

The Nature and Interrelationships
of the Private and Public Sectors
in Health Services

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THE SPEAKER

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THE OCCASION

Prof. Ginzberg delivered this lecture at the McCormick Inn, Chicago on May 19, 1983.

The Nature and Interrelationships of the Private and Public Sectors in Health Services

INTRODUCTION

I am deeply appreciative of the honor of having been chosen as the twentieth Michael M. Davis Lecturer, the more so because both Davis and I are New York City sons and we both received our baccalaureate and doctoral degrees at Columbia.

Having started down the historical track, I ask your indulgence while I note some further ties. My two principal mentors in economics, Wesley Clair Mitchell and John Maurice Clark, both spent time at Chicago, Mitchell as undergraduate and graduate student, Clark as professor in the late teens and early twenties before coming to Columbia. And no student of Clark's would ever look to the market to provide all the answers for an advanced economy.

I recently had the opportunity to read *Health, Economics, and Health Economics*,¹ a collection of essays edited by van der Gaag and Perlman. In his introductory chapter, the British economist, A.J. Culyer, traced the origin of health economics as a specific discipline in the United States to the annual meeting of the American Economic Association held in Chicago in 1950, when Frank H. Knight was president and Milton Friedman was responsible for arranging the program. Milton asked me to develop a special session on health economics for which—as oldtimers in this audience will recall—I recruited a distinguished cast of speakers, including Franz Goldmann, Seymour Harris, Clarence Kulp, Herbert Klarman, Jerome Rothenberg, with Louis Reed and Frank Dickenson as discussants. Upon rereading my introductory remarks, I concluded that some economists do not change their views, at least not very much.²

I was in Puerto Rico when Odin Anderson tele-

¹J. van der Gaag and M. Perlman, eds., *Health, Economics, and Health Economics* (New York: Elsevier Science Publishing Co., 1981).

²Eli Ginzberg, "Perspective on the Economics of Medical Care," *American Economic Review*, XLI:2, May 1951.

phoned to invite me to give this year's lecture. While I am not much persuaded by ESP, I must note that I was at that very moment reading *Bad Blood*,³ in fact the very section that recounts Michael Davis' relations to the now discredited investigation of syphilis among black men by the U.S. Public Health Service. The research protocol that it followed was so clearly unethical, given the availability of effective pharmacological treatment, that many years later Michael Sovern, then a member of the Columbia Law faculty and currently President of the University, sued and won major damages on behalf of the surviving victims and their heirs.

One more introductory comment: during the past few months I have found occasion to mention to a number of younger colleagues in health policy my assignment as Michael M. Davis Lecturer in order to discover what they knew and thought of Davis and his work. I must report regretfully that not one of my sample of ten had ever heard his name, much less was acquainted with his books and other accomplishments. Hence the University of Chicago is to be twice complimented: not only to have had Davis on its faculty but to have seen to it that his multiple contributions remain in the mainstream of current thought and teaching.

My presentation tonight may be called revisionist. I plan to reinterpret the shifting relations among government, the market, and the voluntary sector that have evolved in the period since the end of World War II. I will then present a critique of the assumptions and analyses of two groups of policy protagonists, those committed to the market and those who look to government intervention to reform the health care system. And I will end by setting forth my own premises and the policy implications that flow from them.

A NEW LOOK AT THE LAST FOUR DECADES

A summary consideration of the conditions governing the flow of capital into health care, the education and training of physicians and other health personnel, and

³James H. Jones, *Bad Blood: The Tuskegee Experiment* (New York: Free Press, 1981).

the changing contours of the demand for health services should illuminate our central theme—the respective roles of government and the non-governmental sector.

With respect to the flow of capital, the federal government assumed a leading role when it passed the Hill-Burton Act in 1946. It is worth noting that the leader of the Republican conservatives, Senator Robert Taft, supported the bill. This new source of governmental funding stimulated the voluntary sector to increase its efforts to raise capital, especially in many small communities that lacked a hospital.

