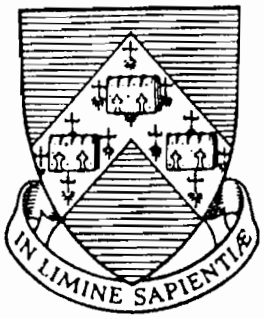

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The Wrong Economic Medicine

by
A. J. CULYER

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(A CRITIQUE OF DAVID GREEN'S WHICH DOCTOR?)

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ABSTRACT

In a recently published monograph of the Institute of Economic Affairs by Dr. David Green entitled Which Doctor?, the argument is made that the ills of the NHS can all at root be laid at the door of one professionally regulated group: the doctors, and that, if only this encumbrance could be removed, the full beneficial fruits of a deregulated market would be harvested. In this Discussion Paper, Professor Culyer mounts a comprehensive rebuttal of Dr. Green's argument, arguing not only that the deregulation of the medical profession is insufficient to produce the market results predicted by Dr. Green, but that it would also produce direct harms while detracting attention from issues whose resolution would have substantial impact upon efficiency in the NHS.

Health Service Ills: The Wrong Economic Medicine
(A critique of David Green's Which Doctor?)

A.J. CULYER

The questions economists ask

The main issues that need addressing in any discussion of the appropriate scope of, or limits on, the medical market can be set out in matrix form. There are issues to do with provision as distinct from finance of medical care and issues to do with demand as distinct from supply. This gives the four cells of Figure 1. It is on their contents, and the interrelationships between them, that health economics principally focuses.

Figure 1

	Provision	Finance
Demand	I	III
Supply	II	IV

In Figure 2 you can see listed some of the important questions that health economists have addressed over the last twenty years, classified into these four cells. I have divided these questions into positive and normative ones. The positive are especially to do with "what is?" and "what can be expected to happen if . . .?". The normative involve someone (not necessarily you yourself) making value judgements about "what ought to be?". I have restricted myself to asking four questions of each type; 32 in all. It should be plain from the nature of the questions that the positive and normative complement one another.

Figure 2

	Provision	Finance
Demand	I Positive . Is the aim to meet demands or needs? . What sorts of demands have high or low price and income elasticities? . What size personal expenditure would be implied for services with low price elasticities at various income levels? . What effects do deductibles and co-insurance have on the demand for health care? Normative . Are there significant externalities of any kind that ought to be taken into account? . What system of subsidies/charges would induce optimal life-styles and service utilization? . What is the welfare loss attributable to moral hazard? . What is the welfare loss attributable to queues for hospital admission?	II Positive . What are the price and income elasticities of demand for various insurance packages? . Does adverse selection lead to the supersession of community rating by experience rating? . How does insurance cover vary by economic (and social) status? . What is the effect of coinsurance and deductibles on the demand for insurance? Normative . What are the welfare losses from compulsory health insurance? . What are the welfare losses from raising coinsurance rates? . What are the welfare losses or gains from tax finance relative to community or experience rated insurance premiums? . Is the burden of health care costs more equitable under one financial regime or another?
Supply	II Positive . What are the effects on physician behaviour of different payment schemes (fee per service, capitation, salary, etc)? . What are the private and social rates of return to medical education? . What is the effect on hospital costs of different methods of reimbursement by the state or insurance agencies? . What differences in case-mix, unit cost, patient insurance status, and utilization exist between for-profit and non-profit hospitals? Normative . What welfare losses are attributable to supplier-induced demand? . How many doctors ought there to be (relative to other health manpower)? . Are public, private for-profit or private non-profit hospitals more cost-effective? . What conditions ought to be satisfied by proposed new technologies or major capital developments before they are introduced?	IV Positive . What are the differences between the outputs of for-profit and non-profit insurance agencies? . Are there economies of scale in insurance provision? . Are the administration costs of insurance systems higher or lower than those of tax-based system? . What types of reimbursement are practised by different insuring agencies? Normative . What are the welfare gains from compulsory insurance? . Which is more cost-effective: public, private for-profit or private non-profit insurance? . What welfare losses are attributable to monopoly in insurance provision? . What welfare losses are attributable to X-inefficiency in insurance provision?

Often a normative issue lies behind a positive question (for example, one wants to know about the price elasticity of demand because, say, one thinks some individuals demand too little care). Sometimes to answer a normative question satisfactorily one needs answers to some positive questions too (for example, if one thinks that an income subsidy might be a good way to increase the consumption of health care one had better find out what the income elasticity is). One can rarely answer a question in one cell without tackling related questions in another. Sometimes this is because the questions involve (positive) behavioural reactions. An example is the relationship between methods of insurance reimbursement to suppliers and professional supplier behaviour - an interaction between finance and provision. Another is the relationship between doctors acting as suppliers of a service and as agents for their patients - an interaction between supply and demand.

