sheets if needed.

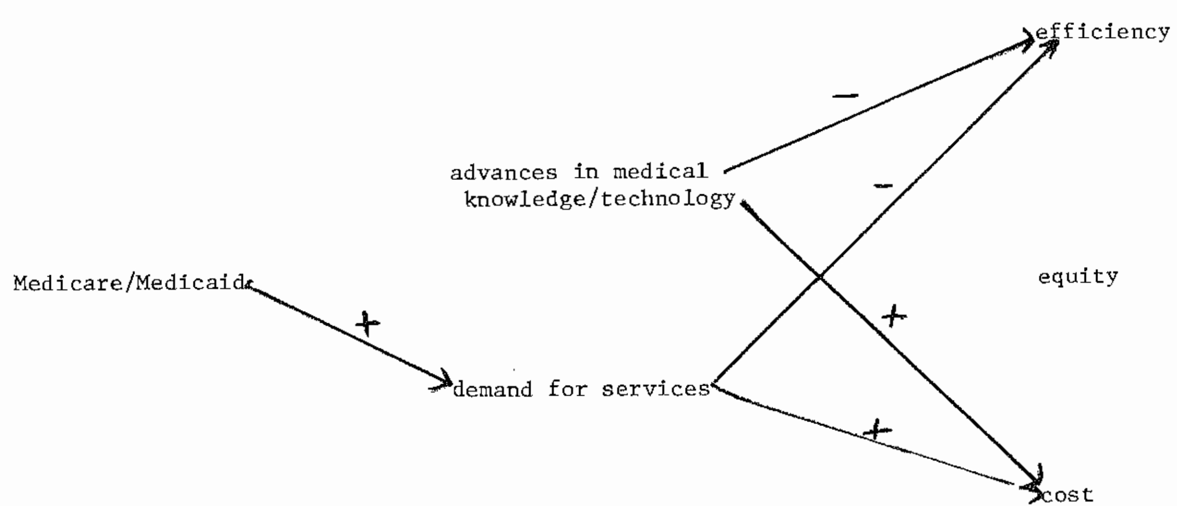
1. Stephanie Coontz, "You Can't Afford To Get Sick"



2. Mark V. Pauly, "Health Insurance and Hospital Behavior"



3. Sidney R. Garfield, "The Delivery of Medical Care"



ACTIVITY EIGHT:

After completing Exercise Eight, the class should be broken up into small discussion groups. The members of the group should share their diagrams drawn for the last exercise and discuss any differences among the answers. Disagreements among members of the group should be settled, and the information of the previous exercises pooled to construct three summary diagrams which the group will submit to the instructor as their summary of the basic contentions made by each author. Please use the sheets provided.

1. Stephanie Coontz, "You Can't Afford To Get Sick"

2. Mark V. Pauly, "Health Insurance and Hospital Behavior"

3. Sidney R. Garfield, "The Delivery of Medical Care"

EXERCISE NINE:

We have now reached that point where the assumptions of the competing policy perspectives can be compared and specific points made about how they resemble or differ from each other. In this exercise -- which can be done individually or with others in the class -- you are to take the results of your work from Exercises Five through Eight and compare the results within the framework of similarities and differences set up in the following forms. However, some preliminary comments are in order:

- FIRST, you must remember that different authors use different labels for the same phenomenon. For example, Coontz makes reference to unnecessary services provided by the health care delivery system, while Pauly implies the same activities both directly and by reference to the overuse of hospital facilities by physicians and patients. Another example is found in Coontz's reference to health maintenance organizations (HMOs) which seems synonymous (although not identical to) Pauly's references to prepayment systems of health care and Garfield's discussion of the Kaiser Plan units. Take care when you compare statements made about these variables, but where possible assume that they are discussing the same phenomenon. This will facilitate your completion of this exercise.

- SECOND, don't be disappointed if you cannot find a specific point of agreement or contention between the arguments; the task of inventorying each position as you have is a complicated and very personal one, and you may not have seen some statement in the same light as others. This is why you ought to consult with others in the class on this work -- why you should consider the general picture obtained through Activity Eight. Such cooperation would not be "cheating," but rather an example of how groups can work on a task more effectively and efficiently than can individuals.

