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Further Comments

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I was pleased to read the several papers responding to my Sobeloff Lecture. The papers are informative and illuminating, and taken together, they complement the lecture by going into many issues for which the lecture format left me no time. I would group the main points of these papers, and my reactions to them, under three headings.

I. THE INEFFICIENCY OF PRESENT EXPENDITURES FOR MEDICAL CARE

In their fine paper, Messrs. Teret and Miller take me to task for saying that American death rates have changed only slightly in the past two decades (that is, the period in which medical care spending began rising with a vengeance). They agree that this is true of crude death rates (which I cited) but make the useful points that age-adjusted mortality rates are more informative and that these rates have decreased significantly over the past two decades. Unfortunately, they have ignored three conspicuous qualifications to my statement.

First, I was particularly interested in the "recent drop in death rates" as "compared to the enormous improvements in mortality experience during the 150 years before World War II and the introduction of modern medicine." Use age-adjusted mortality rates: this comparison still will suggest that many things *other* than medical care affect longevity favorably, and that from a broad historical perspective these other things have had much more impact. The comparison would be made even more dramatically by going back to the time of the Puritans.[1]

Second, I carefully noted that, "in any event, it would be a brave statistician indeed who would attribute the change [*i.e.*, the recent drop in death rates] to improved medical care rather than to other determinants of longevity." Teret and Miller are silent about this key proposition. They do not challenge it, and I do not expect that they would want to try, given the current state of relevant research. They are undoubtedly aware of the recent decline in deaths due to stroke, for ex-

1. One estimate is that life expectancy (in terms of 50% survival of live births) increased from about 18 years in 1693, to more than 70 years by 1970. Most of the improvement occurred before World War II. *See* T. MCKEOWN & D. LOWE, AN INTRODUCTION TO SOCIAL MEDICINE 4 (2d ed. 1974).

ample; they must also be aware that, since the decline started before the widespread use of medicinal means of managing hypertension,[2] it would be rash to attribute all or even the great bulk of the improvement to those medical advances.

Incidentally, by putting in a graph indicating medicine's impact on measles and poliomyelitis, Teret and Miller do seem to suggest indirectly that modern medicine is powerfully effective — perhaps not even subject to the principle of diminishing returns! Just to show the reader the multiple possibilities of this kind of argument, I cannot resist reporting a fact well known to public health and preventive medicine people: in the case of numerous important infectious diseases of the past, such as tuberculosis, whooping cough, and scarlet fever, the great bulk of the decline in American death rates due to these diseases occurred *before* the introduction of specific medical cures or countermeasures. A graph demonstrating this phenomenon appears in the Appendix.[3]

Third, my contrast between an explosive increase in medical expenditures and modest improvements in mortality was presented, not as proving anything, but as raising a *question* — How, given our knowledge of real medical advances, can we make sense of such statistical data? Presenting the contrast was simply a prelude to introducing the more abstract assertion: "one sensible conclusion to draw from all the available evidence is that in modern societies the marginal or incremental contribution of medical care to health status is very small." This assumption was vital to my argument, but it is, I think, virtually conventional wisdom among modern health care economists. It should have been clear that I was not trying to prove or establish that basic proposition in my lecture. The attempted proof would fill a small book; I am well aware of that. What I was trying to do was to give a lay audience some inkling as to what such a statement could mean, and how it could be so. I was trying only to do this much because the main theme of my lecture, and the contribution I was hoping to make, was to demonstrate the depth and breadth of the legal system's deference to the medical profession and to urge that such deference is one significant factor in the failure of health care regulation. In developing this theme, I took as starting points three things, which I think are fairly widely accepted among academic commentators and health care policy makers. First, in modern societies there are diminishing returns to in-

2. Garraway, Whisnant, Furlan, Phillips, Kurland, & O'Fallon, *The Declining Incidence of Stroke*, 300 NEW ENG. J. MED. 449, 451 (1979).

3. The graph is taken from R. RUSHMER, NATIONAL PRIORITIES FOR HEALTH: PAST, PRESENT, AND PROJECTED 7 (1980).

creased investment in medical care. Second, the health care regulatory systems adopted in the 1970's were largely intended to control rising costs and increased investment in medical care, but have failed to do so. Third, this failure is due in significant measure to the continued presence in the medical care market of information inequalities, the prevalence of insurance and the associated diffusion of incentives, massive governmental subsidies, and obstacles to effective competition. The point of my lecture was to propose that legalized deference to the medical profession is also a crucial factor in regulatory failure.

