TABLE MANNERS AT THE HEALTH CARE FEAST

by Uwe E. Reinhardt

"Medicine and deregulation go together like a horse and carriage," declared Susan Stone in her regular column in the *American College of Physicians Observer* upon President Reagan's assumption of the presidency. "Conservatives' promotion of deregulation and *laissez-faire* doctrines foretell an era of re-examination of Great Society programs." She goes on to report: "Traditional Republican marketplace economic theories promise to play a large role in the formulation of National Health Insurance legislation. . . . The name of the game from now on is competitive."[1]

The excitement seems widely shared among commentators on health affairs and, curiously, even among the providers of health services. It is an excitement vaguely reminiscent of the months preceding the outbreak of armed conflict. Everybody involved in such a conflict is certain of victory. While some blood may be spilled along the way, that blood is expected to be someone else's and, in any event, a worthy price for victory. Warfare thrives on such euphoria and so, apparently, does health policy in the 1980s.

But just as armed warfare tends to bring with it many an unpleasant surprise, so may the eagerly awaited economic warfare soon to be unleashed in the health care market. There may be more than a few casualties, and some of the nicest folks may receive direct hits. At this point it is not at all clear who the ultimate victors in the anticipated scramble for health care dollars will be.

Much will depend, of course, upon the *Conventions*—the rules and regulations—society will impose upon this scramble. If economist Milton Friedman and his disciples have their way, there will be few holds barred.[2] The health care sector will become the analog of the infamous Russian front of World War II. For, unlike the marketeers of the corporate-state school, who believe in competition within what they call "orderly markets," Friedman and his disciples truly believe in unfettered economic warfare. They believe in it just as fiercely as General George Patton believed in shooting wars. Patton's glory, of course, was short-lived, and so may be the glory of the true

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marketeers who have managed to jump on board the new administration. These true believers will sooner or later come to be despised for their relentless attacks on the pastoral tranquility of "orderly markets." They are dangerous and thus quite probably an endangered species.

In this essay I shall elaborate on these musings. I shall make the point that, in the profane discourse of noneconomists, such hallowed words as "free markets," "laissez-faire," and "competition" have been debased. They mean different things to different people. Only this confusion in terms can explain how a vision so intrinsically controversial as a truly competitive health care market could have produced so much euphoria.

The terms "deregulation," "laissez-faire," and "free markets," for example, are often used simply as code words to describe the *selective* elimination of whatever government regulation one finds burdensome. The emphasis here is on the word "selective," for the advocates of deregulation in medicine do not invariably favor a wholesale retreat of government regulators. Is one to assume, for example, that physicians and dentists who now celebrate the impending deregulation of medicine are implicitly advocating the abolition of mandatory professional licensure? Would they actually favor letting pediatric nurse practitioners and dental hygienists practice independent entrepreneurship and compete head-on with physicians and dentists? Yet this is precisely what "laissez-faire" means in French. The question is an interesting one, surely, and one to which the advocates of competitive health care markets will soon have to respond explicitly, because there is an alternative interpretation of "laissez-faire" and "free markets": for example, the harsh vision projected by Friedman in *Capitalism and Freedom,* a world in which consumers reign supreme and in which there is absolutely no place for protection of economic turf through the coercive power of government (licensure).

With the rise of the marketeers to political power, those who cheered them on must now be called on to articulate clearly just what they meant, and now mean, by the term "free markets," and what, if any, constraints ought to be placed on competitive forces in health care. It is my purpose to tease the participants in this conference out of their respective closets on this issue. My strategy to that end will be the following.

In the second section I shall describe briefly the emerging competitive pressures in the health care sector and sketch as vividly as I can the economist's vision of laissez-faire and freely competitive markets. I do so with the thought that, if we are to debate the age-old issue of regulation versus competitive markets, we ought to do it in the technically precise language developed by the professionals properly licensed to define such terms—economists.

Furthermore, I present the economist's vision of freely competitive markets in the expectation that the mere description of such a market environment will make most health care providers blanch and run for rescue by—you guessed it—the public sector.

Upon completion of that sadistic exercise, I shall become humane once again and allow, in the third section, that reasonable and honorable persons might prefer "government-regulated competition" to the Friedmanesque vision of the free-for-all. Health care providers will breathe easier in this section. On the other hand, I must at the same time rob them of the illusion that government-regulated competition is an unmixed blessing, that it either can be or ought to be purely provider inspired. Government-regulated competition inevitably invites the government into the health care sector, for better or for worse, if only because feuding providers will look to the government for arbitration of their squabbles.[3] Furthermore, government-regulated competition in health care requires us to reach a political consensus on the extent of government intrusion, and neither reaching nor living with this consensus will be peaceful.

