

“Can Health Care
Be Planned?”

Or, Why Doctors Should Do Less
& Patients Should Do More:
Forecasting the Future
of Health System Agencies

By

Aaron Wildavsky

Dean
Graduate School of Public Policy
University of California (Berkeley)

*The 1976
Michael M. Davis Lecture*

CENTER FOR HEALTH
ADMINISTRATION STUDIES
GRADUATE SCHOOL OF BUSINESS
UNIVERSITY OF CHICAGO

THE SPEAKER

Aaron Wildavsky, Professor of Political Science and Dean of the Graduate School of Public Policy at the University of California (Berkeley), has written widely on politics, public policy, and budgeting. Among his books are: *Budgeting* (forthcoming); *Planning and Budgeting in Poor Countries* (with Naomi Caiden), 1974; *The Private Government of Public Money: Community and Policy Inside British Political Administration* (with Hugh Hecl), 1974; *Urban Outcomes* (with Frank Levy and Arnold Meltsner), 1974; *Implementation* (with Jeffrey Pressman), 1973; *The Budgeting and Evaluation of Federal Recreation Programs, or Money Doesn't Grow on Trees* (with Jeanne Neinaber), 1973; *The Revolt Against the Masses and Other Essays on Politics and Public Policy*, 1971; *Presidential Elections* (with Nelson Polsby), 1971; and *The Politics of the Budgetary Process*, 1964.

Professor Wildavsky received his B.A. from Brooklyn College in 1954 and his M.A. and Ph.D. degrees from Yale University in 1957 and 1959. He is a fellow of the American Academy of Arts and Sciences, a member of the executive committee of the National Research Council of the National Academy of Sciences, and a member of the National Academy of Public Administration.

THE SERIES

The lecture series was established in the name of Michael M. Davis, medical care pioneer, by his friends and admirers. Dr. Davis opened the series in 1963 with an address entitled "America Challenges Medicine." Each year a distinguished leader of medicine, the social sciences, hospital care, social welfare, labor, or management is invited to address persons interested in the improvement of medical services. The intention is to stimulate free and open discussion of the problems of providing medical care and to furnish a forum in which medical care programs may be proposed, elaborated, examined, and presented for public discussion and consideration.

THE OCCASION

Professor Wildavsky delivered this lecture at The University of Chicago on April 23, 1976.

Can Health Be Planned?

*Or, Why Doctors Should Do Less
and Patients Should Do More:
Forecasting the Future of
Health System Agencies*

MOTHER was right! You should eat a good breakfast every day; you shouldn't smoke and you shouldn't drink; you should sleep seven or eight hours a day and not four or fourteen; and you shouldn't worry because it's bad for you. The rich person who does all these things is likely to be slightly healthier than the poor person who does them all, but the poor one who does not do all or most will be much healthier than the rich one who does half or less. The moral of this story is not surprising: health is a product of who we are—our genetic inheritance—and how we live—the air we breathe, the food we eat, the exercise we don't get—not how often we see a doctor.

Evidently what is euphemistically called the delivery of health services (as if the welcome wagon lady were to drive up and present people with packages of health) must be radically reevaluated. We are not talking about peripheral or infrequent aspects of human behavior. We are talking about some of the most deeply rooted and often experienced aspects of human life—what one eats, how often and how much; how long, how regularly and how peacefully one sleeps; whether one smokes or drinks and how much; even the whole question of personality. Delivering health, then, in the absence of a technological breakthrough (the famous pill that's good for all that ails you and only has to be taken once) is a product of innumerable decisions made on a daily basis. To oversee these decisions would require a larger bureaucracy than anyone has yet conceived and methods of surveillance bigger than big brother. The seat belt buzzer that screeches at us if we do not modify our behavior would be but a mild harbinger of the forces that would have to be

brought to bear to improve health habits. When the magnitude of the task is understood—that delivering health involves revolutions in human conduct—it is no wonder that we fail.

Speaking of the delivery of health services is a fundamental misnomer, as if defining a (medical) process by its (health) purpose could, by some verbal sleight of hand, guarantee achievement. Health can be delivered only in small part; it must largely be lived.

What can be delivered? Medical services and medicines, although, of course, that is no guarantee they will be used. If medicine can be delivered, however, what is it worth when it gets where it's supposed to go? What, in a word, is the relationship between medicine and health?