- THIRD, be open in your search for answers to this exercise. Don't read anything into the text of an article which is not there, but at the same time play around with the logic of the author's position to see how he or she might view a particular matter if the question about it was directly put. For example, while Pauly's article is intentionally focused on the behavior of hospitals and people who are insured under certain types of policies, it would not be out of order to extend his logic to the behavior of other actors in the health care delivery system. Just take care to keep one eye on the author's assumptions so that you don't extend his or her logic too far.

Given the nature of the assignment in this exercise, it would be extremely difficult to provide you with examples of answers which might be relevant to your inventory of the three articles. Instead of offering such exemplary answers, hints have been included that might lead you to a possible answer. These are only intended as "leads" if you find yourself unable to develop your own answers. Follow up on these leads by rereading the articles in question on those specific points.

(1) On what basic assumptions do the alternative perspectives agree according to your inventory of their respective positions?

a) agreement among all three: (HINT: What do all three say about the relationship of Medicare and Medicaid to costs?)

b) agreement between Coontz and Pauly? (HINT: What do these authors say about the relationship between unnecessary services to costs?)

c) agreement between Pauly and Garfield? (HINT: What do they feel is the relationship between physician desires for income and other amenities and the efficiency of health care delivery?)

d) agreement between Coontz and Garfield? (HINT: What is the relationship each author sees between the fragmented organization of health care delivery and its efficiency?)

(2) On what basic assumptions do the alternative perspectives disagree?

a) disagreement between Coontz and Pauly: (HINT: Compare what each author says about the number of people covered by insurance and the efficiency of the health care delivery system.)

b) disagreement between Coontz and Garfield: (HINT: Compare what each has to say regarding the relationship between HMO-type organizations and the resulting efficiency of health care delivery.)

c) disagreement between Garfield and Pauly: (HINT: Compare what each has to say about the behavior of physicians and other medical personnel under a prepayment system and its impact upon efficiency.)

D. Critical Tests

Having completed Exercise Nine, you now possess the basic information needed in developing a critical test among competing policy position assumptions: an awareness of the points of agreement and contention among the alternative perspectives. Following the model offered by the "method of multiple working hypotheses," we would regard the contentions found in part 2 of the last exercise as reflections of basic disagreements between the perspectives which can only be settled through empirical tests which give credence to one position over the others. It needs to be emphasized once again that for present purposes these tests cannot prove or disprove the validity of any particular position on the reform of health care delivery in the United States. Tests of "truthfulness" are beyond the reach of social science in general and policy studies in particular. Nevertheless, critical tests and crucial experiments can provide us with information to support or question the credibility of the policy alternatives offered to us. Having that much information is a major advance in itself.

Let us consider two basic points of contention you may have found in your reading. For example, between market and bureaucratic reformers there is a basic disagreement concerning the best organizational form for the supply of health care delivery in America. For market reformers, a pluralized and fragmented supply is a prerequisite to the efficient functioning of the medical services market place. Such an organization would be flexible and adaptive to the continuous ebb and flow of demands made upon the solo practitioner and related functionaries. In short, market reformers believe the efficiency of health care delivery is facilitated by maintaining an unrestricted, unregulated, unconsolidated supply of health care providers and facilities. On the other side of the issue stand the bureaucratic reformers who regard regional consolidation and rational reorganization as the solution to the current crisis. To them, health care delivery system fragmentation is a cause of poor service, not a facilitator of efficiency. From their point of view, the basic organizational premises of market reformers is not only incorrect, but also aggravates the very problem it is said to resolve. This basic disagreement is manifested in Garfield's view that the current organization of the health care system fails to provide needed services to the well and worried well, having room only for those who are ill. This, if you recall, is Garfield's view of an inefficient system, one which wastes the resources at its disposal. This is also contrary to Pauly's claim (mostly implied) that all is well with the current organization of health care providers and that the problem lies elsewhere in the system (with the type of insurance and payment programs available). To Pauly, the current system, fragmented as it is, can provide the right services to the right people as they are needed. The objective is to give the resources to those tasks which are most urgently needed (e.g., taking care of the truly ill in an efficient manner) rather than wasting the resources on extraneous services.