Finally, I shall ask in the fourth section how much competitive economic pressure can be prudently imposed on the key decision-maker in health care, the physician. Do patients really want to have their bodies invaded by persons engaged in fierce economic warfare? I do not offer any insight on this question; I merely raise it for further debate, and expect to come away enlightened.

Throughout the composition of this essay I have been reminded of a fabulous story attributed to that great observer of the animal world, Konrad Lorenz. Two canines meet face to face through a picket fence. Their ferocious snarls suggest beyond any doubt that they would devour one another, should there ever appear a gap in the fence. A gap does appear. Do the dogs devour one another? They do not. They quickly retreat to territory safely divided by the picket fence, there to growl at one another as fiercely as before, suggesting that, but for the fence, they would devour one another at the first opportunity. I do not know why this story has lingered on my mind ever since the new administration promised competitive markets. I merely tell the story for what it may be worth.

ON THE NATURE OF COMPETITIVE MARKETS:

The Dual Social Role of the Health Care Sector

Every economic activity in our economy serves a dual purpose.[4] On the one hand, the activity provides goods or services to a clientele. On the other hand, the activity offers an economic mainstay to the owners of the productive resources used by that activity. Figure 1 depicts this dual function schematically.

Figure 1 immediately suggests a self-evident but often overlooked tautology that will be helpful in our subsequent discussion. The tautology is the following:

> Every dollar of expenditure on the goods and services yielded by a particular economic activity is automatically transformed into a dollar of income accruing to the owners of the productive resources used in that activity.

On application to the health care sector, for example, this tautology implies the equation

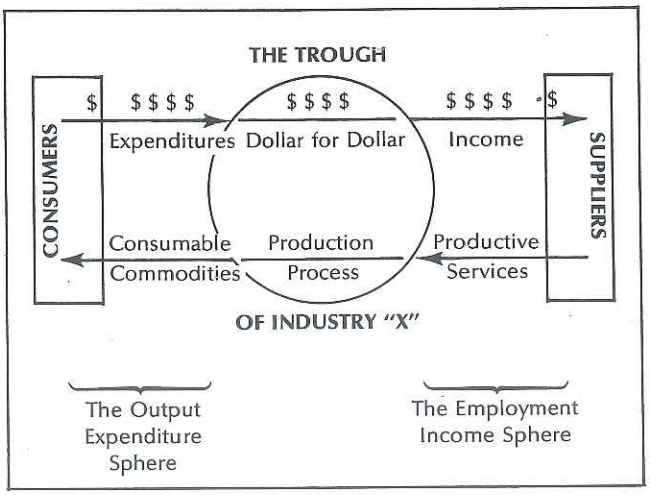
National Health Care Expenditure = National Health Care Income

From the tautology follows the further insight that one may analyze the economic activity in question by examining either its output-expenditure sphere (the left-hand side of the figure) or its income-employment sphere (the right-hand side of the figure). Cultural patterns appear to dictate the sphere we select for policy debates. In discussions of the automobile industry, for example, we tend to treat the income-employment function of that industry as its primary social purpose and act accordingly. By contrast, in discussions of the health care sector, we tend to focus strictly on the output-expenditure sphere and to ignore the income-employment sphere. And so it is that we celebrate additional expenditures on automobiles as a sign of economic health, while deploring additional expenditures on hospital care as a sign of economic malady.

In this essay I take temporary leave from the prevailing cultural pattern and focus unabashedly on the income-employment sphere of the health care sector. As Figure 1 suggests, it is legitimate, from an analytic viewpoint, to treat the health care sector as one of many alternative troughs to which certain creatures who own productive resources (human labor, land, and capital) come in search of fiscal nourishment. In deference to the elevated status of the health care sector, however, one should perhaps substitute the image of a dinner table for that of a trough, and I shall do so henceforth.

Why the guests at the health care dinner table chose that table rather than an equally laden alternative table—the aerospace table or the hoola-hoop table—is a question best left to psychologists and sociologists. It has to do with intrinsic features of the table other than the fiscal diet served. At this point I merely wish to assert that the search for fiscal nourishment is generally the prime motive for a person's seeking out some dinner table in the economy and that it is neither unrealistic nor offensive to examine the operation even of the health care sector through analysis of its income-employment sphere.

Figure 1. Economic Sectors as Troughs at Which People Eat.