ACCORDING to *The Great Equation: Medical Care = Health*. * But the great equation is wrong. More medical care does not equal better health. The best estimates are that the medical system (doctors, drugs, hospitals) affects only a small proportion of the usual indices for measuring health—whether you live at all (infant mortality); how well you live (days lost due to sickness); how long you live (adult mortality). Health rates are determined by factors over which doctors have little or no control, from individual life style (smoking, exercise, worry) to social conditions (income, eating habits) to the physical environment (air and water quality). Most of the bad things that happen to people are presently beyond the reach of the medical system. In the absence of medical knowledge gained through new research, or of new administrative knowledge to convert common practice into best practice, therefore, current

* The general theory about health policy presented here (though not the later application to Health System Agencies) is a summary of ideas presented in "Doing Better and Feeling Worse: The Political Pathology of Health Policy" to be published in *Daedalus* and in a volume sponsored by the Rockefeller Foundation, which sponsored my research.

medicine has gone as far as it can. Hence the marginal value of spending one or ten billion additional dollars on medical care in order to improve health would be close to zero.

The fallacy of *The Great Equation* is based on the *Paradox of Time*: past successes lead to future failures. As life expectancy increases and as formerly disabling diseases are conquered, medicine is faced with an older population whose disabilities are more difficult to defeat. Former victims of tuberculosis are today's geriatric problems. Thus time converts one decade's achievements into the next decade's dilemmas.

The Great Equation is rescued by the *Principle of Goal Displacement*, which states that any objectives that cannot be attained will be replaced by ones that can be approximated. Every program needs an opportunity to be successful; if it cannot succeed in terms of its ostensible objectives, its sponsors may shift to goals they can achieve. The process subtly becomes the purpose. The input becomes a surrogate for the output. And that is exactly what has happened as "health" has become equivalent to "equal access" to medicine.

When government goes into public housing, it actually produces apartments; when government goes into health, all it can make available is medicine, which is far from health. But the government can try to equalize access to medicine, whether or not that access is related to improved health. If the question is: "Does health increase with government expenditure on medicine?" the answer is likely to be negative. Just alter the question to: "Has access to medicine been improved by governmental programs?" and the answer is most certainly, though not yet entirely, positive.

Wait a minute, says the medical sociologist, pain is just as real when it's mental as when it's physical. If people want to know somebody loves them, if today they prefer Doctors of Medicine to Doctors of Theology, they are entitled to get what they want. One can always argue that even if the results of medical treatment are illusions, the poor

are entitled to their share. This is a powerful argument but it neglects the inevitability of rationing.

"No system of care in the world is willing to provide as much care as people will use, and all such systems develop mechanisms that ration . . . services," says David Mechanic, summing up the *Axiom of Allocation*. But why do people want more medical service than any system is willing to provide?

IF MEDICINE is only partially and imperfectly related to health, it follows that doctor and patient often must be uncertain as to what is wrong or what to do about it. Otherwise medicine would be perfectly related to health and there would be no health problem, or it would be quite different: health rates would be on one side and health resources on the other. Costs and benefits could be neatly compared. But they can't because knowledge is often lacking on how to produce the desired benefits. Uncertainty exists because medicine is a quasi-science—more science than, say, political science, less so than physics. How participants in the medical system resolve their uncertainties matters a great deal.

The *Medical Uncertainty Principle* states there is always one more thing that might be done—another consultation, a new drug, a different treatment. Uncertainty is resolved by doing more, the patient by requesting and the doctor by ordering, more service. A simple rule for resolving patient uncertainty is for the patient to seek care up to the level of his insurance or subsidy. If everyone uses all the care he can, total costs will rise; but the individual has so little control over the total that he does not appreciate the connection between his individual choice and the collective result. A corresponding phenomenon occurs among doctors. They can resolve uncertainty by prescribing up to the level of the patient's insurance or subsidy, a rule reinforced by the high cost of malpractice. The patient is anxious, the doctor insecure; this combination is unbeatable

unless the irresistible force meets the immovable object—the *Medical Identity*.

This law states that use is limited by availability. Only so much can be gotten out of so much. If *Medical Uncertainty* suggests that existing services will be used, the Identity reminds us to add the words "up to the available supply." That supply is primarily doctors, who advise on the kind of care to be sought, the number of hospital beds (only one person in a bed at a time in our culture), and the number of patients making demands. Considering only his own desire to call upon medical services in time of need, each individual wants to maximize supply. For this reason expenditures on medical care are always larger than any estimate of the social benefit received. Now we can understand, by combining into one law the previous principles and identity, why costs rise so far and so fast.