At other times the connections are logical. A normative connection is that coinsurance will typically be expected both to reduce wasteful consumption (by reducing moral hazard, insurance costs and premiums) but only at the expense of reducing the benefits of being insured - a logical interaction between finance and provision that requires both to be considered at the same time. A positive interlinkage arises if, under fee-per-service payment of physicians, one seeks to identify the contribution of various factors to increased service utilization: an increase in the number of doctors would depress price, as in traditional supply-demand analysis, but subsequently raise it as physicians generate additional demands to maintain their own incomes in the face of increased competition - a logical interaction between supply and demand, making the attribution between causes of increased utilization more difficult, but again requiring more than the issues in one cell of the matrix to be considered.

Preconditions of reform of NHS

My purpose in introducing this taxonomy of health economics issues is that a remarkable claim has recently been made by Dr. David Green in a new IEA Research Monograph.[1] In the past, economists have spread themselves across the matrix of issues in figure 2 and have liberally offered the world reforming advice based upon analysis within each or several of the cells. No-one has ever claimed that one cell has priority over any other. Green, however, focuses attention on cell II and argues that a particular set of issues in this cell is logically prior to all others. More specifically : "A . . . radical and direct assault on professional restrictive practices is required; reform of the NHS will fail without [it]" (page 32), "a precondition of significant reform of health care in Britain is the elimination of state-imposed barriers to competition [between doctors]" (page 53).

Green argues that most (possibly all) of the ills of health care systems around the world (not just in the UK), regardless of the balance of public and private provision, method of payment of doctors, insurance coverage, method of institutional reimbursement, profit or non-profit character of hospitals, extent of public ownership or public subsidy, sophistication of managerial skills, comprehensiveness of investment criteria, methods of budgeting, and so on, can be laid at the door of the monopoly of clinical practice held by the medical profession - a monopoly that is typically both granted and enforced through the agency of the state.

The logic underlying this remarkable view is not laid out entirely clearly in the Monograph but it seems to run like this. There are two main aims of the health services. One is to give consumers the maximum choice of

practitioner, institution, mode of care and so on. The other is to protect the public from incompetents and charlatans. While the second aim requires a residual role for the state in registering (not certifying or licensing) practitioners, the first requires no state intervention whatsoever. It is from the free play of market forces within whatever constraints are set by the second aim that a host of "neo-Austrian" benefits will flow (consumer choice, higher quality care, more innovation . . .). I presume (although these are not mentioned) that there are also the usual neo-classical benefits to be had as well (maximum present values of consumers' and producers' surpluses).

Currently, argues Dr. Green, in both the UK and the USA the state has far exceeded its legitimate functions as "registrar" (itemiser of practitioners and certifier that they have the qualifications - if any - that they claim to have) by controlling both entry to the profession and the standards that each practitioner is required to meet. From this it follows (though the logic escapes me) that competition is impossible (in the UK) and severely impeded (in the USA, though the Health Maintenance Organizations - HMOs - there are to be applauded). It must also I think be inescapably inferred (though Green does not say as much explicitly) that the other potential impediments to a libertarian Nirvana (from the demand side or the financing side) would somehow vanish, for the solution is seen as competition between suppliers, and this medicine will cure all ills regardless of their source in the typology of Figures 1 and 2: a genuine panacea. I doubt, incidentally, whether Dr. Green would claim competition as a cure for problems that are perceived as equity rather than efficiency based. But equity issues appear to lie beyond (or perhaps beneath) the scope of the Monograph.

Some unanswered questions

Fortunately, no-one will take this kind of argument seriously. No-one is seriously content (apart from Dr Green) to leave quality control solely to "the diligence of the consumer" (page 40) shopping in a market-determined wish-wash of quackery, exploitation of the gullible, impoverishment of the expensively ill, deprivation of the poor, as well as conscientious professionalism. There is, of course, a serious set of intellectual and policy issues here. What (who) defines "good quality"? On what authority? How far does quality control require state intervention? Of what sort? At what cost in forgone freedom or other more conventional costs? But Dr. Green does not contribute to this discussion. He asserts "most people would accept the necessity for some regulations . . to deter incompetents or charlatans" without specifying which regulations, or from what the practitioners are to be deterred (from entering the profession? from practising? from healing? from prescribing? from referring? from practice management? from hospital management? from medical school management? from investment decisions?). The coyness of his "most people would . . ." gives Dr. Green's game away: regardless of whether "most people (really) would . . ." he is not really interested in answering the questions, as he would have had to if he had asked himself fairly and squarely "who ought to regulate whom, to what end and in what way?" Current regulation is simply too much, but just what would be enough is never vouchsafed us.

