FOREWORD: HEALTH POLICY'S FOURTH DIMENSION

CLARK C. HAVIGHURST* AND BARAK D. RICHMAN**

Health policy analysts in the United States have traditionally divided their subject under three headings: access, cost, and quality. This symposium suggests that these analysts have culpably neglected a fourth, arguably coequal issue: namely, equity in the distribution of system costs and benefits among the purchasing, tax-paying population. Although reasonable minds can differ over many issues of health policy, no one can reasonably argue that the system's costs should be borne disproportionately by those with less ability to pay. Nor is it easy to argue against giving individuals and families wanting health coverage the option—within limits—of spending only what they feel they can (with available subsidies) afford, prepaying only for the quantity and quality of health services they deem appropriate for their circumstances. The lead article in this symposium, written by the undersigned Special Editors,[1] identifies a number of issues related to the symposium's overall theme of distributive justice. In general, we develop the hypothesis that the U.S. health care system operates more like a robber baron than like the Robin Hood it is reputed to be, taking excessive amounts from ordinary payers of health insurance premiums and enriching, directly or indirectly, the health care industry and its higher-income customers, both as consumers and as taxpayers. A principal objective has been to show how the linked questions in the symposium's title—who pays and who benefits—deserve equal billing with the three usual suspects.

The overall goal of the symposium is to stimulate wider awareness and discussion of some serious fairness issues in the way the U.S. health care system treats those who foot its enormous bills. The lead article emphasizes, first, that Americans with health coverage pay not only for their own families' health care but also to support a vast health care enterprise that primarily benefits others, many of whom are more, not less, affluent than themselves. The system is able to finance itself in part because U.S.-style health insurance greatly amplifies price-gouging opportunities for health care firms with monopoly power, creating a cost burden that falls ultimately on all premium payers equally, like a severely regressive "head tax." The article identifies a variety of equity issues

---

Copyright ©2006 by Clark C. Havighurst and Barak D. Richman

This article is also available at http://law.duke.edu/journals/lcp.

* Special Editor; William Neal Reynolds Emeritus Professor of Law, Duke University School of Law.

** Special Editor; Associate Professor of Law, Duke University School of Law.

1. Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, 69 LAW & CONTEMP. PROBS. 7 (Autumn 2006).

associated with relying on nonprofit institutions with market power and tax-exempt status to fund a range of health care activities, not all of which would be found deserving of direct public subsidies if submitted to the usual processes for setting public spending priorities. In addition, we suggest that ordinary premium payers may also bear an unfair share of the cost of inducing technological innovation in the health sector.

The second main theme of the lead article is that working-class insured consumers, in addition to paying a disproportionate share of the cost of producing various public goods, also bear excessive costs for their own health care. Here the problem is not only that many unit prices are supra-competitive. Our more important claim is that the coverage that consumers must buy if they are to have any coverage at all necessarily includes an entitlement to many costly services that have only modest marginal value, especially when compared to other uses the consumer might have for the extra money he is forced to spend. The article gives many reasons why lower- and middle-income consumers buy coverage that seems suitable only for the affluent. The most obvious explanation is the absence in the marketplace of significantly lower-cost insurance options. Here the problem is partly overregulation, including the professionally dictated standards of medical care that are both incorporated by reference in insurance coverage and enforced in malpractice litigation. An insurer offering access to only basic care (rather than to everything that the health and legal systems deem "medically necessary") would face not only daunting legal barriers and risks but also a difficult marketing task and competition from the so-called safety net, which protects uninsured consumers against at least some risks at no up-front cost; moreover, an insurer probably could not recover its investments in meeting these large challenges because its competitors could quickly imitate its success. Paradoxically, of course, it is consumers themselves who have long demanded high-quality, costly coverage and resisted efforts to economize. Our explanation for their seemingly perverse preferences is that, because of the tax subsidy for employer-sponsored health coverage, consumers do not see with any clarity the very heavy costs that their own high expectations cause them to bear. Our article emphasizes not only the market, but also the political, effects of a tax system that induces consumers to believe that the cost of their health coverage falls mostly on their employers, not themselves.

Our article also provocatively suggests some reasons for believing, even in the absence of definitive empirical evidence, that lower-income insureds get significantly less out of their employers' health plans than their higher-income coworkers, despite paying the same premiums. The net direction of wealth transfers here is difficult to determine in part because lower-income persons tend to have poorer health and thus greater need for certain health services. Yet, we suspect that intra-plan subsidies are regressive on balance because higher-income insureds tend to make greater use of their entitlements.

The eleven other articles in this symposium are in varying degrees comments on and elaborations or criticisms of specific observations or arguments in the lead article. Readers should find these articles and comments valuable in exposing both strengths and shortcomings in our work, in expanding our insights, and in putting issues we raise in larger contexts. The task of exploring health policy's "fourth dimension" has only just begun, however. The following paragraphs describe areas in which there is a need for deeper exploration of distributive justice issues than this symposium is able to provide.