THE *Law of Medical Money* is that expenditures rise to the level of insurance and subsidy. The medical system absorbs all inputs. Broadly speaking, payments will equal the total of all private insurance and government subsidy. Since these resources expand faster than the factors of production, prices rise.

What process ultimately limits medical costs? If the *Law of Medical Money* predicts that expenditures will increase to the level of available funds, then that level must be limited to keep costs down. Insurance may stop increasing when out-of-pocket payments exceed the growth in the standard of living, so that individuals are not willing to buy more. Subsidy may hold steady when government wants to spend more on other things or to keep its total tax take down. Expenditures will be limited when either individuals or governments reduce their inputs into medicine. The fact that both lack incentive to reduce inputs is responsible for creating the sense of crisis over health policy.

Surveys show that more than three-quarters of the population are satisfied with their medical care. Every subgroup in the population is healthier

than it was in past decades: rich and poor, black and white, now see doctors about the same number of times a year. The vast majority are generally satisfied but they specifically wish medical care didn't cost so much and they would like to be more certain of contact with their own doctor. So far as the people are concerned, then, the basic problems are cost and access.

But how can larger proportions of people in need of medicine be getting it at the same time as there is universally agreed to be a crisis in health care? The "bads" we face are a direct consequence of the "goods" we have tried to accomplish. Medicaid for the poor and Medicare for the elderly have increased use of the medical system, as they were intended to do, thus making it more crowded and, according to the *Law of Medical Money*, more expensive. Governments are faced with phenomenal expenditure increases. Administrators alternately fear charges of incompetence in restraining real financial abuse and niggardliness toward the needy. Doctors fear federal control because efforts to lower costs lead to more stringent regulations. The proliferation of forms makes them feel like bureaucrats; the profusion of review committees threatens to keep them permanently on trial. New complaints increase faster than old ones can be remedied. If money is a barrier to medicine, the system is discriminatory. If money is no barrier, the system gets overcrowded. If everyone is insured, costs rise to the level of the insurance. If many remain underinsured, their income falls to the level of the disaster that awaits them. The better government tries to be, it seems, the worse it is criticized. The more we-the-people do collectively, the less we like it individually. Why can't we break out of this bind?

BASICALLY there are two sites for relating cost to quality, that is, for measuring needs, which may be infinite, against resources, which are limited. One is at the level of the individual and the other at the level of the collectivity. By comparing individual desires with personal resources, through the private market, the individual in-

ternalizes an informal cost-effective analysis. Other valued objects—say, a vacation—might compete with medicine, thus reducing the inputs into (and the total expenditures of) the medical system. Even if apparently knowledgeable doctors make consumption decisions for evidently ignorant patients, they would both have to consider their joint limits of time to spend on medicine versus limits of income to support it. This creative tension may also be had at the collective level—a tension between some public services like medicine, and others like welfare, a tension between the resources left in private hands and those devoted to the public sector. If all health expenditures were shifted to the central government, it would be so large—well over a hundred billion dollars—that government would be motivated to reduce its inputs. And once government set its contribution, there would have to be real resource allocation because it would no longer be possible to shift costs to other parties; the "buck" would stop with the federal government because its appropriation would be all the medical system could spend. The fatal defect of the mixed (public and private) system, a defect that undermines the worth of its otherwise valuable pluralism, is that it does not impose sufficient discipline either at the individual or at the collective level. The individual need not face his full costs and the government does not carry the entire burden of expenditure.

But we-the-people are not willing to have either a purely private or a gigantic governmental medical system. To our credit, we will no longer allow money to be the main mechanism of access to medicine. Because of our desirable devotion to freedom of choice, we will not forbid the private practice of medicine. Thus a mixed system is inevitable. Truly it reflects our willingness to embrace contradictions: more medicine at lower costs and higher quality. We-the-people call the tune, but we are not willing to pay the piper. That is why we insist government do more, but when it does, we like it less.

What else can government do that it has not yet done? Send our medical problem children on a

visit to distant relatives by turning the problem (though not, of course, the money) over to regional or local authorities. As the old joke has it, "Let his mother worry." Does this approach appear flippant? Don't worry. We have a plan.