Diagrammatically, the two positions are obviously contradictory. Garfield believes the current fragmentary health care delivery system in the United States will produce the inefficient use of available resources, while Pauly views that same system as potentially efficient, if only the financial aspects of the delivery mechanisms were corrected. (See Figure IV.11)

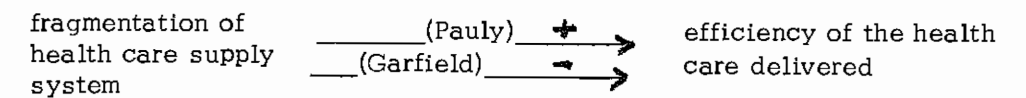


FIGURE IV.11

Two points must be noted at this time to clarify just what the disagreement does or does not involve. First, it must be stressed that what each author focuses on is the current organization of health care delivery in the U.S. This is important to note for one must be careful to reflect on the targets of each perspective's criticism rather than confusing their criticisms of one condition with another. The second point is related to the first, for we must be explicit in regard to what each author means by efficiency. For Garfield efficiency is the rational use of available resources, while for Pauly it is the rational distribution of those scarce resources among alternative uses. The differences here may seem subtle, but they can be extremely important when we try to develop a crucial test of these competing positions.

For example, say we wish to develop a critical experiment to test for the relative credibility of Garfield's and Pauly's positions based on this particular point of contention. The first thing to ask is for a specification of exactly what is being disputed. As we have noted, both are speaking of the current organization of the health care delivery system as the independent variable, and both view that current system as fragmented, i.e., lacking in any bureaucratic coordination. Thus our test might be based on a comparison between two communities which, except for the organization of their health care system, are in every way alike. Were it possible to find two such communities (a highly unlikely possibility in fact, although one might find two very similar communities with different health care systems), the next question would be whether the difference in their health care delivery systems reflects the points made by Pauly and Garfield. If one community had a system dominated by a single hospital and one or two prepayment clinics (e.g., HMOs) while the other had a traditionally fragmented system, then a reliable critical experiment might be possible.

Even were the conditions available, we must consider which possible dependent variable we would measure -- Garfield's view of efficiency or Pauly's. Under Garfield's measure we would evaluate how the "well and worried well" are being treated in both communities, Garfield's argument positing they would be better treated in the bureaucratized system as opposed to the traditional. Pauly's test of efficiency would measure to what extent the resources available for health services were going to those most in need. Here the more traditional measures of "cost effectiveness" (e.g., how much care is being received for each additional dollar spent) might be applied to the delivery systems in both communities, the one proving most cost effective getting the nod as being more efficient.

If two similar communities were not available and research resources were, it might be possible to accomplish the crucial test between Garfield and Pauly by focusing on one community as it moved over a period of time from a fragmented health care system to a more bureaucratic. For example, let us assume that corporation X in your city currently has a Blue Cross/Blue Shield Plan for its employees and all are enrolled. You read in this morning's paper that X's personnel office has announced the Blue Cross/Blue Shield Plan will be replaced next year with membership in a local HMO. Here is a grand opportunity, for it might be possible to develop measures of the efficiency of health care delivered to workers of company X both before and after the shift from a private and highly traditional system to the consolidated HMO system. There are, of course, numerous problems. First of all, Pauly is as critical of Blue Cross/Blue Shield Plans as he is of the potential of HMOs. He might dismiss any findings contrary to his assumptions as

not reflecting his position that the fragmented system without the current financing scheme will be more efficient than it is with it. A second problem is in the test of efficiency itself, for one must decide which definition should be applied in the experiment. If you use the amount of service provided to the well and worried well, Pauly's position defenders could regard the test as irrelevant; if you used cost effectiveness, Garfield's supporters could make the same charge. In addition, there are any number of technical problems to consider. The measurement of any variable over time reflects the impact of many factors, not merely the one a researcher designates as the "cause." It is unlikely that any critical test can hold everything constant except the change in health care plans, especially over a period of one year or more. Thus what might seem to be an increase in efficiency due to a change from Blue Cross/Blue Shield to HMOs may in fact be the result of cleaner air or purified water, better weather conditions, or even a fad in which the company employees all became exercise fanatics running 5 miles per day and staying in good (and healthy) shape.

