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Health Care Reform: The Clash of Goals, Facts, and Ideology

Henry J. Aaron

In 1994, the United States engaged in a great, if confused, national debate on how to modify financing and delivery of health care. Despite general satisfaction with the quality of care they receive, Americans tell poll takers that their health care system is badly awry and in need of fundamental change. While in seeming agreement that something needs to be done, the public and health care experts alike seem confused and divided on just what to do.

4.1 Why Consensus Is Elusive

The sources of disagreement are several. First, a major goal of health care—the ability to enjoy high-quality life as long as possible—is not very well defined and is affected more by the external environment, personal behavior, and genetic inheritance than by health care. As a result, discussion of health care finance often loses focus when observers point out—correctly—that health gains from reform of health care financing will be small unless violence is controlled, housing upgraded, diet improved, drug abuse curbed, or some other change in the social environment or personal behavior achieved. It is certainly likely that such steps would improve health more than would reform of health care, and such reforms are important for other reasons as well. Furthermore, the concept of “high-quality life” is multifaceted. How large are benefits from cure of somatic disease if people live in dreadful conditions or suffer from other devastating diseases? The question takes on particular force when somatic illnesses result from personal actions—smoking, substance abuse, reckless driving, hunting, or poor diet.

Thus, debates about health care financing slide easily into a host of related questions concerning human behavior. But they are not what reform of health

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care financing is about. Coherent consideration of health care financing requires that most of these issues be left for separate consideration. It also requires an awareness that health care serves important purposes other than purely medical ends, such as providing care and comfort during travail and, most notably, at life's two momentous transitions, birth and death. As Victor R. Fuchs (1979) observed, physicians and other health providers now perform important functions once the responsibility of the family or organized religion.

A second obstacle to the achievement of consensus on reform of health care financing arises from disagreements over the proper realms of individual choice and of social intervention. Once again, health status depends on many behaviors that are clearly the responsibility of individuals, not society. In addition, people disagree on whether health care is primarily a commodity, similar to VCRs and restaurant dinners, the allocation of which capitalist societies leave to individual choice, or more like voting and elementary and secondary education, the entitlement to which is a right of citizenship. Two decades ago, Arthur Okun (1975) noted that standard economic theory easily shows that welfare would be increased if people could sell votes or if military draftees could pay others to serve in their stead. Similar arguments can be adduced that people should be permitted to buy or sell organs for transplant. In each case, it is argued that a willing buyer and a willing seller will carry out a transaction only if it makes each of them better off. Yet such behavior is explicitly prohibited by law because of a widely shared belief that some things should not be bought or sold, but enforced as inalienable rights or obligations.

Thus, some observers hold that society may have an obligation to ensure that people can buy insurance at actuarially fair prices (with associated subsidies for the poor, elderly, or chronically ill, as deemed necessary), but that no further collective obligation exists. For them, the goal of reform of health care financing is to remove alleged shortcomings in the market for insurance.¹

Others hold that public policy should ensure access to health services at prices no greater than sufficient to deter utterly frivolous use. This result can be achieved through direct public financing or private insurance—with limited copayments, deductibles, or coinsurance in either case. Private insurance can achieve universality, however, only if subsidies make it affordable for those with low incomes and if individuals or their employers (or both) are required to buy insurance, a step regarded as unnecessary or harmful by those concerned primarily with *access* to insurance.

A third obstacle to consensus is the pace of change in the technology of insurance, health care, and organization of delivery. Insurers are increasingly adept in using statistical techniques to identify individuals and groups with high expected health care costs. Biomedical research is beginning to identify

1. I use the mushy term "shortcomings," rather than the standard economists' term "imperfections," because some observers are concerned about asymmetric information and the possibility of instability or failure of insurance markets, while other observers are even more upset about the results of accurate experience rating, surely *not* a market imperfection.

genetic markers that predict predispositions to develop specific diseases. The power and accuracy of these procedures can only increase, perhaps very fast. These techniques have created one of the few areas of consensus in the debate about health care reform—an understanding of the perniciousness of untrammelled risk selection and unlimited underwriting by insurers. These techniques promise—or threaten, depending on one’s point of view—to convert health insurance into a form of prepayment.

The advances in the technology of health care are even more dramatic than the progress in risk selection. Some of this progress rests on hardware, some on pharmaceutical products, and some on clinical technique. The net effect is to cause frequent changes in recommended courses of therapy for major diseases.

An additional dimension of change concerns the organization of the market for health care. Partly under pressure to control costs and partly from efforts to anticipate the future consequences of legislation, physicians, hospitals, and insurers are merging, reorganizing, and regrouping. How these efforts will affect the delivery and cost of care remains obscure, but they have sown uncertainty among providers and insurers regarding the future.

Confronted with this dynamism, some observers focus on health care delivery and financing as they stand, some on projections of the directions in which arrangements are evolving. The former group tends to see some problems but no crisis. Costs are high, but areas for achieving economies exist. Some people are uninsured, but the number can be reduced. Quality of care is high on the average. Sometimes physicians intervene too early and too much, and sometimes they do too little, often because uninsured patients come too late for care.

The group that attends to projections of risk selection and health technology is prone to see crisis. They see current trends leading to reduced coverage, to much increased expenditures on low-benefit care, and to deterioration in quality from poorly designed efforts to control spending. Technological dynamism creates continuing pressures on costs, which in turn generate behaviors by individuals, businesses, and governments that tend to narrow insurance coverage and access to care. Whether the reactions of public and private payers to rising costs will suffice to squeeze out low-benefit, high-cost care remains a matter of hot dispute.

4.2 A Few Facts

Against this background, several key facts—and disagreements about some of them—help explain why agreement on how to reform health care financing has proven so elusive.

Fact 1. Annual health care outlays are highly concentrated, with 1% of the population accounting for roughly 30% and 5% of the population accounting for more than half of acute-care outlays. This fact is the arithmetic expression

of the simple truth that most people are healthy most of the time and healthy people consume little health care. This spending pattern holds in several countries for which data are available.

Fact 2. Health care technology is advancing rapidly. The degree to which scientific advances improve the quality of care varies across both technologies and patients. Typically, new medical technologies improve the diagnostic accuracy or therapeutic efficacy for many patients but are used on many other patients where the medical value is questionable. Thus, new technologies improve the quality of care for some patients and may extend the quantity of care by enabling diagnosis or treatment of patients for whom nothing similar could be done previously.² They also tend to be used wastefully on other patients. The long-term value of new technologies is difficult to appraise because they are used not only for current patient care but also as part of ongoing research. Part of the value of medical advance is its role in undergirding further research on new methods of patient care.

It is commonplace, even among economists, to note that advances in medical technology, unlike advances in other fields, have not reduced costs. While commonplace, this statement reflects muddled thought. First, scientific advance has not led to reduced “costs” in many fields, at least if the term “cost” is used, as in the case of medical care, to refer to total spending. Technological advance tends to reduce *price*, but not necessarily *total spending*. The price of a floating-point operation has plummeted, but total expenditures on computers have skyrocketed. The quality-adjusted price of automobiles has fallen relative to the price of most other goods, but total spending on automobiles has increased.

In the case of health care, we simply do not know whether the price of quality-adjusted medical services has risen or fallen (Aaron 1991; Newhouse 1992). No good definition of health outputs exists. In the absence of such a measure and in the face of revolutionary changes in the methods of care—that is, in the unit of output—no meaningful price index is possible. Common price indices that indicate that health prices have risen faster than other prices are

2. Total outlays have risen not only because medical advances make possible the treatment of previously untreatable conditions, but also because these advances often reduce contraindications for therapy and thereby increase the number of patients for whom the cost/benefit ratio of treatment or diagnosis is favorable. Furthermore, successful medical interventions raise total spending also because they often spare people low-cost deaths who then survive to absorb really expensive care for chronic illnesses—that is, for diseases that are not immediately lethal but for which the only available care is palliative or supportive but not necessarily cheap—or they make possible treatments that are curative but often very costly. Antibiotics illustrate these phenomena. They have slashed mortality and morbidity from infectious diseases among children and young adults, thereby sparing them to live until they can generate really large medical bills. They have sharply reduced the incidence among the elderly of pneumonia, once called “the widow’s friend.” And they have made possible aggressive and costly cancer therapies that ravage defenses against potentially lethal infections.

close to meaningless.³ Whether health prices really have risen faster than other prices, not as fast, or have actually fallen remains quite unclear. This uncertainty is heightened by the sharp declines in length of hospital stays and the dramatic shifts of therapy from inpatient to outpatient care.

Fact 3. Every rich nation socializes the financing of health care in two senses. Sick patients and their families are spared most of the cost of care when ill. In addition, the actual cost of health care is only loosely related to outlays expected ex ante. Some countries socialize costs through public finance, some through private insurance. Socialization is less in the United States than elsewhere, in part because the United States covers a smaller share of costs through public budgets than do other countries, but even more importantly because private financing is largely experience rated.

Fact 4. Alone among rich nations, the United States imposes no effective constraint on outlays of hospitals, the locus of most acute-care health spending. The U.S. system of financing health care is perfused with moral hazard and attendant incentives for economic waste. While moral hazard is inescapable if patients bear little cost for care when ill and particularly if providers are paid on a fee-for-service basis, other countries limit moral hazard by some combination of budget and fee controls or pay providers through salary or capitation.