To adopt the novel perspective I propose, we shall obviously need new terminology. Our traditional jargon, tailored as it is to the output-expenditure sphere, just will not do. Table 1 presents a modest beginning of the linguistic transformation we shall require. The reader is invited to commit the novel dictionary to memory for our subsequent discussion, and to apply the new terminology to a traditional cost containment speech to appreciate more fully the analytic power of the perspective.[5] It is my assertion that we shall understand health policy in the 1980s, and the health care sector's reaction thereto, much better if we learn to substitute the new jargon for traditional terms.

Equipped with these analytic tools, we may now return to the main focus of this essay: the table manners that should be exhibited at the health care feast during the next decade or two. It may be well to begin with a brief look at the past, if only to appreciate why table manners have hitherto received such fleeting attention.

Table 1. A New Dictionary for Health Policy Analysts.

Traditional Terminology (based on the service-expenditure facet of the health care sector)	*New Terminology (based on the employment-income facet of the health care sector)*
1. National health care expenditures	1. National health care incomes
2. The demand for health services	2. The supply of health care incomes
3. The supply of health manpower	3. The demand for health care incomes
4. Containment of health care expenditures	4. Containment of health care incomes
5. Health care cost containment	5. Containment of the income provided per unit of health service
6. Increased efficiency in the production of health services	6. Reduction in employment per unit of health service
7. Federal subsidies to health manpower training	7. Federally stimulated increases in the demand for health care incomes

Table 2. Resource Allocation to the Health Care Sector, United States, 1970-78.

Item	*Dollar Expenditure on Health Care*		*Percentage Increase*	
	1970	*1978*	*1970-78*	*Average Annual Compound Rate*
1. National health expenditures (billions of dollars)				
A. Current dollars (undeflated)	74.7	192.6	159	12.6
B. As a percentage of GNP	7.6	9.1		
2. Personal health care expenditures per capita				
A. Current dollars (undeflated)	315.4	753.0	139	11.5
B. Deflated by the implicit price deflator for the GNP	340.9	501.3	47	4.9
C. Deflated by the implicit price deflator for personal health	345.7	456.9	31	3.4

The Health Care Feast: Past and Future

During the past several decades the health care dinner table grew rapidly larger, added many empty chairs, and offered a richer and richer fare. It was widely agreed during the 1950s and 1960s that there was a health personnel shortage all around and that the imperative of national health policy was to bring added guests to the table, whatever the expense.

To entice the added guests, we paid part of their way to the table, through loans and scholarships directly to them and through grants to the institutions that trained them. These policies increased substantially the demand for health care incomes (the supply of health personnel).

To meet this enhanced demand for fiscal nourishment we obviously had to enrich the offerings at the health care dinner table, and this we did—with unprecedented generosity. Table 2 illustrates the extent of our generosity. As is shown in line 2b, after adjustment for general price inflation and population growth, our annual appropriations to the health care sector increased by an average annual rate of about 5 percent during the 1970s. These appropriations, it must be noted, were made at a time when real gross national product (GNP) per capita grew by only about 2.5 percent per year.

Our ever larger offerings at the health care dinner table made it possible to seat an ever increasing number of guests at the table and to feed each guest very well indeed. In return for our generosity, these guests comported themselves graciously. There was very little squabbling among the guests, and they treated with courtesy and good care the throngs of patients who brought the fiscal nourishment to table. It was, all in all, a splendid feast.

Some of this splendor may disappear from the health care feast in the 1980s. The new administration has declared itself tired of the "coast-to-coast

soup line" of which the health care sector has become an ever longer part. Other bearers of fiscal sustenance—for example, the business sector—seem equally fatigued and threaten to be more parsimonious in the future. In short, the supply of health care incomes in the future is unlikely to grow as rapidly as it did during the last decade. The health care table will be lucky to see its share of the national pie grow at all during the next decade, and that pie itself is not growing in size as fast as one would wish.

At the same time, the government continues to send out dinner invitations through direct and indirect subsidies to the training of health professionals and even through continued subsidization of hospital capacity. There may soon come a time when the guests presenting themselves at the health care feast will outnumber the chairs, and when those lucky enough to be seated at the table will scramble for the offerings to be had there. Physicians in ambulatory care, for example, may seek to shoulder aside their fellow guests from the hospital sector by performing one-day ambulatory surgery or one-day ambulatory diagnostic workups hitherto performed in the hospital. The hospital sector may push back by developing more fully its outpatient operation. Next, physicians in ambulatory care may begin to chase away from the table the hungry auxiliary personnel, including physician assistants, whom the governess invited to table. Under current licensure laws—one of the government's more appreciated favors—physicians have the license to chase away these miserables, although the latter may seek to have these licensure laws changed. Finally, there may be shoving matches among duly licensed physicians themselves. The American College of Surgeons, for example, may seek to bar family practitioners from their corner of the table, and the latter may be reluctant to refer patients to any specialist's corner for fear of losing that patient for good.

