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RESPONSE TO PARADIGM SHIFT IN AMERICAN HEALTH CARE: ARE WE READY FOR A COMPREHENSIVE SYSTEM?

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INTRODUCTION

THE ANTICIPATED paradigm shift from that of the "competitive market" to one based on the primacy of "human need and equity" with regards to health care would signal a change in motivation as fundamental as any since the Pentecost. Therefore, it is important to understand how this might occur and how it might be evidenced in the comprehensive system suggested by Dr. Golenski.

At a first level, such a shift would provide a philosophical foundation for reform. As an economist, this underpinning would be only an interesting external factor related to an observed change in market or social choices. It is the change in actions and choices themselves that are the raw material of an analysis from an economic perspective. Of course social scientists observe, predict and foment change all the time without the benefit of the sea change hypothesized here. Those of us concerned with the Oregon approach are likely to do the same, in spite of the starting point grounded in philosophy. We should realize, however, that fundamental change in human motivation, such as that suggested by Dr. Golenski, is usually documented only long after the fact by historians and theologians, and only recognized in advance by newly elected U.S. Presidents.

So, at a second level, the question concerns what evidence exists for the shift. What can be found in observable changes in action and choice? In order to determine whether these are harbingers of

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the desired "comprehensive system" based on need and equity, one also needs to determine the chain of causation. What other actions or perceptions are behind the current system structure and its failures? Only then might one guess why and how is it likely to change. As a result, this review will consider whether the logic of Mr. Golenski's article is sound and the degree to which any evidence exists that it is other than a philosopher's wish and policy maker's justification—both of which may be worthwhile in themselves.

Going beyond the author's framework, however, my conclusion is that the Oregon Priority Setting Project is desirable and entirely consistent with the political and practical economic needs of the current system. Indeed, I would argue that it is a prime ingredient of the next logical extension of our mixed market system. This mixed system involves both *private choice* regarding the commercial products of health care delivered to the "independents" of society at some nominal price, and *public choice* about the size and kind of social goods provided to the "dependent" sector. The dual, if not schizophrenic, approach to health care is virtually mandated by American history, individual taste, and industry structure.

LOGIC OF THE PARADIGM CHANGE PROPOSED

As presented by Mr. Golenski, the paternalism of earlier decades based on the truth provided by "medicine as a science" was followed by the "competitive market" which appears to have emerged in the 1980's as the reigning paradigm of health care. This change was thought to have occurred as a response to the inevitable inflation coming from unchecked medical "truth" dominating all. As a result of this, the free market was thought to be the answer.

Mr. Golenski maintains that the scientific view fostered both a reduction in the "medicine-as-care" component and a belief that all problems could be managed to a successful end. The unspoken result is a view of health care as a commodity that can be produced and managed. The obvious parallel is that it can also be bought and sold in a competitive market on the normal basis of individual consumer choice. Since competition works to control costs for other commodities, why not health care?

Mr. Golenski further contends that this competitive paradigm was tolerated as long as the benefits were widely distributed, regardless of ability to pay (in a body politic apparently viewed as basically egalitarian). However, when the benefits are perceived as

maldistributed and cost inflation is still a problem, Mr. Golenski's logic indicates the ground is fertile for a new age paradigm to rapidly emerge. The end result is thought by the author to be some sort of public utility model for health care as a regulated monopoly.

While there is a certain positive ring to the direction of this argument, there is a key missing link. The perceived value of health care services is critical to what we are willing to pay and how eager we are to change things. The question of whether or not "few of us would disagree that the current system of care is not adequately serving most of us" can be resolved only by comparing our expectations to what we actually receive. Dissatisfaction arises from the size of the gap. Since Dr. Golenski argues convincingly that the prior "medicine as a science" paradigm created inflated false expectations as to what the system can deliver, dissatisfaction is bound to occur even with good performance. The fundamental problem is the size of the gap in basic services, access, and outcome from what we collectively and individually think is possible. Thus one could argue that rather than reform in delivery, this dissatisfaction suggests education as to realistic outcomes achievable with the resources available might be in order on the demand side. In fact, this may turn out to be the key role of the Oregon plan.