The federal government also took the lead, which the Blues followed, in recognizing depreciation as a proper charge in its reimbursement formula for hospital care. Following the passage of Medicare and Medicaid in 1965, federal depreciation allowances and cost reimbursement created the preconditions for nonprofit hospitals to enter the capital markets and borrow substantial funds for building, renovation and equipment. Government provided another assist through its authorization of tax exempt bonds.

Even this abbreviated account of capital flows into health care must not overlook the fact that the federal government, through the National Institutes of Health and other instrumentalities, as well as many state governments made considerable funds available for capital projects in the field of medical education and research

Finally, all levels of government spent large sums for the erection of new hospitals and the modernization of existing facilities which served patients for whom they had primary responsibility—the military, veterans, the mentally ill and the indigent in need of acute care.

In sum, government and the voluntary sector provided the overwhelming proportion of new capital which undergirded the rapid expansion of the health care sector, surely up to 1970; without government support via depreciation, cost reimbursement, and tax exemption it is unlikely that nonprofit hospitals would have been able to tap the private capital market in the 1970s and early 1980s.

If one shifts the focus to the education and training of physicians and other health personnel—the founda-

tion of a health care delivery system—one again finds state and federal governments in lead roles with the voluntary sector also an important contributor. Responsibility for the training of physicians had long been divided among state governments, nonprofit universities and a limited number of free-standing medical schools, a pattern that continued in the post-war period, supplemented by the belated admission to partnership of the federal government.

The years between 1945 and 1960 saw a relatively slow response by the states to the need for new medical schools and the expansion of existing ones. The voluntary sector also moved slowly, primarily because of the high costs that were involved. Congress indicated its willingness to participate in the effort, a policy successfully thwarted by the AMA which feared that direct federal support for medical education would place the government in the powerful position to dictate future health policy. The AMA did acquiesce, however, to the indirect federal funding of medical education through the inclusion of institutional costs in its grants for biomedical research. The suspicion of market economists that the AMA was committed to a restriction of the supply is probably an oversimplification, although the memory of the depressed 1930s when many physicians had difficulty earning a living undoubtedly influenced the leadership.

The flow of funds via the National Institutes of Health into the academic health centers intensified the pressures in favor of specialization which transformed medical education from a five year program to one of eight or nine years of training. In the process a powerful new constituency came into being—a much strengthened Association of American Medical Colleges and its key academic supporters that operated in close league with Senator Hill and Representative Fogarty, the controllers of the federal purse for medical research.

Despite the ever larger flows of funds into the health care arena, the vast superstructure of graduate medical education—residency training—had no independent financial base. It was supported through reimbursement to teaching hospitals for patient care. I have

referred to this anomalous situation as “the soft underbelly of U.S. medical education.”⁴

The post-war period also witnessed a major shift in the training of nurses, from independent diploma schools of nursing based in nonprofit and government hospitals to colleges and universities where associate degree programs experienced the most rapid growth, and baccalaureate programs gained as well. Today these programs account for about four out of every five new graduates. State and federal funding also became available to educational and training programs both new and old, many located at academic health centers, for a host of allied health professionals and technicians.

Finally, in 1963, the AMA, having decided to concentrate its legislative efforts on the defeat of Medicare, acceded to direct federal support for expanding the supply of physicians and other health practitioners. The next eight years witnessed an outpouring of federal funds for new construction, support for schools in financial distress, incentives to existing schools to expand enrollments, special assistance to minorities and students from low income families, support for residency training in family practice—all aimed at resolving the putative shortage of physicians variously estimated at between 50,000 and 80,000, and, more recently, at improving the distribution of the available supply by specialty and location.⁵

It would be hard to find even a trace of market forces operating in those halcyon days when the feder-

⁴Eli Ginzberg, “Is Graduate Medical Education Meeting the Country’s Needs?,” *Bulletin of the New York Academy of Medicine*, 50:11, December 1974, pp. 1199-1203; and Eli Ginzberg, “Who Should Pay for Graduate Surgical Education: The Economics of Residency Training,” *Surgery*, 70:4, October 1971, pp. 500-502.