These four facts taken together explain why health care spending is so much higher in the United States than elsewhere and why it is rising so fast. The U.S. financing system encourages patients to seek care whenever medical benefits are deemed to be positive (some would say “nonnegative”). Rapid technological advance continuously and rapidly lengthens the menu of beneficial interventions. In both of these respects, the United States does not differ from other rich nations. The United States is unique, however, in that its reimbursement system encourages providers to render all beneficial care and perhaps more besides. This system might not lead to waste, but two conditions necessary for efficient decentralized decision making are not satisfied.

Fact 5. Households face incentives to purchase excessive health insurance. In addition, households would be unable to make rational decisions about either the quantity or kind of health care even if they did not buy excessive health insurance. Economists universally accept the first of these statements. The exclusion of employer-financed health insurance from personal income and payroll taxes means that, at any given level of earnings, a dollar of additional health insurance reduces income available for other consumption by less than

3. The consumer price index (CPI) for health, for example, weights hospital service and dental services similarly, although total spending on hospital services greatly exceeds that on dental services. What counts for the CPI is consumer spending. Since third-party payments cover most hospital spending but little of dental spending, direct outlays are similar.

one dollar, according to Martin Feldstein (1973).⁴ Feldstein also observes that the resulting incentives encourage the purchase of insurance with inefficiently small deductibles and other cost sharing. Fuchs (1979) has suggested that people overinsure for an additional reason—to escape the need to face the kinds of marginal calculations they normally make during ordinary economic life.

The second of these statements provokes widespread opposition among general economists and some health economists as well, although I believe that except for professional economists few would regard it as other than a banal truth. The reasons can be stated in economic terms. As with many complex goods, laypersons lack expert knowledge about the indications for or the value of various health care services. Accordingly, they hire experts—that is, physicians or other health professionals—to provide advice and, in many situations, to make actual decisions for them.⁵ In principle, healthy people could write contingent contracts specifying the care they want when ill.

Two facts render such contracts chimerical. First, the technical complexity of defining the physical effect of particular diagnostic or therapeutic interventions is so multifaceted that it is impossible to write a contingent contract instructing providers regarding what rational people—healthy or sick—would want when sick. Approximately ten thousand separately defined medical diagnoses exist. Many of these conditions can appear in varying degrees of severity. With respect to each of these diagnoses, patients can present with widely varying conditions, complicating conditions, history of treatment. In addition, treatment options for many conditions vary, and the medical outcomes depend on severity, patient history, and complicating conditions. Thus, a complete contract would have to deal, literally, with millions of contingencies. Further complicating the situation is the matter of cost—treatments differ widely in cost. Finally, the impressive technological dynamism of medicine means that the contract would have to be rewritten in significant ways almost continuously if patients are not to be trapped in obsolete contracts.

A second consideration indicates why contingent contracts for medical care would be of doubtful usefulness even if they could be written. The expected utility of medical services depends on actual health status and on random external events, such as whether one's spouse has died or grandchildren arrive in one's life. Thus, the utility of health services for the sick may differ from the healthy person's expectation of the utility of such services. In recognition of

4. This statement is false for the narrow range over which the earned income tax credit is rising and exceeds the payroll tax and personal income tax rates are zero. The standard work is Feldstein (1973).

5. Physicians suggest that surrendering such decision-making functions is therapeutic for the patient. When made by practicing physicians, this statement emits an aroma of self-service and self-glorification. One physician, who was accustomed to making all medical decisions himself, described the process by which, when ill, he surrendered such decision making to others and characterized this behavior as entering "the sick role."

this possibility, durable powers of attorney and advance medical directives are subject to repeal on the slightest of indications by their authors at any time and under any circumstances. As Thomas Schelling (1984) has observed, reconciling conflicting preferences of a single person at different times and under different circumstances raises problems of incommensurability similar to those raised by interpersonal comparisons of utility.

Thus, people must cede to professionals detailed decisions on medical treatment. But even decisions on how much to spend on insurance and hence on the volume of resources available to professionals is likely to be flawed. The probability of most major medical events is quite low during the usual periods over which insurance contracts are written. The evidence that individuals have flawed perceptions of low-probability events is overwhelming. Thus, a strong possibility exists that people will attach irrational weights to the low-probability events that account for most acute-care outlays. Economists should recognize that, given choices about the risks against which to insure and the degree of protection to purchase, many people will choose unwisely.

4.3 The Way We Are

As far as the financing of health care is concerned, “the U.S. system” is a misnomer. The congeries of financing arrangements by which payments flow to health care providers reflects ancillary consequences of policies adopted for reasons having little or nothing to do with health care and the more or less independent actions of governments, religious organizations and other charities, and private businesses and individuals. These arrangements are ill-coordinated and disorganized. Except under the most Panglossian presumption that whatever is must be best, these arrangements would never be accorded any presumption of efficiency. This state is not the well-ordered cacophony of a normal economic market, but the chaos of uncoordinated actions by people and groups that are heedless of effects on third parties.

4.3.1 How We Got That Way

Irrationalities in wage controls during World War II gave employer-financed health insurance its initial push. The cost of health insurance was excluded from wartime limits on compensation, enabling employers to raise workers’ pay without running afoul of wartime controls. The exclusion of employer payments for health insurance from taxable compensation under the personal income tax and the payroll tax reinforced and perpetuated the linkage of insurance to work in the post–World War II period.

The McCarren-Ferguson Act entrusted insurance regulation to the states. The Employee Retirement Income Security Act (ERISA) then blocked state regulation of self-insured health plans. It thereby encouraged self-insurance, which is simply workplace-based experience rating. More than half of those

insured through work now receive coverage through self-insured plans, and the proportion is rising.

This system has the virtue of encouraging employers to pay attention to workers' health and working conditions, but it creates two serious problems. First, it encourages discrimination in hiring on the basis of age, race, sex, and disability status that civil rights statutes go to great lengths to prohibit. Second, relative to individual underwriting, it also significantly mutes workers' financial interest in their own health. Community rating deals with the first problem, and does essentially nothing to aggravate the second. Individual underwriting deals with the second problem, but drastically increases sales and administrative costs. For these and other reasons, I believe that community rating within no more than a small number of distinct categories is more efficient than extensive experience rating (Aaron 1994).

Public health care programs, particularly the federal-state Medicaid program, likewise display unmistakable signs of accident and caprice. Because Medicaid eligibility is tied in part to the design and generosity of Aid to Families with Dependent Children and of Supplemental Security Income, people who are eligible in one state would be ineligible in another. Medicaid pays for services of podiatrists, chiropractors, and Christian Science practitioners in some states but not in others. Some states limit hospitalization while others do not. Physician and hospital fees differ widely. Distinct and uncoordinated programs cover Native Americans, the military, families of the military, veterans, and federal employees.

Other historical circumstances have led to enormous variation in the way health care is delivered across the United States. While it is barely conceivable that the differences reflect differences in tastes and resource costs and availability, no one familiar with the delivery system believes that. Hospital lengths of stay differ markedly across the United States. The incidence of many medical procedures differs across states and smaller areas in ways epidemiological or demographic factors cannot explain. The penetration of health maintenance organizations (HMOs) ranges from dominance in Hawaii, through significant penetration in the western states, Minnesota, and Massachusetts, to negligible in much of the rest of the United States. Currently, the organization of physicians, connections between hospitals and physicians, and linkage among hospitals are undergoing tumultuous change. Given the long history of efforts by various groups in medicine to cultivate and defend rents, I believe one should harbor little hope that the current ferment will push the system to a social optimum.

Huge international variations in the staffing of health care systems also raise serious questions about the efficiency of organization of health care provision. In 1980, the United States employed 2.8 nurses for each physician, Canada 4.4, Germany 1.4, and Belgium 0.3 (Parkin, McGuire, and Yule 1987). While these data are stale, they differ so widely that it is virtually impossible to imagine how these systems could all be operating efficiently.

4.3.2 Institutional Failures

Because the financing of health care in the United States reflects countless independent decisions, many made for reasons having little or nothing to do with health, significant institutional failures should surprise no one.

Insurance. Insurance markets are failing for several distinct reasons. First, advances in risk analysis based on both statistics and biology are narrowing the scope of true insurance, as steadily increasing proportions of the variance in future use of medical services can be predicted on the basis of characteristics of the insured at the time the insurance contract is written. These characteristics include age, race, sex, disability status, occupation, place of residence, marital status, sexual orientation, and, most notably, past use of medical services.

Such information creates a serious problem whether or not it is equally available to the insured and the insurer. If no information asymmetries exist, then insurance becomes prepayment, transforming poor health prospects from bad fortune into a negative dowry, a lump-sum charge against personal net worth. This problem declines as the duration of insurance contracts increases, but so long as premiums reflect all available information, it remains even if a lifelong contract is mandated at conception, since health background and longevity of one's parents, siblings, aunts, and uncles are correlated with one's own subsequent health and longevity. If the insurer is less well informed than the insured, adverse selection and its attendant problems arise. As Stiglitz and Rothschild (1976) showed, a sustainable insurance market equilibrium may not exist, and complete market failure is possible. As the capacity of insurers to predict use of health care services improves, the variance in underwritten rates increases, and the likelihood that those most likely to use health care will find insurance attractive declines.

Aid for poor sick people, whether privately or publicly funded, discourages people with low actual or expected incomes from buying insurance because they can count on subsidies when ill.⁶ Rich nations without exception provide such help on the principle that at least some forms of health care should be available whether the recipient can afford it or not and sometimes whether the recipient wants it or not. Thus, public and private programs discourage the poor from buying insurance privately, at the same time that tax rules encourage those who face positive personal income or payroll tax rates to buy too much insurance.