The Tax Subsidy. This subsidy has been a much-criticized feature of the U.S. health policy landscape for so long, yet has seemed so immune to political reform, that it seldom receives the rigorous scrutiny it deserves. For example, the principal problem is not the regressivity of the subsidy itself (indeed, the lead article questions whether its net effect has been regressive at all) but its distorting effect on choices by employers, employees, union leaders, insurers and health plans, consumer advocates, voters, public officials, and legislatures. It is no coincidence in a political world that the true costs of coverage are kept largely hidden from those who pay them and that regulatory and other policies consistently enshrine the values and advance the interests of the health care industry and other elites. To be sure, consumers like to think of health care, not as a consumer good featuring tradeoffs between benefits and costs, but as a technocratically determined entitlement provided to them mostly at someone else's expense. In fact, however, most of them are paying good money for health care and would be better off if they took more control or exercised more influence over the many spending decisions that others make on their behalf. Although articles herein by Mark Pauly[2] and Lawrence Zelenak[3] helpfully put the tax subsidy in economic and tax-policy contexts, further research is needed to verify and quantify the resulting inequities and to test our hypothesis that the subsidy's most worrisome effects are essentially political.

Health Care Law and Regulation. Legal scholars and other analysts should ponder our claim that, in health care perhaps more than any other sector, the true interests of consumer-voters are ill-served by the political, regulatory, and legal environment. Christopher Conover's article[4] herein reports some early, admittedly imprecise estimates of the costs of health-sector regulation. Tom Miller's article[5] argues that excessive regulation of the health care market might induce individuals to seek inputs that neither efficiently nor effectively lead to

2. Mark Pauly, *The Tax Subsidy to Employment-Based Health Insurance and the Distribution of Well-Being*, 69 LAW & CONTEMP. PROBS. 83 (Autumn 2006).

3. Lawrence Zelenak, *Of Head Taxes, Income Taxes, and Distributive Justice in American Health Care*, 69 LAW & CONTEMP. PROBS. 103 (Autumn 2006).

4. Christopher J. Conover, *Distributional Considerations in the Overregulation of Health Professionals, Health Facilities, and Health Plans*, 69 LAW & CONTEMP. PROBS. 181 (Autumn 2006).

5. Tom Miller, *Measuring Distributive Injustice on a Different Scale*, 69 LAW & CONTEMP. PROBS. 231 (Autumn 2006).

better health outcomes, and Lesley Curtis and Kevin Schulman[6] explain how regulation may block competitive offerings that, even if facially inferior to currently available goods and services, would in fact enhance the welfare of many consumers. The political economy of health care remains poorly understood, yet is the root cause of many of the health system's failings with respect to access, cost, quality, and distributive justice.

The Law of Medical Malpractice. Unlike most literature on medical malpractice reform, the lead article treats the tort system as an essential part of the regulatory regime, yet another driver of costs that ordinary premium payers should not be forced to pay. It also emphasizes the regressive consequences of treating lost income as a principal component of tort damages, suggesting—contrary to the current trend in tort reform—that caps should be placed on certain economic damages, not noneconomic ones. The symposium's only contribution to the limited literature on distributional consequences of the tort system is Chen-Sen Wu's thoughtful article on pharmaceutical torts.[7]

The Uninsured. A key argument in the lead article is that giving people opportunities to economize would both enable more people to insure themselves and make it easier (that is, cheaper) for government to help everyone procure coverage—by, say, offering a refundable tax credit of a certain amount. There has been relatively little research on how the market might be enabled and encouraged to make radically lower-cost coverage available to ordinary Americans. Yet nothing would be more constructive than successful public or private efforts to define more limited, affordable entitlements and to confer legitimacy on the resulting limitations on access to arguably beneficial services by ensuring that they reflect reasonably informed, appropriately subsidized consumer choices.

The Interaction of Health Insurance and Monopoly. One of the more important insights in our lead article is our hypothesis that health insurance, while curbing monopoly's usual misallocative effects, exacerbates the price-increasing, redistributive effects of health-sector monopolies. Economists need to verify the soundness of this insight and to estimate whether monopoly overcharges are in fact a serious problem in markets where insurers seem well positioned to keep prices competitive. Assuming they validate our hypothesis that monopoly is a problem, economists might estimate, and suggest ways to minimize, the distortions that supra-monopoly profits earned by hospital, patent, and other health care monopolists cause in the larger economy.

Tax-exempt Firms. The lead article argues that the monopoly problem is no less great in the health care sector because many monopoly profits are plowed back into more and better services and products. Indeed, we say some rather scathing things about nonprofit monopolies, the "head tax" they impose on

6. Lesley H. Curtis & Kevin A. Schulman, *Overregulation of Health Care: Musings on Disruptive Innovation Theory*, 69 LAW & CONTEMP. PROBS. 195 (Autumn 2006).

7. Chen-Sen Wu, *Distributive Justice in Pharmaceutical Torts: Justice Where Justice Is Due?*, 69 LAW & CONTEMP. PROBS. 207 (Autumn 2006).

working Americans, and their potential for seriously misallocating resources. The article by Richard Schmalbeck[8] provides helpful background on tax exemptions in the health sector, and an article by one of us[9] explores the implications of our hypothesis for antitrust policy toward hospital mergers. There is much more here for economists and other scholars to study than just differences in the way nonprofit and for-profit firms behave.