⁵See Eli Ginzberg, Edward Brann, Dale Hiestand, and Miriam Ostow, “The Expanding Physician Supply and Health Policy: The Clouded Outlook,” *Milbank Memorial Fund Quarterly/Health and Society*, 59:4, Fall 1981, pp. 508-541; and Eli Ginzberg, “The Future Supply of Physicians: From Pluralism to Policy,” *Health Affairs*, 1:4, Fall 1982, pp. 6-19.

al government, with support from the states, poured ever larger sums into medical research and medical education to speed the discovery of new knowledge and to assure its widespread application.

We come now to the third prong—the changing contours of the demand for health care. In my view, the story begins with World War II when fifteen million men in uniform (and many of their dependents) were exposed to a high level of medical care, many for the first time in their lives. I recall being told by a much decorated sergeant who had been rotated back to the United States that his current assignment at Fort Meade, Maryland, was to instruct recruits from the Tennessee mountains in the use of soap and running water. More to the point: the U.S. Army lost only 4 percent of all casualties who were reached by a medic during the course of the battle, a record that made a deep impression on the soldiers and their families.

It is often overlooked that hospital insurance did not really take off until World War II when the Wage Stabilization Board ruled that the provision of hospital benefits under new contract settlements did not violate the national wage stabilization statute. Moreover, the government provided further impetus to the growth of hospital insurance when the IRS issued a definitive ruling in 1954 that such benefits qualified as legitimate business expenses for employers and did not constitute reportable income for employees. For some three decades it has been the explicit and implicit policy of the federal government to encourage employers to improve the health benefits of their employees. It is only in the last few years that some moralistic economists have begun to rail against this “give-away,” convinced that if tax deductions were capped a large part of the cost inflation in health care would vanish, an assertion that has failed to elicit any broad support among employers, trade unions, insurance companies, or other informed parties.

The striking advances in therapeutics during the post-war period were a major spur to the efforts that were mounted in the 1950s and the 1960s (Kerr-Mills, Medicare and Medicaid) to assure that the elderly and poor would have access to acute hospitals and the same range of services enjoyed by employed workers (and their dependents). Once again, federal and state

governments were in the lead to broaden and deepen the demand for health care.

The revisionist views sketched above underscore the fact that prior to World War II the health care system was in large measure a shared function of the voluntary sector, which had primary responsibility for the establishment and operation of the nation's hospitals, and of state government, which in tandem with the voluntary sector was responsible for the education and training of physicians, nurses and other health personnel. In addition, state and local government, again alongside the voluntary sector, provided most of the care for the poor as well as the patients suffering from serious chronic disease such as tuberculosis and mental illness.⁶

In the post-war period it was the federal government that assumed the leadership role by encouraging the expansion of hospital insurance, contributing to hospital construction, financing biomedical research, and (after 1963) allocating large sums for medical education to expand the supply of physicians and for vast entitlement programs to provide access to care for the elderly and the poor. There are those who, like David Stockman, write about the necessity of reestablishing the market as the dominant instrumentality for the production and distribution of health care to the American people. But history does not support their argument.⁷

Let us examine the assumptions and analyses first of the market advocates, then of the proponents of a larger role for government. Clearly I must be selective in the analysts whose work is reviewed. I have deliberately skewed my selection in favor of economists with linkages to the University of Chicago which has been in the forefront of those who support the market.

A good place to begin is Milton Friedman's dissertation, *Income from Independent Professional Practice*, which demonstrated, by means of a complex

⁶Eli Ginzberg, *A Pattern for Hospital Care, Final Report of the New York State Hospital Study* (New York: Columbia University Press, 1949).

⁷Eli Ginzberg, “Stockman's Medical Marketplace Reexamined,” Letters Section, *Health Affairs*, 1:2, Spring 1982, pp. 118-120.

analytic exercise, that organized medicine, through the control of admissions to medical school, extracts rent for physicians; this is proved by the fact that physicians earn more than dentists after account is taken of differences in their period of training. Two questions: does it make sense for a society to provide medical education for all who want to enter the profession? I doubt it. And second, will the public not be willing to pay more for an hour of work by a surgeon whose judgment and skill can make the difference between life and death, than a dentist who relieves them of a painful molar? Adam Smith had addressed this issue and had come out on the other side. No proof that he was right, but cause for caution.⁸

