Viewpoint

Wealthier Is Healthier

Aaron Wildavsky

WHENEVER I think about trends in health policy and the current rash of proposals to make us healthier still, I try to retain a little of the sense of wonder that what we are doing goes against the grain of all our experience—namely, that people are living longer, that at comparable ages they are healthier than ever before. Clearly we are doing something right. But just as clearly, our health planners do not believe enough is enough. The assumptions underlying their recommendations can be described, without overly gross simplification, as these: The health of the U.S. population is either deteriorating or, given current knowledge and technology, is much worse than it ought to be. Medical care is positively related to this health. Therefore, the more medical care, the more health—in an upward spiral apparently without limit. So if some of our citizens do not take their medicine, then they also, ipso facto, are losing health.

This dogma is not without its critics, to be sure. Indeed, it seems to be a staple of much current public policy analysis to recognize the imperfect connection between medical care and health, though not yet that more of the one may lead to less of the other.

But then I look over the national health insurance bills pending before Congress and are staggered by what they would cost. I also find that the best way to tell them apart is by the number of their sources of funding. On this scale, the Carter administration's bill comes out on top because it has at least six: excise taxes on alcohol and tobacco, taxes on employers and employees, tax credits, tax deductions, payroll taxes, the works. That means it would also be the most expensive judged by the rule of experience—the more sources of revenue, the more you spend. (This rule may be elementary, but because the politics of medicine works by spending as much money as possible in every available account, I find it a useful measure.)

So it is time, I believe, to undertake another frontal attack on the current dogma and show not only that medical care is imperfectly related to health, and not only that overmedication is harmful, but that the additional dollars we are told must be spent on more of the same, were they spent on other purposes, would bring positive benefits in health. I will explain why I believe this, why all of us should believe it, and why it is so difficult to get it generally believed.

The basic conclusion derived from the dogmas relating medical care to health is this: Because more medicine equals more health, it follows that it is necessary to imperil or even reduce economic growth by diverting resources to medicine—all the resources it may take. Less quantity, apparently, means more quality. There is no point in worrying about creating jobs or any other form of wealth. Just turn all those resources to medical care, and they will make you healthier.

Suspending the Usual Disbelief

Suppose we were to become believers and accept the hypothesis that *wealthier* is healthier? Would we then want consistently to divert resources from the economy, from a host of productive uses—resources that used in their normal way actually do make us healthier—in order directly to make us healthier through medical care? I do not think we would.

The argument is one in which we all have engaged. It begins this way: "Why should we pour these limitless billions of dollars into this or that medical program? Doing so is not cost-

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effective, for 10,000 good and sufficient reasons." The typical response—called "monster-baring" in anthropology—is to say: "You are a monster and a menace, you are as good as a murderer." Obviously all of us retreat at this point and seek the soft answer that turneth away wrath: "Look, I'm not one of those depraved persons who puts a price tag on human life. Not me. My message is that there are ways of spending all this tax money that will produce more health than you'll get your way."

By this diversion, instead of comparing money with life, we end up comparing life with life. But the response, which is the standard ploy in such discussions, satisfies no one, neither those who make it nor those to whom it is made. The latter—the life-at-any-cost people—know it is false. They know that the tax money diverted from one medical program will not automatically go to another. They know that there neither is, nor ever will be, any such thing as an expenditure allocation for "health in general"—no national health budget in any real sense. (If, moreover, they thought such a thing might come to pass, they would fight us tooth and nail, because if people were asked to decide how much they wanted to spend, in all, on medical care, they would likely do what they do in Britain—spend less.)

And the response is no more convincing to those of us who make it. Even while we hear ourselves arguing that these billions (whatever the sum may turn out to be) should be spent our way, in the backs of our minds we are thinking, "Do we really want to spend all this money on medical programs? Aren't there even better ways to spend it?" In turning away wrath, we put ourselves in a false position.

What, then, should we be saying? In my view, we should spend a lot less time looking at what makes people sick and a lot more time looking at what makes them healthy. Which gets us back to my theme—that wealthier is healthier.

