THE PERIODICAL OBSERVER

Reviews of articles from periodicals and specialized journals here and abroad

Health-Care Reform: Where's the Pain?

A Survey of Recent Articles

"This health-care system of ours is badly broken, and it is time to fix it." So declared President Bill Clinton to Congress last September. His perception is widely shared. Unfortunately, the specialists and the general public are at odds about just what needs to be fixed.

The specialists, their opinions amplified by the news media, look mainly at the "big picture." They worry that the nation's health-care expenditures in 1993 amounted to 14 percent of gross national product (GNP) and are projected by the Congressional Budget Office to grow to 18 percent by 2000. Most Americans agree that health-care costs must be controlled, but the costs they have in mind are their own. They do not want less care; they want to pay less, or at least not more. And that, many specialists believe, is a large part of the problem.

Many Americans seem to have the notion that they are (or should be) getting a "free lunch." Employers or insurance companies foot the bill, so let's have another helping of health care, please, and with all the advanced technological trimmings. In reality, of course, notes Princeton University economist Uwe Reinhardt in *Health Affairs* (Special Issue, 1993), higher insurance premiums for employers mean lower wages for employees—a fact also noted by contributors to a *National Review* (Dec. 13, 1993) supplement on health care.

Some employers, Rachel Wildavsky reports in *Reader's Digest* (Oct. 1993), have been trying to make workers aware of costs. For example, they have begun offering bonuses to those whose annual medical claims do not exceed a certain amount. At *Forbes* magazine, claims plummeted and reimbursements fell by more than one-fourth after employees were offered bonuses if they kept their 1992 claims below $500. Wildavsky believes that such an approach, if widely used, "could help rescue American health care from possibly dangerous 'reforms.' In the process, it could save big money and help expand health coverage to those now without."

But a prescription that raises awareness of costs may fly in the face of public feeling: Americans are "satisfied with their current health-care arrangements—except for the price tag," as Robert J. Blendon and John M. Benson of the Harvard School of Public Health put it in the *Public Perspective* (March–April 1993). To the satisfied majority, adds *Newsweek* (Sept. 20, 1993), "change can only be threatening."

Clinton's health-care plan tries to be unthreatening. His complex proposal would define a standard package of benefits that all Americans would be entitled to receive (along with a "health security card"). States would establish regional "health alliances" that, on behalf of millions of consumers, would bargain with doctors, hospitals, and others. Most alliances would offer consumers a large selection of plans, but all would offer at least one traditional "fee-for-service" option, which would almost certainly cost more than the other choices, particularly health maintenance organizations (HMOs). Clinton's proposal thus aims to keep costs down by making consumers more aware of them and by encouraging competition among the provider networks. A National Health Board would

POLITICS & GOVERNMENT 127

FOREIGN POLICY & DEFENSE 129

ECONOMICS, LABOR & BUSINESS 132

SOCIETY 134

PRESS & MEDIA 138

RELIGION & PHILOSOPHY 140

SCIENCE, TECHNOLOGY & ENVIRONMENT 142

ARTS & LETTERS 145

OTHER NATIONS 148

monitor the system. If this "managed competition" does not work, the Clinton proposal has a backup approach ready: government price controls on insurance premiums. Costs are to be kept to 17 percent of GNP in 2000.

Clinton and First Lady Hillary Rodham Clinton insist that their reforms—including the extension of health insurance to the 37 million Americans now without it—can be accomplished "without enacting new broad-based taxes." Others are not so sure. Clinton's plan, the editors of the *New Republic* (Nov. 8, 1993) complain, "asks no sacrifice from anyone. Every American will be guaranteed a lifetime of health security; quality will be maintained; individuals, businesses, and the federal government will all pay less for care. Only drug and insurance companies have been slighted."

From a financial standpoint, asserts Rich Thomas in *Newsweek* (Sept. 20, 1993), Clinton's blueprint is an "exercise in wishful thinking." His plan assumes that the rate of growth in Medicare and Medicaid, now running at 13 percent a year, can be cut to under five percent, for a savings of $238 billion between 1994 and 2000.

Princeton sociologist Paul Starr, one of the advisers on the Clinton plan, claims in the *New Republic* (Dec. 6, 1993) that the proposal "presumes neither a free lunch nor any fiscal fantasies.... As states carry out reform beginning in 1996, expanded coverage will raise spending by about eight percent, while other reforms aimed at stimulating cost-conscious choice, backed up by a regional cap on premium increases, will cut the rate of increase in per capita costs."

In the same magazine (Nov. 22, 1993), New York University economist William J. Baumol argues that concerns about the economic impact of rising costs is exaggerated—a view shared by a number of other economists. Baumol argues that the problem in health care is not, as the Clintons and others assume, an absence of competition. Competition has been rising, as the growth of HMOs suggests. The real problem is slow productivity growth: Medical care simply does not lend itself to labor-saving techniques because physicians still must see patients one-by-one. But if productivity is rising elsewhere in the economy, Baumol notes, consumers can afford to pay more for health care. A jump in the cost of a certain medical treatment from, say, $1 to $10 does not matter much if a general rise in productivity also lifts *wages* so that it still takes only an hour of labor to pay for the treatment.

The Heritage Foundation's Stuart M. Butler, writing in the *New York Times* (Sept. 28, 1993), calls the Clinton plan a prescription for "permanent price controls by stealth." It is "folly," he says, to expect such a system to deliver quality health care at a lower price. "Price controls have never achieved such results in the past, and they won't work now."

Even if managed competition worked exactly as its proponents wish, says Harvard's Joseph P. Newhouse in the *Health Affairs* special issue, it would not slow the rate of increase in medical-care costs more than temporarily, so long as "it continues to be true that much of the cost increase reflects enhanced medical capabilities that society is mostly willing to pay for."

Willard Gaylin, president of the Hastings Center for bioethical research, contends in *Harper's* (Oct. 1993) that the Clinton administration has embraced the ideas of "efficiency experts" who assume "that the elimination of waste will obviate the need for 'rationing' health care." He argues, in contrast, that "the greatest part of the increase in health-care costs can best be understood as the result not of the failures of medicine but of its successes." Some advances, such as the polio vaccine, have reduced outlays over the long term, Newhouse notes, but most, such as invasive cardiology and renal dialysis, have increased outlays. The very concept of health has been expanded, Gaylin says. Infertility, for example, did not used to be considered a disease. In saving lives, effective medicine *increases* the number of ill people in the population.

Controlling waste will save money only for a while, Gaylin believes. The time thus bought, he says, should be used "to figure out a way to confront the deeper and more challenging reasons for escalating health costs: our unbridled appetite for health care and our continuing expansion of the definition of what constitutes health." That confrontation may necessitate a debate about much more than just "reform."