In the late 1950s, Reuben Kessel published his far-ranging analysis of physician behavior, indicating how organized medicine at national, state and county levels pursued policies that reinforced the professionals' ability to act as price discriminators with the aim of blocking the introduction of new systems of health care delivery that could jeopardize fee-for-service practice.⁹ Several points: the world that Kessel described with knowledge and insight is no longer the medical environment of the early 1980s. Yet fee-for-service still dominates. The monetarization of the health care system subsequent to the passage of Medicare and Medicaid put an end to the considerable amount of "unrequited" labor that physicians used to perform both in their offices and in hospitals at which they had admitting privileges. It has never been clear to me that such monetarization was an unequivocal social gain and the fact that many physicians are once again providing services free of charge, at reduced fees, or on credit for large numbers of persons who have lost their insurance coverage bears on this point.

Martin Feldstein, who also has a spiritual affinity for Chicago, has argued for years that first dollar coverage is bad and that only high co-payments can

⁸Adam Smith, *An Inquiry into the Nature and Causes of the Wealth of Nations (1776)*, (Homewood, Ill.: Irwin Press, 1963).

⁹Reuben A. Kessel, "Price Discrimination in Medicine," *Journal of Law and Economics*, 1:20-54, October 1958.

control runaway hospital costs.¹⁰ I have never understood how a market economist can deny consumers the right to buy products that they desire nor have I understood how he can reconcile high co-payments with the principle of hospital insurance which was introduced for the explicit purpose of protecting the individual from sudden, large outlays.

Clark Havighurst, Chicago once removed, formulated the most cogent argument that more competition offers a superior alternative to more regulation. Up till now, the arguments for and against competition in health care have been exchanged in scholarly journals to which I have of late been a prolific contributor.¹¹ But we will soon see the debate move from paper to reality. If I were a betting man, I would predict that increased competition will result in the flow of more resources into the health care system, a further stimulation of demand, and a substantial increase in the proportion of the GNP directed to health care.

It would be wrong for me to omit Enthoven from the list of market advocates even though I know no way to tie him directly to Chicago. Three quick points:

¹⁰Martin Feldstein, *Hospital Costs and Health Insurance* (Cambridge: Harvard University Press, 1981).

¹¹See Eli Ginzberg, "Cost containment—Imaginary and Real," *New England Journal of Medicine*, 301:20, May 19, 1983, pp. 1220-1224; "Competition in Health Care: A Second Opinion," *Hospitals*, 56:6, March 16, 1982, pp. 81-85; "The Grand Illusion of Competition in Health Care," *JAMA*, 249:14, April 8, 1983, pp. 1857-1859; "Health Institutions and Market Incentives," *Bulletin of the New York Academy of Medicine*, 58:6, September 1982, pp. 545-555; "Health Care Forecast: Adapt to Changing Environment," *Hospital Progress*, 63:3, March 1982, pp. 8-12; "Human Resources as Regulators," *The New Regulators*, A Report of the Ross Health Administration Forum, Sept. 23-25, 1982; "Reforming the Health Care System—Potential and Limits," *Proceedings*, Conference on Demand for Health Care Services sponsored by the Blue Cross and Blue Shield Associations, April 6-7, 1982, Rosemont, Ill., pp. 27-48; "Patient Charges, Reimbursements, and Health Care Costs," *Proceedings*, Council of Medical Specialty Societies Invitational Conference to Examine the Roles, Relationships and Issues of Physician and Non-Physician Health Care Providers, October 26-27, 1981, Chicago, pp. 34-40.

Enthoven, to his credit, believes that government must regulate competition among insurers and prepayment groups. Further, he recognizes the need for special provisions (through government) to assure that persons of limited or no income have access to the system. However, much of his competitive strategy was based on the apparent success of the Federal Employee's Health Program Benefits just a short time before it revealed serious deficiencies resulting from adverse selection.¹²

A few more germane comments about the advocates of the market. They deal with health care as if it were a standardized product, with little or no consideration of the inevitable control that the physician exercises over its production and the importance that attaches to quality.¹³ They also neglect or minimize the role of caring in the relation between the physician and his patient. They have no ready explanation for the slow growth of prepayment plans even after the active opposition of organized medicine had been eliminated. With the conspicuous exception of Enthoven, they are silent about how the market will provide access to essential services for the poor and the medically indigent.