Initially, of course, such jostling will be accompanied only by hushed murmurs, and these will be not about fiscal sustenance, but about the patient's welfare. Eventually, however, table manners may deteriorate both audibly and visibly, and society will be forced to meet the issue of manners at the health care table head-on. We must then decide who is to enforce good manners at the table, and what book of etiquette is to be used for that purpose. Although these questions have long been settled for most other dinner tables in our economy, we have only just begun to address them in health care.

In the abstract, it can probably be agreed that a good book of etiquette for the health care table should meet at least the following minimal desiderata:

1. It should allow guests free access to the dinner table and prohibit strong ruffians from chasing away daintier guests when the offerings at the table are sparse.
2. It should force the guests at table to treat the bearers of fiscal nourishment—the patients—courteously and with good care. Indeed, the richness of the fare should depend directly on the patients' satisfaction with their treatment.
3. The guests should observe some propriety in determining the size of the portions they scoop for themselves at the table. Heavy eaters who dip their arms up to their elbows into the salad bowl ought to be sanctioned somehow.

Do these desiderata suggest one evidently superior approach to the issue of table manners? Economists may think so, but, in fact at least three alternative approaches have been advanced as the "perfect" solution:

1. Table manners in health care should be defined and enforced by that great governess, the government, who alone can know the common good. The governess will hover over the table at all times. She will plan the menu and the guest list, and generally supervise the deportment at table.
2. Table manners in health care should be defined by the dinner guests themselves, who alone can know the common good in this sector and who will enforce the code of etiquette selflessly through self-regulation, with only occasional help from the great governess (e.g., in determining the seating order at table through licensure).
3. The health care table will be so organized that both the dinner guests and the bearers of fiscal sustenance (the patients) are forced to act out the manners prescribed for a truly competitive market.

It is now said that we have tried approach (1) and that it has failed. This conclusion appears to have emerged after countless conferences on the topic of regulation versus markets. The complaints against the governess have been that she was fickle, often unduly enamored with one or the other group of dinner guests, or just plain unsophisticated in the articulation of rules.

Economists were widely used—and willingly let themselves be used—as a spearhead in the assault

on the much depised great governess. Never known for their political savvy, these fighters for economic efficiency generally believed that their relentless attacks on the governess paved the way for approach (3), the economist's vision of a preferred social order. Oddly enough, in its travail the economic brigade was cheered on by the guests at the dinner table—health care providers. That circumstance alone should have given a thoughtful person pause, for obvious reasons.

A competitive market system is, after all, a social arrangement whereby life is made hell for providers to make life cheap and easy for consumers. That this should be the natural order of things is probably obvious only to economists, who are rarely suppliers of anything. Surely where one stands on issues of this sort must depend on where one sits,[6] and where the providers of health care sit on this particular issue is perfectly clear. The question is how economists could ever have regarded health care providers as their natural allies in the campaign for competitive health care markets. Perhaps they thought that health care providers would deem virtually any book of etiquette preferable to that written by the great governess. But somehow I cannot escape the nagging suspicion that, in the end, the economists will have been tested in their good fight—that they were cheered on by providers who expected all along that, once the great governess was slain, they would be able to implement their preferred strategy (2)—that is, that a sort of Platonian health care state with "orderly markets" managed by a highly trained priesthood for the common good would emerge.

With the demise of the big, bad governess, economists may soon find themselves put out to pasture on this issue, unless they muster the strength and the courage to tip lances with the very folks they sought to liberate from the bad beast.[7] In this connection, it is illuminating to read the adventures of our latter day Don Quixote—Professor Alain Enthoven—whose "Does Anyone Want Competition? The Politics of NHI" describes in mournful tones the underwhelming enthusiasm with which the health care sector has responded to his valorous ideas about competition.[8]

On the Rigors of Competitive Markets

To see why the second, and probably much tougher, stage of the battle for competition in health care is now upon us, one need only articulate the conditions that must be met before purists would declare a market freely competitive. A review of these conditions will be particularly instructive for physicians, who have always thought of themselves as the living symbols of free enterprise and who find it difficult to see what more could be done to make their corner of the market more competitive.