PLANNING is the ability to control the future through present acts; the more future consequences one controls, the more one can be said to have planned effectively.* Control of the future requires knowledge (so one knows what one is doing) and power (so one can compel others to do what one wishes). But there does not have to be a plan to have planning. Any process of decision that effects behavior, whether it be a market or an administrative mechanism, may be thought of as a plan, insofar as it provides incentives for generating one sort of future behavior rather than another. Normally, the planners' problem is that they lack both power and knowledge; they cannot control the behavior of others and, if they could, the desired consequences would not ensue. When knowledge is missing and power is absent, planning becomes a word for the things we would like to do but do not know how to do or are unable to get others to do. Planning need not be a simple solution; it can be, and often is, a convoluted way of restating the problem: Can we increase quantity and quality of medical services while decreasing costs? The answer is "we can't," as the National Health Planning and Resources Development Act of 1974, establishing health system agencies (HSAs), will prove once again.

The main power of some two hundred HSAs now being established is negative: by refusing to approve certificates of need (or otherwise objecting), HSAs can delay or prevent the construction of regional medical facilities and therefore the provision of medical services. Toward this end, HSAs are given administrative funds of their own

and a local power base, in that their membership must comprise at least one-third of medical providers and perhaps a half of consumer representatives.

The Act of 1974 is a plan in that it creates incentives encouraging certain types of behavior. But the plan is perverse. HSAs are mandated to reduce costs and improve the delivery of health services. They will actually increase costs and transfer ineffective service delivery from the have-littles to the have-nots. Why? Because they do nothing to affect the law of medical money—that expenditures and costs rise to the level of insurance and subsidy; on the contrary, they enhance the force of that law by creating incentives to increase rather than to decrease use of medical resources. Every decision they make will be paid for elsewhere by someone else—patients, insurance companies, taxpayers. No actors will limit inputs into the medical system because they are not in charge of any fixed sum of money that would have to be allocated. All will continue to make internal decisions, secure in the knowledge that the costs they generate will ultimately be passed on to others and that these others, because costs are so widely diffused over so many people, will lack sufficient understanding and interest in these decisions to exert a restraining influence.

HSAs will immediately espouse the doctrine of the three increases—more professionals, more lawyers, more data. It is self-evident that establishment of HSAs will lead to an enormous increase in demand for health professionals, thereby bidding up their price. As they have in all other major policy initiatives in recent decades, lawyers will be involved in greater numbers and with enhanced authority in order to straighten out conflicts among previous acts and among new regulations, particularly criteria and procedural safeguards made more complex by interaction with various private and public agencies at different levels of government. HSA lawyers will generate countervailing action on the part of providers and consumers, thus making more work for all. What will they produce? More data. There

* This paragraph is adapted from my "If Planning Is Everything, Maybe It's Nothing," *Policy Sciences* 4 (1973): 127-53.

will be vast proliferation of data on efforts, because that is what will be produced, but not, of course, on effects, because there won't be any, at least not relating to changes in health rates. Like the Humpty Dumptys they resemble, HSAs cannot put the great equation—medical care equals health—back together again. To do that they would have to do less, but they are designed to do more.

In the beginning, one can imagine, various providers will be directed to join with their neighbors in combining facilities that are regarded to be in oversupply. The HSAs will issue orders but these orders will not be obeyed. HSAs can say "no" but they cannot mandate "yes." They cannot command, so they will have to bargain. What will they give up to get what they want? The answer is the same as that given to investors who want to reduce their risks—other peoples' money. HSAs will, in effect, levy a toll on taxpayers and holders of medical insurance policies who will, "in real life," pay for the increased availability and/or use of medical goods and services by other people.

The self-evident fact that administrative expenses will increase is not the main reason for expecting a substantial rise in individual costs and total system expenditures. For this conclusion my case rests on the incentives HSAs have for resolving internal differences by the time-honored political method of log-rolling (or, you scratch my back and I'll scratch yours). If there were a fixed sum to distribute among applicants, of course, more for one would mean less for another. But since there is not, the interests of the main parties will lead them to resolve their differences by providing more rather than less largesse.

FIRST THE PROVIDERS. It will be difficult for providers of medical services to maintain a united front if resources like beds are taken away from some and given to (or left with) others. They will find a better way of solving this problem by trading beds for machines and other facilities. I don't know how many CATs (Computerized Axial Tomography) equal how many beds or

kidney machines or heart units, but talented professionals will find a common currency as well as a common language. The costs will be spread around by increasing bed rates, by the usual practice of cross-subsidization in which simpler forms of surgery pay for the more complex kinds, and by finding more treatments for which these devices are relevant. Despite innumerable administrative controls, cost overruns will not be curtailed because somebody else has to pick up the tab.