To see the point, array the countries of the world by income. Except at the very top level—to which I will return—wealthier *is* healthier. The richer the country, the healthier its people, the fewer accidents they have, the less morbidity, and the longer the span of mortality. The income array matches up with the array of health indices. Next, array groups of Americans by economic level. The result is the same: richer is healthier, except again at the very top level, where you will find the intellectuals, the workaholics—and people with bad habits generally. But those of us in this category are such a tiny proportion of the population that we can rule ourselves out as (at the very least) statistically irrelevant. But take blacks or Jews or Poles, or whomever, and in each case richer is healthier.

Why, then, do we insist on acting contrary to all of our experience—to what we know to be the better alternative? Why are we diverting resources from the one mechanism that seems ineluctably and inexorably, and even against our best intentions, to make us healthier?

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The answer doubtless harkens back to the Great Debates in which Adam Smith and others were involved, debates on society as a product of design versus society as a product of action. Do you want to do things directly? Then put money into medical care to increase health. The other way—putting money into the economy, into growth and development—seems to have no direct connection with increasing health.

The Better Alternative

But take a closer look. Let us suppose we could choose whether to put the multibillions that national health insurance would cost either into the economy or into subsidizing, in one way or another, medical care. What would be the effect on health of increasing the real income of every economic stratum in the country by, say, 3 or 5 or 8 percent, or whatever it would be, as against increasing direct and (more particularly) governmental expenditures on medical care by the same amount? My intuition is that economic growth would be immensely more effective in improving health than would be the direct approaches.

When McCormick invented the reaper, he probably was not thinking, "this is going to improve everybody's nutrition and they will thus have more calories and more protein—and more health." In all likelihood he was simply thinking of improving farm production and

profits. Yet it appears to be the case that nutritional quality standards, even when some of us abuse them by eating too much, are positively related to health: which is to say that overeating is not nearly so serious a condition as undereating—a fact we tend to forget. Or consider hard work. A little hard work is good for all of us, but doing extremely hard work for sixteen or eighteen hours a day is not so good. Recall the portraits of homemakers in the Midwest at the time when Hamlin Garland was writing *The Sons of the Middle Border.* Back then when the working class really worked—and the middle class knew that the best way to keep people out of trouble was to send them home utterly exhausted every night —people were old by their late 20s or early 30s.

When money is put into the economy, all sorts of things begin to happen, stimulating not only variety in nature but also new artifices of mankind. Most of these artifices fail and are never heard of again, for the good reason that they are awful. But some catch on and some of those that do have the virtue of actually improving health—not because anybody intended it to be so but because they save time and labor, create wealth, and (in all sorts of ways) enhance life. Given two things differing only in that one is more health-producing than another, then that one will marginally be preferred. And given enough such choices over a long enough period of time, a healthier condition will result.

Anyone who reads *The Great Gatsby* understands the ways in which money and the layers of redundancy it buys protect people against the outrages of the world. If you have a little bit more, you hire a babysitter, somebody to clean the house, somebody to fix the plumbing, and you can use some things as throwaways. There are just lots of ways in which more resources make life easier for people. Put another way, in the long run the lower classes and the middle classes undoubtedly will be healthier with more income than they would be with more medical care—dollar-for-dollar, one use against the other.

Now it is possible, of course, to revert to Sperlich's Law (named for my esteemed colleague at the University of California at Berkeley), which says that all interesting relationships are curvilinear. It may be that there are certain income levels above which health does not improve in this way. If so, it would suggest that rising income is good for everybody except those at the very top, which could provide a class explanation for why those at the very top so often seem to want less economic growth!

If Dogma Triumphs . . .

The remarkable thing about the current rash of health bills is that, except for those whose strategy is to introduce some competition into the system, they are basically sleight-of-hand. One may well ask, who would pay if Congress were to adopt national health insurance? Obviously not the federal government, because the proponents of such schemes claim that the Feds would not spend any more than they are spending now (President Carter) or than they would have spent anyhow (Senator Kennedy). Also, clearly, not state and local governments, nor consumers. Perhaps employers would be the ones to pay, because they would be required to contribute to employee medical insurance plans. (The idea here, presumably, is to keep the cost from showing up in the federal budget, to diffuse it throughout the system so that it does not come together in any one place.) But, then, many of the proposals provide loopholes—special tax benefits—for employers, and the Kennedy bill even provides a special place for employers to do their crying. So I keep asking myself, who is it that *is* supposed to do the paying?

