On the Future of the American Economy and its Impact on the Health Care Sector

By

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The 1980
Michael M. Davis Lecture

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

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THE OCCASION

Prof. Reinhardt delivered this lecture at the University of Chicago on May 28, 1980.

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I. INTRODUCTION

In the annals of the United States, the 1970s will probably be recalled as the decade of the Great American Bellyache. Somber pundits informed the nation that its political and military power had limits and that its economic resources were finite. While most other nations on earth had long ago come to appreciate such limits—some as early as man's fall from grace¹—the very thought of finite resources struck Americans with a shock from which they have yet to recover.

As Americans in general turned morose during the '70s, the nation's health care sector fell into downright despair. Speaker after speaker on the health conference circuit spoke of "cost containment," "trade-offs," and even "the need to ration health care," brazenly violating the time-honored tradition of refraining from that type of language in debates on health policy. While economists took a certain joy from seeing their jargon become household words even in health care, the providers of that care saw in the novel jargon a direct assault on the two things they cherish most: the quality of their product and their incomes.

On the surface, the apprehension of Americans over their economy seems paradoxical. Indeed, from at least one perspective the 1970s might be called one of America's more glorious decades. During that decade our economy absorbed, with reasonable flexibility, two stunning increases in the cost of energy. At the same time, the economy accommodated the entry of the postwar baby boom into the labor force by providing 18 million additional jobs—an increment equal to 80 percent of the entire labor force of France and 65 percent of

¹In this connection, see the Old Testament, Genesis, Book III.
that of West Germany (whose labor force grew hardly at all in that period and even declined in the end). Finally, during the decade Americans devoted themselves in earnest to the long overdue task of implementing the United States Constitution. In the process, basic civil and economic rights were extended to persons who hitherto had been shamefully denied these rights.

A pastoral decade it was not; nor, however, can it be called a social or economic disaster. Indeed, the real (inflation-adjusted) value of the nation’s total output of goods and services per capita rose by roughly 24 percent over the decade. After accounting for taxes absorbed by the government and transfers paid to individuals, disposable income per capita grew even more rapidly. Average consumption per capita grew more rapidly still, indicating that private households somewhat reduced their rate of savings. Taken by themselves, these figures certainly do not betoken the “worst economic mess since the Great Depression,” nor do they furnish a proper basis for a national bellyache.

While real GNP per capita grew by about 2.4 percent per year during the decade, real health care expenditures per capita grew at an annual percentage rate of 4.5 percent, that is, almost twice as rapidly. (In this connection, see table 2 further on.) There was much talk about the need for budgetary constraint in health care, but not, in fact, much action. Out of these generous budget appropriations—or should one say “expropriations”?—those seeking a livelihood in health care could carve for themselves ample financial rewards and, in the process, do well by the patients they were to serve. They seem to have done both.

The question that arises is how Americans could have turned so morose in a decade that brought them continued prosperity, and how they have come to look to the 1980s with such apprehension.

In part, of course, our sour mood may be just a phase in the nation’s perennial oscillation between unbridled chauvinism and pitiable self-flagellation. Perhaps the 1970s simply coincided with the downward phase of this oscillation, and perhaps the 1980s will see an upward phase, regardless of the underlying real economic factors thought to drive the national mood.

On the other hand, the data referred to above do mask certain troublesome trends that were in the nascent stage during the 1970s, and might turn malignant in the future if left unattended. The alternative explanation for our mood, then, is that these trends are widely perceived and that their potential consequences are fully appreciated, if not exaggerated.

In the following section of this essay, I shall review some of these troublesome trends and present my perception of the social and economic challenges they pose.

II. TROUBLESOME LEGACIES

It will be recalled that sometime in July 1979 President Jimmy Carter retreated to a mountain top—along with some thirty of America’s wisest people—there to reflect upon our nation’s ills. About a week or so later he descended. With an expression properly somber for the occasion, he then delivered his diagnosis on national television. He said the nation was in the grips of a “malaise” that threatened to paralyze our economic and social progress unless we all mended our ways. In plain Georgian, he might have said: “Y’all sick, y’hear!”