But let us nevertheless focus on my first assumption. Do Teret and Miller disagree with the economic notion that in modern societies the marginal impact of increased *medical* care expenditures on health status is small? Many features of their paper suggest that they do not disagree. In fact, they add additional support to the proposition. They stress that today's "new killers [such as heart disease and cancer] involve the environment, man-made products and behavioral patterns" and are not susceptible to decisively effective drug therapy (or other medical procedures, presumably). They mention the relationship between benzene exposure and leukemia and the Supreme Court's overturning OSHA's benzene standard. They highlight the importance of death due to injuries, and they note the regrettable obstacles to the introduction of known technologies, like air bags, for preventing thousands of motor vehicle deaths. To me, these and other features of their paper suggest a question: Isn't it ironic, therefore, that society has been so bent upon increasing spending for *medical* care, as opposed to *preventive* health measures? At the end of their comment, I rather expected Teret and Miller to argue that resources ought to be diverted from expensive tertiary care toward attempts to discover and implement preventive measures, such as an effective anti-smoking program. Yet, paradoxically, they seemed quite upset about the idea that someone could believe that "we are not getting our money's worth" for all our massive increases in expenditures on *medical* care.

Perhaps a quick analysis in economic categories will help explain this paradox. Both the paper by Teret and Miller and the paper by Mr. Rome exhibit little appreciation of the economic concepts of *scarcity* and *efficiency*. But consider their relevance. Since resources are scarce, we cannot have all currently producible goods and services in the amounts we want. If we adopt every new technology that ameliorates a chronic or irreversible condition, like end stage renal disease, and we spend so that every victim of such conditions will have the benefit of the new technology, we will make resources unavailable to other benefit-producing activities, such as factory modifications to reduce worker

exposure to benzene. Furthermore, since we are interested in efficiency — in getting the most "bang" for the buck — we must always look at the ratio of benefits to costs that could be expected from alternative uses of our resources. To put it another way, we must always look at opportunity costs. It is therefore incomplete to argue that for $\$X$ billion spent on a new machine or use of a certain type of surgery we have bought Y thousand years of extra life. We must consider how the benefit-to-cost ratio of the activity compares with many others. Similarly, it is not very persuasive to argue, as Mr. Rome seems to do, that hospitals employ people, that employment is a good thing, and that this and other such goods may justify large hospital expenditures even in the face of doubts about their beneficial impact on health status. Almost every economic activity employs people. But surely it is better if the employees are producing something of independent value rather than running in circles! If this much is granted, one can readily see how the question of efficiency, or the *relative* size of benefit-cost ratios, is crucial.

With these clarifications in mind, the reader may better understand why I will stand by my assertion that there is a socially excessive consumption of medical services in this country.

II. THE EXPLANATION OF REGULATORY FAILURE

Mr. Cohen makes the powerful point that a major problem in the health care industry "is a market structure that masks opportunity costs." He is referring primarily to the rise of third-party payment systems. He astutely points out that public utility-type "regulation of hospitals can neither stop consumers from demanding what they do not pay for as individuals nor can it stop physicians from practicing medicine in ways which make separately funded hospitals more costly." I agree. I only question whether this factor should be regarded as *the* exclusive source of our problems. I think that professionalism and the deference it generates are also important. Indeed, in a sense the two explanatory factors are complementary rather than competitive. Deference to professionalism may help explain *why* our cost-masking market structure has persisted so long, despite years of complaining by economists, politicians, and enlightened regulators like Mr. Cohen.

III. THE TABOO ON NEW REGULATION

Professor Havighurst, in his wonderful comment, extends my analysis significantly by dealing with past displays of judicial deference to professionalism in antitrust litigation. But he also laments my call for

new and better regulation, insisting that we resort instead to unleashing competition and consumer choice.