Market or Budget Discipline. Those who provide health care services face little economic discipline in the United States. The fact that insurance, public or

6. Several comments during the discussion of Alan Garber's paper (chap. 5 in this volume) remarked that the availability of Medicaid makes the purchase of private insurance for the costs of long-term care a poor investment for most people.

private, makes patients insensitive to costs is well known among economists, at least since the seminal article by Arrow (1963) and the comment by Pauly (1968), which characterized this insensitivity as “moral hazard.” Physicians and other health professionals would simply be instruments for effectuating this moral hazard if they acted as perfect agents for patients. In fact, the fee-for-service reimbursement system creates strong incentives for providers to increase the problem, as the literature on physician-induced demand strongly, if inconclusively, suggests (Cromwell and Mitchell 1986; Fuchs 1986; Phelps 1986).

Theory suggests that such a payment system will produce waste—the purchase of services worth less to the user and (in the absence of significant externalities) to society than they cost society. The extent of such waste depends on the shape of benefits curves associated with the menu of available medical technologies. Concave benefits curves will be associated with considerable waste; convex curves with less. I know of no good research on how much of current medical spending represents waste in this sense. Although it is tempting to conclude that an increase in the number of available procedures and of outlays will be associated with increased waste, I know of no analysis on whether waste in this sense is increasing or decreasing. Personal experiences and studies of selected procedures suggest that waste is large. Brook and Vaiana (1989) have suggested that some procedures may be inappropriately used in as many as 30% of applications and that their use is equivocal in a similar proportion of cases.⁷ One recent experiment dealt a body blow to this line of reasoning, however. One of the procedures found by Brook and Vaiana (1989) to be useless, or equivocal in half or more of all cases, was carotid endarterectomy, the surgical removal of fatty deposits from the carotid artery to minimize chances of stroke. The managers of a controlled experiment to test the efficacy of this procedure not only did not confirm this judgment, but felt obliged to terminate the experiment because the results indicated such large and positive results that failure to communicate the findings immediately to physicians would constitute an indefensible disservice to patients (Altman 1994).

The practical question is how best to reduce such waste. At first blush, it might seem that if households faced the full price of insurance (that is, if the tax distortions were repealed), the price constraints created by the requirement that insurers make nonnegative profits to remain in business would establish the requisite incentives.

This outcome requires that the regulatory powers exercised by insurers exactly offset waste from moral hazard. This result is unlikely because of multiple agency problems connecting patients to insurers, patients to providers, and insurers to providers. Physicians, in particular, are trained to act as agents for patients and to assure that they receive all *medically beneficial* care. They are

7. Whether “inappropriate” and “equivocal” imply “harmful,” “useless,” or “low-benefit” is unclear. In either case, of course, benefits should be calculated *ex ante*, not *ex post*.

not trained to weight costs against benefits, but to weigh benefits from action versus benefits from inaction. Even if the agency problems are solved, a deeper problem remains: since patients may regard as suboptimal the contracts they signed when well, accurate enforcement of these contracts by agents trying to effectuate the interests of the healthy purchasers of insurance may act in ways contrary to the revised preferences of the sick. Whose life is it anyway?

According to Aaron and Schwartz (1984), physical constraints *can* force physicians to use available resources to achieve highest medical benefits. Thus, limits on the availability of operating rooms or diagnostic or therapeutic radiological equipment *can* cause those responsible for managing these capital goods to ration efficiently. Much the same is true if hospitals work with salaried staff in critical specialities, such as cardiac surgery. In these cases, providers work at full capacity but cannot care for everyone, and medical ethics align well with social objectives of using available resources to produce highest net benefits. While such a happy result is possible, it is by no means assured unless good information on outcomes of interventions is available and widely disseminated and unless regulations or incentives make it costly to practice in violation of this information. Incentives created by limits on general medical supplies and pharmaceutical products are much less likely to produce efficient outcomes, because monitoring physician behavior in the countless small decisions comprised in normal care is probably impossible, and each physician faces a conflict between obligations to specific patients and diffuse obligations to see that total resources are efficiently used.⁸

Since capital equipment typically is purchased by provider groups, effective control over the purchase of such equipment when numerous payers are involved requires that each payer establish enforceable rules limiting access to such equipment similar to those that would arise under supply constraints. But it is not at all clear how they would go about doing so, particularly since physicians control the flow of information to the insurer.

Once again, prepaid health plans seem to provide the incentives for insurers to allocate resources efficiently. But serious obstacles stand in the way. The low quality of information makes it difficult to write clear and enforceable guidelines for when to use various medical procedures.

Research. Medical research, like much other research, ranges from fundamental science to highly applied product and device development. At the fundamental end of the spectrum, serious public good issues have led the United States to underwrite basic biomedical research through government grants and

8. At one time, the British rationed dialysis by limiting the availability of dialysis machines. The primary criterion for rationing was age, with occasional exceptions based on other considerations. According to medical testimony, this method of rationing was reasonably efficient. The ability to limit dialysis diminished when continuous ambulatory peritoneal dialysis (CAPD) replaced machine-based dialysis, because the supplies necessary for CAPD were less easily monitored and controlled.

direct research (principally through the National Institutes of Health) and through private foundations, the largest of which is the Hughes Foundation. At the applied end of the spectrum, most research is carried out by pharmaceutical companies and device manufacturers. These two forms of research are complements.

Current arrangements for financing applied research may not rise (or descend) to the level of market failure, but they *are* peculiar. A crude characterization of current arrangements would be the following: Entrepreneurs invest in a company that sells products and uses the profits from current sales to fund many diverse research projects, most of which will fail. Patents on the few that succeed enable monopoly pricing, the profits from which are then used to fund further diverse research projects, most of which will fail. But some succeed, and patents on them permit monopoly pricing, the profits from which . . . And so on, ad infinitum.

Thus, the funds to pay for applied research come from the relatively few patients who benefit from the fruits of past research. This crude characterization is inaccurate in one important detail. While the patients who consume the products of past research pay for future research through drug prices well above production cost,⁹ third parties—private insurers and government programs—pay for many of these products. To the extent that third parties pay for these products, the cost of future research is effectively socialized. To the extent that patients bear the costs, however, the allocation of the cost of research raises troubling questions because vulnerable people are required to pay far more than production costs for drugs and devices that are indispensable. Inevitably, some potential users find the costs insupportable and fail to buy important or even vital products because the price exceeds production cost.

This possibility is the legitimate basis for concern about high drug prices. This concern has triggered various proposals to curb drug prices that raise serious problems of their own, because the limits threaten the profit base on which much applied research rests. According to Linda Cohen and Roger Noll (1991), since the public record in supporting applied research is poor, increased government support could not effectively replace any curtailment of private research support.

4.4 The Elusive Prize of Health Care Financing Reform

Public opinion polls report that Americans think something is fundamentally wrong with the U.S. health care system. A highly articulate president with unmatched capacity to explain complex issues in simple terms made reform of health care financing his major domestic initiative. The president's party

9. They also pay for high total profit margins and associated dividends and appreciation and for large outlays on sales and advertising to promote product differentiation and associated profit opportunities (U.S. Congress 1993).

controlled both houses of Congress. Yet the effort to enact major reform failed utterly. Whether one of the more limited proposals cobbled together as the 1994 legislative calendar moved to its close would have been passed if the administration had embraced it earlier will occupy doctoral students for years.

Why the 103d Congress ended without major legislation demands attention. Was the explanation bad staff work and political maladroitness? Did the administration do about as well as possible given the forces that it confronted? Or were serious mistakes committed on behalf of a cause that in any case had little chance of success? Are future efforts to reach consensus likely to fare better than those of the Clinton administration?

I shall present a number of interrelated arguments, none of which is capable of being tested definitively with the techniques economists are trained to use and to trust. These arguments cannot be so tested because each is created to correlate with observed facts. This is data mining in its most fundamental sense.

- In any democracy, times when it is possible to pass legislation restructuring a tenth or more of the economy are exceedingly rare. No such time has occurred in all U.S. history, except under the exigencies of war. We are not currently living in such a time. The willingness to contemplate far-reaching legislative change requires either extreme duress (devastation from war or economic collapse) or a high order of faith that leaders are trustworthy and capable. Neither condition is currently satisfied.
- Despite diffuse agreement on the need for major changes in the system and on the specific goals of reform, no consensus exists on the weights that should be attached to the various goals of reform or on how best to achieve those goals.
- Key underlying facts about the delivery of health care are in dispute or are unknown. Relevant facts include both actual, potentially observable behavior and estimates of how people will change behavior if incentives are modified.
- Given large vistas of ignorance and complexity, people take intellectual and political refuge in ideology, which I define for current purposes as presumptions about group and individual behavior that are weakly supported but can be overridden, at best only with powerful evidence and sometimes not even then.
- The tenth or more of the economy that is the subject of health care reform is extraordinarily messy and complicated. The result of this heterogeneity is an inescapable dilemma. A proposal for sweeping reform must be bewilderingly complex; or, if it is simple, it will produce highly disparate effects in various parts of this enormously diverse nation. Moreover, reforms that extend services to some people must produce large numbers of losers—those who must pay higher taxes if spending is increased, or those whose services or incomes are cut if spending is held constant. With the aid of generally avail-

able models, little cleverness is needed to identify the losers and use them as a cudgel to beat the proponents of change.

4.5 The Many Faces of Hubris

Economists, political scientists, and others who try to analyze public policy are trained to look at large trends and major problems, not to focus on uninformative specificity. To deal at the macro level requires abstraction and generalization, a suppression of detail in order to highlight the structure of the problem at hand. Students of economic regulation, for example, examine the emergence in many domains of certain behavioral regularities—for example, the tendency for regulatory capture or the inefficiencies from use of process rules rather than outcome standards. On the basis of such accumulated insight, analysts who know practically nothing about an industry can effectively criticize the decisions of people who spend their lives studying and regulating the industry. Few economists know much about how products move by barge, for example; but their ignorance does not materially impair their analyses of policies of the Interstate Commerce Commission.