Was the president right and was his assessment fair?

In truth, I did find myself in the grips of a malaise that day, as must have many millions of

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2 Between 1970 and 1979, the civilian labor force in the United States expanded from 78.6 million to 96.9 million. During the same period, the percentage of the noninstitutional female population in the labor force increased from 43.3 percent to 51.0 percent. (See Economic Report of the President 1981, table B-27.)
other Americans who had spent the preceding several weeks pulling duty in some odorous queue for gasoline. I found myself both fatigued and irritated—irritated, because we were being buffeted by a so-called "energy crisis" that was manufactured not on the distant shores of the OPEC nations (as the president’s staff sought to have us believe) but right here at home, in the bureaus of our own Department of Energy. The department, it turns out, had been busily and faithfully implementing the counterproductive energy regulations which President Nixon had signed into law, President Ford had lacked the political courage to repeal, and President Carter had not yet found time to have eliminated. Americans were being hounded by a bipartisan snafu infelicitously billed as an "energy crisis" but more appropriately called a "regulatory crisis."

My point in recalling this incident is not to make sport of President Carter, nor even to offer the by now almost obligatory mutterings on the evils of government regulation (counterproductive as it often is). Rather, I wish to draw a distinction between that part of our malaise which is but a normal reaction to hostile external buffeting, and that part which is properly identified as a problem of the mind. One might call the first set of factors "structural" and the second "attitudinal."

Although one can identify in our society certain attitudinal factors that may eventually engender serious economic problems, a good part of our current malaise probably represents mere normal responses to uncomfortable structural changes. The rising cost of energy is one such change. A proper medicine for structural malaise is not exhortation from the bully pulpit—the politician’s favored strategy—but rather a judicious management of the underlying structural changes. This management will involve deliberate changes in the structure to the extent that it is under our control. An example of such a change is alteration of the economic incentives implicit in our tax laws. Where structural changes are beyond our control (e.g., the rising cost of energy) public policy should facilitate a sensible adaptation to novel circumstances. In either case, however, public policy should build on the assumption that the typical American can digest the truth, and that it is just as dangerous to ring false alarms as it is to convey a false sense of security.

Attitudinal malaise is less easily diagnosed than structural malaise. It is also less tractable from the viewpoint of public policy. This type of malaise originates in the individual’s perceptions of his or her claims on society’s resources and of his or her responsibilities toward society. These individual perceptions strongly shape a society’s response to the economic challenges and opportunities posed by structural changes. Some historians see in this social response to given economic opportunities one of the prime determinants of a nation’s economic development. Unfortunately, these perceptions form and change only gradually over time and are not readily amendable by public edict.

A. Sources of Structural Malaise
A nation’s economic well-being—measured by, say, real national product per capita—is determined by the size and by the productivity of its workforce. Blessed by peace on their soil, a relative abundance of natural resources, and a rich native stock of human capital (supple-

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3I am referring here to the Emergency Petroleum Allocation Act of 1973 (EPAA) and subsequent refinements, including the Energy Policy and Conservation Act of 1975 (EPCEA). These acts established a complex system of price controls on crude and refined oil products that required, inter alia, an equally complex system of government-directed allocation of crude oil and refined products. The so-called "energy crisis" of 1979 was the result mainly of unrealistically low price ceilings on gasoline. It is to President Carter’s credit that he pushed hard for the eventual deregulation of energy in this country.

4See, for example, Barry E. Supple, ed., The Experience of Economic Growth (New York: Random House, 1963).
mented by selective pickings from abroad) American workers throughout the postwar decades have registered the highest average productivity in the world. Several factors now threaten this prime source of economic prosperity.

Prior to the mid-1960s average output per labor hour in this country tended to grow at an average annual compound rate of slightly more than 3 percent. This growth had been sustained for most of the postwar years. It came to be viewed by labor leaders and policymakers as something akin to a natural constant.