The principal contribution of the market proponents to the ongoing debate about health policy has been to sharpen the analysis of the issues. In my view, however, they have contributed very little to policy guidance.

Let us now turn our attention to the exponents of social reform—among whom Michael Davis was a long-time leader—who prefer an enlarged role for government in the direction of the health care system. They have emphasized the following arenas of reform:

- The expansion of prepayment plans.
- A shift in orientation from therapeutic to preventive services.
- The greater use of paramedical personnel.

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

¹³Eli Ginzberg, "Services, Health Services, and the General Welfare," in *Working for a Healthier America*, Walter McNerney, ed. (Cambridge: Ballinger, 1980).

—An enlarged role for consumers in health planning.

—The introduction of national health insurance.

A few brief, critical comments on each of the foregoing objectives. I have long been impressed with the indifferent performance of HMOs in Washington D.C. and New York City and their relatively slow growth in their home state of California where the soil is favorable to the culture of exotic plants. I have also been impressed with the degree of continuing uncertainty about their lower hospitalization rates—a range of 10 to 40 percent is too large for comfort. Finally, cost escalation in HMOs has apparently paced cost escalation in the rest of the system.

No one will quarrel with the desirability of greater emphasis on preventive services but the question that requires answering is, just what preventive measures that have proved themselves are not being utilized more or less to the full? If the answers relate to the control of smoking, drinking, exercise, diet, then one has shifted the focus from prevention to prudence—a rarified level of behavior since the beginning of time and one which, the efforts of religious leaders and philosophers notwithstanding, we have never learned to inculcate or practice.

As a long time student of human resources, I clearly favor the optimal use of paramedical personnel. However, we now staff our health care system with fifteen ancillary workers to every one physician, up from three to one at the turn of this century. Admittedly, we could move to extend still further the use of paramedics but it is worth mentioning that Kaiser-Permanente and other large delivery systems (the military and the Veterans) have encountered difficulty in absorbing large numbers of nurse practitioners effectively.

Our recent experience with area health planning in which consumers played a prominent role must surely raise questions as to the utility of widening the scope for community participation in policy formulation. For better or worse, policy is carried out by the providers and they must be key participants in decisions to effect any significant, even minor, changes in the system. Consumers should have the right to propose changes, but only providers can implement them.

As for national health insurance, after having been

on the nation's agenda since the Bull Moose campaign of 1912, it may yet stage a comeback if we fail to find viable solutions to the financing and delivery problems that appear to be multiplying. But the odds are that even under such a pessimistic scenario, we will try other nostrums before resorting to NHI.¹⁴

In short, I am not persuaded by the preferred solutions of the pro-government exponents. They too, like their market cousins, have little to offer by way of policy guidance.

PREMISES AND POLICY DIRECTIONS

Now that I have offered my reconstruction of the post-war evolution of the medical care system and have reviewed critically the assumptions and conclusions of the market analysts and the social reformers, it is incumbent on me to clarify my preconceptions and to set forth my recommendations for change.

To begin with my premises:

- The American people have exaggerated expectations of the potential of modern medicine, and this creates the backdrop for policies that, even if well designed and implemented, will be found wanting. The most striking and aberrant of all the conventional beliefs is that the physician has the skill and power to postpone indefinitely the patient's death. In fact, death has no part in the public's expectational system with respect to medicine.
- For a variety of reasons, some planned and others fortuitous, expenditures for the institutional sector of the health care system—hospitals and nursing homes—rose from under one-third to over one-half of total outlays in the post-war period, thereby contributing substantially to the rapid increase in costs.
- In response to the growing gap during the early post-war years between the greatly increased demand for medical care and the inelasticity in the supply of physicians, the state and federal governments undertook in the late fifties and

¹⁴Daniel S. Hirshfield, *The Lost Reform* (Cambridge: Harvard University Press, 1970).

early sixties a program of accelerated expansion that vastly overcompensated for any actual or presumed shortages. Even at this late date there is no general perception by the public that the country is producing too many physicians and that there are dangers, both therapeutic and economic, linked to an oversupply of physicians.