Key among the conditions for a competitive market are:

1. That there be free entry into that market
2. That consumers be free to choose among alternative providers

These conditions, most any physician will tell you, are clearly met in medicine as long as the great governess keeps out of it. But are they? To gain perspective on this point, let us review what Milton Friedman, the free marketeer par excellence, observes on this particular point. In connection with occupational licensure, Friedman remarks that:

> It is clear that licensure has been at the core of the restriction of entry [into the health care field] and that this involves a heavy social cost, both to the individuals who want to practice medicine but are prevented from doing so and to the public deprived of the medical care it wants to buy and is prevented from buying.[9]

Friedman's more extended analysis of occupational licensure makes clear that he is not concerned solely with entry into the medical profession. By "entry" he has in mind entry into the practice of medicine, even by persons who do not have a formal medical degree. To guarantee the individual the right of entry into medical practice, Friedman would replace the current system of mandatory licensure, which prohibits medical practice by anyone not properly licensed, with mere certification, known technically as "permissive licensure."

Under permissive licensure, a person is prohibited from claiming possession of a professional title unless he or she has been certified to possess the competencies implied by that title. But he or she could still render professional services without the title. Writes Friedman:

> If the argument [for mandatory licensure] is that we [consumers] are too ignorant to judge good practitioners, all that is needed is to make the relevant information available. If, in full knowledge, we still want to go to someone who is not certified, that is our business.[10]

This passage clearly indicates what economists of Friedman's persuasion mean by "free choice among providers." To physicians, the term "free choice" implies the patient's freedom to choose among duly licensed physicians. To a true believer in laissez-faire markets, the term embraces also the freedom to choose medical care from either medi-

cal or nonmedical personnel. In practice, the concept would permit two consenting adults—one a dental hygienist and one a consumer—to contract freely for the cleaning or scaling of teeth, with or without a dentist's supervision. It would allow a consumer to consent to the dilation of his or her pupils by an optometrist. It would permit a consenting adult to purchase well-baby care from a pediatric nurse in independent practice. It would allow consumers to have their teeth drilled and filled by dental nurses engaged in independent practice, as in New Zealand. The free marketeer's preferred order would accord patients the right to pick from the entire array of price and quality combinations the market would make available in the absence of mandatory professional licensure. It would never occur to a free marketeer to give physicians the right to limit the consumer's choices in this respect, if only because physicians could not devise such limits free of a direct economic conflict of interest.

Fundamental to the Friedmanesque vision of a freely competitive health care market are two further conditions that must be met:

1. Consumers must be able, technically, to choose rationally among the price and quality options available to them in the health care market.
2. Consumers must have available to them all the information essential to a rational choice.

Serious people sincerely believe that condition (1) is so commonly violated in health care that it is pointless to meet condition (2), and that the Friedmanesque vision of consumer choice itself is laughable. This belief appears to have wide currency among members of the medical profession and, remarkably, among the profession's harshest critics. Naturally, the two groups draw from their belief diametrically opposed policy implications.

To the medical profession it seems self-evident that, if consumers are unable to choose sensibly among alternative price and quality combinations in health care, physicians must presort these combinations for the consumer and eliminate the risky ones from view (through the mechanism of licensure). "Who is better equipped to make such judgments," asks the profession, "than physicians whose technical expertise in these matters is unsurpassed and whose motives are properly constrained by the Hippocratic Oath?" "Who would be the last group on earth one would give this responsibility," retort the critics, "but the very persons who stand to gain financially from the limitations they would impose on consumers' choices?" As economist Paul Feldstein has recently observed:

> It would appear . . . that the concern of the medical profession (as well as of other health professions) with quality is selective. Quality measures that might adversely affect the incomes of their members are opposed, such as reexamination, relicensing, continuing education, and any measures that attempt to monitor the quality of care. The hypothesis that quality measures [such as licensure laws] are instituted to raise the return of practicing physicians appears to be consistent with the position on quality taken by the medical profession.[11]

Obviously, we have here a dilemma that we have solved so far by letting the medical profession have its way. Given an ever growing supply of physicians and society's apparent desire to rechannel resources away from social programs into military and industrial hardware, we may want to consider different solutions. Those who would be loath to leave the matter in the hands of the medical profession propose one of two alternatives. The free marketeers among them, as we have seen, would dump the matter into consumers' laps in the belief—and a belief it is—that consumers are quite able to fend for themselves. Those who do not share that belief—that is, those who judge consumers incompetent to choose intelligently in health care—would presumably leave the matter in the hands of the great governess. To whom else could one turn?