As is shown in table 1 below, however, the

| TABLE 1 |
| Labor Productivity Growth |
| 1948–80 |
| (Percentage Change per Year) |
| Sector | 1948 | 1965 | 1973 |
|         | 1980 | 1973 | 1979 |
| Private | 2.4% | 0.8% |
| Nonfarm | .2%  | .6%  |

Note: Data relate to output per hour for all persons. Source: Economic Report of the President (January 1981), table 8, p. 69.

growth of labor productivity is anything but a natural constant. It is man-made and subject to change. Since the mid-1960s, the growth rate in labor productivity in this country has declined noticeably. It was negative even during some periods of the late 1970s. Just what it will turn out to be in the 1980s is anybody’s guess at this time. It is clearly not a matter completely beyond our control.

It is tempting to attribute the decline in our productivity growth to the rapidly rising cost of energy after 1973. That a relationship between the two exists—certainly in the short run—is beyond dispute. The decline in productivity growth, however, predates the steep ascent of energy prices by almost a decade. Indeed, during the period from 1965 to 1973, when the real price of energy continued to decline year after year, the rate of growth in labor productivity had already declined some 35 percent, that is, to two-thirds of the traditional rate of 3 percent or so per year.

Among Americans it is equally tempting to attribute the decline in productivity growth to factors peculiarly American. As it happens, however, most other industrialized nations have shared our fate. To be sure, by international standards our absolute rate of productivity growth through the postwar years was much lower than rates registered elsewhere in the industrialized world. This observed differential may reflect in part our nation’s remarkably low savings ratio—a matter to be explored further on—or simply the fact that Europe and Japan were digging out of the ashes left by World War II and were therefore on the lower, steeper portion of the economic growth curve. While most of the industrialized nations continue to exhibit relatively higher absolute rates of economic growth, all of them shared our experience of rapidly decelerating economic growth rates. Indeed, the growth rate in West Germany, a nation often regarded as a model of economic performance, has recently hovered around values close to zero.

What can explain the remarkable deceleration of economic growth observed in the United States and elsewhere? The answer, unfortunately, is not obvious. In his recent analysis of the phenomenon, for example, Edward F. Denison, one of the nation’s foremost students of the phenomenon, concludes that “what happened is, to be blunt, a mystery.”

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Denison assesses the role of some seventeen potential culprits, among them: slower growth in the capital-labor ratio during the 1970s, fewer advances in knowledge, the growth of government regulation, an alleged decline in the work ethic, the rapid absorption during the 1970s of a large number of inexperienced workers into the labor force, and of course, the rising cost of energy. In the end he concludes that probably all of these factors were at work and reinforced each other, but that none of them was powerful enough by itself to explain a major proportion of the decline.

B. ATTITUDINAL MALAISE

In the Western democracies with their built-in, semi-autonomous economic power blocks, any rapid decline in economic growth can have serious consequences. It is reasonable to assume that the typical household in such nations develops life cycle financial plans based on a particular projection of future real incomes. One can think of the household’s projected future income stream as a measure of the wealth it imagines it will possess. The projected income streams will depend crucially on the assumed growth rate in real income. If households are bombarded with the news that their hitherto assumed growth rates are much too optimistic and that only one-half or one-quarter the projected growth rate will obtain, then all income projections need to be realigned and the household’s imagined life cycle wealth shrinks. And thus it is possible that people may feel they are vastly impoverished while their current income has not declined at all. An effect of this sort may have played a role in souring the nation’s mood during the 1970s. Unless people are taught to absorb this effect gracefully, it can trigger acute cases of attitudinal malaise.

In principle, of course, a nation ought to be able to adapt itself fairly smoothly to variations in economic growth. This point has been one of the central theses of classical economics. Few modern societies, however, meet the specifications of the classical model. In modern societies, variations in growth—certainly declines in economic growth—tend to trigger heightened social tension. The origin of this tension resides in certain attitudes that seem an almost inevitable product of a prosperous and dignified civilization. In the 1970s, these attitudes—a growing entitlement mentality and an unwillingness to hold the individual responsible for his or her own actions—were inexplicably augmented by a growing hostility towards one of the chief purveyors of economic privilege in our society: the nation’s business sector. Together, this set of attitudes could spell serious problems for our future economic development. They represent some of the warts that may grow to malignancy if left unattended.

