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FOREWORD

This symposium will appear in the midst of a national debate on health policy. One of the symposium's purposes is to provide disciplinary and informational perspective and thus to facilitate the formulation of the national health care program that will best meet the nation's needs. It begins by developing some of the social and economic aspects of health care with a view to showing how the present system's deficiencies came to be and to suggesting at least some of the policy considerations and alternatives. Next, the symposium focuses on the all-important matter of maintaining high quality standards in the face of rapid change and serious shortages of essential resources. Finally, Part I of the symposium develops some of the political background, particularly that involved in the near-debacle of the Medicaid program, and looks ahead to Part II, which will appear as a later issue and will attempt further development of the specific issues in the on-going policy debate.

There are many subissues in the controversy over health policy, but the overriding choice that has to be made is between a market-oriented delivery system and a system in which the financing of health care is taken over by the federal government; adoption of the latter expedient would necessitate extensive regulatory measures to perform the allocative and cost-controlling service normally rendered by market forces. The Nixon administration's proposals look toward improving the functioning of the health care marketplace and making care more accessible to all citizens by providing federal coverage for the poor and compelling employers to provide either health insurance or provider prepayment for their employees. The Kennedy-Griffiths proposal, which appears to be the primary contender against the administration plan at least until Congressman Mills' plan is completed, would have the government assume the entire health insurance function. This plan of "national health insurance" would tax employers and employees through the Social Security mechanism and would return health benefits in the form of prospective or retrospective payments to providers. Although the administration's program contemplates regulatory monitoring of the quality of care and of other features of the system, it would not lead, at least immediately, to the same comprehensive regulation that the national health insurance proposal would necessitate. Thus, charges for health care services would be less directly controlled, although some temporary ceiling on charges would be almost mandatory in view of the certain exacerbation of the

existing supply-demand imbalance by proposed improvements in the access of the poor to health services. The Kennedy-Griffiths proposal would require a complete and permanent system of fee schedules for physicians and cost-reimbursement for hospitals. Under this approach it seems that no aspect of health care could long avoid direct federal control.

Posing the issue as a choice between reliance on the market and reliance on regulation is helpful. Some will see this as a choice between the system we now have and the only remaining alternative. It is possible to demonstrate, however, that, due to past restraints imposed by or at the behest of the medical profession, the market has never been given a chance to prove itself in delivering health care. The choice is therefore between two strategies of reform that each hold out a realistic hope for some fundamental improvement over the discouraging situation that we now confront. On the basis of precedent from other fields, it seems a reasonable presumption that regulatory displacement of the market for health services must be justified by showing that the market cannot in fact deliver the needed services at an acceptable cost. This case has not been conclusively made, although facile pronouncements about how the health care marketplace departs from the models of theoretical economics are common. But of course all markets depart in some respects from the textbook model. Moreover, regulation also often falls well short in practice of its theoretical objectives. The editor believes that a market-oriented system, enforced by traditional antitrust principles and mechanisms, would be by far the more successful venture in restructuring the health care system, an opinion he will attempt to document in an article to appear in Part II of this symposium.

The trade restraints to which the health care delivery system has been subjected are of two kinds. First, the medical profession's long-standing stranglehold on the supply of physician manpower long ago created a chronic shortage of physicians, thereby enhancing the incomes of those admitted to the trade. It is perhaps a fitting irony that this artificially maintained shortage is a primary ingredient of the crisis that now threatens to overwhelm physicians and convert them into adjuncts of a statist system.

The other variety of trade restraints practiced by the medical profession reflects its dedication to preserving fee-for-service medicine, particularly against possible encroachments by plans of provider prepayment. Maintenance of a particular kind of pricing system is a hallmark of cartel behavior, and the AMA's vigorous opposition to alternative forms of payment is in keeping with the classical style of monopolistic trade associations. Not surprisingly, it has been the profession's object to preserve and perpetuate those very market imperfections—consumer ignorance, delegation of decision making to physicians, and patient willingness to pay handsomely where health is thought to be at stake—that the critics of the system now point to as justification for scrapping market forces in favor of a regulatory regime. Unfortunately, many would-be reformers of the health care system have tended to accept

the profession's idea that consumers should not be trusted with decisions regarding the manner and mode of delivery of the health care they purchase. Though consumers are certainly incapable of evaluating many fine points, there are many valid preferences—for prompt service, reassurance, and personal attention—that they should have an opportunity to express. National health insurance would allow some consumer choice, but any system that fails to make price a factor in consumer judgments can be extremely expensive.