ON GOVERNMENT-REGULATED COMPETITION

I began this essay with a jubilant quotation from a medical journal according to which laissez-faire and medicine go together like horse and carriage or like love and marriage. To understand more fully that journal's joy, I depicted, in the second section, the precise meaning of the terms "deregulation," "laissez-faire," and "competitive markets." In the search for purity, I turned to the writings of Milton Friedman, widely acknowledged as one of the deans of the free-market school. After exploring Friedman's vision of a freely competitive health care market, I conclude that celebrants either endow the technical term "laissez-faire" with an unconventional interpretation or belong to the chain-and-leather crowd. Friedman's vision should send shivers up the spine of any straight-thinking physician.

To crystallize their attitudes on this issue, readers may wish to complete, and possibly extend, the litmus test for the true marketeer given in Figure 2. If the noes predominate among the answers, the reader obviously does not favor a freely competitive health care market, as true believers understand that term. He or she favors a regulated mar-

ket environment, one in which the forces of competition are reined in for specific purposes. He or she is then left with the following questions:

1. What limits to free competition should be drawn in the health care sector?
2. Who shall set and enforce these limits?

We shall be debating the first of these questions throughout the coming decade and reach, at best, an uneasy compromise. As to the second question, I have no doubt that we shall ultimately settle once again on the great governess. We were rather silly to debate the issue of table manners in recent years under the heading "Government Regulation *versus* Competition." The options actually before us were government regulation *for:*

1. Direct government control of decisions in the health care sector
2. Government-controlled competition in the health care sector
3. Complete laissez-faire competition in the health care sector

Figure 2. Litmus Test for True Marketeers.

DO YOU FAVOR INDEPENDENTLY* PRACTICING

—DENTAL HYGIENISTS WHO PROVIDE PROPHYLAXES?	Yes	
	No	
—DENTAL NURSES ON THE NEW ZEALAND/SASKATCHEWAN MODEL?	Yes	
	No	
—DENTURISTS?	Yes	
	No	
—PEDIATRIC NURSE PRACTITIONERS DELIVERING WELL-CHILD CARE?	Yes	
	No	

* By "INDEPENDENT" is meant persons selling their services on a fee-for-service basis in competition with dentists or physicians.

Here it may be noted parenthetically that even the free markets envisaged by classical economists—and by Friedman and his disciples today—generally cannot flourish in the absence of vigorous government supervision. There has to be a statutory framework that preserves the conditions essential to the proper functioning of free markets—for example, rules on the dissemination of accurate information, and rules prohibiting anticompetitive collusion among agents in the market.[1,2]

It seems unlikely that health care providers would favor a move in the direction of option (3). On the contrary, I suspect that, if health care providers were truly put to the test of living under raw, laissez-faire competition, most of them would yearn once again for the more orderly world of option (1)—a world, after all, the regulated have always somehow learned to control in the end.

The current mood in Congress, and in the new administration, seems to be a swing away from (1) and toward (2). The task at hand, therefore, is the development of government regulations for carefully controlled competition in the health care market. To appreciate the complexity of that task, one need only enumerate the many government regulations that will be required to make Professor Enthoven's consumer choice health plan (CCHP) operational. A foretaste of these regulations can be had in the several procompetitive health insurance bills now before Congress. The regulations in these bills are but an augury of things likely to be required upon full implementation of the CCHP concept.

What overall social objectives might one posit for government-regulated competition in the health care sector? The bulk of the discussion on this question has focused on three goals:

1. The arrangement should bestow on patients high-quality care and leave them satisfied.
2. The arrangement should encourage a careful juxtaposition of costs and benefits each time services are rendered to patients.
3. The arrangement should slow the rapid growth in health care expenditures.

Here it may be thought that achievement of the second goal automatically implies achievement of the third, but that is not necessarily so. Indeed, one can question the legitimacy of the third goal altogether, as I have in the past.[13]

Controlled competitive forces could be brought to bear on health care decisions at: (1) the nexus between patient and health care providers and (2) the nexus between patient and third-party payer.

The first of these is emphasized in the traditional catastrophic health insurance plans—for example, Martin Feldstein's maximum liability risk insurance (MLRI) plan. The central idea underlying these plans is that cost-effectiveness in health care will be achieved only if patients themselves have a direct financial stake in efficient health care delivery. This financial stake is assured through heavy cost sharing, up to a maximum risk exposure per year. Obviously these schemes place a good deal of trust on the ability of consumers to fend for themselves in the health care market and to force competition on price and quality among health care providers. In

fact, so strong is the implicit faith in the market power of consumers that these plans rarely suggest any explicit measures policymakers might suggest to enforce competitive behavior on the part of health care providers. Perhaps this oversight—or undue faith in the consumer—has contributed to the rather lukewarm reception catastrophic insurance plans have received among health experts.

