Review: Fuchs' Who Shall Live? Health, Economics, and Social Choice

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Fuchs' *Who Shall Live? Health, Economics, and Social Choice*

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■ In *Who Shall Live?*,[1] Victor Fuchs produces a broad but concise critique of the nation's health care system. His exposition is lucid. His arguments, if not always convincing, are at least provocative. And he succeeds in his expressed intent to transmit "the big picture" to the lay reader. His message to economists, however, is his disclosure of the extent of our ignorance of the determinants of health, the behavior of physicians and hospitals, and the economics of nonprofit institutions generally.

The analysis repeatedly stresses four themes. First, the total contribution of modern medical care to life expectancy may be substantial, but its marginal contribution at the current level of technology is in fact quite small. Hence, a national policy to improve health is not synonymous with increased expenditure on medical care. Second, there is considerable room for improving technical efficiency within the medical care sector. Despite the popular conception of a fixed set of scientifically dictated treatments for each disease, a wide variety of treatment modalities can, in fact, be substituted without apparent effect on health outcomes. Third, the market for medical services operates inefficiently. There is an excess supply of sophisticated offerings in the face of an excess demand for primary or "first encounter" services. And fourth, the central feature of the health care system—in fact the key concept in understanding its inefficiencies—is the absolute dominance of the physician as decision maker in the production and distribution of medical services. Therefore, any strategy to improve the technical efficiency or the distributional equity of medical care requires informed modification of physicians' incentives and behavior.

The title chapter details the case for the lack of correlation between medical care expenditure and health outcomes. The introduction of antibiotics in the 1930s permitted medical care to play a significant role in improving health, but this and similar therapeutic advances have now been widely diffused among developed countries. As a result, it is asserted, the level of medical care expenditure does not correlate with life expectancies. Improvements in the health of populations over time may be achieved by future scientific advances; but not through increases in the quantity of existing types of medical care. For empirical support, Fuchs relies on infant mortality studies and analyses of the effect of income, race, education, and marital status on mortality. His primary supporting evidence, however, is that the leading causes of death in the U.S. comprise (in the younger age group) accidents, suicide, and homicide, and (in the older group)

[1] Victor R. Fuchs, *Who Shall Live? Health, Economics, and Social Choice* (New York: Basic Books, Inc., 1974).

heart disease, cancer, strokes, and cirrhosis. The incidence of all of these, it is contended, is determined more by genetic factors, environment, life style, diet, smoking, alcohol, and similar variables, rather than by the level of medical care expenditure. Therefore, "[t]here is no reason to believe that the major health problems of the average American would be significantly alleviated by increases in the number of hospitals or physicians" (p. 54).

This conclusion must be accepted cautiously. Mortality rates as measures of health do not adequately reflect many dimensions of the quality of life. And it would be erroneous to dismiss this problem as Fuchs does (p. 16) merely by assuming that most deaths are preceded by unalterable periods of illness. In fact, the construction of a statistically reliable health status index which is sensitive to morbidity, disability, and symptomatology remains an important research task. In addition, the data presented by Fuchs indicate only that levels of medical care expenditure fail to explain all of the differences in mortality rates. This does not mean that the marginal effect of an additional medical care dollar is trivial. In linear regression terms, its coefficient may be significant no matter what the R^2 is. Further, many of the behavioral factors which explain variation in death rates (e.g., education) may be highly correlated with increased access to or better use of medical facilities. Finally, to regard some aspects of health as influenced more by behavior than by medical care is to ignore the potential role of health care in influencing such behavior.

Fuchs tempers his argument by acknowledging the role of future scientific advances, but this important qualification is never taken seriously. This is regrettable but understandable, for little is known about the nature and role of technical change in health care. Since much of this innovation is in fact accomplished by experience with existing clinical procedures, the distinction between what is scientific "research" and what is actual medical "practice" breaks down. It might be contended, for example, that the Acute Leukemia Group B protocols exhaust vast resources with only marginal increases in survival (and possibly more suffering) for those afflicted. Yet this underestimates the potential yield of such a clinical endeavor in terms of new understanding of the disease. The role of such learning-by-doing will be especially significant now that the mode of innovation is shifting in the direction of new types of health care organization rather than more sophisticated capital equipment. In sum, to take the position that medical care has no marginal contribution to health outcomes would be erroneous and dangerous.

In the remaining chapters, Fuchs shifts attention directly to the medical care industry. Again, his bias against the expansion of medical care expenditures is clear. Increases in the supply of hospital beds or physicians or insurance coverage will not substitute for basic and necessary revisions of an inefficient and inequitable system. In every case, the key to the appropriate policy is informed modification of physicians' incentives.