Disregard for “irrelevant” detail permits policy analysts to approach public policy much like students in a military academy who analyze Lee’s strategy at Gettysburg. They model the terrain, place the forces in their respective locations, move stick figures around, comment on how they might have acted, and reach conclusions about alternative strategies. It is all so intellectually challenging, so stimulating, to think that one is mentally replaying an event in which tens of thousands of soldiers died. And it is so exhilarating to imagine the reconfiguration of an industry through which close to \$1 trillion of resources flow, to dream of making the world a better place by designing a superior system of paying for health care. It is so intoxicating, in fact, that one can easily forget the herculean labor necessary in a democracy to bring about large-scale changes in social policy and institutions.

This mental numbing is doubly important, as in the case of the U.S. health care system, when the object being manipulated is extremely diverse and complicated in relevant ways. Thus, reformers must beware of a kind of policy makers’ narcosis, a condition in which pride (often justified) about the power of one’s analytical skills deadens awareness of the distinction between, for example, talking about cutting spending by \$100 billion and the practical steps necessary to make such changes happen. Between what one person has called “Lotus policy analysis” and real change lies the task of writing legislation and regulations, securing popular acceptance of proposed actions, setting up new agencies, hiring staff, and, among other things, causing half a million doctors to practice medicine differently from ways learned in medical school and repeated for years or even decades.

The history of social policy in the United States gives little comfort to those

who hope to enact a single major law that will reform the U.S. health care system. With the exception of war mobilization and the desperate measures of the Great Depression, U.S. history contains no example of legislation remotely approaching the ambition and complexity of major reform of health care financing and the magnitude of change in behavior and established institutions it requires. Legislation creating land grant colleges and Social Security produced enormous ramifications, but modified or replaced few existing institutions. Economic regulation, which intrudes in much of the U.S. economy, arose piecemeal over many years.

In short, the disproportion between easy talk of fundamentally reforming health care finance, a mode of discourse abetted by the rhetorical habits of scholars, and the magnitude and complexity of the task of reforming health care financing is grotesque. The most surprising aspect of the debate about health care reform is not that consensus has been so elusive but that anyone ever expected it. The most disappointing aspect of the debate was the operation of a political Gresham's law, with epithets, oversimplification, and plain lying driving out serious debate over the complex issues that might have enlightened the electorate, even if it did not persuade their elected representatives to act.

4.6 Goals and Weights

The goals of health care reform, like Caesar's Gaul, are divided into three parts: cost control, extension of insurance coverage, and maintenance or improvement of quality of care. If the delivery system were thought to be efficient, the inconsistency of these goals would be transparent.

But few would place efficiency among the many virtues of the U.S. health care system. A large theoretical and empirical literature, supported—one might almost say, made unnecessary—by every observer's personal experiences testifies to widespread inefficiencies. Moral hazard induced by insurance under a fee-for-service system causes consumption of much health care with lower social benefit than social cost. Flaws in the tax system lead to excessive insurance. Both of those factors reduce incentives for providers to operate efficiently. Eliminating or reducing these inefficiencies would assuredly release resources that could be diverted to those whose access to care is now inhibited by a lack of good insurance.

4.6.1 Goal Trade-Offs

Not only goals but weights attached to various goals differ. Inevitably choices must be made about how aggressively to pursue cost control, how far and how fast to extend financial access, and how much quality to seek.

The relationship between efficiency and quality is particularly subtle. The term "waste" for economists encompasses two phenomena: use of resources that produce no benefits at all—services that are useless or harmful and pro-

duction methods that generate costs but no added benefits—and use of resources to produce services that generate benefits worth less, in some sense, than they cost.

Elimination of the first form of waste reduces costs and, since some care is harmful, may even improve quality of care in the short run. Elimination of low-benefit, high-cost care lowers quality of care as the term is commonly used, because such economies deny to some patients care they would choose to have under current financing arrangements.

In the long run, however, eliminating both kinds of waste threatens quality of care. Expenditures on research and development of new medical procedures respond to potential sales. The elimination of waste lowers potential sales and thereby discourages profit-motivated research. Over the long run, eliminating waste is likely to reduce the flow of innovation.¹⁰ Whether a reduction in innovation is to be celebrated (because innovation widens the scope of moral hazard and, therefore, of economic waste) or decried (because large serendipitous advances may be lost), is one of many important unknowable matters in medical financing.

Even if waste is extensive, savings may not be large enough, or may not be realizable quickly enough, to pay for the costs of extending access without short-run loss of some beneficial care, quite apart from any long-term retardation of medical advance.

4.6.2 Weights

Among advocates of access, cost control, and quality one can identify a wide variety of latent goals.

- Advocates for the poor, including many of the long-time supporters of government-sponsored health insurance, attach dominant weight to universal access.
- Business supporters of government involvement in health care seem motivated mostly by concern about controlling growth of costs. They seem to believe that private agents, acting alone, cannot solve problems of moral hazard—problems they see growing as the menu of diagnostic and therapeutic tools lengthens.
- Many observers, including representatives from the medical community, acknowledge that lack of financial access and rising costs are serious problems but dwell on the high quality of currently available care and warn that efforts to extend access and cut costs could impair quality, if not immediately, then over time.

10. One needs to be cautious in making such forecasts, as the essence of research is identification of unexpected production possibilities. To the extent that research activities are shaped by opportunities and incentives, the transformation of the financial environment for medical services into one that rewards parsimony might produce startling results, such as the discovery of low-cost alternatives to current methods of diagnosis or treatment.

More generally, many participants in the health care reform debate deny that curtailments in the growth of spending may necessitate trade-offs among desired ends.

4.7 Ignorance

When a member of Congress asked Congressional Budget Office director Robert Reischauer whether he was confident that the CBO estimates of the cost of President Clinton's health reform proposal were "in the right ballpark," Reischauer responded, "I am pretty sure they are in the same city the ballpark is in."¹¹ This exchange crystallized the extraordinary uncertainty surrounding the debate about health care reform—not just about the president's plan, but about any proposal for far-reaching reform.

4.7.1 Facts and Behavior

Reliable predictions of the consequences of major reforms of health care financing are simply impossible because information on actual use of health care services is spotty and out of date, and understanding of how people will respond to changed incentives is appallingly inadequate. Data on actual household expenditures are based on surveys that are several years old and that do not permit estimates of expenditures for substate geographical areas that played a prominent part in major reform proposals debated in 1994. Analysis of how people will respond to new organizational arrangements is unavailable because each of the major reform proposals would place people in situations never before observed. The president's plan and several others include new administrative entities—regional health alliances or health purchasing cooperatives—that exist nowhere and whose effects on the marketing of insurance or organization of care is a matter of speculation. Managed competition, a congeries of market reforms to promote cost-conscious buying, looks extremely promising on paper, but it has not run the gauntlet of legislation, regulatory drafting, and implementation. How much of the current cost advantage of HMOs, the leading managed care settings, is attributable to superior efficiency and how much to rationing, selection, or cost shifting through negotiated discounts remains unclear. In their recent review of research on HMOs, Miller and Luft concluded, "[T]he findings suggest that HMOs provide care at lower cost than do indemnity plans. Recent peer reviewed literature did not produce estimates of three other central summary indicators of managed care plan performance: the rate of growth of expenditures and the level and rate of growth of premiums" (1994, 1517). Attempts now to quantify the pace or amount of retardation in growth of spending from managed care recall Alec Cairncross's advice to economic forecasters: "Give a number or a date; never both."

While the debate is occurring, major events are taking place in the organiza-

11. Testimony, House Committee on Ways and Means, February 8, 1994.

tion of health care. A bewildering variety of organizations is swallowing up solo or free-standing group practices of physicians throughout much of the United States. The range of managed care settings increases daily. Managed care is being born without the aid of legislative midwives.

4.7.2 Cost Estimates

Uncertainty is the defining characteristic of the health care reform debate. For purely illustrative purposes, consider the question of how the medical system will respond to the extension of coverage to those who currently consume health care but do not pay for it. Providers now recover the costs of such care by charging the insured more than the full cost of care. Because Medicare and Medicaid have considerable market power, these programs also pay less than the full cost of care, according to estimates of the Prospective Payment Assessment Commission. Thus, private payers face charges for hospital services that average 31% more than the actual cost of care rendered to privately insured patients, although the excess varies widely from state to state.

The vitally important question for projecting costs concerns what will happen to charges when everyone is insured. Reimbursements will be available for previously uncompensated care. How will providers respond in setting fees? Some argue that the correct answer is that nothing will happen to the level *or* growth of fees, that total payments to providers for services currently rendered will increase because of increased insurance and that the growth of charges will be unaffected. This view implies an increase in rents, waste, or both unless some action is taken to prevent them.

This projection is open to challenge on several grounds. First, the behavior of providers should be influenced by the market conditions they face. Advocates of managed competition would argue that, in a properly structured market, insurers will sooner or later bid premiums down to offset the added revenues and then bid them down some more as pressures for efficient provision and elimination of low-benefit, high-cost services proceed. Others favor regulatory measures—premium caps, hospital budgets, or fee regulation—to avoid what they see as the doubly uncertain promise of competition as to timing and amount of savings eventually achieved.