- The monetarization of the health care system that reached its apotheosis with the passage of Medicare and Medicaid obscured an earlier rule, appreciated by providers and consumers alike, that is, that all decisions about medical care must be related to economic resources. No societal function, not even medical care, education or defense, can expect to have an unlimited credit line to the U.S. Treasury.
- The contrast between the many words that have been directed this past decade to "cost containment" and the slow progress, if any, that we have achieved should be a warning that effective responses are difficult to design and still more difficult to implement. Most of what parades as cost containment is nothing more than expenditure control.¹⁵

Let me identify, primarily for illustrative purposes, a few of the policy directions that flow from the foregoing premises. With respect to unbounded expenditures, the time is long overdue for the initiation of a broad discussion by the public, physicians, jurists, religious leaders, and politicians about the choices that must be permissible in the case of terminal patients. I recall a senior surgeon who revealed to me that, seeing General MacArthur in the ICU, he was unable to tell whether the General was alive or dead. The practice of hooking patients to life-prolonging but not life-improving apparatus for days, weeks and months clearly requires reexamination, the more so because such action in many instances is not in conformity with the desires of the patient or his responsible relatives.¹⁶

¹⁵Eli Ginzberg, "Cost Containment—Imaginary and Real," *New England Journal of Medicine*, 301:20, May 19, 1983, pp. 1220-1224.

¹⁶Eli Ginzberg, "More Care Is Not Always Better Care," *Inquiry*, 19:3, Fall 1982, pp. 187-189.

It is about three years since GMENAC alerted the country to the substantial oversupply of physicians that looms ahead, but thus far there has been relatively little response from the medical or political leadership. Most recently, Dr. Alvin Tarlov, the chairman of GMENAC, provided an update on the problem and the steps that should be taken. But it remains to be seen whether those with the primary responsibility to act will continue to play possum.¹⁷ Dr. Francis Moore of Harvard has made use of a spatial model to indicate the geographic location of surgical specialists through the final decades of this century, an exercise that points to the probability that as the year 2000 approaches only the smallest communities, those of 5,000 to 15,000 population, will be able to absorb any new practitioners.¹⁸

Multiple opportunities exist to reverse long-term trends that have favored inpatient over ambulatory care settings as the preferred locus for treatment. To begin with, variations of 100 percent or more in hospital days per 1000 population speak to the influence of physician practice modes in determining patterns of hospital care. The frail elderly have repeatedly stressed their preferences to avoid placement in nursing homes in favor of remaining in their own homes and in their own communities. Congress recently offered terminal patients the choice of hospice care over treatment in an acute hospital. Insurance companies are belatedly writing policies with mounting incentives favoring patients who opt for the performance of specified procedures in an ambulatory setting. Massachusetts General Hospital has increased the proportion of ambulatory surgery it performs to over 30 percent of all cases. The area where we have made the least progress and where gains will come slowly is in the regionalization

¹⁷Alvin R. Tarlov, "Shattuck Lecture—The Increasing Supply of Physicians, the Changing Structure of the Health-Services System, and the Future Practice of Medicine," *New England Journal of Medicine*, 301:20, May 19, 1983, pp. 1235-1244.

¹⁸Francis C. Moore, "A Community-Size Model for Physician Distribution in the United States: I," *Journal of Clinical Surgery*, 1:3, 1982, pp. 162-173; and "A Community-Size Model for Physician Distribution in the United States: II," *Journal of Clinical Surgery* 1:4, 1982, pp. 242-255.

of highly specialized care, where duplication of costly, underutilized services is economically wasteful and carries no inconsiderable therapeutic risk.

