



## Case Western Reserve Law Review

---

Volume 36 | Issue 4

---

1986

### Commentary

Theodore R. Marmor

Follow this and additional works at: <https://scholarlycommons.law.case.edu/caselrev>

 Part of the [Law Commons](#)

---

#### Recommended Citation

Theodore R. Marmor, *Commentary*, 36 Case W. Res. L. Rev. 686 (1986)

Available at: <https://scholarlycommons.law.case.edu/caselrev/vol36/iss4/5>

This Symposium is brought to you for free and open access by the Student Journals at Case Western Reserve University School of Law Scholarly Commons. It has been accepted for inclusion in Case Western Reserve Law Review by an authorized administrator of Case Western Reserve University School of Law Scholarly Commons.

# COMMENTARY

*Theodore R. Marmor\**

THE HISTORY of medicine in the United States over the past fifteen years has been one of terribly confusing change. In 1971, Senator Edward Kennedy and his aides wrote a book about the world of American medical care entitled *In Critical Condition: The Crisis in America's Health Care*.<sup>1</sup> The sense of trouble typified by this book was so widespread that both Republicans and Democrats, liberals and conservatives, competed over which form of national health insurance to enact. In 1974, for instance, the now forgotten Kennedy-Mills proposal received extended consideration in the finance committees of the Congress, as did the Nixon CHIP plan and the catastrophic health insurance bill of Senators Long and Ribicoff. It all seems very long ago, looking back from the Reagan era, this flurry of proposals and stalemate over universal government health insurance.<sup>2</sup>

In 1986, the picture is much different, both politically and intellectually. No one of political significance is directly advocating universal health insurance, either for the nation or for a particular state. Politically, the deficits of the first Reagan administration dominate political discourse and severely limit the practical and realistic scope of discussion. Intellectually, we are living with the debris of the reform mentality of the 1970's.

In medicine, that reform mentality resulted in a morass of governmental interventions, each certain to disappoint standing alone, but yet collectively regarded as a group of incremental steps toward sensible governmental intervention in the financing of health services. The regulation that in fact emerged was bureaucratically dispersed, disconnected from the major financing of care, and celebrated with visions of eventual success no reasonable analyst

---

\* Professor of Public Management and Political Science, Yale University. B.A., Harvard College (1960); Graduate Research Fellow, Wadham College, Oxford (1961-62); Ph.D., Harvard University (1966).

1. E. KENNEDY, *IN CRITICAL CONDITION: THE CRISIS IN AMERICA'S HEALTH CARE* (1972).

2. The politics of this period are reviewed in both L. BROWN, *POLITICS AND HEALTH CARE ORGANIZATION: HMOs AS FEDERAL POLICY* (1984); and T.R. MARMOR, *POLITICAL ANALYSIS AND AMERICAN MEDICAL CARE* (1983).

should have accepted. A new form of health planning emerged in 1974. Two hundred and five little agencies were established all over the country, equipped with the authority to veto major capital expansion, but not equipped with a financial carrot to induce anyone to affirmatively do very much but rush to the state legislature or to the courts to protect planning restraints. Professional Standards Review Organizations (PSROs)—programs to monitor quality of care—were given in 1972 to yet another set of agencies, dominated by physicians and disconnected in practice from Medicare, Medicaid, or the commercial and nonprofit health insurance plans. Medicare and Medicaid, once separate entities, were in 1977 technically fused into what is now known as HCFA, the Health Care Financing Agency of the Department of Health and Human Services.

All through the decade observers complained about the relatively high rates of inflation in medicine, but little was fundamentally altered. The Carter administration supported serious legislation to contain hospital costs, but was defeated by a combination of hospital lobbyists, distrust of Carter's team, and doubt as to whether the federal government could accomplish what it promised. Inflation continued unabated amid drivel about a voluntary effort to control costs by the health industry as a new set of actors came to play much more important roles in American medicine.

Attracted by the gold mine of funds flowing through a system of retrospective, cost-based reimbursement, the captains of American capitalism saw opportunity where the politicians saw only cause for complaint. In the hospital world itself, small chains of for-profit hospitals—the *Humanas* and *Hospital Corporations of America*, to name the most prominent examples concentrated in the South—grew into large companies throughout the disappointing regulatory decade of the 70's. The growth of *Health Maintenance Organizations (HMOs)*—slower than promised by the enthusiasts of the 1973 authorizing legislation—came to include for-profit firms as well. Industrial giants, such as *Baxter-Travenol* and *American Hospital Supply*, took their conventional ideas of competitive growth and extended them to vertical and horizontal integration. A growing glut of physicians weakened the traditional power of doctors to determine their own terms of work.