Another possibility is the hospitals. This comes closer to the truth because, under both the Carter and Kennedy bills, cost limits would be imposed on hospitals, and they, presumably, would have to ration their services in some way or other. It is also conceivable that doctors are meant to pay, that the basic purpose of all this is to squeeze down the income levels of the medical profession in a roundabout way. Kennedy's program would keep these incomes high the first few years but, after that, perhaps not. Carter's does not mention this matter at all. So it may be that we would end up imitating the Russians and make the medical profession less desirable financially.

In seeking a reasonable health policy, we must begin with what we know. We know that medicine is imperfectly related to health. We know that without all this additional spending, we are getting healthier anyhow. Most of the

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Soviet Ammonia

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But economics is one thing, geopolitics another—and, as the new year began, U.S.–Soviet relations displayed a fluidity of their own. Under the legislative veto contained in the Trade Act, Congress had until March 6, 1980, to overturn the President's overturning of the ITC. And it became conceivable that it would do so, for reasons relating to the science pioneered by Machiavelli rather than by Adam Smith.

January 21: Shortly before press deadline for this issue, the President beat Congress to the punch—reversing his earlier action and limiting the importation of Soviet ammonia to 1 million short tons in 1980. In a proclamation issued on January 21, he stated that "recent events have altered the international economic conditions under which I made my determination that it was not in the national interest to impose import relief." Actually, the applicable statutory phrase (and the phrase used in the December 12 memorandum denying import relief) is not "national interest" but "national economic interest"; and the discrepancy suggests the basic question of whether the President may act under this provision of the Trade Act for geopolitical rather than domestic economic reasons. This question, however, is not a likely basis for a successful court challenge.

The President's latest action was apparently not an attempted second bite at the ITC's recommendation (which would be of dubious validity) but was based on a Trade Act provision that enables him to impose emergency import restrictions pending the outcome of a newly requested ITC investigation. Reportedly, he has made such a request—so it is back to the drawing board for the ITC. How ironic it would be if that body was convinced by the President's persuasive December memorandum and found no adverse effect on the domestic industry, thereby requiring termination of the import restriction! Clearly, this time around bad economics is good politics.

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indices seem to be improving quite of their own volition—right up to the day before yesterday, indeed, and the latest official status report *(Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention,* 1979). These developments, naturally, are the result of forces operating in earlier decades, without vast governmental programs. Somehow, it seems almost perverse today for health to improve without a program aimed at that end.

Perhaps it is time to discuss whether, beginning now, spending more money on medical care not only would not help very much but would be a positive detriment to health. By focusing on buying health rather than living healthily, we probably end up with less of both.

The United States, to be sure, is rich enough to afford almost any additional medical program it wants, if that were all there was to it. But that is far from all. On the contrary, the purpose of diversifying sources of finance is to dissipate the financial effects so that their full impact cannot be felt in one place. The totals then become more difficult to control. Like the proposed "windfall" (really an excise) tax on domestic oil production, comprehensive national health insurance would in effect create hundreds of billions in "funny money" outside the normal budgetary disciplines. "Abracadabra"—and both a (nearly) balanced budget and huge additional expenditures are possible.

But billions more for medical care means less for innovation elsewhere. The secret of more health and safety lies in a richer life. By making ourselves poorer in order to stay healthier, we would invest less in the living from which unexpected improvement comes. We would lose the resiliency, the free-floating resources, to make use of change by coping with contingencies. What is at issue here is not some spooky "invisible hand" but a vibrant society learning through innumerable experiences how to enhance health and safety better than before. Fantastic fixed expenditures for medical care would institutionalize existing errors while reducing the prospects for future experimentation. The result would be not only a duller but a more dangerous, less healthy society.

This cannot be proved, because once opportunities are lost—opportunities we could not anticipate or we would already be taking advantage of them—it is not possible to rewind the reel of history and retrieve them. What we do not know *will* hurt us. But if we choose a path from which there is no return, an overmedicated and undersurprised American people will never find out. ■