Health, economics, and health economics

In 1981, it has been estimated, 22 percent of all federal and state government expenditures on income support programs in the United States will go to Medicare and Medicaid.[1] For the nation as a whole, the costs of medical care are absorbing rapidly increasing shares of national resources; in 1950, national health expenditures were $12 billion—4.5 percent of GNP; in 1965, the year before Medicare and Medicaid were put into operation, they totaled $43 billion—6.4 percent of GNP; and in 1978 they were $192 billion—9.1 percent of GNP.[2] It is not surprising that the need to find administratively and politically feasible ways to control these costs has become a central issue for researchers and policymakers alike.

Research interest in the economics of health care has grown steadily, worldwide, over the last quarter century. Both the amount of information available and the sophistication of methodological approaches have been greatly advanced by several conferences on the topic. The latest, and perhaps the most truly international, with far wider representation of European and Asian scholars than any preceding conference, was held at Leiden, The Netherlands, in September 1980. A selection of the papers presented at the conference has now been edited by Jacques van der Gaag, research associate at the Institute for Research on Poverty, and Mark Perlman, professor of economics at the University of Pittsburgh. The volume will be published in summer 1981 under the title *Health, Economics, and Health Economics* (Amsterdam: North-Holland).

With a wealth of submitted papers to choose from, the editors have focused upon five main areas: the role of government, the demand for medical services, physician behavior, the measurement of health status, and the structure of the health care market. Research represented in this volume moves beyond the kinds of cost-benefit analysis that have been the traditional focus of health economic research to question some of the long-accepted assumptions about rights to health care, about the character and purpose of government intervention, and about the behavior of physicians, not as healers, but as economic agents. Research over the last decade is reviewed and new directions are indicated; European and American experiences, especially with government intervention, are compared; new ways of measuring supply of and demand for health care—indeed, for measuring the "commodity" of health itself—are set forth; and early results are reported from the Health Insurance Study being conducted by The Rand Corporation on behalf of the U.S. Department of Health and Human Services.

The character of the volume can perhaps best be indicated by noting some of the more interesting and provocative issues addressed by the authors in their own words, in the following excerpts arranged under the main topics.

The role of government

"Health care is not and never has been a commodity whose production and distribution satisfied the conditions for optimal allocation through competitive markets. . . . Until recently, however, the available technology made it relatively inexpensive to regard health care as a right, not as an ordinary economic commodity. Little economic waste attended this approach. The recent and continuing revolution in the technology of medical care has inflated the cost of that right. . . . The scope for waste is large and getting larger. Nations can deal with this situation (a) by accepting waste as a price of sustaining a valued approach to human life and of maintaining an institution that contributes to social solidarity, (b) by imposing regulations to curb the natural tendency of a zero-marginal-cost, positive-marginal-revenue system to generate waste, (c) by imposing budget limits on providers, (d) by increasing cost sharing for patients, (e) by putting providers at financial risk, or by some combination of all of the above. Unless countries choose option (a), the role of governments as guarantors of the right to health care must end. They will be forced increasingly to make ethically painful decisions about what care shall not be provided."

Henry Aaron, "Economic Aspects of the Role of Government in Health Care"

The demand for medical services

"When most consumers are insured, the behavior of the insurer as well as the consumer becomes presumptively relevant to the reimbursement that the provider receives. . . . How prices and utilization behave in heavily insured markets looms as one of the most important frontiers to explore. . . . Many believe that the United States has too many surgeons, and too few primary care physicians such as pediatricians. The study of Fuchs et al. (1972), for instance, suggests underemployment among surgeons. Suppose these beliefs are true; what might explain them? The pattern is suggestive of markets with prices fixed at levels other than the price in competitive equilibrium. Could prices be fixed? Insurance coverage for physicians whose services are mostly rendered in the hospital, such as surgeons, has historically been quite extensive, whereas insurance for physicians whose services are primarily delivered on an outpatient basis, such as pediatricians, has been more scanty. Might extensive insurance coverage have fixed fees in a way that induced exces-

sive entrance into specialties such as surgery? The standard partial equilibrium model suggests not; if prices are flexible, surgeons should not be underemployed. Alas, we seem to have no theory other than the standard model to explain how prices are set in heavily insured markets and whether they might be set so as to induce an inappropriate distribution of physicians across specialties."