The second nexus is, of course, the prime focus of Alain Enthoven's CCHP, which, in turn, has spawned what has come to be called the "procompetitive health bills" now before Congress.[14] The central idea underlying these plans is that cost sharing by patients, while helpful at the margin, is unlikely to furnish the countervailing market power required to force providers into competitive, cost-effective behavior. To encourage such behavior, the CCHP would encourage the formation of closed-panel insurance plans in which a limited set of providers ally themselves with a given plan which in turn sells comprehensive insurance coverage to patients. There would emerge, it is hoped, competing high-cost and low-cost panels, permitting patients to trade off certain perceived dimensions of quality—for example, the degree of freedom to choose among physicians, or highly resource-intensive treatments—for the sake of lower insurance costs. Cost sharing may be a feature of particular plans, but it is not the central workhorse of the concept. The central workhorses are, on the one hand, competition among closed-panel plans for insured members and, on the other, competition among health care providers for alliances with particular plans.

As already noted, the reception of the CCHP plans by health care providers, by consumers and by the business world in general has so far been mixed and, by and large, cautious to unenthusiastic.[15] In some quarters, there is uncertainty over the precise set of rules and regulations implied by the idea. In other quarters, there is probably great certainty about the deleterious effect this type of plan could have on entrenched economic positions. Other speakers at this conference will address these problems in detail, and I shall not dwell on them here.

There is, however, one other goal which neither of the procompetitive insurance plans addresses explicitly: the development of opportunities for entrepreneurs. It is rarely mentioned in our debates on health policy because the goals traditionally posed for government-regulated competition in health care usually involve only the quality and cost of the output. As I have argued earlier, however, there is another important function performed by the nation's health care sector: the provision of economic opportunities to the owners of productive resources.

One can argue that, wherever technically feasible, a given economic sector should seek to maximize the range of economic opportunities it offers members of society. By "economic opportunity" is meant not only the ability to earn an income in the health care sector, but also the ability to do so on the terms preferred by the recipient.

The freedom to exercise entrepreneurship in health care is now severely circumscribed. It is restricted to the owners of inpatient facilities, pharmacies, and licenses to practice medicine and dentistry. The desirability of delegating tasks from dental or medical to paradental or paramedical personnel is typically assessed, even by policymakers, strictly in terms of the impact of this delegation on the quality and cost of health services. If substantial cost savings at constant levels of quality cannot be demonstrated, the case for task delegation is closed. In thinking about competitive markets, however, one might inquire also into the desirability of offering, through task delegation, added outlets for entrepreneurial talent, even if the cost savings from the patient's viewpoint seem modest. We should explore the social merits and demerits of permitting independent paramedical and paradental practice. Although this is unquestionably a proposal fraught with a problem or two, I consider it worthy of open debate.[16]

IN CONCLUSION

For most of the postwar period, commentators on the American health care sector tended to describe it as rather backward by international standards—a cottage industry that kept our infant mortality rate just above that of Portugal. Actually, that image has always been misleading. Although our health insurance system still leaves too much fiscal agony at the fringes and saddles enormous loads of paperwork on almost everyone, it is the complement of a highly innovative health care delivery system—a system that is advanced by international standards, not only in medical technology, but also in the technology of health care organization and marketing.

In few if any other nations does one find the sheer range of alternative production and marketing schemes in health care we have come to take for granted in this country. Indeed, the statutes of most other nations would not even permit experimentation with alternative delivery systems such as HMOs or individual practice associations

(IPAs). And few if any other nations have been quite so bold as the United States in experimenting with competitive market forces in the organization of health care delivery. On this score alone, the United States health care sector will undoubtedly attract many foreign observers to these shores in the decade to come.

For American observers of the health care sector, the coming decade is apt to be one of the most fascinating in memory, as corporate, financial, and managerial muscle begins to penetrate hitherto tranquil health care markets, and as the competitive scramble for the health care dollar unfolds. Health care providers undoubtedly will be uncomfortable. The question is: How much discomfort is enough and how much is too much?

Economists are of the persuasion that a constant threat from competitors and the daily struggle to protect one's economic flanks bring out the best in people. The only way to build one's defenses, the reasoning goes, is to please one's customers. And thus, spoke Adam Smith, is private avarice converted to the common good.