All of these changes in the structure of American medicine took place within the context of increasingly antiregulatory and anti-Washington rhetoric. Both Democrats and Republicans had been influenced by a generation of academic policy analysts (mostly economists) who ridiculed the regulatory costliness and the cap-

tured quality of decisions of the independent regulatory agencies in Washington. The Civil Aeronautics Board and the airlines industry came to epitomize the distortions that are likely to occur when governments regulate industries. With time, the convention of describing any set of related activities with economic significance as an "industry" demythologized medicine as well. So even before the Reagan administration came into office, the time was ripe for celebrating "competition" in medicine, getting government off the industry's back, and letting the fresh air of deregulation solve the problems of access, cost, and quality.

The irony is that the most consequential health initiative of the Reagan period—Medicare's prospective payment system of diagnosis-related groups (DRGs)—is an exceedingly sophisticated, highly regulatory form of administered prices that changes the incentives facing hospitals. The further irony is that medical inflation has somewhat declined just at the time that the massive federal deficit makes unthinkable a direct attack on the problem represented by the thirty to forty million Americans who lack anything resembling adequate health insurance. So fifteen years after talk of a medical world in critical condition, the problem of access continues to be serious, the relative rate of inflation has slowed slightly, and truly extraordinary changes in the rules of the professional game are taking place as American capitalism flexes its muscles in the \$400 billion industry that once was called medicine.<sup>3</sup>

At one extreme in the debate over public health expenditures is the idea of complete government control over and administration of medical care. Some Americans—policymakers and medical care professionals as well as ordinary citizens—think that the only way to control the problems of America's health care system would be to follow something like the British National Health Service. That model, however, invokes the unhappy image of the rationing of care and long waits for all but the most pressing medical problems.<sup>4</sup> It also conjures up images of "socialized" medicine, with all the loss of individual control and freedom of choice for both practitioner and

---

3. For a varied discussion of these new elements in American medicine, see Goldsmith, *Death of a Paradigm: The Challenge of Competition*, 3 HEALTH AFF., Fall 1984, at 7; P. STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1984); and Marmor, Schlesinger & Smithey, *A New Look at Nonprofits: Health Policy in a Competitive Age*, 3 YALE J. ON REG. 313 (1986).

4. See, e.g., H. AARON & W. SCHWARTZ, *THE PAINFUL PRESCRIPTION: RATIONING HEALTH CARE* (1983). For a critique of the Aaron and Schwartz use of the British experience, see Marmor & Klein, *Cost vs. Care: America's Health Care Dilemma Wrongly Considered*, 4 HEALTH MATRIX, Spring 1986, at 19, 19-24.

consumer that those words connote. The seriousness of American medicine's current problems, as Professor Wing's article correctly notes, does not mean there is concomitant widespread public support for implementing either the British system or the Canadian version of national health insurance in America.

At the other extreme in American health policy debates is a set of ideas known as the "competitive health strategy." Though their arguments vary, advocates of competition believe that restructuring market incentives is crucial to restraining medical care expenditure increases and, thus, government health outlays. They argue that the key to reducing medicine's expenditures is the introduction of greater price competition in the delivery of care. In light of widespread health insurance, the scope for price competition is greater for premiums than for fees and charges through substantially increased consumer cost-sharing. The striking feature of this perspective is the gap between the rhetoric of competition and the reality of the constraints on the room to maneuver.

A significant impediment to the enactment of pro-competitive legislation is the imprecise connection between effective competitive markets and reductions in medical care expenditures. A competitive strategy, even if implemented, does not necessarily produce visible economic gains. Even its most optimistic supporters concede that it would take ten to fifteen years for a competitive market to develop and, if effective, to begin to reduce medical expenditures in any given area. During the developmental period, medical care expenditures would continue to increase, as would pressure on politicians to "do something." Lastly, the eventual outcome of a competitive strategy is uncertain, since it has not been implemented anywhere on a wide scale in the post-war period. For these reasons, all touched on in Professor Wing's article, the reality of health politics in the 1980's is one of incremental steps of both a regulatory and competitive variety. It is a state of what one might call "agitated incrementalism."<sup>5</sup>

Professor Wing's magisterial article addresses two aspects of this melancholy tale. First, he describes the size of the health sector's financial outlays over the past two decades, disaggregates these expenditures into their component parts, and tries to make sense of the composition of American health spending. Second, he attempts to explain politically why this state of affairs transpired. That in-

---

5. These ideas are drawn from T.R. MARMOR & J. CHRISTIANSON, *HEALTH CARE POLICY ECONOMY APPROACH* 220-29 (1982).

volves characterizing the national apprehension of the so-called health cost crisis and simultaneously accounting for the discrepancy between the rhetoric of concern and the reality of unsystematic, marginal reforms in how we pay, and how much we pay, for medical care. Professor Wing is eminently successful with the first task and moderately successful with the second.