In the market for physicians' services, for example, almost all of the patient population seeking care requires no specific treatment other than the provision of basic information and reassurance (what Fuchs terms "caring" as opposed to "curing"). Other trained personnel could clearly function as near perfect substitutes for physicians in these cases. But current licensure laws have permitted only a

minimum of this type of innovation. Further, the remaining fraction of patient visits requiring specific therapeutic intervention are mostly of the "primary encounter" type, that is, those seeking initial access to the system. Yet training programs continue to turn out a brand of sophisticated physician equipped only for referral practice. Motivating these inefficient adaptations is a system of remuneration which makes fees dependent upon the sophistication of the inputs employed—not the outcome of treatment. Here, as a remedy, Fuchs supports the introduction of capitation fees for physicians. Also advocated are an expansion of the use of physician extenders and training of more primary care physicians.

Hospital cost inflation is similarly attributed to underlying distortions in incentives. Resource allocation decisions in hospitals are made not by administrators or financial intermediaries, but in reality by physicians, who are motivated by a "technological imperative" to expand the quality of services without constraint. This tendency to excess expenditure is reinforced by a system of financing which reimburses according to costs instead of outputs and which unnecessarily shifts incentives in the direction of long and expensive inpatient stays. Here, the recommendation is to couple prepaid capitation plans with institution-based licensure of physicians, prospective output-based reimbursement schemes, and a moratorium on hospital expansion.

Drug manufacture is also tainted with a basic institutional weakness: "the almost total absence of any connection between the retail sale of drugs and the practice of medicine" (p. 126). As a result, the physician has no financial stake in the cost of drugs. This condition perpetuates professional ignorance of drug costs, naivete of drug utilization, and ultimately the monopoly in the pharmaceutical market. Here, Fuchs proposes the inclusion of prescription drug costs in prepaid capitation plans.

The discussion of alternative financing systems considers a number of issues—universal versus selective coverage; comprehensive versus major-risk insurance; decentralized, competitive private plans versus a centrally administered federal system. But the underlying criterion is the effect of the form of financing on the efficiency of medical practice. Here, universal, comprehensive coverage offered under competing private prepaid capitation plans is proposed. In support of this recommendation is the cost reduction achieved by existing prepaid plans (e.g., Health Maintenance Organizations) without objective evidence of decreased quality of care.

Most of the issues Fuchs raises have been well aired in the health economics literature. His solutions, as he acknowledges, are certainly disputable. But his casting of the physician as the central character in the drama is unorthodox, perceptive, and undoubtedly the book's most significant achievement. In this portrayal, the physician is not the banal income-maximizer, but a decision maker under uncertainty, motivated by peer and patient approval, life-style considerations, intellectual needs, and what Fuchs terms "an instinct for workmanship" (p. 60). Equipped with this enriched characterization, Fuchs is able to apply a rather stringent test to alternative policy proposals—namely, what will be their effect on the nature of the physician's medical practice. The application of this technique, however, has a serious limitation. Not much is, in fact, known about physician moti-

vations, hospital internal operations, or for that matter any "nonprofit" institution with supposedly social, nonpecuniary motives. Perhaps Fuchs comes closest to these central issues in his brief references to the role of uncertainty and "trust" in economic relations and to the desire to fix responsibility in the physician-patient relation (p. 62). Beyond this, these issues are never directly addressed. Yet if "informed modification of physician behavior" is to be achieved, then an entire set of related economic phenomena must be understood—the sources of physician dominance, the special relation between physicians and hospitals, the diffusion of command and multiplicity of objectives in hospitals, and the limits to which the physician-patient relationship can be stretched.

A new research strategy aimed at a precise understanding of the behavior of health institutions is therefore required. To this end, the theoretical fiction that hospitals are self-contained entities interacting on market terms must be abandoned. In its place, a more micro-analytical view of the internal operations of these institutions is needed. Such a theory should recognize the importance of understanding nonmarket interactions between physicians, hospitals, insurance intermediaries and governments. Prediction of the consequences of such institutional changes as universal insurance or prospective reimbursement would therefore proceed by explicit recognition of their effects on such nonmarket transactions within the enterprise. This would represent a considerable improvement over the usual comparative statics methodology.

Fuchs' attitude throughout the analysis is naturally that of the welfare economist—the attainment of national health, like any other objective, requires obedience to the basic rules of social choice. To make rational allocation decisions, we must avoid illusions that the health care sector's resources are unlimited or have no alternative uses and that individual preferences are always consistent with health goals. Consummate "health as a right" is therefore viewed as authoritarian and romantic. And the assumption that medical care is the exclusive method of making us healthy is dismissed as too rigid. The book is, basically, an attempt to produce a well-informed perspective for making such choices. But in this pursuit Fuchs stumbles upon the book's central paradox. The physician as nuclear decision maker is asked to obey contradictory impulses. He must at the same time follow the rules of equalizing marginal values and yet adhere to the ethical dictum to "do everything possible" for his patient—a rule which compels him to behave as if the marginal cost of the health inputs he commands is vanishing. Somehow, he must balance social "rights to medical care" with what Charles Fried has called the patient's "rights in medical care." The solution, perhaps, is to train physicians in the rules of welfare economics—or better still, to put some economists at the bedside.