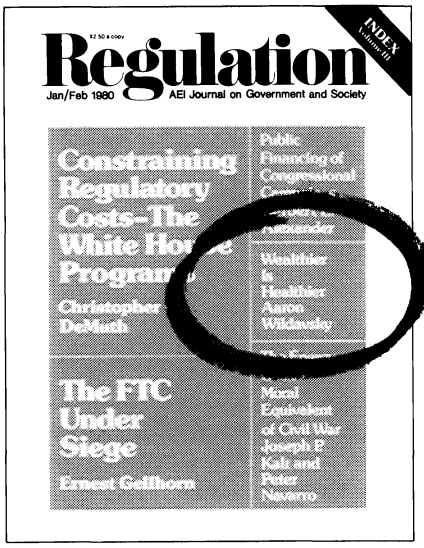
Letters

We welcome letters from readers, particularly commentaries that reflect upon or take issue with material we have published. The writer's name, affiliation, address, and telephone number should be included. Because of space limitations, letters are subject to abridgment.



Single-Goal Programs

TO THE EDITOR:

Professor Wildavsky's provocative essay on the fallacy of implementing an "urgently needed" national health-care program at the expense of economic growth ("Wealthier is Healthier," *Regulation,* January/February 1980) points up a larger problem of the Washington policy-making community: the bias against recognizing trade-offs.

For many politicians today, policy proposals are seen not as ways to get a little more of this in exchange for a little less of that, but as means for accomplishing a single, obvious good. Would you like to be healthy? Avoid cancer? Breathe pure air? Take safe drugs? The politician agrees with you and he will attempt to implement each desire in a separate program.

That each program entails costs is downplayed, since to express any reservation about a program designed to implement an absolute good betrays a deplorable lack of enthusiasm. You mean you *want* Americans to be sick, get cancer, die of starvation, or drive unsafe cars?! And, besides, it takes two breaths to explain a trade-off, whereas television allows only one.

Ignoring trade-offs, however, does not make them go away. The negative consequences of single-goal programs usually come out in one form or another—generally as other problems to be solved with more single-goal programs. The result is that policies often come in twos, the second policy counteracting the bad side effects of the first: massive subsidy of health care and then hospital cost containment; legislation to promote automobile safety and then the Chrysler bail out; environmental protection and then an Energy Mobilization Board.

The wastefulness of attacking each side of a policy trade-off independently is all too obvious. Naturally, citizens want to eat their cake and have it too. But taxing the having of the cake—to encourage the eating—and then taxing the eating—to encourage the having—hardly represents sound policy.

James L. Payne,
Texas A&M University

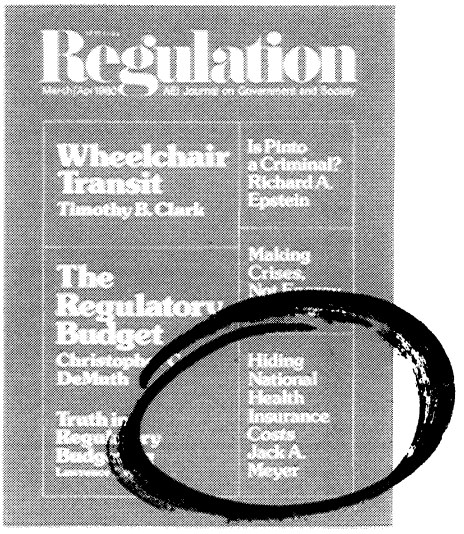
Containing Health Costs

TO THE EDITOR:

Before considering the basic point of Jack Meyer's article, "Hiding the Costs of National Health Insurance" (March/April), let me note that his title is somewhat misleading. The article is basically concerned with methods for containing health-care costs—not with national health insurance per se. Most people would probably agree that a national health insurance proposal ought to expand health-care coverage to at least some additional segments of the population. But the competitive, tax-incentive proposals which Meyer discusses and which are now before Congress apply only to insurance coverage offered by employers on a voluntary basis, and do not provide incentives for employers to initiate such plans or otherwise expand coverage.

Current information indicates that increased competition in health care may be needed, but that this approach has real limitations for containing costs. The proposed tax incentive schemes are largely new and untried. There is, in fact, very little hard evidence that they could provide substantial *immediate* relief from health-care inflation.