The extension of coverage to the currently uninsured may cause charges to fall—whether through competition or regulation. Especially if they do not, the rate of growth may abate. Rents and waste may still increase, it is alleged, but not by the full amount of the windfall. On one's view about this question hinges projections of the effect of health care reform on national health care spending and on the federal budget. Given the rules of congressional budget accounting, these projections determine by how much taxes must be raised or other spending cut. Given the long history of savings claimed but never realized and the legislative responsibilities of the CBO to prevent budgetary trickery, the CBO is prepared to count as savings only what is embedded in law, not what advocates hope and claim will materialize. Thus, the political environment for the

debate on health care reform depends inescapably on projections that cannot be conclusively demonstrated. These projections, in turn, influence views on the importance of regulatory measures to siphon off the windfall at the outset.

This way of looking at the issue actually understates uncertainties surrounding critical details. It ignores the important variation among and within the United States in the estimated degree to which cost shifting against private payers now occurs. Estimates indicate that the excess of payments over cost by private payers for hospital services varies widely among the states. A national view omits consideration of the wide disparity among states and localities in the distribution of the uninsured or in the proportion of patients covered by Medicaid and Medicare. Thus, the windfall to providers from the extension of coverage varies enormously from state to state. Equally important variations occur within states, a relevant fact if any legislated reform relies on substate administrative entities; the magnitude of these variations is simply unknown.

4.7.3 Consequences

The lack of information necessary to predict the full consequences of major reform of health care is pervasive and ineradicable. In these respects, reform of health care is not unique. The full effects of any large-scale action can never be fully foreseen. Hagiography of entrepreneurs rests on their extraordinary capacities to bear risk. National leaders and honored generals receive accolades for their capacity to guide nations and armies through dark uncertainties. The key in each case is a willingness by responsible leaders to decide on a course of action under conditions others find bewildering and on their capacity to persuade others that the larger purpose justifies the risks entailed. In the political domain, action requires consensus, which can emerge from an overpowering sense of crisis or from a concordance of views on facts and goals. When no such consensus on a larger purpose exists or when profound disagreements exist on how best to achieve those purposes, lack of information becomes paralytic. No sufficiently persuasive case for action is possible; or, to be more precise, advocates of alternative courses of action contend fratricidally on how best to proceed. Attention to principle and prudence produces inaction.

4.8 Ideology

All actions rest on faith. The faith is simply the inductive leap that previous regularities will continue to apply in the current case. Two centuries ago Hume showed that such inferences are not rigorously provable. When actions concern major restructuring of incentives and when information is missing at every turn, few dependable forecasts of the consequences of action are possible. Such is the case with health care reform. The result is that health care reform becomes a kind of political Rorschach test in which the images conjured up by one proposal or another reflect and reveal the observers' ideologies more than their analytical or empirical reasoning.

The ideologies in evidence in the debate about health care reform closely resemble those displayed in other political debates. The most fundamental ideological cleavage concerns who is responsible for determining whether individuals should have health insurance or not. Views are ranged along a two-dimensional spectrum. On one axis views vary on the nature of health insurance (or on access to health care—not the same thing). At one pole is the view that health insurance is an ordinary market commodity, not fundamentally different from restaurant meals or automobiles in the sense that free consumer decisions based on available household resources should govern allocation. At the other pole is the view that health insurance is a right, a perquisite of citizenship or national residence, much like suffrage, the right to attend public school, or the assurance of police protection.

For those who believe that some collective responsibilities exist regarding health care, disagreement occurs along the axis of what constitutes acceptable coverage—public hospitals for the indigent? insurance for the costs of treatment during catastrophic illness? coverage for the costs of all “routine,” but not for “elective,” procedures? coverage for all medical care?

This dispute, heavily shadowed by views on the role of the government in promoting egalitarian income distribution, includes the sensitive question of what rules should govern the purchase of health care outside of any government-regulated system. Should individuals be free to use their own resources to buy supplemental insurance, should such insurance be taxed or otherwise penalized, or should they be prohibited from buying such insurance? Should individuals be free to buy care outside a regulated system, should price penalties or regulatory obstacles be imposed, or should the delivery of care outside the regulatory system be flatly prohibited? This group of what I call safety-valve questions is among the most important and least studied issues that will determine the long-run viability of any government-managed system.

Ideological disputes arise also with respect to cost control. Would governmental attempts to restrain growth of spending deteriorate into ineffectual bureaucratic tangles that obstruct organizational and scientific innovation and that become the vehicles for regulatory logrolling which might even raise spending? Would such regulations, instead, slow the growth of spending, as they have done in other nations, with some possible loss of efficient innovations but with certain gains from reallocation of resources from low-benefit medical services to higher-benefit alternative uses? Should one expect cost controls to cause elimination only of low-benefit services? Not if one looks at analyses of expenditure differences among nations. But perhaps outcomes analysis will change all that.

Or take the proposed health alliances or purchasing cooperatives found in proposals both Democrats and Republicans advanced early in 1994. Experts expressed doubts that the alliances could actually be created and staffed and that data necessary for their operation could be gathered in the time allotted by draft legislation. Popular and congressional criticisms focused not on practi-

cality but on principle. Are alliances necessary to remove current imperfections in markets for health insurance? Or, if they are mandatory and especially if they are exclusive, would they be bureaucratic golems that will stifle household choice among insurance plans and physicians? Should they be run by people knowledgeable about the health industry, thereby risking regulatory capture? Or should they be managed by people untainted by such interests, thereby courting amateurishness and ignorant blundering?

If strong alliances or cooperatives prove unacceptable, what can one expect from restrictions on the marketing practices of insurance companies? Are prohibitions on underwriting practices such as denial of coverage for preexisting conditions a reasonable extension of recognized powers to regulate insurers or an unreasonable enlargement of an authority that has already been abused, for example, by mandating coverage for particular services? Taken alone, will they expand coverage by mandatory issue and limits on premiums, or will they narrow coverage by bringing sick people into insurance pools and thereby raising average premiums? In that connection, is the ERISA exemption of self-insured plans from state regulation a desirable limit on abusive regulation or the creation of a market imperfection?

I could extend this list of “ideological” issues virtually without limit. Some may demur that these are not issues of ideology but of analysis and fact. It is surely right that these issues *could* be matters of analysis and fact. But they currently are not. Like the land of the Fisher King, whose domain stretched beyond the world known to cartographers of old, the land of ideology fills the globe of health care reform because so little of the globe is charted by fact and research.

4.9 Gordian Knots

One of the reasons that information about the U.S. health care system is so spotty is that the system is so intricate and varied.

Go to Great Britain, and one need only master the structure of the National Health Service system, noting that an adjunct private system has some importance in selected areas and is growing. Go to Germany, and one faces the somewhat more formidable problem of mastering the scores of employment-centered insurance plans and the organization of the delivery of care to which these plans give access.

But return to the United States, and one confronts not one but fifty-two government health plans (Medicare plus fifty-one Medicaid plans) and tens of thousands of employment-based plans. One finds intricate systems for providing free care and financing it through excess charges on private payers, and a large industry selling group insurance to employers and individual insurance to families and individuals, a delivery system that contains virtually every arrangement for providing care found anywhere else in the world and that is daily creating new ways to handle the financing and delivery of care. While

financing and delivery of care may be distinct in logic, they are entangled in practice as providers become risk bearers through HMOs, preferred provider organizations, and hospital-physician networks, and as physicians and other providers come increasingly to derive their incomes from several sources.

Depending on one's ideology, this diversity is a tribute to the unique flexibility of the U.S. system and its capacity to reform itself, or it is the fibrillation of a chaotic system in extremis. Regardless of one's ideology, however, this diversity is very bad news for would-be reformers operating at the national level. Deep insight is not required to understand that the essence of national reform of the financing of health care is the establishment of *national* rules governing financing. But when practices are diverse, when these differences appear in varying degrees in different places, and when the system is changing fast in sundry ways in various places, national rules have geographically dissimilar effects.

Moreover, the diversity of practice creates vexing dilemmas for would-be planners. They can try to recognize the diverse starting points of the various communities and move the nation gradually toward some common future. Given the bewildering variety of actual practices, this approach is a recipe for impossible complexity. Or they can ignore diverse starting points and require widely varying adjustments in different areas.

The subsidy structure of the Clinton plan illustrated this dilemma. Employers were to pay for health care up to certain nationally uniform percentages of payroll, and households were to be eligible for subsidies if their costs exceeded certain nationally uniform percentages of income. In addition, the Clinton plan called for the creation of regional health alliances within which community rating would prevail. Two facts of geographical diversity make the effects of this system highly varied across the United States.

First, Medicaid patients were to be covered through the alliances. The federal government would fully reimburse the regional alliances for costs of covering the "categorically eligible" Medicaid patients—those eligible because of receipt of Aid to Families with Dependent Children or Supplemental Security Income. But the federal government would reimburse the alliances only at the community rate for the "medically indigent"—patients who become eligible for assistance because of high medical expenses. Because average costs for these patients are high, their inclusion in the group used to define community premiums would raise the community rate and require other payers to pick up the difference between the community rate and the actual cost of these patients. The proportion of Medicaid patients who are medically indigent varies widely from state to state. The additional charge imposed on private payers to cross-subsidize the medically indigent varies commensurately. The exact calculation is complicated by the maintenance of effort provisions the Clinton plan would have imposed on states.

Second, per capita health care expenditures vary widely by state, ranging from \$3,031 per year in 1990 in Massachusetts to \$1,689 per year in South

Carolina. These cost differences mean that the flow of subsidies under formulas based on nationally uniform proportions of payroll or income would have varied widely across alliances and states. Subsidies to companies and households in high-cost states would have been larger than those paid to similar companies and households in low-cost states.