NEXT THE CONSUMERS. They believe the people they represent need health services and that health delivery could certainly be improved. With this providers will agree. But consumers are not likely to have accurate cost information or know how to interpret it or, worst of all, feel its impact directly on themselves. Faced with a choice between fighting for lower costs for all, with its implication of lesser services for their clients, and agreeing to support superior services for themselves without worrying about others, they will invariably choose the path of least resistance. They will negotiate with providers for larger packages in which their constituents can get more services, and perhaps jobs as well, in return for going along with the latest provider interests. Why should producer and consumer conflict when they can coalesce by giving every someone something: you co-opt me and I'll co-opt you and we will all co-opt each other.

Alain Enthoven tells an instructive story:

... about a man who left the presidency of a medical products company to become a professor of management. One day he decided it would be fun to see some of his old associates from business days, so he organized a lunch at a nice restaurant. At the end of the meal, from habit, he reached for the check, but his successor as company president took it and said, "Let me have it; for us it's a deductible expense and the government will pay half of it through reduced corporate profits tax." But the local hospital administrator took it out of his hand

saying, "No, let me take it; this will be an allowable conference expense, and we can put the whole thing in our overhead and get it back from Blue Cross and Medicare." But his neighbor took the check from him and said, "Let me have it; after all, I'm a cost-plus contractor to the government and not only will we get the cost reimbursed, but we'll get a fee on top of it." But the fifth man at the table got the check: "Look friends, I'm from a regulated industry, and we're about to go in for a rate increase. If I can put this lunch in our cost base, it will help justify a higher rate not only this year, but projected on out into the future."*

The moral of the story is that regulation is taxation, taxation with representation to be sure, but still a hidden form of taxation.

Consider the HSAs combination of log-rolling with barriers to entry. Naturally, HSAs will be composed of providers and consumers who are already there. They can be expected to give future providers and consumers a hard time. The most likely loser will be new proponents of health maintenance organizations. Either they will be denied certificates of need, because everything that needs to be done is ostensibly being done by those who are already there, or, if HMOs cannot be resisted, they will be added on to what already exists. Every innovation that challenges existing interests will either be attacked as unnecessary or added on, to maintain harmony. One cannot say exactly what will happen except that we know in advance the one important thing that will not happen: old services will not give way to new ones.

The trouble with failure is that it can happen to anyone. If failure by medical providers were possible before, with old facilities dying when they had outlived their usefulness, it will no longer be permitted. Providers will understand their mutual

interest in insuring against failure by agreeing to bail out each other at public expense. Medical providers and their consumer customers may not be able to improve mortality rates of the population but they will certainly be able to keep each other alive.

WHO WINS is obvious, at least in the short run. But who loses? The answer depends on who is least able (a) to pass on costs or (b) to lobby effectively for subsidy. To no one's great surprise, the near-poor will get it in the neck again. The upper class will find ways to reduce taxes and the middle class will improve their insurance; the poor will get a superior subsidy. Both the top and the bottom exert influence in different ways, but they are influential. Only the near-poor lack either a governmentally protected program or market leverage. Hence HSAs will transfer income from the near-poor to the officially designated poor.*

Presumably HSAs are designed to take the heat off the central government—don't harass your Congressman, picket your local HSA instead!—by adopting the time-honored method of diffusing conflict over large numbers of areas. Presumably, this intended effect will occur for a while if only because the confusion will be so great, the actors so numerous, the consequences so elusive, that most energies will be absorbed in figuring out whether HSAs work. When it becomes clear that they don't and won't, the conclusion is unlikely to be that collective regulation is bad but that private or pluralistic medicine has failed. By loading the medical market with the burden of regulation—capture by the interests most immediately affected, delay in adaptation to emerging conditions, passing the price of monopoly on to others—it will be condemned for its high cost and lack of responsiveness. The lesson will be that the private

* Alain C. Enthoven, draft of "National Health Insurance and the Cost of Medical Care," an address to the Detroit Academy of Medicine, May 13, 1975, pp. 10–11.

* For further findings on how and why the near-poor lose out, see Frank Levy, Arnold Meltsner, and Aaron Wildavsky, *Urban Outcomes* (University of California Press, 1974).

market has failed and that only public administration can save us. The lesson should be that doctors should do less and that we-the-people should do more about our own health.