In the economic sphere, the entitlements mentality alluded to above manifests itself as the registration of claims on the nation’s economic resources as a matter of presumed right. No one would deny that the social contract binding together a civilized society does grant the individual some such rights, either explicitly or implicitly. As a matter of chosen principle, we are not prepared to let people starve or die in the street for want of medical care. We guarantee the individual access to certain levels of education and to legal representation under certain circumstances. There are a good many such entitlements which we take largely for granted and would probably endorse overwhelmingly were they reexamined by means of referendum.

A phenomenon largely of the postwar period, however, is the ever-growing spread of pre-
sumed entitlements in altogether novel areas. Decades of rising prosperity seem to have persuaded entire generations that economic growth just happens somehow and that the individual in society is entitled to share in that growth regardless of his or her own contribution to it. It is primarily the emergence of this entitlements mentality that makes it so difficult in our economies to adjust to external shocks such as the rising cost of energy.

It is sometimes not realized that in a society which accords entitlements mentality respectability—as we do—inflation is one of the most useful devices to arbitrate the inevitable social conflict over claims on the nation’s resources. It is a device by which economic or political power blocks can transfer their own economic misfortune to their less powerful fellow citizens.

Consider, for example, the economic impact of a sharp increase in the price of imported oil. The increase will force someone in society to forego the extra goods or services extracted from us by the exporters of crude oil. One might think that this “someone” would be primarily one who directly or indirectly relies rather heavily on the use of imported oil. Not so in a society equipped with the device of inflation and run on an entitlements mentality. A labor monopoly that has achieved a so-called cost-of-living allowance (COLA) in its contract, for example, has already signaled its unwillingness to be that “someone.” Without denying the fact that someone must indeed bear the sacrifice, such a union somehow feels entitled to have that someone be someone else. A dairy industry protected by price floors which, in turn, are tied to the cost of production, exercises a similar “right,” and so do retired civil servants, retired military personnel, and the recipients of social security. All of these groups are entitled to escape the impoverishment represented by the increased price of oil.

Someone, of course, must do with less, and as already noted, that someone will be the individual who has failed somehow to find shelter within an organized political or economic power block. Such persons find their income and savings mercilessly eroded by inflation. Among them are the weakest and poorest members of our society who are, in this sense, the victims of a perfectly legal form of organized theft. Because the thieves obviously benefit from the arrangement, we should not expect them to pay more than mere lip service to the need to fight inflation.

C. The Economic Challenge of the 1980s

By delving as deeply as I have into the troublesome legacies of the 1970s, one may easily exaggerate the relative magnitude of these problems. They are, in effect, but warts on an otherwise resilient social and economic fabric. They deserve intensive illumination because, if left unattended, they might grow to malignancy in the coming decades. One of the challenges of the 1980s, then, is to excise these warts at their early stages, particularly the attitudinal malaise examined earlier. One senses a mood abroad in the nation to begin that therapy.

Unfortunately, a broad assault on the entitlements mentality in this country may sweep away genuine entitlements which most people would be quite content to grant. Health care for the nation’s poor, for example, may become a victim of the political steamroller, at least temporarily. A ray of hope, of course, is that an assault on the health care of the poor is also an assault on the incomes of health care providers, who do know how to parry these attacks. In the end, other worthy entitlements now granted the poor, but not as well protected by organized recipients of the associated income flows, may bear the brunt of any such assault. It would be a sorry price to pay, but one that is probably inevitable.

A second major challenge this nation seems willing to take on is an acceleration of economic growth. This policy is a matter of free choice
rather than a form of crisis management. In principle, this nation might decide to content itself with an annual growth rate in GNP of 1 or even 0 percent and then develop adaptive social policy to that chosen growth path. The nation, alas, seems otherwise inclined.

Figure 1 illustrates the challenge implicit in the nation's decision to accelerate economic growth. The diagram presents a familiar tale from the theory of economic growth. The solid lines A and B are thought to represent the long run growth paths in real consumption per capita a society could offer its members if it always had and always will set aside a constant fraction of its GNP for the replacement of old and the accumulation of additional capital (including education and research). Thus, the lower of the two lines might represent savings ratio of, say, 15 percent (roughly the U.S. ratio) and the upper line a savings ratio of 25 percent (roughly the West German ratio).