Joseph P. Newhouse, "The Demand for Medical Care Services"

Physician behavior

"Economists and public policymakers have tended to focus on unit prices or unit costs of health care services because those are the variables their tools can measure and control. . . . Such a focus . . . produces an incomplete view. Provider-determined variations in utilization may be of much greater interest from the point of view of cost-reduction. Inducing providers to curtail the rendering of those services which yield very low or no marginal health value may be a far more effective and acceptable way to limit spending than attempts to reduce the price or unit cost of services, or to make consumers pay a larger fraction of the price. . . .

"In the United States, the largest and (with the exception of nursing home care) the fastest growing component of health care spending is hospital services. . . . While physicians' services account for less than one fifth of the grand total, physicians control or exert a very strong influence over most of the rest of health care spending, especially hospital spending. Physicians recommend hospitalization and admit patients. They recommend and perform surgery. They order and may perform other diagnostic and therapeutic procedures. They prescribe drugs, and they decide when to discharge patients. Blumberg (1979) has estimated that physicians control 70% of total health spending. Thus, physician propensities to prescribe costly services are of particular interest from the point of view of total health care spending."

Alain C. Enthoven, "The Behavior of Health Care Agents"

The measurement of health status

"There are a myriad of ways in which health can be characterized . . . for the purposes to which I see this health status measure being put, measures based simply on presence or absence of disease, or on changes in mortality, are inappropriate. . . . The best measure of health for the purpose of economic evaluation must be a 'feeling-functional' one, in which the presumed ideal is a long life in which each individual is able to undertake the normal pattern of activities free of pain and distress. . . . Since 'normal' functioning is a socially conditioned notion, this notion of healthiness may well fall short of 'perfect' health, in the sense of the maximum attainable by anyone, anywhere, ever. Rather it will have the more modest (and more useful) connotation of accepting that there is a threshold below which society considers someone as 'to all intents and purposes' healthy (warts and all, and although not 100% fit as judged by Olympic standards).

"But what lies at the opposite extreme from healthy? The obvious answer seems to be 'dead,' but herein lies a hornet's nest of problems which are not at all easy to resolve. For instance, it could be argued that the opposite of 'pain-free ability to conduct normal activities,' is 'in very severe pain and totally unable to conduct normal activities.' It may further be asserted that this is worse than being unconscious (i.e., in no pain but totally unable to conduct normal activities), and perhaps even worse than being dead (as witness: the proponents of voluntary euthanasia). There are two ways of resolving this dilemma in the present context. One is to constrain individuals to conform to society's view (whatever that is), by postulating what the worst state is . . . . The other is to let each individual choose which is the worst (i.e., zero-valued) state, and let that be part of the realm of individual valuation."

Alan Williams, "Welfare Economics and Health Status Measurement"

The market for health care

"A comprehensive national insurance system would recognize that it is in the interest of both individuals and the society at large to provide the entire population with access, at low money and time price, to certain minimal levels of health care. Above these minimums a system of deductibles and coinsurance would restrain demand, with some exemptions for low-income families. Thus, above the minimum levels the consumer would pay all or part of the cost of care. The traditional objection to national health insurance has been that the system would boost demand and lead to substantial cost increases. In recent years, however, such cost increases have occurred in the absence of a national health insurance plan. Given the substantial share of cost already paid by third parties, especially the federal government, a comprehensive system of national health insurance may, in fact, restrain, rather than promote cost increases."

Michael D. Intriligator, "Major Policy Issues in the Economics of Health Care in the United States"

---

[1]Irwin Garfinkel, "Overview," Table 1.1, in Irwin Garfinkel, ed., *Income-Tested Transfer Programs: The Case For and Against* (New York: Academic Press, forthcoming).

[2]Figures for 1950 from R. M. Gibson and C. R. Fisher, "National Health Expenditures, Fiscal Year 1977," *Social Security Bulletin, 41* (July 1978), p. 5; remainder from *Statistical Abstract of the United States, 1979,* Table 145, p. 101, Table 715, p. 437.