On the supply side, there is no question that (borrowing from Uwe Rinehardt's Christmas card) the high price per unit of health care limits the quantity of "kinder and gentler acts" in this area. If providers could lower the price, we certainly could supply more care to marginal consumers through public funding and private generosity. The problem might be less in the size of our collective guilt or its reaching a critical mass (in a political sense), than in the current cost per unit of assuaging it.

The point is that there are many other responses to deal with those who fall through the cracks than to build a substantially new system on the hope of "a basic shift in human consciousness." Considering other alternatives is especially imperative given the degree of change required by Mr. Golenski's position. To state it so dramatically makes it sound like a combination of the French Revolution and the Protestant revivals of the 18th century must occur—most unlikely possibilities!

Furthermore, such a fundamental reordering of societal priorities may be unnecessary. The market clearing price and the actual amount of care provided to both independent patients and those dependent on the state, is determined at the margin. That is, the actions of the last individual or group purchasers in the commercial

health care market (which clearly now exists), and the votes of enlightened citizens in the political market of noneconomic social values determine how much we buy for what price. By definition, the value received is greater than the price paid for all who engage in purchase decisions on *both* the private and public sides. Additional purchases in both markets are contingent, as in any other market, on the perception of the amount of value received for each dollar spent at the margin (i.e., for one more service provided or one more beneficiary covered).

Thus there are three ways to close the perceived gap in services: (1) increase the actual value provided by suppliers for each additional dollar of purchases; (2) cut the cost per unit of services provided; or (3) reduce the unrealistic expectations of value perceived to be possible from additional services, which drives up the demand. We might choose to either provide substantially more services, or provide different services, or dampen demand, or all three. These three choices, incidentally, are the same regarding additional services to the "dependent" sector in question regardless of the source of resources. Both a more equitable redistribution based on distributive justice, as envisioned in this paper, and additional funding from a separate political choice require parallel explicit or implicit choices of this sort.

A PUBLIC UTILITY FOR HEALTH CARE

The ill-formed concept of health care as a public utility does not follow from either Dr. Golenski's conceptual development or from the Oregon view of the health care economy for several reasons.

First, utilities usually exist where there is a *natural monopoly* for basic services (i.e., gas, water, transportation). The natural monopoly occurs where there is a very high capital cost or where purchasers are held captive in some sense.[1] High entry barriers for potential new competitors make the threat of competitive entry as a disciplining force unlikely, thus allowing antisocial behavior on the part of the company or provider. Furthermore, the high cost of switching to another provider, if there is one, leaves customers locked-in and vulnerable to gouging. Regulation to prevent abuse where competition at the margin is unlikely is usually the intent where a monopoly would otherwise allow it. Utility-type franchises are also sometimes awarded with guaranteed returns to enhance

1. It is unclear whether the formation and regulation of a public utility *can* create a monopoly where it would not otherwise evolve.

capital investment into a risky new venture (i.e., railroads, cable franchises, etc.).

Secondly, utility regulation rarely works well in the long-run. Regulators are typically captured, such as in the savings and loan industry, and technology erodes the natural monopoly such as for long distance telephone services. In fact, utility regulation is a response to market failure, pure and simple.

The social aspects of utilities are also debatable, although this seems to be the underlying reasoning of the paper. Utilities do not guarantee "entitlement" of a service in the normal use of the concept. While they may require due process in the withdrawal of the service, there is no guarantee of water or gas to someone who has no prospect at all of paying.

Furthermore, utility regulation can be used as an off-budget, social transfer mechanism by imposing an indirect sales tax on some customers through higher prices to subsidize others at a lower per unit price. This is not a particularly efficient means of financing social welfare although it may be politically prudent since no votes on taxes are necessary. The end result is the same, however.

Health care has almost none of the characteristics of a natural monopoly. There are many substitutes and rampant technology exists to erode any definition of services included. Entry barriers to new competitors and the switching costs for customers are quite low compared to other competitive business. In addition, aggressive new agents arising are increasingly effective in bargaining for their clientele. From a purely pragmatic basis one might conclude that a health care utility would be doomed to failure.