But the effects of covering the medically indigent at the community rate are far more problematic. The premium increase from this source was expected to average roughly 20%. In alliances with large populations of medically indigent, insurance premiums for employers that now sponsor insurance would have risen more than 20%, in alliances with small populations of the medically indigent, less. The Clinton plan would have imposed regulations to inhibit such increases. The administration claimed such limits were justified because providers would have been paid for current unreimbursed care. But geographical diversity guarantees that the relationship between the added costs imposed on private payers by the community rating of the medically indigent and the added incomes to providers from covering the uninsured would not have matched up well, even if they were similar in magnitude nationally. Furthermore, it is insurers who would have been put at risk by this pairing of provisions. If providers did not cut *prices* when the uninsured were covered, insurers would have faced increased costs because the *quantity* of care for the medically indigent is higher than average.

This pair of provisions created a serious dilemma for financing of the Clinton health plan—regulate premiums stringently and risk defection by insurers from certain markets, or dispense with regulations and face the likelihood of a sharp increase in premiums that would be budgetarily and politically devastating.

I have gone into this particular provision in some detail for two reasons. First, the dilemma that flows from it is an inescapable consequence of geographical diversity. Second, while more serious than most such dilemmas, it is far from unique.

When confronted with such Gordian knots, one may try to untangle them by dealing case by case with the complexities, a sure road to legislation of unimaginable complexity. Or one may cut the knot, by imposing nationally uniform rules and damning the uneven consequences. I believe that the latter course is the only one that is manageable. But this approach runs afoul of the variant of medical ethics that Charles Schultze suggested typically guides political action: “Do not be seen to do obvious harm.” This rule of political action can be suspended, but only in the presence of an overwhelming shared sense that an urgent problem demands action.

The campaign for health care reform during 1994 should be viewed in that light. It was not a debate about the Clinton plan, or the Chafee plan, or the Cooper plan, or about any other single piece of legislation. It was a debate about the status quo. Was the American public sufficiently disturbed by actual or threatened erosion of private health insurance coverage, which fell from

75% to 71% between 1988 and 1992? Were households sufficiently fearful that they would suffer the loss of some or all benefits? Could businesses be persuaded to fear capriciously and uncontrollably rising costs enough to overcome their dislike of increased government regulation? Only if these conditions were met would the public have caused elected officials to fear returning for the midterm elections empty-handed more than voting for legislation the full effect of which could not be foreseen and that would create as many losers and winners.

The job of creating these conditions fell to President Clinton and his administration, who traveled and spoke across the United States on behalf of health care reform in an effort more like a presidential campaign than usual efforts to win support for legislation. This campaign had two themes: that the status quo could not be allowed to continue, and that the Clinton plan was the way to change it. The public initially and in general terms embraced the first element of this campaign, but was divided on which of the many approaches to reform was best and eventually feared to make any change at all. The president's task was to sustain public commitment to change, to persuade the citizenry that his plan was both workable and preferable to the alternatives, including the status quo, and to block off avenues of retreat so that querulous members of Congress had to stand and fight through to compromise.

In the end, President Clinton lost this campaign. He lost it in part because of the enormous difficulty of the task, in part because of genuine flaws in his plan and blunders in its presentation, in part because critics distorted and misrepresented his plan, and in part because events ranging from international crises to charges of personal improprieties distracted popular attention. The president's plan contained structural flaws and was not implementable on the schedule proposed. Critics charged the plan with shortcomings it did not possess, for example, by alleging that the president's plan narrowed patient choice among physicians, which was the opposite of the truth.

Perhaps most fundamentally, however, the trust necessary to win approval of major reform, the full consequences of which are always unpredictable, was and is wholly lacking. Successive presidents, from Carter through Bush, and countless congressional candidates have run campaigns against official Washington, alleging perverse motivations and general incompetence throughout the federal government. For all of these reasons, the chances for far-reaching health care legislation were bleak from the outset.

With the American public unsure of the nature of the problem, distrustful of elected officials, and wildly unenthusiastic about the Clinton recipe for reform,¹² elected officials retained their preferred option—to resolve doubts in favor of tinkering rather than large-scale reform.

12. In recounting travels on behalf of the Clinton plan, one high administration official told me, "I have heard many things on my travels, but one phrase I have never heard: 'We have to have the Clinton plan.'"

4.10 Next Steps

The trends that led President Clinton to place reform of health care financing at the top of his domestic legislative agenda will not change.

Rising federal health care spending fully accounts for all of the projected increase in the federal deficit and more over the next decade. If federal spending on health care grew no faster than gross domestic product, the federal deficit would decline to less than 1% of gross domestic product by 2004. Given current projections, the deficit will reach a trough at 2.3% of gross domestic product in 1998 and then rise to 3.5% in 2004 and continue increasing.

The principal force driving up health care costs—the proliferation of medical technology—shows no signs of abating (Schwartz 1994; Schwartz and Mendelson 1994; Aaron 1991; Newhouse 1992).

Reports abound that private efforts to control costs have slowed the rise of national spending, but little evidence can be found to support such claims in the growth of health care spending as a share of gross domestic product. Health care spending deflated by the gross domestic product deflator as reported in the national income accounts rose an average 6.3% from 1980 through 1990, 5.7% from 1990 through 1992, and 5.7% in 1993. Whatever their promise for cost containment, privately initiated financing reforms have yielded little so far. For a further discussion of this subject, see Levit et al. 1994; Huskamp and Newhouse 1994; Aaron 1994.

In the face of these trends, the behavioral responses that have caused unease among the American public regarding the security of coverage are likely to intensify. Governments are likely to continue to abuse their market power as the largest purchasers to buy services at marginal cost, shifting overhead costs to private payers. Large employers and health providers with the buying clout to negotiate discounts from hospitals and physician groups will engage in a similar game. Both technological advance and intensified cost shifting will strengthen incentives for employers to cut back generous fringe benefits and to buy from suppliers with meager fringe benefits items they previously made themselves. As governments and companies yield to these temptations, the reach of private health insurance will continue to shrink.

Without some form of national action, there is little reason to think that health insurance coverage will stop narrowing or that total health care spending will stop rising at excessive rates. Restrictions on private insurance companies, such as mandatory reissue, limits on denial of insurance for preexisting conditions, or limits on premium variability will help some people to buy or retain insurance. But the net effect on coverage is unclear. These reforms bring coverage to people who have higher than average expected health care costs. The inclusion of these people in insurance pools would raise premiums for many of the currently insured. As a result, some currently insured would drop coverage. Even some who believe that privately initiated reforms will retard the

growth of spending acknowledge that it will take many years for reforms to become nationally effective.

Despite these trends, the conditions under which health care reform could once again be the leading legislative priority of a Washington administration are hard to imagine. Natural political selection guarantees the extinction of candidates who revel in glorious defeats. President Clinton, having staked his administration's domestic agenda on health care financing reform, is seen to have failed in that effort. Persuading Democratic members of Congress to shoulder once again the herculean labor of working through the complexities of health care reform will likely be impossible. And Republican members of Congress are unlikely to reward a president they see as vulnerable by backing legislation he would find it congenial to sign and that members of his own party refused to embrace.

The revival of health insurance as a national issue will await the conjunction of two events. The first is intensification of the problems of rising cost and insecurity of coverage. As noted, I believe that this condition will be achieved almost automatically. The second condition is identification of incremental measures that promise comprehensible, tangible progress in solving these problems. Such reforms should be consistent with long-term, nonincremental goals, but must not, like recent proposals, promise institutional turmoil or demand broad trust of elected officials.

Progress toward the goals of universal coverage and reduction in the inflationary consequences of moral hazard will be possible only when two conditions are satisfied. The first is creation of entities capable of administering measures to achieve these goals. A key element of all of the major reform proposals is the creation of some form of regionally based, politically legitimated, administratively capable entity (or entities) that have the knowledge, data, and staff to enforce order in the financing of health care. President Clinton called such entities regional health alliances. Senator Chafee and Representative Cooper called them purchasing cooperatives. Privately proposed reforms also called for such entities, according to Alain Enthoven and Richard Kronick (1989) and Aaron (1991).

In 1994, the idea of a single administrative entity for each geographical area proved politically unacceptable. Such entities, it was feared, would limit individual freedom to choose providers, function as clumsy and unresponsive monopolies, or choke off financial innovation. Most of these fears were unjustified or could have been put to rest with simple revisions. But the idea died.

Despite its political failure, the impulse that led reformers of widely varying stance to recognize the need for such regionally based entities is solidly based. Sponsors of alliances or purchasing cooperatives had divergent visions of the powers such entities should have. But they recognized that freely operating insurance markets suffer from a variety of widely studied imperfections, most of which arise from informational asymmetries. Furthermore, the bedrock of freely operating insurance markets, the incentive to price insurance at expected

cost (which takes the form of pricing based on retrospective use, so-called experience rating), produces dubious social and economic consequences (Aaron 1994).

Successful reform of health care financing requires the creation of entities capable of doing what alliances and purchasing cooperatives were expected to do—enforce rules regarding the marketing of insurance, enforce premium limits, provide subsidies to needy households, and act as conduits for the flow of funds from payers to providers. Some of these functions may, in the end, be left to other organs of government. Federal legislation or state action can create such entities. Competing alliances or cooperatives can be allowed to exist, without entirely vitiating their functions and purpose, although single entities in each geographical area have important advantages.