We do not intend to discuss research design problems in detail in this module other than to make the point that while critical tests and crucial experiments might be desirable, they might not be feasible -- technically and otherwise. This becomes even more evident when we consider a second point of contention, this one between Coontz and the other two perspectives. Of the three perspectives, only Coontz advocates the nationalization of health care, her point being that this will guarantee the treatment of health care as a right rather than a commodity, thus leading to increased efficiency and equity, and decreases in costs as she defines those variables. In a world where the national organization of health care varies from the privately owned and operated to the substantially nationalized, it might be possible to make comparisons of health care efficiency, equity, and costs between systems which differ along this specific dimension. Coontz refers to one such study done by the U.N. International Labor Organization which shows that systems improve in the delivery of health care as they are disconnected from private sector control. She goes on to cite other studies which indicate the same results. Does this make her perspective more credible than the others? Answering that question would entail more investigations -- studies based not only on Coontz's views of efficiency, equity, and cost, but also the meanings those terms have for Pauly, Garfield, and other reformers. In addition, showing evidence that Coontz's position is credible does not mean some equally valid studies cannot be cited which show Pauly, Garfield, or others to be just as credible. Then what?

CONCLUSION:
A Prelude to Research

As you can see, we have reached an important juncture in this module where there are a number of new and interesting questions being raised. To this point we have established that different policy proposals regarding health care delivery in the United States are based on alternative sets of assumptions. On certain points these assumptions are similar, but on many substantial matters they differ. You have seen how these differences and similarities can be made explicit through a careful process of analysis and diagramming. You have also seen how these can be used to compare policy alternatives, the assumption being that more credible premises are likely to lead to more credible conclusions (i.e., policy proposals). Having established all this, the questions now raised deal with the matter of how one goes about testing the competing alternatives. Where Pauly and Coontz and Garfield differ, can we determine which set of assumptions is more credible? Is Pauly's view on the organization of health care delivery more credible than Garfield's? Are Coontz's beliefs about the treatment of health care as market commodities more warrantable than Pauly's premises? Is Garfield's assumption that the problem of health care delivery in the United States today is rooted in poor organization more reliable than Pauly's position that it is based in the distorted demand schedule of Americans seeking medical services? These are empirical questions, and to answer them we must turn to valid and reliable empirical research methods.

A sufficient discussion of critical tests and research designs cannot be accomplished in this short module. Evaluating competing policy assumptions is a difficult and serious task which must not be dealt with lightly. It should go without saying that the results of such research must also be seen in light of other evidence, for no empirical test -- regardless of how well designed and carefully implemented -- is going to supply information which is completely valid or wholly reliable. Yet evidence from such research should be considered as one among several means for helping policymakers and others systematically make some of the critical choices they face from time to time. What we have attempted to do here is familiarize you with this approach with the hope that your interest for both health care reform and public policy analysis will be extended to include an interest in the research which should follow.

Bibliography and Guide to Some Helpful Sources:

As is probably evident by now, the debate over health care delivery has generated a voluminous literature. The resources for any student concerned with this issue are so vast that it would be impossible to attempt any semblance of a listing on these few pages. In addition there is the matter of providing you with some citations on the public policy analysis approach we have applied in this module. To facilitate your research on these various matters while not inundating you with too extensive a list of titles, the following bibliography is organized along the lines of the module presentation itself and the number of citations is held to "readable" minimum.

I. The Problems of Health Care Delivery

The problems related to the delivery of health care in the U.S. come in a variety of forms. Some are technical, others financial, but all have an impact on the personal lives of millions of Americans. There are several works which focus on these problems and their dimensions; some even challenge the idea that there are problems. While they are often works written in the tradition of "muckraking" journalism, this does not detract from the picture they provide of Americans contending with their health care system.