Suppose now a society finding itself on the lower consumption path B desired to swing itself up to path A. It would be nice if that could be accomplished simply by following the dotted trajectory C. Unfortunately, ever since the fall from grace God has so organized this planet as to make trajectory C infeasible. That trajectory violates the no-free-lunch law. The only feasible approach would be a trajectory such as the dashed line D; to reach the higher long run consumption path implies a conscious decision to make do for some period (say, a decade or two) with less consumption than could actually be enjoyed were society content to remain forever on the lower path. The technical question raised by that decision is how to extract from society the requisite sacrifice in consumption (the scored area in figure 1). The associated ethical questions are: (1) whether it is defensible to impose on one generation a sacrifice in consumption so that future generations may consume more and (2) even if one answers the first question in the affirmative, whose consumption in the sacrificing genera-
tion should be cut to yield the added savings?
These questions are currently debated in our
country under the general heading of "supply-
side economics."

A detailed examination of this debate,
although fascinating subject matter, would go
much beyond the compass set for this essay.
Suffice it to mention in passing that there are at
least two distinct types of supply-side econom-
ic. One may refer to these as the "old" and the
"new."

The "old" supply-side economics tends to be
favored by persons now derogatively referred
to as Keynesians. The approach is based on the
hypothesis that a nation's savings ratio is cul-
turally determined and rather insensitive to the
after-tax rate of return available on savings. To
increase the savings ratio, the "old" supply-
siders would therefore run a tight fiscal policy
designed to yield forced national savings in the
form of public budget surpluses. These
surpluses are then to be rechanneled to the pri-
ivate sector via financial intermediaries. To
make sure that the private sector will actually
undertake the desired investment, the policy is
accompanied by a relatively easy monetary
policy (a low-interest policy) and by targeted
fiscal incentives such as investment tax credits.

The "new" supply-side economics envisages
nearly the opposite policy mix. The approach is
based on the hypothesis that a nation's savings
ratio is very sensitive to the after-tax rate of
return on savings, and that the United States
ratio is so low precisely because of the high
marginal tax rates on corporate earnings and so-
called "unearned income" (returns to finan-
cial securities) of our country. "New" supply-
siders therefore advocate across-the-board tax
cuts that would increase, at once, the rate of
return to investments, and the rewards to
human effort (labor) and to savings. It so hap-
pens that this school of thought is also inclined
towards the so-called monetarist approach to
macroeconomic policy. Under that approach
the monetary authorities control the growth in
the money supply, whatever that may do to
nominal interest rates. Thus, while the "old"
supply-side economics may be described in
shorthand as "tight fiscal and easy monetary
policy," the "new" supply-side economics
would manifest itself in our current inflationary
environment as an "easy fiscal and tight mono-
etary policy." It is clear that although both ap-
proaches share roughly the same overall mac-
roeconomic goal, they differ in the incidence of
the sacrifice they imply. Our nation, therefore,
will choose between them not on technical but
on political grounds.

No matter which policy the nation eventually
adopts, however, there will be a concerted at-
tempt to redirect resources away from con-
sumption and into investment. Health care ex-
penditures are viewed, in this context, as a
form of consumption. It follows that the na-
tion's decision to seek accelerated long run
growth and to shift added resources to the de-
fense sector will exert downward pressure on
the budgets made available to the health care
sector, at least in the short run (say, the better
part of the 1980s). In the next section of this
essay I shall offer some remarks on the probable
impact of these policies on resource allocat-
ion within the health care sector.