The tax-incentive proposals aim to contain costs through two mechanisms. First, they seek to encourage alternative health delivery systems that have lower costs and can produce economies in the health-care market. However, such alternatives do not exist in many parts of the country. Only 4 percent of the population is now enrolled in health maintenance organizations. The most optimistic projection of the Department of Health and Human Services is that no more than 10 percent of the population will be enrolled in an HMO by 1988. The fact is that, even with federal grant support and tax incentives, it would take considerable time to establish functioning HMOs in areas where they do not now exist.



Second, the proposals seek to change consumer purchasing habits, by requiring, among other things, that employers offer a choice

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of health-care plans, contribute equally to the plans they offer, and provide cash rebates to workers choosing less expensive coverage. The proposals would also limit the amount of the employer contribution to health insurance that is counted as tax-free income to the employee.

We have little practical experience to show us how the majority of consumers would actually behave if the incentive structure were changed. Would most of them respond to cash rebates by choosing coverage with higher coinsurance—or are they sufficiently concerned about the possibility of paying high medical bills out-of-pocket that they would still choose first-dollar coverage? If consumers do purchase low-option plans, what would be the effect on low-income workers, who may be less able to cover uninsured medical expenses out-of-pocket. The answers to these questions would determine, to a large extent, the effect these proposals might have on health-care costs. Even if consumers do respond to tax incentives in the manner predicted by supporters of this approach, the change would probably happen very slowly and over a number of years.

Limiting the subsidy for the employer's contribution to insurance raises additional concerns. Under proposals to apply a flat national limit to the employer's subsidized contribution to insurance, for instance, some workers will have to pay more for their insurance—not because they choose a richer package of benefits or a more inefficient plan—but because they work for an employer whose premium costs are higher.

For these reasons, it is unlikely that a tax-incentive scheme would have an immediate impact on health-care inflation. The most appropriate policy option should, therefore, reflect both short-run and long-term objectives. Jack Meyer has chosen to present the alternatives as dichotomous—either regulation or competition. In reality, regulation and competition can be mutually supportive approaches to achieving cost containment.

The Carter administration's National Health Plan couples various regulatory and competitive features into an overall strategy for cost containment. (Parenthetically, it is interesting to note that Meyer ignores the competitive proposals encompassed in this bill and presents it as a purely "regulatory" program.) On the regulatory side, the National Health Plan includes provisions to contain the rate of increase in hospital costs and to reform the method of paying for physician services. These features would provide immediate relief from escalating health-care costs. To encourage competition, the plan requires employers to offer a choice between the more conventional plans and health maintenance organizations, to make equal employer contributions to plans offered, and to provide rebates to employees choosing less expensive coverage. These features are similar to those included in the tax-incentive bills discussed by Meyer.

John L. Palmer,
Department of Health
and Human Services

TO THE EDITOR:

I have two quarrels with Jack Meyer's article. First, its title. Carry Mr. Meyer's logic a step further and you will see that the word, "National," can be dropped. His criticisms apply equally well to private health insurance.

We have a wasteful and inefficient health-care delivery system which has experienced runaway costs for many years. The system is fed by health insurance provided by over 1,200 companies and Blue Cross/Blue Shield plans, and by government programs for the elderly and the poor. The whole rigamorole is subsidized by U.S. business and industry.

Can you imagine a food insurance system under which employers agree to contribute $2,000 annually for employees' food needs? The employee takes his food card to the supermarket where the manager fills the cart with items of his choosing. Since the manager earns a commission on each item, he stuffs the cart with the most expensive cuts of meat and gourmet delights. At the checkout counter, the employee signs the bill, and the supermarket sends it to the insurance company to be paid. Next year, the employers' food insurance premium is raised to $2,500. This is not totally different from the way things work in medical care, with the doctor ordering the items received by the employee and the insurance company paying the bills with the employers' money.

Private expenditures for health tripled from 1970 to 1980. Clearly, we have a fat system. Hospitals generally are reimbursed on a cost basis and physicians negotiate only with themselves on how much they will be paid. It calls to mind the observation that "all things being equal, a fat person uses more soap than a thin person." The health-care system uses more money than a lean and efficient system would need.

Instead of continuing to pump a million dollars more every hour into health care, we must encourage more healthful lifestyles and find a countervailing force to control medical costs. The insurance approach will not do unless it is structured totally different from all plans of the past. Most important, it would have to contain prenegotiated amounts for both hospital and physicians' services, and there would have to be incentives for both doctors and patients to concern themselves with holding down costs.

That is what Kennedy's national health insurance bill proposes. And that is why the American Medical Association opposes it. Which brings us to my second quarrel with Meyer's article: the accompanying cartoon, which depicts the public as antagonistic to national health insurance. The fact is that recent public opinion surveys consistently find that a substantial majority of Americans support national health insurance.

