in industrial structure caused by international competition or increases in female labor force participation may be the explanation, but at this point they are only hypotheses that have not been adequately tested. We, in fact, don't even know whether the increased variance of earnings reflects increases in permanent or transitory income.

Which leaves this review in an awkward position. Isabel Sawhill has argued that it may not do us very much good to know that increases in inequality are as important as lowered economic growth in accounting for changes in poverty if we don't know why inequality is growing.[1] Another way of putting it is that we may know as little about why inequality has increased as we know about why growth has slowed. But just as the profession has devoted considerable resources to trying to account for the reduction in growth, I see the profession starting to pay attention to what I consider to be an equally important problem.

We are slowly making progress in a field whose intellectual roots and methodology can be traced back to a few influential people, among them Robert Lampman.■

[1] "Poverty in the U.S.: Why Is It So Persistent?" *Journal of Economic Literature*, 26 (September 1988), 1073-1119. Also available as IRP Reprint No. 599.

Thoughts on access to health care

by Burton A. Weisbrod

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Concern about normative, distributional aspects of antipoverty policy have occupied a central place in Robert Lampman's research career. The following remarks address some issues involving access by the poor to medical care and to compensation for accidental injury or death. My goal is to identify issues worthy of further thought and analysis. I will assert a number of propositions and then indicate briefly some analytic or policy issue involved with each.

> Proposition 1. From a normative, equity, perspective, health care services are "fundamentally" different from standard commodities such as a chocolate cookie; thus, it is widely held that access to health care should not be determined by ability to pay.

Some elements of an individual's health status, medical "need" for health care, and the effectiveness of health services received depend heavily on heredity and on environment before birth and during childhood. Even so, access to health care can have a major effect on health status. There appears to be widespread agreement that grossly unequal initial endowments of health status—especially at birth and during childhood—*should not* be permitted to determine lifetime opportunities. Such a view can be the result of an ethical judgment that access to health care, especially for pregnant women and for children, should be made as from behind a Rawlsian "veil of ignorance"—that is it should be determined as if by individuals who did not know whether their families could afford to purchase care.

An important question is how far such an ethical judgment does and should extend. Should it apply to adults? The older a person is, the weaker is the argument that health status is essentially exogenous. For an infant there is no doubt; for a 40-year-old it is less clear. Relatedly, to what extent should a social guarantee of access to health care be conditioned on

whether the individual "contributed" to his or her poor health? Should an alcoholic in "need" of a liver transplant to survive be guaranteed access to it? Should motorcyclists who do not wear helmets be assured of medical care in the event of an accident, regardless of ability to pay? What of automobile riders who do not wear seatbelts? Smokers who develop heart disease?

If society judges that access to some well-defined health care should be provided to persons, such as children, for whom the "bad luck" of being born into a poor family ought not be permitted to determine lifetime opportunities, to what extent should access to other investments, especially education, be similarly distributed independent (or less dependent) of ability to pay?

> Proposition 2. If a social judgment is reached that the poor should be assured access to medical care, there remains great ambiguity as to how far that access should be extended.

The cost of guaranteeing full access to the very latest technologies would surely be staggering, although it has not been estimated seriously. If access is to be assured to some level of "basic" health care, how should that level be defined and operationalized?

> Proposition 3. The level of basic health care is likely to be a function of the state of medical technology; thus, with technological change in health care comes the need for redefining the basic level.

This is complicated enough, but the issue is even more involved once we recognize that the rate and character of technological change depend on incentives to do research and development, which depend, in turn, on the market demand for new technologies. A public policy that assures access to medical care also assures demand for new technologies; thus, the cost of providing access by the poor to medical care is not the cost of making available a fixed array of services but rather an endogenously determined constellation of medical services.

> Proposition 4. How to define "health care"—to which access is to be assured through social policy—is a complex issue, made more complicated by the changing technology.

One example can illustrate the issue—*in vitro* fertilization for women who would otherwise be unable to bear children. There is currently debate over whether the cost of *in vitro* fertilization should be covered under private health insurance contracts; although the issue of access by the poor to this technology has not yet surfaced as a major issue, it illustrates the growing ambiguity of what should be regarded as within the realm of the "health care" that is financed socially; indeed, the question is already being raised as to whether the ability to bear a child should or should not be regarded as an issue of medical care. There are substantial cost implications of alternative definitions.

> Proposition 5. From the perspective of allocating resources efficiently, the value that people place on their own, or someone else's, life and health status is an important variable; yet the willingness-to-pay approach has virtually no support except among economists.

Why this is the case is worthy of attention. Does it reflect a societal view that allocative efficiency is simply irrelevant when human life is involved? Not likely. Courts hearing cases involving wrongful death and disability do not disregard differences among the injured in what are termed "economic losses"; while they routinely disregard willingness-to-pay arguments as a basis for measuring those losses, they do accept the "human capital" estimates of foregone earnings. In short, courts do go beyond treating all plaintiffs as deserving of equal access to compensation but do not use the conceptual basis for valuing losses that prevails among economists. The matter of how to value life and limb goes beyond issues of access of the poor to medical care. However, insofar as such values are lower for the poor they relate to the broad question of allocating resources to health-promoting uses such as disease and accident prevention as well as to care for those already ill.

These brief remarks touch on but some of the issues one encounters in thinking about the distribution of resources for promoting the health of the poor.■