The second condition that must be satisfied is the realization in practice of some of the reform measures that now exist only as intellectual abstractions. The Clinton plan, for example, depended on regional alliances, which exist nowhere; subsidy payment schemes unlike those under any current program; risk-adjustment payments to insurers, of whose feasibility some scholars are highly skeptical; and the elimination of inefficiencies that, by their very existence, have defied previous efforts to economize. If, as Louis Brandeis said, the states are the laboratories of democracy, it is important to encourage states to undertake efforts to deal with these issues in a practical way. The ERISA now effectively bars states from dealing comprehensively with health care, because it bars states from regulating self-insured health plans, which now cover more than half of all workers. Multistate employers have legitimate concerns that repeal of this ERISA protection would expose them to disparate regulations in every state where they now operate. While it is important to honor these concerns, many self-insured plans are operated by employers whose operations are overwhelmingly within one state. One approach would be to allow states to regulate self-insured plans of employers that operate within one state. Alternatively, states could be limited in the stringency of rules that could be applied to multistate employers. In either case, measures to enable states to undertake programs that would test ideas bruited about as abstract intellectual principles in the debate of 1993 and 1994 would permit the next round of debate on health care reform to be based on more solid information.

4.11 Last Words

The health care reform debate should, but is not likely to, teach lessons to analysts and elected officials alike about the limits of far-reaching reforms in a constitutional democracy based on checks and balances. Except in periods of great upheaval, progress almost invariably is incremental, particularly when legislation requires the reconstruction of powerful existing institutions. Yet the U.S. electoral system rewards candidates who convey to electors strong visions of far-reaching change. The transition from campaigning to governing requires

that newly elected officials, who have just shown by their victory that they can surmount an electoral process that is death defying, both literally and figuratively, plan with genuine humility about what they can accomplish. While recognizing that their rhetorical reach must often exceed their political grasp if they are to achieve anything, officials not yet bloodied by the real-life frustrations of governing must understand that the policies they propose cannot exceed the digestive capacity of the U.S. political system. A refusal to understand those limits is a recipe for official failure and popular disillusionment.

The U.S. health care system is now so large that measures to change it are guaranteed to generate fierce and well-financed opposition. The media, which thrive on exciting controversy, not sober debate, further obstruct the formation of consensus about how to proceed. In the case of health care, the media cannot be blamed, because no professional consensus exists on how best to reform the current system. The era in which reform of the health care system could be accomplished by one "big law" is over. The task for the future is to identify specific modest changes that do not require a grand consensus on the character of the ideal grand reform, but that will nudge the system in directions regarded as desirable. It is grubby and unexciting work, but somebody has to do it.

References

- Aaron, Henry J. 1991. *Serious and Unstable Condition*. Washington, DC: Brookings Institution.
- . 1994. Issues Every Plan to Reform Health Care Financing Must Confront. *Journal of Economic Perspectives* 8:31–43.
- Aaron, Henry J., and William B. Schwartz. 1984. *The Painful Prescription: Rationing Hospital Care*. Washington, DC: Brookings Institution.
- Altman, Lawrence K. 1994. Surgery Is Found to Fight Stroke. *New York Times*, October 1, 1.
- Arrow, Kenneth. 1963. Uncertainty and the Welfare Economics of Medical Care. *American Economic Review* 53:941–73.
- Brook, Robert H., and Mary E. Vaiana. 1989. *Appropriateness of Care: A Chart Book*. Washington, DC: George Washington University, National Health Policy Forum.
- Cohen, Linda, and Roger Noll. 1991. *The Technology Pork Barrel*. Washington, DC: Brookings Institution.
- Cromwell, Jerry, and Janet B. Mitchell. 1986. Physician-Induced Demand for Surgery. *Journal of Health Economics* 5:293–314.
- Enthoven, Alain, and Richard Kronick. 1989. A Consumer-Choice Health Plan for the 1990s: Universal Health Insurance in a System Designed to Promote Quality and Economy. *New England Journal of Medicine*, January 5, 29–37; January 12, 94–101.
- Feldstein, Martin. 1973. The Welfare Loss of Excess Health Insurance. *Journal of Political Economy* 81, no. 2, pt. 1:253–80.
- Fuchs, Victor R. 1979. The Economics of Health in a Post-Industrial Society. *Public Interest*, 3–20.
- . 1986. Physician-Induced Demand: A Parable. *Journal of Health Economics* 5:367–68.

- Huskamp, Haiden A., and Joseph Newhouse. 1994. Is Health Spending Slowing Down? *Health Affairs* 13 (winter): 32–38.
- Levit, Katharine R., Cathy A. Cowan, Helen C. Lazenby, Patricia McDonnell, Arthur L. Sensenig, Jean M. Stiller, and Darleen K. Won. 1994. National Health Spending Trends, 1960–1993. *Health Affairs* 13 (winter): 14–31.
- Miller, Robert H., and Harold S. Luft. 1994. Managed Care Plan Performance since 1980: A Literature Analysis. *Journal of the American Medical Association* 271:1512–19.
- Newhouse, Joseph. 1992. Medical Care Costs: How Much Welfare Loss? *Journal of Economic Perspectives* 6:3–21.
- Okun, Arthur M. 1975. *Equality and Efficiency: The Big Tradeoff*. Washington, DC: Brookings Institution.
- Parkin, David, Alistair McGuire, and Brian Yule. 1987. Aggregate Health Care Expenditures and National Income: Is Health Care a Luxury Good? *Journal of Health Economics* 6 (June): 109–28.
- Pauly, Mark. 1968. The Economics of Moral Hazard. *American Economic Review* 58:531–37.
- Phelps, Victor R. 1986. Induced Demand: Can We Ever Know Its Extent? *Journal of Health Economics* 5:355–66.
- Schelling, Thomas. 1984. *Choice and Consequence*. Cambridge: Harvard University Press.
- Schwartz, William B. 1994. In the Pipeline: A Wave of Valuable Medical Technology. *Health Affairs* 13 (summer): 70–79.
- Schwartz, William B., and Daniel Mendelson. 1994. Eliminating Waste and Inefficiency Can Do Little to Contain Costs. *Health Affairs* 13 (spring): 224–38.
- Stiglitz, Joseph E., and Michael Rothschild. 1976. Equilibrium in Competitive Insurance Markets: An Essay on Imperfect Information. *Quarterly Journal of Economics* 90:129–49.
- U.S. Congress. Office of Technology Assessment. 1993. *Pharmaceutical R&D: Costs, Risks, and Rewards*. OTA-H-522. Washington, DC: Government Printing Office.

Comment Martin Feldstein

Although I disagree profoundly with many of the assumptions and conclusions of Henry Aaron's paper, I think it is useful because it raises fundamental issues about health care and health care financing that economists should be considering. The decisive political and popular rejection of the Clinton health plan and of the related congressional plans in 1994 may remove proposals for the radical reform of health care financing from the political agenda during the next few years. But a half century of historic experience suggests that the issue will resurface again before long. With health care spending now exceeding 14% of GDP and soon to be the largest component of the government budget, economists should be thinking about the effects of alternative reforms in anticipation of that renewed political interest.

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It is difficult to comment on a paper like Aaron's, which is not a technical analysis but rather a carefully nuanced policy discussion. I will therefore present a more general comment that contrasts two approaches to reforming the financing and organization of health care: tax and insurance reforms aimed at strengthening the market process and individual choice versus a nonmarket approach to the provision of health care. The first of these views reflects my own attitude. Some but not all of the alternative position is relevant to the Aaron paper.

Strengthening the Market and Individual Choice

Health care is not like other goods and services. Because a small fraction of households incur very large medical bills each year, some form of insurance is appropriate.¹ Eighty-five % of the American population now has formal insurance coverage through private or public programs, and many of those who are technically uninsured know that their medical costs will be absorbed by the providers or by government because of their low income. For those with formal insurance coverage, patients' out-of-pocket spending at the time of care is generally 20% or less of the marginal cost of providing their care. This distorts the decisions of patients and their doctors at the time of care, inducing a consumption of medical care that patients and doctors value at far less than its cost of production.

Although financial risk aversion implies that some insurance is desirable, in the second-best outcome individuals would balance the gains and losses from increased insurance such that at the margin the additional deadweight loss that results from the excess consumption of medical services would be balanced by the additional reduction of financial risk. This would lead to much larger copayments than we now observe.² The current excessive insurance coverage reflects the tax rules that exclude employer-financed health insurance from taxable income. The combination of a 28% marginal federal income tax rate, a 15.3% combined employer-employee Social Security payroll tax, and state income and sales taxes means that many employees choose between a dollar of employer-paid health insurance premiums and 50 cents of after-tax spendable income. The resulting revenue loss to the federal government alone is esti-

1. Aaron's comments suggest that he believes that private insurance may soon not be feasible because insurance companies will have the technological capacity to predict which individuals will incur large medical expenses. A perfectly predictable event is not insurable. Although some genetic screening now does permit identifying individuals who are more likely to develop some diseases, this relates to a very small number of examples and, while identifying higher-risk individuals, is very far from predicting those who will become ill.

2. See Feldstein and Gruber (1995) for an explicit evaluation of the welfare gain that could be achieved by shifting from existing insurance coverage to plans with substantially higher copayments. A system in which individuals select the policy that reflects their own individual tastes and risk assessments would involve self-selection problems that can be overcome in practice by the use of employer-based plans and other natural groups. Although the requirement that all members of the group choose from a limited range of insurance options reduces the welfare gain from tailoring coverage to individual preferences, the higher copayment plans can still raise welfare substantially relative to the current very comprehensive insurance.

mated to be \$79 billion a year. It is not surprising therefore that individuals choose excess health insurance and therefore excess health care spending.