The argument has enormous intuitive appeal when applied to the markets for shoelaces and hoola-hoops. Here we can be sure that, the more competitive pressure there is on the supplier, the better the customer will fare. Curiously, Adam Smith himself stopped short of applying this line of reasoning to physicians:

> The wages of labour vary according to the small or great trust which must be reposed in the workmen. . . . We trust our health to the physician; our fortune and sometimes our life and reputation to the lawyer and attorney. Such confidence could not safely be reposed in people of a very mean or low condition. Their reward must be such, therefore, as may give them that rank in the society which so important trust requires. The long time and the great expense which must be laid out in their education, when combined with this circumstance, necessarily enhance still further the price of their labour.[17]

Adam Smith quite clearly believes that ethical conduct—including medical ethics—is a luxury good of which proportionally more will be consumed as income rises. One doubts, therefore, that Adam Smith would favor the immersion of medical practitioners into daily cutthroat competition with their peers.

By contrast, Milton Friedman has the following observation on this point:

> When [physicians] explicitly comment on the desirability of limiting numbers to raise incomes they will always justify the policy on the grounds that if "too" many people are let in, this will lower their incomes so that they will be driven to resort to unethical practices in order to earn a "proper" income. The only way, they argue, in which ethical practices can be maintained is by keeping people at a standard of income which is adequate to the merits and needs of the medical profession. I must confess that this has always seemed to me objectionable on both ethical and factual grounds. It is extraordinary that leaders of medicine should proclaim publicly that they and their colleagues must be paid to be ethical. And if it were so, I doubt that the price would have any limit. There seems little correlation between poverty and honesty. One would rather expect the opposite: dishonesty may not always pay but surely it sometimes does.[18]

Milton Friedman, then, believes that medical ethics would be unlikely to be eroded by fierce price competition among physicians. Presumably he would argue that, the fiercer the competition among physicians, the better their patients will fare.

Once again two prominent economists disagree. We are faced here with an empirical question, and one to which, quite candidly, I do not have an answer. I can but expose the problem for debate and hope to come away properly instructed.

NOTES

1. Susan Stone, "For Medicine, Deregulation Is on the Way," *American College of Physicians Observer* 1, nos. 1 and 2 (January/February 1981): 5.
2. See Milton Friedman, *Capitalism and Freedom* (Chicago: University of Chicago Press, 1962), Chapter 9, "Occupational Licensure."
3. To illustrate, in the state of Washington feuding ophthalmologists and optometrists are currently carrying their squabble to the state legislators. The state's ophthalmologists there seek to enlist the coercive power of state government to bar optometrists from their economic turf.
4. This section draws on several of my earlier papers, especially, "Health Care Expenditures and the Economics of the Health Care Trough" (Paper presented to the National Health Leadership Conference on American Health Policy, Washington, D. C., April 29-30, 1976).
5. A speech beginning "We must reduce health care expenditures through greater efficiency in the delivery of hospital care" becomes: "We must eliminate some health care incomes by reducing the employment opportunities per patient day in the hospital." These are analytically equivalent statements.
6. The famous Rufus Miles law.
7. Their strength is already being sapped by deep cuts in the budgets for health services research.
8. C. M. Lindsay, ed., *New Directions in Public Health Care* (New Brunswick, N. J.: Transaction Books, 1980), pp. 227-50.
9. Friedman, *Capitalism and Freedom,* p. 155.
10. *Ibid.,* p. 149.
11. Paul J. Feldstein, *Health Care Economics* (New York: John Wiley and Sons, 1979), p. 327.
12. Ironically, but certainly not surprisingly, the Federal Trade Commission came under severe attack from the private

sector just as the thrust of its activities shifted from direct control of production and marketing decisions to concern merely over full disclosure of pertinent information.

13. See U.E. Reinhardt, "Health Care Expenditures and the Economics of the Health Care Trough" (1976), and "Health Manpower Policy and the Cost of Health Care," *Nursing Dimensions* 7, no. 3 (Fall 1979): 60-68.
14. Both Richard Schweiker, Secretary of Health and Human Services, and David Stockman, director of the Office of Management and Budget had, as legislators, introduced procompetitive health bills. Similar legislation has been introduced by Congressman Richard Gephardt, Senator David Durenberger, and Senator Orrin Hatch.
15. See Alain Enthoven, "How Interested Groups Have Responded to a Proposal for Economic Competition in Health Services," *The American Economic Review* 70, no. 2: 142.
16. For a more extensive exploration of this issue, see U.E. Reinhardt "Health Manpower Substitution in Dental Care," *Journal of Dental Education* (in press).
17. Adam Smith, *The Wealth of Nations* (New York: Random House, 1937), p. 105.
18. See Friedman, *Capitalism and Freedom,* p. 152.

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On the cover: Dr. and Mrs. Busse play a good doubles game. This one, in the mountains. (photo by Steve Myles)

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