III. HEALTH CARE INCOMES AND HEALTH
POLICY IN THE 1980s
In several prior papers7 I have reminded
readers of the truism that, just like any other
sector in our economy, the health care sector
has two distinct facets that reflect its dual social
role: the real facet representing the transfor-
mation of human labor and capital into health
services, and the fiscal facet representing the
transformation of health care expenditures into

7See for example, "Table Manners at the Health Care
Feast: Regulation vs. Market" (Paper presented at the Sixth
Private Sector Conference, Duke University Medical Cen-
health care incomes. The real facet highlights the sector's role in servicing consumers. The fiscal facet represents its equally important role in providing an economic mainstay to the owners of the resources (capital and human labor) used by the health care sector.

During the 1950s and 1960s health policy in this country was aimed primarily at a perceived shortage of health services all around. The thrust of health services research and policy was therefore aimed at the real facet of the health care sector—at the supply of real health care resources, their geographic distribution, and their organization in production. Relatively little attention was focused on the fiscal facet of the sector. Society seemed ready to appropriate whatever funds were required to provide all Americans with access to needed health care.

During the 1970s the perception emerged that, save for scattered pockets of unmet need, the problem of access had been more-or-less solved. At the same time, the fiscal facet of the health care sector began to exert increasing pressure on public and private budgets. The attention of policymakers therefore shifted away from the real facet to the point where the fiscal facet now seems to dominate the discussion on national health policy. Indeed, with only mild exaggeration it seems reasonable to suppose that health policy in the 1980s will emerge primarily as a by-product of a struggle over the transformation of health care expenditures into health care incomes, and less as the product of deliberate decisions to respond to health care needs.

For the remainder of this essay I shall adopt the fiscal perspective exclusively. Thus I shall not discourse upon the demand for and supply of real health services, but instead upon their fiscal mirror images: the supply of and demand for health care incomes. Because all health care expenditures ultimately turn up as someone's health care income, I shall use the terms "national health care expenditures" and "national health care incomes" interchangeably.

A. THE SUPPLY OF AND DEMAND FOR HEALTH CARE INCOMES

1. Supply and Demand in the 1970s

Table 2 below presents a perspective on the supply of health care incomes during the 1970s. That supply grew apace, at a rate much in excess of the growth of gross national product. The data might suggest that the individuals working in the health care sector enjoyed commensurate increases in their real income. The

| TABLE 2 |
|---------------------------------|--------|-------|--------|
| **Gross National Product per Capita** | $4,799 | $5,936 | 2.4% |
| **Health Care Income supplied per Capita** | $15.4 | $470.7 | 4.5% |

*Based on the implicit price deflator for the GNP: 1970 = 100; 1979 = 162.77.

*Otherwise known as "personal health care expenditures per capita."

real incomes of some health workers did indeed increase during the decade—sometimes in the form of a catch-up with alternative earnings opportunities. On the other hand, the real net incomes of physicians actually appear to have declined, as is evident from figure 2 below. In fact, for the most part the rapid growth in total health care expenditures (alias "health care incomes") represents an ever growing total number of individuals seeking an income in health care delivery, either by working directly in the sector or by working for industries supplying the health care sector. Between 1970 and 1978, for example, the number of civilians employed in the health service industry grew from 4,246 million to 6,673 million; that is, by 5.8 percent per year. This figure does not even include persons deriving their livelihood indirectly from health care (e.g., employees of the pharmaceutical or medical equipment industries) or persons in health related occupations employed in enterprises other than health care facilities (e.g., school nurses or pharmacists). In other words, against a generously increasing supply of health care incomes pressed an ever increasing number of individuals demanding health care incomes.

2. Supply and Demand in the 1980s

A central conclusion emerging from Section II above was that the supply of health care incomes (i.e., total health care expenditures) is unlikely to grow as rapidly during the 1980s as it did during the 1970s. Even if real gross national product per capita once again grew at an

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8 It is possible that the data in these displays represent to some extent a voluntary reduction in hours worked and a growing proportion of recently graduated physicians still on the lower portion of their lifetime earnings curve. The real hourly net practice income of any given cohort of physicians may therefore not have declined as much, if at all. Even so, the 1970s was surely not a decade in which the individual physician experienced enormous economic advance.

average annual rate of 3 to 4 percent—an optimistic scenario—pressures will emerge from many sides to constrain the future growth of total health care incomes, as the nation seeks to reallocate resources from private consumption into private and public investments (including investments in the military sector).