Furthermore, utility regulation would be difficult, ineffective, and also doomed to failure. Regulation would be difficult in all respects and in great danger of being captured. It would likely be ineffective in controlling costs. The pressure for innovation and efficiency in response to the marginal value required by a marketplace would be focused through the regulator rather than diffused in multiple powerful purchasers. Therefore the proposal may have little impact except by budgetary fiat.

It is possible that Mr. Golenski's suggestion may encourage access, but only through a relatively inefficient, indirect taxation method. However, this may only allow the government to avoid its obvious public duty to provide adequate financing for this social good. Thus, although utility type regulation may be a pragmatic way to handle a need perceived by a minority of the body politic, it

is probably inappropriate as a long-run means of solving this basic dilemma of our health care system.

THE OREGON PROPOSAL

The proposed Oregon solution is, in fact, entirely consistent with the market model as some would currently conceive it. This is based on a perception of optimal value received for both the commercial product (i.e., paid health care services) and the social service side (i.e., uncompensated) health care. The unique aspect of the Oregon plan is the way collective guilt, or, more positively, "consciousness" is handled outside the normal political process. The external community based consensus process might blunt the usual role of providers as proxy representatives of the public with their obvious conflict of interest. It also allows something much more akin to a Pareto optimal condition to result than is usually the case in the market for social goods as well as commercial goods. That is, there are likely to be no better solutions achieved than through this process of priority ranking.

The evidence on financing and legal reform actually realized (rather than what might be individually desired by any of us) is scarce. Likewise, there is no obvious shift in paradigm towards a "communitarian perspective." In fact, the government displays no predisposition even to patch up the failures of the market based on individual autonomy and choice. The key piece of evidence is the recent failure of the Medicare Catastrophic Care Act. Even within the limited community of the elderly, this cataclysmic political event for health care policy clearly illustrates a lack of consensus towards a community perspective.

Furthermore, the role of more effective agents in negotiating health care is not consistent with the paradigm shift proposed by Mr. Golenski. Corporate, cooperative, and government purchasers acting as agents for the underlying patient base have become increasingly aggressive in their negotiations with the industry on cost, quality, and with Oregon data, perhaps efficacy. There is no reason to assume that this impulse for the best value in health care purchases will suddenly change.

In fact, the natural result of an increasingly competitive private market is to highlight the failure of the private institutions of society to provide what is essentially a public product when they are forced to compete with each other. It may well be that providing the social goods of health care (i.e., free care to the poor, education,

and other services) is simply incompatible with the competition which inevitably arose under the conditions of the 80's. The current paradigm will hasten change in the public sector by showcasing the failure of the private system to serve as a proxy for public action. As the number of uninsured and the documented cases of patient dumping rise in number, our collective guilt will also rise. This is a precursor of political change.

The Oregon approach is a logical response in the public sector to the natural phenomena of market change. In my opinion, it does not signal a fundamental shift in philosophy in our country.

CONCLUSION

I believe that the solution to this dilemma will come from a combination of several factors. Foremost is a heightened public awareness. This may be evidenced through recognition of "collective guilt" or the voting of additional financing. The Oregon Plan may do an admirable job of educating the population.

Secondly, we need a more intelligent public role as a purchasing agent for the less fortunate of society. This may be evidenced by payment reform and pricing under the Prospective Payment Systems for hospitals or the Relative Value System for physicians. The consumer information implicit in the Oregon Priority Setting System may be another element of this purchasing reform.

Finally, we need a far better product from the sellers of health care based on science, service, and need. If providers were vying to provide real value (not just volume *per se)* to all purchasers, public and private, collectively and individually, we would move far towards the end goal of this paper.

None of this is to detract from the humanitarian goal of providing more health care to the uninsured or underinsured population of the United States. That should be and will be the consistent goal of those of us motivated by a variety of forces and logic who believe this is appropriate. However, it is premature to declare a revival of a human spirit based on a new age paradigm. Fortunately, it is quite possible to end up with the same conclusion on the value of the Oregon Plan based on an entirely pragmatic and completely different set of logic than that proposed in the paper. In this sense, both Dr. Golenski and I wish the people of Oregon the best of luck in their brave venture.