1. Edwards, Marvin H. Hazardous to your Health: A New Look at the "Health Care Crisis" in America. New Rochelle, N.Y.: Arlington House, 1972.
2. Ehrenreich, Barbara and John. The American Health Empire: Power, Profits, and Politics. New York: Vintage Books, 1970.
3. Kennedy, Edward M. In Critical Condition: The Crisis in American Health Care. New York: Simon and Schuster, 1972.
4. Klaw, Spencer. The Great American Medicine Show: The Unhealthy State of U.S. Medical Care, and What Can Be Done About It. New York: The Viking Press, 1975.
5. Kotelchuck, David, ed. Prognosis Negative: Crisis in the Health Care System. New York: Vintage Books, 1976.
6. Magnuson, Warren G. and Segal, Elliot A. How Much For Health? Washington, D.C.: Robert B. Luce, Inc., 1974.

II. Proposals for Health Care Delivery Reform

Perhaps the place to start here is to consider some historical background material which might explain just how national health care delivery policy came to be what it currently is. For this purpose see one of the following:

1. Feingold, Eugene. Medicare: Policy and Politics. San Francisco: Chandler Publishing Co., 1966.
2. Marmor, Theodore R. The Politics of Medicare. Chicago: Aldine Publishing Co., 1973.
3. Sundquist, James L. Politics and Policy: The Eisenhower, Kennedy, and Johnson Years. Washington, D.C.: The Brookings Institution, 1968; see Chapter VIII.

On the current issues, especially the various proposals for national health insurance, see:

1. Davis, Karen. National Health Insurance: Benefits, Costs and Consequences. Washington, D.C.: The Brookings Institution, 1975.
2. de Lesseps, Suzanne, "Controlling Health Costs," in Editorial Research Reports on National Health Issues, edited by Congressional Quarterly. Washington, D.C.: Congressional Quarterly, Inc., 1977; pp.1-20.

3. Margolis, Richard J. "National Health Insurance -- The Dream Whose Time Has Come?" New York Times Magazine, January 9, 1977.
4. Russell, Louise B. "Medical Care Costs," in Setting National Priorities: The 1978 Budget, edited by Joseph A. Pechman. Washington, D.C.: The Brookings Institution, 1977; Chapter 6.

III. The Debate: Three Views on Health Care Delivery

The Robert Alford book cited in the body of the module provides a summary of the general debate, especially Chapters 1 and 8. Then there are the three works used in this module to illustrate each of the primary views. As was noted before, each is fairly representative of the position they represent. However, there are other works which can help provide more background for each approach.

The radical reformist perspective is reflected in the publications of the Health Policy Advisory Center (Health-PAC) which includes two of those cited under part I of this bibliography, specifically the Ehrenreich and Kotelchuck works. Other versions of the radical reformist argument are usually found within the context of more general critical presentations on life in America. See, for instance, the collection of readings edited by Richard C. Edwards, Michael Reich, and Thomas E. Weisskopf titled The Capitalist System: A Radical Analysis of American Society (second edition. Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1978); also see comments on health care by Charles H. Anderson in his The Political Economy of Social Class (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1974).

For a broad view of the market reform approach, see the essays which accompanied the Pauly presentation in New Directions in Public Health Care: An Evaluation of Proposals for National Health Insurance, edited by Cotton M. Lindsay for the Institute for Contemporary Studies of San Francisco (1976). A more direct assertion of the market perspective was provided by Harry Schwartz in his "Health Care in America: A Heretical Diagnosis," published in the August 14, 1971 issue of Saturday Review (pp. 14-17, 55).

The bureaucratic reform approach is well represented by the Garfield article which is a classic in its own right. Other analysts have been looking at this solution, however, and some of their works -- although perhaps technical in places -- may well be worth a look. Specifically, see:

Lehman, Edward W., Coordinating Health Care: Explorations in Interorganizational Relations. Beverly Hills, Ca.: Sage Publications, 1975.

Somers, Anne R. Health Care In Transition: Directions for the Future. Chicago: Hospital Research and Educational Trust, 1971.