The pressure to constrain health care incomes will not come just from the public sector’s struggle to control the rapidly growing budgets for the Medicare and Medicaid programs. Private industry also will become increasingly reactive as an ever larger share of total national health care income (expenditures) is loaded onto their product prices via fringe benefits. Finally, consumers themselves are likely to apply greater downward pressure on health care incomes. With the virtually certain demise of national health insurance for some time to come, consumers are likely to retain a strong financial interest in constraining health care incomes, certainly in the less well insured markets for ambulatory care. Indeed, I should not wonder if sometime during the 1980s physicians will develop a taste for just the kind of national health insurance programs they rejected during the 1970’s, and that they will regret their earlier opposition to such programs.

The future supply of health care incomes, then, will grow more sluggishly during the 1980’s. Although it would be bold to offer a concrete forecast, I doubt that aggregate health care incomes will be permitted to grow much more rapidly than gross national product. Much will depend, of course, upon the absolute growth rate in the GNP itself.

What about the future demand for health care incomes?

Although here, too, it would be presumptuous to offer a forecast for all individuals likely to seek a livelihood from health care, it does seem fairly certain that the physician-population ratio in this nation will continue to grow during the next decade or two, at an estimated annual rate of about 2 percent. These physicians will seek to carve their incomes out of the national total just at a time when the nation’s hospital sector may find itself forced to eliminate an acute prevailing nursing shortage through commensurate increases in nurses’ compensation. Since the other segments of the health care sector (e.g., the pharmaceutical industry, the manufacturers of medical equipment, the nursing home sector, and so on) also expect some growth in their total incomes (wages and profits) during the 1980’s, I would not expect the transformation of health care expenditures into health care incomes to be quite as smooth and civil as it was during the 1970’s. It may even become tempestuous.

The total pretax net income earned by American physicians constitutes only about 10 to 12 percent of overall national health care incomes (expenditures). As is widely recognized, however, this statistic belies the influence physicians actually wield over the distribution of aggregate health care expenditures (income) among health workers. If external factors prevent physicians from expanding the aggregate, they must surely have some leeway in determining its distribution to themselves and to their fellow health workers.

I would expect physicians to use that leeway to their own economic advantage and suspect that public policymakers will cheer them on in that endeavor. The reason for cheering would be this: to protect their own income, physicians will be likely to reduce the role of inpatient services in the management of given illnesses. This can be achieved, for example, by greater reliance on ambulatory surgery. Critics of the health care sector have long advocated just such shifts.

Physicians may also protect their income by detaching from the hospital certain profitable diagnostic or therapeutic product lines, a policy

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10Ibid., p. 213.
that should be relatively easy for group medical practices. Indeed, we could imagine the emergence of large scale multispecialty group practices coupled to an adjacent motel that can be used either for patients or tourists. Severe economic reverses in the 1980s are thus likely to be suffered only by those physicians who prefer solo practice or small partnerships and/or those physicians who render uninsured primary care that does not offer many opportunities for lucrative diagnostic workups. Pediatricians, for example, may find the going a bit rough in the 1980s as they already have during the 1970s (see figure 2).

Would hospitals stand by passively if physicians in private practice seek to divert patient revenues in this manner? They need not, and they may not. Hospitals have on their side considerable managerial and marketing talent. Many of them also have relatively easy access to the capital markets, especially if they belong to multihospital systems. One could imagine, for example, that hospitals would meet any encroachment on their turf by physicians with the development of their own ambulatory centers. These centers might be profitable in their own right, or at least serve as feeders for the inpatient department. Management consultants are already carefully instructing hospitals on the organizational structure best suited for such a strategy.11

B. MANAGING THE TRANSFORMATION OF HEALTH CARE EXPENDITURES INTO HEALTH CARE INCOMES
The question arises of what, if any, rules public policymakers should impose upon the forthcoming scramble for the health care dollar. Here we may follow at least two distinct routes:

1. We may seek to solve the conflict over dollars by assigning well-defined entitlements—economic turf—to particular groups of income claimants in the health care sector.
2. We may decide not to assign well-defined entitlements and instead solve the conflict within the framework of competitive markets.