To most Americans, whether business executives or patients, the problem of health care in America boils down to costs. We can control these costs by instituting a totally new national health insurance plan, such as Kennedy's, or by dropping health insurance altogether. A growing number of American businesses have saved many millions of dollars by uncovering the hidden costs of insurance and turning to self-insurance or self-funding of health benefits.

Max W. Fine,
Medical Cost Management
Systems, Inc.

JACK MEYER responds:

John Palmer's letter is a useful reminder of the danger involved in expecting quick results from an "incentives" approach to the problem of rising health-care costs. He correctly notes the uncertainty about the degree and timing of consumers' responses to changes in health-care tax subsidies.

While Palmer's caveats are important, I do not believe that they

support his conclusions. After noting that immediate favorable effects on inflation are unlikely, he states that "the most appropriate policy option should, therefore, reflect short-run and long-term objectives. . . . [R]egulation and competition can be mutually supportive approaches to achieving cost containment." While this has the appearance of a reasonable compromise, in reality it is likely to be a corollary of Gresham's law—in which bad policies drive good policies into hiding. The problem with an eclectic approach to reducing inflation is that fundamental reforms geared to the heart of the problem typically fade into the background, while stop-gap measures or panaceas are propelled forward by political expediency.

Palmer correctly observes that President Carter's National Health Plan (S. 1812) contains some of the features of the "incentives" proposals; but, my article suggests that the floor placed under "acceptable" benefit packages would limit the favorable impact of these incentives. The consumer would be permitted to "shop around," but only within a very limited range of options. Moreover, as the minimum benefit package is inevitably upgraded over time, the favorable effects of consumer choice would continue to shrink.

It is also somewhat perplexing that Palmer ends by noting that the Carter administration's National Health Plan includes some of the features of the tax-incentives bills, inasmuch as the basic thrust of his letter suggests that the beneficial aspects of these proposals have been greatly overblown.

This reply is not intended, however, simply to defend recent legislative initiatives to increase consumers' incentives to select a low-cost health insurance plan. Indeed, a basic tenet of my article is that in some respects all of the national health plan bills are more alike than different. It would not be difficult to convert one of the "incentives" bills into a "regulation" bill, and it is this land mine that my article tries to uncover.

I believe insufficient attention has been given to proposals for restructuring *existing* government health-care programs and tax schemes in order to reduce wasteful spending, while steering clear of a universal health plan that all employers in the country are compelled (or, in the case of the incentives bills, enticed) to adopt. Thus a combination of structural reforms in tax subsidies and improvements in the efficiency and equity of Medicare/Medicaid reimbursement and eligibility provisions represents a sound course for federal health-care policy. If these steps are taken, a continuation of rapid cost increases would no longer be a cause for corrective government action, but rather a manifestation of consumers' desires to devote greater resources to health care.

Mr. Fine characterizes our current health-care systems as "wasteful, inefficient, and fat." While there is clearly wasteful health-care spending—along with some wasteful expenditures for food, housing, and education—rising health-care outlays are also associated with improved quality of health-care services, new technology, an aging population, and the impact of the general acceleration of inflation.

Ironically, Fine correctly points to the insurance system as the force behind sharply rising health costs, but supports an approach (Senator Kennedy's) that would make health insurance more universal and comprehensive. He argues that, from a cost-control standpoint, a world with *no* health insurance is the only alternative to the Kennedy bill. In other words, an insurance system should either be structured along the lines of the Kennedy bill *or* there should be no insurance system at all. This is a Hobson's choice—which I refuse to make. I believe that neither conventional fee-for-service nor prepaid group plans should be forced on the entire population. It is true that the deck has been stacked in the past against prepaid plans; this argues for a pluralistic system in which consumers choose their plans from a fair deck, not a deck stacked against fee-for-service.

Fine argues that for "most Americans . . . the problem of health care . . . boils down to cost." I disagree. Most citizens are concerned not only with the cost of health-care services, but also with their *quality* and *availability*. In my view, Senator Kennedy's plan would systematically subordinate quality and availability to cost and bury the private health-care system under an avalanche of new federal regulations. The thrust of my article is that prospective budgets and regulatory networks may cause the costs to change in form, but not to evaporate. Until we stop postponing lasting solutions, we will not solve the health-care cost problem in a way that corresponds with the wishes and needs of consumers. ■