IV. Analyzing Competing Policy Alternatives

The approach used here owes much to the work of Elinor Ostrom who has used it in her courses and research at Indiana University. For those interested in examples of this approach, see the following:

Dubnick, Mel. "Comparing Policy Alternatives," Policy Studies Journal, 6 (Spring, 1978): 368-375.
Gant, William R. "Applying Political Theory," Change, 8 (July, 1976): 64-67.
"Metropolitan Reform: Propositions Derived From Two Traditions," Social Science Quarterly, 53 (December, 1972): 474-493.
Ostrom, Elinor. Urban Policy Analysis: An Institutional Approach. Washington, D.C.: American Association for the Advancement of Science, forthcoming.

The methodology of the crucial experiment or critical test underlies this approach, and for those interested in looking further at this subject, the following would be useful:

Chamberlin, T.C. "The Method of Multiple Working Hypotheses," reprinted in Science, 148 (May 7, 1965): 754-759.
McDavid, James C. "'Crucial Testing' for the Study of Complex Institutions," in Problems of Theory in Policy Analysis, edited by Phillip M. Gregg. Lexington, Mass.: Lexington Books, 1976, pp.137-147.
Platt, John R. "Strong Inference," Science, 146 (October 16, 1965): 347-353.
Stinchcombe, Arthur L. Constructing Social Theories. New York: Harcourt, Brace and World, Inc., 1968; pp. 24-28.

Your Evaluation Form

In order to improve this learning module, we would appreciate your answers to the following questions. Your completed survey will be sent to the American Political Science Association and the results forwarded to the author of the module so that the module can be revised for final publication.

PART A
General Information

Date ________________

1. Your college or university:

____

2. Exact title of course (please give the name, not the course number)

____

3. How many social science courses (i.e., courses in political science, economics, sociology, anthropology and psychology) did you complete before taking this course?

_____ (Please indicate the total number of such courses)

4. Head instructor for this course:

____

5. Was this analytical module taught by a teaching assistant?

a. _____ Yes Name ________________
b. _____ No

6. Are you a:

a. _____ Freshman
b. _____ Sophomore
c. _____ Junior
d. _____ Senior
e. _____ Graduate student

7. Is your major field of concentration:

a. _____ Political Science
b. _____ Other; please specify ________________
c. _____ No major yet

PART B
Evaluation of the Supplementary Analytical Unit

8. How would you rate this analytical module in terms of the following:

	Excellent	Good	Adequate	Poor
a. clarity of the author's explanation				
b. clarity of figures and tables				
c. quality of the exercises				
d. quality of factual material which was presented				
e. clearness with which the module differentiates among varying analytical approaches				
f. readability of the text				

9. How would you rate this module in terms of accomplishing the following goals:

	Excellent	Good	Adequate	Poor
a. acquiring knowledge about government and politics				
b. understanding concepts and theoretical approaches				
c. providing experiences in political research				
d. understanding relations between theoretical approaches and facts				
e. stimulating you to do research				
f. actively engaging you in instructional material				
g. extending your analytical skills				

10. How would you characterize the following aspects of this analytical unit:

	very interesting	interesting	adequate	dull
a. text of the module				
b. figures and tables				
c. factual material				
d. exercises				
e. presentation of analytical approaches				

11. How well did this module fit together with:

	very well	well	adequately	poorly
a. course lectures				
b. course textbook and readings				
c. other activities in the course (such as discussions, audio visual materials, etc.)				

12. Which exercises from the module did you do?

13. Which exercises stand out as particularly good; bad; and why?

14. Did you learn something from the use of this module that you did not learn from other course materials?

a. ________ Yes
b. ________ No

If your answer (to question 14) is yes, what did you learn that was different?

15. Taking everything into account, would you recommend that political science courses:

a. ________ use many more such materials
b. ________ use more such materials
c. ________ don't know
d. ________ use fewer such materials
e. ________ use far fewer such materials

16. What other suggestions do you have that might help make this analytical unit a better learning module?

Thank you for your time and trouble in filling this out.