1. The Entitlements Strategy
There are at least two distinct means by which the entitlements route could be taken. One of these would be the system of top-to-bottom budgeting envisaged in the series of health insurance proposals traditionally favored by organized labor. Whatever the practicality and merits of that approach might be, it does not seem to stand a chance in the political climate likely to prevail in the near future. Perhaps the strategy will be dusted off again at the end of the decade, should other approaches have failed in the interim.

An alternative approach to the entitlements route might be a Platonist health care state, that is, a market environment organized and supervised by the most highly trained health professionals—physicians, dentists, pharmacists, and so on. I refer to the system as “Platonist” because it is vaguely reminiscent of Plato’s utopian state in which a high priesthood of philosopher kings is to govern (completely selflessly) the remaining segments of society, with each segment being expected to perform its assigned function. The contemporary systems of professional self-regulation are modern, albeit imperfect, attempts to approximate the Platonist ideal in particular economic sectors.

In the Platonist health care system the presiding health professionals have decisive influence over the assignment of tasks to particular categories of health workers further down in the health care hierarchy. In the process the presiding professionals also determine who may or may not exercise entrepreneurship in health care, that is, who may compete with them and on what terms. Our current licensure

laws are the instruments through which that system is enforced. Such a system implicitly assigns individual claims on total national health care incomes. Although these claims are neither rigid nor completely determined by the presiding professions, it seems reasonable nevertheless to characterize the "self-regulatory" or Platonist approach as an "entitlements system."

The Platonist approach to managing health care has enormous intuitive appeal to both the health professions, to politicians, and I suspect, to many patients. Economists are typically less enamored with it. Endowed as economists are by a philistine disposition, they see in the arrangement numerous conflicts of economic interest that may serve, in the aggregate, to enhance the economic position of the presiding priesthood at the expense of other health workers, of consumers, and of taxpayers. In real life, economists tend to argue, the ruling high priests cannot be counted on to organize the health care market completely selflessly, especially not in an era of impending health manpower surpluses. Economists recognize that all human beings are human.

2. The Competitive Strategy
To avoid these problems many economists and health policymakers would abandon altogether the entitlements system implicit in "orderly," provider-organized health care markets. They would prefer instead to entrust the distribution of health care resources among consumers, and the distribution of health care incomes among health workers, to the proverbial "Invisible Hand," albeit one guided and constrained by the particular humanitarian concerns we reserve for the distribution of health care. Alain Enthoven's *Health Plan* is a carefully articulated illustration of such proposals.12

Will the competitive strategy work, or is it even more utopian than the Platonist health care state? The fact is that we cannot answer that question with certainty at this time. One can point to real-world, local approximations of the competitive model in several areas in the United States and, as Enthoven has shown, one can at least conceive of paper-design analogues for the nation as a whole.

It turns out, however, that the actual implementation of such a system involves numerous vexing problems (e.g., the problem of adverse selection, the problem of financing teaching hospitals, and so on) whose solution will require considerable legislative and managerial ingenuity. The task will be all the more taxing because one should expect health care providers to obstruct the implementation of the competitive strategy at every step. A competitive market is, after all, a device designed to make life hard for providers so that consumers may fare cheaply and comfortably. Why should any red-blooded, straight-thinking provider wax enthusiastic about it?

My own preference is to move firmly but cautiously in the direction of more pervasive competition in health care delivery, including a careful review of the anti-competitive elements inherent in our licensure laws. I see virtue in learning from limited experiments, and for proceeding in stages, beginning with facets that can be more readily legislated and managed.

Finally, I see virtue in exploring more carefully than we have the question of how much economic pressure a society can safely impose on its professional entrepreneurs. In their more pensive moments—usually in their role as patients—most card-carrying economists would probably admit that entrepreneurial as our physicians and dentists surely are, in important respects they do differ from the vendors of fruits and hula-hoops. Such a thought might find respect even at the University of Chicago. It does at Princeton.

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12Alain Enthoven, *Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care* (Addison-Wesley, 1980).