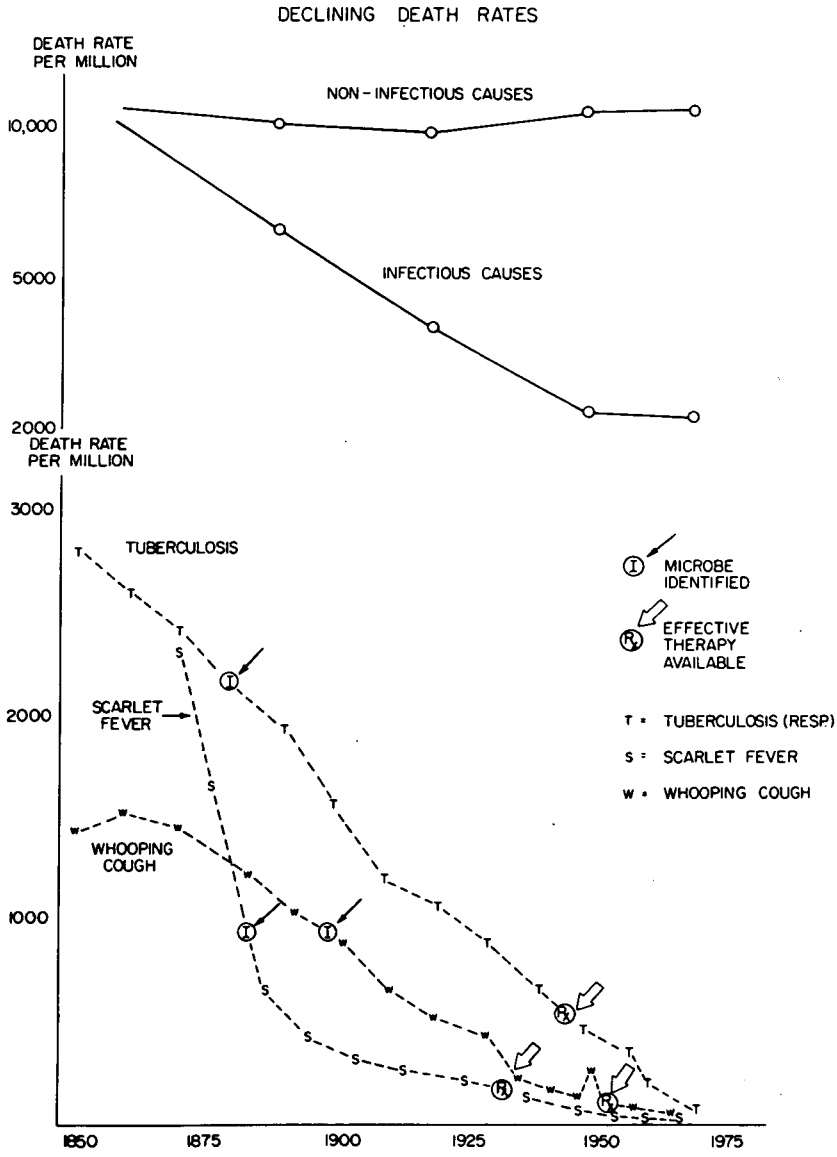
Several comments may help to show that the real differences between Professor Havighurst and myself may be rather modest. First, I basically agree that it is important to implement a procompetitive approach to the legal governance of the medical care market. I want laws that encourage greater competition among health plans and am currently working with a group of students on the development of a federal legislative proposal that would help do that. Second, I would approve of substantial deregulatory efforts. I am inclined not only to dismantle the PSRO program, the certificate of need laws, and perhaps the rate-setting laws, but also to abolish most health licensing laws. Before I am labelled as "regulation oriented," I would like to have these inclinations weighed in the balance! Third, the new regulatory effort that I did call for — the evaluation and structuring of norms of medical practice (alias 'technology assessment') — concerns an area in which economists have long recognized that government intervention is often necessary. Because of free-rider problems, the private sector is not likely to generate a socially optimal amount of research into questions of medical efficacy and cost-effectiveness. Fourth, I recognize the difficult problems involved in trying to design and implement a program of technology assessment, and I admit that in the end those problems might be fatal. So why do I want to try? In order to rationalize current and foreseeable government involvement in the financing of medical care. Professor Havighurst says, "In my view, the hard decisions concerning cost-benefit tradeoffs should be left primarily to the private sector and to competing providers and health plans. Government should assist only in sponsoring research, disseminating information, and policing abuse." It seems to me that this might very well be the proper approach *if* governmental units were not so heavily involved in paying for medical care. At the present time federal and state funds are used to run the sizable medicare and medicaid programs, federal tax subsidies pay for a sizable fraction of the health insurance purchased by employers for employee group health plans, and local governments grant generous property tax exemptions to non-profit hospitals. Thus, government is already buying a substantial proportion of the health care provided in this country. If it does not embark on "hard decisions concerning cost-benefit tradeoffs" with respect to care it is paying for, who else do we expect to have the incentive to do it?

Fifth, the observation that my regulatory proposal "seems out of step with the new political milieu, in which regulation generally is disfavored," is not convincing. It is not clear that currently "ascendant"

policymakers are radical ideologues on the subject of deregulation; rather they seem to be selective deregulators like myself. The Gephardt-Stockman "procompetition" bill,[4] for example, does not propose even to eliminate governmental tax subsidies for health insurance, but only to limit them; nor does it clearly propose use of the federal preemption power to radically reduce or eliminate state licensing laws (as I would urge). In any event, an academic commentator should "call'em as he sees'em" and not bend his views to fit some model of the currently dominant form of political ideology. In the long run, this is the only way that the academic community can serve the political process well.

4. H.R. 850, 97th Cong., 1st Sess. (1981).

APPENDIX



A precipitous fall in age adjusted death rates from various infections was clearly visible beginning by the mid-1800's, and persisting into present times. The death rates from noninfectious causes did not decline significantly during this period. The death rates from some of the most prevalent and serious infectious diseases (i.e., tuberculosis, scarlet fever, whooping cough, diptheria, etc.) were declining years before the causal microbes were identified and decades before effective therapy or immunization was available. This phenomenon is now ascribed to substantial improvement in nutrition and living conditions.