To suppose that "deregulation" of the profession is a necessary condition for "radical reform" of the financing side strikes me any way as grotesquely misconceived. What, say, would deregulation contribute to the achievement of scale economies in insurance firms; or to the (rival) claims made (variously) for any of fee-per-service, salary, capitation, or some combination of methods of paying doctors; or to

consumer utilization as one variously introduced or removed lump sum copayments, percentage coinsurance, no claims bonuses, or fixed indemnities? But it is also no less grotesquely unreal on the supply side itself, staying firmly within cell II. Why, for example, should you have to suppose deregulation to be a necessary condition for clinical budgeting to lead to improved efficiency in the NHS, or for the more imaginative and rigorous use of Capricode, or for reducing "frivolous" demand?

In each case the answer is, I think, obvious: deregulation is not a necessary condition for any of these things to work. Not a single one of them.

But if the central message of this Monograph is fatally flawed (which is a pity since some kinds of deregulation, while not yielding up the earth, may nevertheless have some advantages) it is also strewn with idiosyncratic assertions, straw men, Aunt Sallies, non sequiturs and other litter that in themselves amount to a pretty impressive exercise in the art of misinformation. The following, in no particular order, is a sample to amuse or enrage.

Taking libertarian liberties

States of mind. A mysterious supply-side York School of Health Economics, of which I am said to be a member, has committed the offence of believing that things (in the UK or elsewhere) could be made better without radical deregulation of the medical profession. If there is a school at York, I hope they have more to their credo than that. However this school might be best characterised, this way scarcely gets at any truly distinctive doctinal feature. The doctrinal location of this new York is certainly vaguer than its geography.

Non Sequiturs. One example must suffice. The fact (let us agree it is one) that "hard choices" (a quotation from the Royal Commission on the NHS) have to be made is asserted (page 20) to entail the assumption that "experts" should tell the public what their reasonable expectations are to be. Experts? Which from the following sinister set: Conservative Ministers? Members of Health Authorities? Members of Community Health Councils? Consultants? Family doctors? Who said only "experts" make (or ought to make) "hard choices" and what, in any case, has this to do with creating public expectations?

Libertarian trade-offs. "How much cash he wishes to allocate to health" is "for each person to decide" and "for doctors to respond accordingly". This is interpreted as a libertarian imperative (page 20). It requires each to pay his costs as he demands services. This in turn requires no insurance (or someone else would pay the cost) and no prepayment (under which practitioners decide how much of the prepaid care each patient gets). Are we really to be denied the freedom to insure or prepay in the libertarian Nirvana? Why such an unbalanced trade-off? Why are some freedoms valueless?

Straw men. The extremely subtle and important issues (in both positive and normative discourse) surrounding suppliers' ability to create demand (and its legitimacy) is mentioned briefly on pages 20-21. This "agency" relationship lies, I believe, at the heart of any full understanding of what defines a "profession" and "professional behaviour". Here, however, its significance is pooh-poohed, and Dr. Green concludes "if the medical profession has an unlimited capacity to create demand for its services, it would not have permitted a real fall in its incomes". Who ever claimed that the profession had? Someone at nongeographical York?

How about the more interesting question "what happens if the profession has a partial ability to create demand?" Are such demands wasteful? If so, do they erode the plain advantages of agency? If so, can they be reduced by changing the methods of paying doctors?

Static Dynamics. Everyone knows that inflation is rising prices. It is dynamic. It always needs a dynamic cause too (rising expectations, rising money supply, . . .). On page 22 of Green's Monograph you will hear, however, that government subsidies (not increasing subsidies) cause medical care inflation (hence enabling blame to be firmly placed at Medicare's and Medicaid's doors in the USA). Similarly, subsidies on insurance (not increasing subsidies) have caused further inflation in the USA. I searched in vain for some theory of 'static dynamics' - or is it 'dynamic statics' to complement this new analysis, which reminded me of those crude non-economic diagnoses one used to hear of Britain's poor economic growth rate (overmanning, not increasing overmanning, etc.).