Professor Wing's treatment of the politics of medical inflation is relatively straightforward, but extended in exposition. There is little public concern, he argues, about the rising costs of health care in the United States. Rather, the concern that does exist, he correctly states, deals with the cost of care in more parochial senses. Individuals are concerned with the cost of premiums or cost-sharing. Employers worry about increased expenditures for employee health insurance. Governments voice concern about rising outlays for public programs: Medicare and Medicaid in the federal context, and Medicaid in the state arena. Relative inflation in medical care—the concern that society is spending increasingly more for care in the aggregate than its citizens receive in benefits—is an academic's problem rather than a public concern. The result, as Brian Abel-Smith wrote some years ago, is an America where we receive insufficient "value for money."<sup>6</sup>

The implication Professor Wing draws is this. If cost containment is attempted, it will likely be aimed at controlling the federal government's rising expenditures for health care. The problem with that approach, he astutely notes, is the obvious one that actions which save federal dollars—for Medicare, Medicaid, or other health programs—are not necessarily anti-inflationary successes. Rather than decrease total spending, such policies may only succeed in substantially shifting costs from the federal government to other payors. Equally worrisome is the possibility that reduced federal outlays may be obtained from the denial of care, rather than from the streamlining of care through providing similar services at less cost, or more services at the same price per unit, or more health results at given prices. Budget deficit reduction, in short, is a goal that can be reached by a variety of means, only some of which meet acceptable criteria for national health policy.

I take this to be true and easily defended. Indeed, I have so argued in a number of places.<sup>7</sup> Professor Wing makes his case ex-

---

6. B. ABEL-SMITH, *VALUE FOR MONEY IN HEALTH SERVICES* (1976).

7. See, e.g., MARMOR, WITTMAN & HEAGY, *The Politics of Medical Inflation*, in T.R. MARMOR, *POLITICAL ANALYSIS AND AMERICAN MEDICAL CARE* 61 (1983); Marmor & Dunham, *The Politics of Health Policy Reform: Problems, Origins, Alternatives, and a Possi-*

tensively, drawing upon the details of medical prices and outlays regularly distributed by the Department of Health and Human Services. If there is any problem with his presentation on this point, it is what I would politely call legal long-windedness—quite evident from the number of pages taken to establish an important but not overly complicated claim about the character of the politics of medical inflation.

Professor Wing spends far more time characterizing medical inflation and its political expression than explaining these phenomena. He strenuously emphasizes, correctly, that there is no consensus whatsoever regarding either the composition of the problem of rising medical costs or its possible solutions. He observes that there is a “divisive political struggle among interest groups in which defining the nature of the problem is as much in controversy as in fashioning a remedy, and in which the reform or remedy sought for one problem, as frequently as not, could only exacerbate the problems of the others.” This is as accurate a description of the past fifteen years of health politics as I know. “The reasons for this political state of affairs,” Professor Wing readily admits, “are not altogether clear.” It is quite true that the delivery of medical care can be simultaneously “described as a system on the brink of crisis and as a strong and growing industry, with equal levels of accuracy.”

The elements of an explanation for this state of affairs are touched on in this Commentary. Professor Wing correctly emphasizes the enormous influence of providers in the imbalanced political marketplace of health policy. Exacerbating the imbalance is the lack of sustained public opinion marshalled around any one of the various formulations of the cost, access, and quality problems of American medicine. Surely, a very large measure of the explanation for this state of affairs is the pluralism of American politics and the parallel dispersion of countervailing power in both the political and economic market places. Our federalism has spread the authority for regulating medical care between the national government and the many states. Our method of financing medical care differentiates between private and public payors, and there is also considerable variation within each sector itself.

Two explanatory factors, then, become central. Medical care is a merit good, widely insured through employment, a part of the

---

*ble Prescription*, in *HEALTH CARE: HOW TO IMPROVE IT AND PAY FOR IT* 33 (1985); Marmor & Klein, *Cost vs. Care: America's Health Care Dilemma Wrongly Considered*, 4 *HEALTH MATRIX*, Spring 1986, at 19.

private and public welfare state we have fashioned in America. The fragmentation of finance has resulted in a shift in focus from global concerns to narrow self interest. Once payors are aroused, the problem each separately addresses is that of their own costs, not of American medicine in general. Pluralistic finance, combined with extensive third-party health coverage, is a predictable recipe for medical inflation. Only those regimes that have concentrated the stakes of medical payors—Great Britain, Canada, and France, for instance—have been able to restrain the forces of medical inflation. And such countervailing power is but the necessary condition for restraint; it does not ensure restraint. In some cases, as in Sweden, the stakeholders with concentrated authority have chosen to spend more, instead of less, on medical care. But they have made such choices through balancing the gains and losses of expenditures. In the United States, we have discovered, rather than chosen, our inflating health outlays. How this came to be the case is illuminated by Professor Wing's extensive essay.