Some of us would like to see the government remedy this tax system distortion, hoping thereby to encourage a market in which individual preferences and individual willingness to pay would be reflected in a diversity of insurance alternatives. Without the tax distortion,³ some individuals would want indemnity policies with high copayments, accepting the additional financial risk in order to reduce the costly distortion in the consumption of health services. Others would join prepaid groups (HMOs), accepting the risk that providers will offer less than the optimal amount of care rather than accept the high premium cost of traditional low-copayment plans or the higher financial risk of indemnity plans with large coinsurance. The key point is that this second-best outcome would reflect the diversity of individual preferences.⁴

Not all economists who have studied health care accept this as the appropriate goal for policy. Some of them would prefer a "single-payer" government monopoly at the national level, rather like the traditional English National Health Service. Others hope for a sequence of political actions that would lead eventually to some system of regionally based prepaid health care systems in which all individuals would receive the same care regardless of tastes or willingness to pay. Since individual preferences and willingness to pay are not to count under such arrangements, the government must decide the aggregate spending on health care and then leave it to physicians to use the health care budget in what they regard as the technologically best way. Since all individuals are to receive the same package of financing and benefits, the financing must be equivalent to a combination of substantial subsidies and taxes. The experience with all of the 1994 health care financing proposals indicate that such a tax would involve a sharp increase in marginal tax rates as the implied subsidy at low and moderate incomes is phased out.

Nonmarket Solutions

Why do some health specialists propose a nonmarket solution for the financing and organization of health care? My reading of their papers suggests three reasons that alone or in combination also explain why many other health care writers favor government provision.

A Desire for Greater Equality. Since health care spending is a very large part of personal consumption, an increase in government finance of health spending

3. The tax distortion could be eliminated or reduced by ending or limiting the current exclusion of employer insurance payments from taxable income. A similar and politically more likely effect might be achieved by allowing uninsured health care to be paid for with pretax dollars.

4. Many writers on health care reform assume that the appropriate care for each individual is a technical question that physicians can answer. In reality, the combination of technological uncertainty and heterogeneous preferences means that the appropriate treatment for many conditions will depend on individual preferences and not just on medical facts. This in turn implies that the appropriate form of insurance will also differ from individual to individual. I return to this later in this comment. See also Feldstein (1995) for a discussion of this issue.

(whether directly through the budget or indirectly through a system of mandates on employers or insurance companies) could substantially equalize households' cash available for spending on other things. The experience of the 1960s showed that voters are more willing to support income redistribution disguised as specific in-kind benefits (of which the clearest example is food stamps, a cash equivalent masquerading as a feeding program) than explicit income redistribution through cash transfers.

Some health specialists regard the equality of health care as specifically desirable. They compare health care to votes, implying that complete equality is the appropriate standard. I don't see why health care is like votes. Voting directs government power over others. If your vote is effective, it is likely to affect my well-being directly. An individual's purchase of health care does not have such externalities.⁵ The nature of voting is also such that an increase in the number of votes that you have reduces the value of my votes. In contrast, an increase in the amount of health care that you consume does not reduce the availability of health care to me any more than is true for other goods and services. With a time horizon of a few years or longer, health care is not specifically scarce. As the rapid growth in health care spending shows, the American economy is able to expand the resources devoted to providing health care very rapidly.

The ability to purchase better health care for oneself and one's family, like the ability to purchase better food or housing or education, is a strong economic motivator. Taking health care out of the marketplace would weaken overall economic incentives even if there were no change in the link between effort and disposable money income.

A Distrust of Individuals' Choices of Insurance and Health Care. It is easy to agree with the proposition that choosing health insurance and medical care involves complex decisions without jumping to the conclusion that individuals should be denied the right to choose. If the government knows what insurance is best, government experts could provide that information without requiring that we accept it. Similarly, government experts could indicate what they believe is the "right" treatment for any given condition without requiring that patients and their doctors accept that advice. Consumer ignorance provides a rationale for information, not for government control.

If it were appropriate for the government to control consumption of any type of good and service about which individuals are not fully informed, there would be few things that could not be shifted to government control. We need only think about how little individuals know about the food they eat and the cars they drive.

5. To the extent that health spending involves externalities, it is because of too little spending. We may all have a reason for wanting others to get at least some minimum level of care. But that is very different from wanting all care to be equal.

The government's ability to make good decisions in health insurance and health care is also very doubtful. The insurance coverage provided by Medicare and Medicaid is the most old-fashioned indemnity plan. Private industry and individual choice have been the innovators that have developed managed care, point-of-service plans, and so forth. And the Veterans Administration hospitals are models of government inefficiency in the provision of care.

An Indifference to the Diversity of Individual Tastes. The effects on health and longevity of diet, exercise, smoking, alcohol, and other aspects of lifestyle are widely known. Some people act in all the ways that the health experts tell us are good for us, while most of us do so to a more limited extent. People do not injure their future health and reduce their life expectancy just because of ignorance or because of an inability to afford better habits, but because they find a less virtuous lifestyle more enjoyable. The same diversity of tastes for health and for other pleasures of life suggests that, among any large group of individuals with the same income, some would want to spend more on medical care and others would want to spend less so that they could spend more on other things.

Differences in taste also extend to insurance. Just as individuals with different risk tolerances hold different investment portfolios and choose different careers, those individuals would, *ceteris paribus*, want different health insurance. Those individuals who want to spend more on health would also generally want more comprehensive insurance.

Many writers on health care seem to me to give no consideration at all to these differences in preferences. Like so many physicians and health planners, they appear to view the choice of medical care as a technical decision in which preferences are irrelevant. In fact, there is overwhelming uncertainty about how patients should be treated under many medical situations, uncertainty that can only be resolved with reference to patients' preferences.⁶

The Legislative Rejection of the 1994 Health Proposals

Henry Aaron devotes a substantial portion of his paper to discussing why Congress did not enact the health care plans proposed by President Clinton, Senator Mitchell, and others. He offers several reasons, but his primary explanation is that the American public accepts a radical new government program only when the national situation is one of extreme disorder and there is a high degree of faith that the government leaders are trustworthy and capable. He concludes that neither condition prevailed in 1994 and that it was therefore

6. Consider, for example, the treatment of cancer of the breast or the prostate. Alternative treatments have different residual risks for the rest of the patients' lives and different effects on the individuals' enjoyment of life. Or consider that older people have different attitudes about the amount of care they should be given if they become very ill. Why should the government impose the same standard of care on all individuals? Why should the financing cost be the same for individuals with different tastes for health care?

impossible to enact a proposal that, as he characterizes it, was change on a greater scale than anything ever done before except the wartime mobilization of World War II.

That diagnosis suggests that a more modest series of changes could gradually gain acceptance and bring us ultimately to a system that the public was unwilling to accept in one step. I hope that the public will not be fooled into accepting radical reform in small steps.

I believe that most Americans do not favor the status quo in health care and would support a modest reform package that focuses on some of the problems of the existing private insurance system, including new rules that would prevent the exclusion of preexisting conditions for job changers and the cancellation of coverage by insurance companies. Indeed, these were the features that President Clinton emphasized in his most popular appeal: insurance that cannot be taken away. I believe that the 85% of Americans who have insurance would welcome that reform and that many of the remaining 15% would find that it permitted them to obtain and keep coverage.

But that is not what the Clinton administration or the congressional leaders, including Mitchell, Chafee, and Cooper, offered. They put forward a take-it-or-leave-it package that emphasized vast expenses and, in the Clinton plan, tight controls on government spending. Although the issues were complex, I think the American public rejected this take-it-or-leave-it offer for three reasons.⁷

First, they did not want government to limit their health spending. They might want to spend less, and they might be willing to accept such things as HMO plans and point-of-service insurance contracts that achieve lower costs, but they do not trust the government to control health care.

Second, they did not want to pay a great deal in taxes or lost wages to redistribute income to those with incomes above the poverty level who already have health insurance and who would have gotten most of the subsidies under the various plans.

Third, although they believe that no one should be denied needed health care because of an inability to pay, they did not want to pay tens of billions of dollars in taxes each year to give *formal* insurance coverage to those who now receive free care for major problems and to provide equal care for those who are now uninsured. Americans recognize that the care received by the poor, especially when they are well or have minor problems but sometimes even when they have more serious problems, is not as good as the care received by the average American family, but understand that that is true also for their housing, their food, their schools, and virtually everything else.

Looking ahead, the interesting question raised by the legislative outcome of 1994 is whether the supporters of radical take-it-or-leave-it reform in 1994 will

7. These issues are discussed in more detail in several articles that I wrote for the *Wall Street Journal* and that appear in the references to this comment.

now accept the more modest reforms of private insurance or will continue to try to hold those popular reforms hostage to their more radical agenda.

References

- Feldstein, Martin. 1993. Clinton's Hidden Health Tax. *Wall Street Journal*, November 10.
- . 1994a. A Hidden \$100 Billion Tax Increase. *Wall Street Journal*, August 9.
- . 1994b. Income Based Subsidies Won't Work. *Wall Street Journal*, June 17.
- . 1994c. Mandates Would Hurt the Middle Class. *Wall Street Journal*, July 21.
- . 1995. The Economics of Health and Health Care: What Have We Learned? What Have I Learned? *American Economic Review* 85 (May): 28–31.
- Feldstein, Martin, and Jonathan Gruber. 1995. A Major Risk Approach to Health Insurance Reform. In *Tax Policy and the Economy*, ed. James Poterba. NBER Working Paper no. 4852. Cambridge, MA: National Bureau of Economic Research, September.

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