Hero Worship. Health maintenance organisations (HMOs) are good partly because they emerged in the American health market (page 29) and partly because they are asserted to provide cost-effective (a York school term this!) care. Unfortunately, while it is not surprising to hear that the cost-effectiveness of American medicine can be dramatically improved (at least according to measures of effectiveness familiar to most health economists - although unmentioned by Dr. Green), there has been no theoretical or empirical study of the way an HMO system as a replacement for the NHS may be expected to work. So they may not be so wonderful after all. Moreover, US friends of competition in health care are far from agreed at the technical level on to the price that may have to be paid for what may be an illusory efficiency gain because of cream-

skimming.[2] Acts of faith are all very well - but do they have to be so blind?

Aunt Sallies. Central planning is a libertarian's bete noire. On page 27 you are invited to believe that the NHS is subject to "central direction". This revelation will doubtless come as news to the Minister of Health and the Secretary of State for Health and Social Security. However, those of us who know what the NHS is really like know that if the cause of advancement of medical knowledge is being hindered in the UK at the present time it has nothing to do with the "central direction" of the NHS or the absurd belief that someone (will he please stand up?) in the NHS, DHSS (or York) knows the future (pages 26-27) and arranges things so that what would have happened anyway is certain to happen. Research atrophy may, of course, have something to do with the centralisation of finances for research - but that is entirely another issue.

. . . and Statistics. ". . . the factual evidence supports the conclusion that the market can supply more cost-effective health care than the NHS". Without begging too many questions (by what measures is "effectiveness" represented?) all the evidence I have seen supports precisely the reverse (but the "effectiveness" measures are admittedly crude). Delivery costs, administrative costs, surgical intervention rates, are all invariably higher per head in the more market based systems than in those resembling the NHS (I do not know, of course, about the market systems that exist only in Dr. Green's mind). In general, morbidity and mortality statistics are either worse or not better. Even worse for Dr. Green's case: those countries which, like Canada, have increased the purchase of the state on the medical system have seen substantial improvements in their measured cost-effectiveness.

Envoi

Suppose you believed Dr. Green's case against regulation (though I cannot imagine why you should). Suppose you believed his case for deregulation (here I cannot even begin to imagine why you should). Suppose you believed that the resulting competition would be cost-effective - and not just cost-effective but producing the ideal outputs and the ideal qualities too (having strained at the two preceding camels, this one is a mere gnat). You would, I fear, be a lonely person for there are few doctors or economists to share your belief (I say few, because, although I know none, one should never suppose that the number of people that can be discovered to believe the unbelievable is actually zero).

One of the lessons that is commonly learned as our depth of understanding increases is that we understand very little indeed. This is true of health economics as it is of economics generally. Although we know inestimably more today than even ten years ago, what we chiefly know in health economics is that economists are most reliable when they are most modest, and that there are lots of common economic assertions that are simply untrue.

Had Dr Green limited himself to the relatively modest task of speculating about what it means to talk, say, about quality in medicine, making distinctions, for example, between quality of physician care, nursing care and hotel care in the hospital sector and exploring how these three may interract, and then enquiring about some of the means, including particular types of competition, that might plausibly be expected to promote quality, his Monograph might have given a valuable impetus to our thinking about these problems. That would have been so even if he had abstained from discussing what defines optimal quality, or is likely to produce it.

Instead he offers a panacea: professional deregulation. This cure-all has two problems. One is that it is extremely unlikely to come about. If that judgement is correct, it leaves us helpless in the face of the undoubted problems of health services, many of which we reflected in the questions I put in Figure 2. Of course, my judgement may be wrong. Academics have an inglorious record at assessing political feasibilities. Given, however, the international omnipresence of the sort of institutions Dr Green deplores and the great power of the professions they protect, I think it highly unlikely that I am wrong.

The other problem would apply, however, even if I were wrong. Although there may be some benefit to be had from easing some professional restrictions, it is wholly false to suggest that such an easing is even a necessary, let alone a sufficient, condition for economic efficiency in health care. There are no simple answers here and those who peddle them deflect our gaze from important research into answerable questions, mislead the public as to the contribution economics has to make in the quest for efficiency in health care, and do their own cause no small disservice by substituting grandiose implausibilities for modest good sense.

Notes

1. David G. Green, Which Doctor? Research Monograph 40, London, Institute of Economic Affairs, 1985.

2. See the exchange between Mark Pauly and Joe Newhouse in Journal of Health Economics, Vol.1, No.1, 1982, and Vol.3, No.1, 1984.