The principal payers for medical care—federal and state governments, and business and labor (through their participation in group insurance coverage)—are belatedly bestirring themselves to slow the flow of funds into health care. Walter Mc Nerney, the Michael Davis lecturer in 1982, reviewed developments with respect to business Health Care Coalitions.¹⁹ Since that time the Secretary of HHS has complied with the Congressional directive to propose a system of prospective payment for Medicare patients and DRGs that will be operational before the end of this year. But it would be naive to expect even a much enlarged and strengthened number of business Health Care Coalitions and well-functioning DRGs to bring financial stability to the U.S. medical system. The prospective deficit for the Medicare Trust Fund for 1995 is in the \$300 billion range and, as Paul Ginsburg of the Congressional Budget Office recently noted, nobody in Washington is yet facing up to this issue.²⁰ Congress will delay as long as possible cutting back on entitlements, levying new taxes and surcharges, raising co-payments, and otherwise forcing the private sector via insurance and out-of-pocket payments to cover more of the total health care bill. But if government is to moderate its outlays, it has only two alternatives: to reduce services or to extract more funds from the non-governmental sector—or to do both. In the event, however, that services are cut back, there is a serious danger that the poor and the medically indigent will fall through the net, an outcome to which only the most myopic would be indifferent.

Given an imbalance of dollars and services and the projection of an even greater imbalance in the years ahead, there is no easy way to restore equilibrium. No

¹⁹McNerney, Walter J., "Health Care Coalitions: New Substance or More Cosmetics?", Michael M. Davis Lecture Series, Center for Health Administration Studies, Graduate School of Business, University of Chicago, 1982.

²⁰Paul B. Ginsburg and Malcolm J. Curtis, "Prospects for Medicare's Hospital Insurance Trust Fund," *Datawatch* section, *Health Affairs*, 2:1, Spring 1983, pp. 102-112.

interest—the federal government, private insurance, the medical profession, the hospital establishment, the academic health centers, industry, or the trade unions—has the power to shore up the system, and surely not if each acts independently. Neither greater reliance on the market nor greater governmental direction holds the answer. Ours has long been a “mixed” health care system—supported by government, insurance and out-of-pocket payments by consumers—with physicians and hospitals making many of the critical decisions. Academicians and policy analysts have been able to design on paper improved health care systems that are at once efficient and equitable but they have glossed over the complexities of transforming ideas into institutions and behavior. We have no option but to continue along the path that we have been going, seeking to introduce feasible changes while preserving the many virtues of the mixed system that has evolved.

The following are some guidelines for selecting among the various changes that have been and will be proposed:

- The desirability of shifting the locus of treatment from high cost inpatient settings to ambulatory settings.
- The need for experimentation with new forms of health care delivery that advance beyond the classic two—fee-for-service and prepayment.
- The urgency of measures to reduce the excess capacity of hospital beds, the proliferation of costly services, and the training of health professionals and technicians beyond present and prospective requirements of the system.
- The need to assure sufficient new funds, even in a period of constricted finances, to encourage the development of the new knowledge and innovative techniques which hold the greatest promise of true long-term cost constraint.
- The moral and political imperative to maintain access to the system for those who lack the means to pay their own way.

It would be desirable, if time permitted, to flesh out each of the foregoing and to indicate how the extant system might be modified so that it will move in the desired direction. I can only call attention to a forth-

coming long article (*Inquiry*, Fall 1983), where I address this challenge.

In closing I will share with you an excerpt from the preface to *The Social Control of Business*, written by my teacher, J.M. Clark, some sixty years ago, in the mid-1920s, when he was a member of the Chicago Department of Economics:

The principle of free exchange offers expression to certain needs, and opportunity to certain interests to organize themselves into a sort of partial community. But this partial community of free exchange never includes all the interests that make up a complete community; and a complete community, capable of sustaining life, can never be made up of the transactions of free exchange alone. The community of free exchange cannot maintain itself except in the enveloping medium of a broader community life, which furnishes the conditions on which free exchange depends and stands ready to do the innumerable things it leaves undone and to care for the interests which it neglects.²¹

I wish to acknowledge with thanks the assistance of my colleague, Miriam Ostow, in preparing this lecture for publication.

²¹John M. Clark, *The Social Control of Business*, 2nd ed. (1939), (Fairfield, N.J.: Augustus M. Kelley).