Given the chance, provider prepayment plans—the familiar forms of prepaid group practice and the newer forms that could be encompassed under the rubric of “health maintenance organizations” in the administration's program—could provide the means for allowing the consumer to select a provider not only with regard to convenience, quality, and affinity but also with regard to price. Fee-for-service doctors would be driven by the price and service competition of the prepaid sector, as transmitted through health insurers, to reduce overutilization of the system, to improve their efficiency, and to attend to combining the elements of health care in a package that consumers will find reason to prefer. Free choice would prevail to a degree not found in the present system despite the AMA's persistent fostering of “free choice of physician.”

The profession's trade restraints have been foisted upon the public, including a substantial number of state legislatures, by appealing to certain “ethical” considerations and the need to preserve the quality of care. Since it was somehow assumed that doctors could safely be delegated the task of protecting the public in these regards, a great deal of activity has been tolerated and even encouraged that would have been unacceptable in any other field of endeavor. The strength of the consensus favoring quality in medical care has uniformly excluded adequate consideration of the effect of quality-maintenance policies on the cost of care and on the quantity of it available. Thus, the proliferation of licensure—to the extent that California now licenses some twenty-one separate health professions—has led to serious obstacles to efficient manpower utilization, with high economic costs to some health care consumers and a denial of needed care to others. Professor Kessel's article in this symposium demonstrates the mechanisms by which the medical profession has used quality claims to reduce the number of physicians in practice to a fraction of what the public was willing to support. There is of course no way by which any improved care obtained by some patients can justify the effective denial of care to millions of less advantaged persons.

Against this background it seems time that policy makers give up much of their thoughtless effort to maintain quality by wholesale exclusion of people or institutions from working in the health care system. While some oversight of quality is clearly needed, it can be safely provided after the fact by supervisory efforts which, though having regard only for the end product, would induce providers' best efforts to achieve desirable outcomes. The expected further increase in the demand for medical

services cannot be met in reasonable time unless there is a lifting of legal impediments to on-the-job upgrading of health workers' skills and to efficient assignment of duties. Thus physicians should be allowed, and vigorously encouraged to exercise, complete freedom to delegate tasks to anyone whom they trust and can supervise. The only really essential condition is that doctors and hospitals, the primary decision makers on these critical questions of quality, not be freed from the incentive for care inherent in their legal responsibility for any harm ensuing from their manpower policies.

Further, the medical profession's predictable preference for excluding non-physicians from decision- and profit-making roles in the industry must not be further indulged. By claiming that an ethical principle is involved, the profession has successfully excluded entrepreneurs capable of introducing organizational innovations into the system. The result is a system that is essentially unmanaged and disorganized, again with the consequence that it has failed massively to deliver needed care.

The lesson is that it was not the market but a combination of legislative and professional restraints that blocked the delivery of health care resources when and where they were needed. This conclusion should argue for directing attention to the elimination of these restraints and the recreation of a market system. In a fair market test, provider prepayment plans would outperform traditional forms and win substantial consumer allegiance. Fee-for-service doctors would then have a major but altered role, catering to patients with a preference for that more costly form of care and to prepaid providers seeking specialists' attention for their enrollees. Performance in the fee-for-service sector would be substantially improved by the greater sophistication of this latter class of purchasers, who, like their own subscribers, would place an emphasis on price that has heretofore been effectively excluded from the health care marketplace.

The issue before the public is whether health care should become the next great "regulated industry," indeed the first one brought by Congress under comprehensive economic regulation since the 1930s. The experiments of that era have proved difficult to undo, and there would similarly be no turning back once the government had embarked on an all-out regulatory course in dealing with the health care crisis.

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