R&D in Health Care. Without disputing that R&D yields large social surpluses and is generally undersupplied in free markets, the lead article offers the especially challenging hypothesis that U.S. premium payers are bearing too much of the cost of inducing innovation in health care. In addition, we suggest that, because U.S. health plans lack—de facto and to some extent de jure—the power to resist the price demands of true monopolists, they may over-reward them, possibly inducing misplaced investment in health care R&D. Our concerns about fairness add an important new dimension to the already complex problem of getting innovation incentives right in the health sector.

Income-related Inequities in Health Plans. The lead article hypothesizes, with only suggestive supporting evidence, that disparities exist in the distribution of benefits within individual health plans, whose subscribers pay essentially equal premiums but may not receive actuarially equivalent value in return. Mark Hall's article[10] expands helpfully on our speculations, but we are struck by the paucity of studies focusing on disparities of this particular kind.

Macroeconomic Effects. Although the health care sector is often admired for being largely recession-proof, its special lock on the economy's resources is a function of people's difficulty in economizing on health care when family budgets are squeezed. The difficulties faced by working Americans in tough times may also include, moreover, lessened job security because the health sector's one-sixth of the economy is relatively immune to recessionary pressures. Again, we have not seen (or found) research on such questions, which relate directly to our larger concern about distributional equity.

Health Savings Accounts. Though widely advocated as a way to re-empower consumers in purchasing health care, health savings accounts (HSAs) make more policy sense as a new tax-favored way to purchase health care and thus as at least a second-best strategy for reducing some of the market distortions caused by the tax subsidy. Unfortunately, the direct benefits of HSAs currently accrue chiefly to high-bracket taxpayers while doing relatively little to make health coverage any more efficient or affordable by the rank and file.[11]

---

8. Richard L. Schmalbeck, *The Impact of Tax-Exempt Status: The Supply-Side Subsidies*, 69 LAW & CONTEMP. PROBS. 121 (Autumn 2006).

9. Barak D. Richman, *The Corrosive Combination of Nonprofit Monopolies and U.S.-Style Health Insurance: Implications for Antitrust and Merger Policy*, 69 LAW & CONTEMP. PROBS. 139 (Autumn 2006).

10. Mark A. Hall, *Paying for What You Get and Getting What You Pay for: Legal Responses to Consumer-Driven Health Care*, 69 LAW & CONTEMP. PROBS. 159 (Autumn 2006).

11. In addition to Mark Hall's article herein, see Mark A. Hall & Clark C. Havighurst, *Reviving Managed Health Care with Health Savings Accounts*, 24 HEALTH AFF. 1490 (2005) (discussing how

Medicare. Although the articles in this symposium focus almost exclusively on the special burdens borne by lower- and middle-income payers of private health insurance premiums, public programs, too, are less progressive than is generally believed. Although the Medicaid program is generally progressive in its impact, there is real uncertainty about the net distributional effects of Medicare—notwithstanding its iconic status among progressives.[12] In any event, any past inequities are trivial in comparison with those that could be expected if the federal government attempts to meet the program's vast unfunded liabilities by increasing payroll taxes on a shrinking number of working Americans. The lead article's endorsement of efforts to find ways of defining significantly limited entitlements may point the only feasible way to making Medicare's future manageable.

* * *

Neither ethicists nor policy analysts have focused appreciable attention, beyond concern for the poor and uninsured, on distributive justice issues in American health care. Yet such issues are central in any effort to address problems of access, cost, and quality. Moreover, they are cumulatively very significant. Thus, our article herein suggests that as much as half a trillion dollars per year in inappropriate spending in the United States comes mostly from the pockets of middle-class premium payers. Notably, these are the same Americans whose real incomes have been growing for some time, if at all, more slowly than incomes of the affluent.

Articles herein by Jonathan Oberlander[13] and David Hyman,[14] representing different ends of the political spectrum, comment provocatively on how our concerns about distributive justice relate to prospects for major health reform. Even though our article only hints at, rather than prescribing, specific policies for the future, these commentators agree that the path to reform of any kind will be difficult. They also agree, as others undoubtedly must, that the unfairnesses identified and discussed in this symposium add significantly to the urgency of reforming American health care.

HSAs might be closely integrated with health coverage, thus making the latter more efficient, and suggesting that HSAs may in time make consumers cost-conscious enough to induce needed deregulatory reforms).

12. *See* Havighurst & Richman, *supra* note 1, at 8–9 n.1.

13. Jonathan Oberlander, *The Political Economy of Unfairness in U.S. Health Policy*, 69 LAW & CONTEMP. PROBS. 245 (Autumn 2006).

14. David A. Hyman, *Getting the Haves to Come Out Behind: Fixing the Distributive Injustices of American Health Care*, 69 LAW & CONTEMP. PROBS. 265 (Autumn 2006).