Values in Health Policy and Health Services Research

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Needless to say it is both a great honor and pleasure to be able to be with you all today and participate in this meaningful event. There are few more meaningful rewards for teachers than to see one of their students rise to heights that surpass their own accomplishments—and then be accorded, even if incorrectly, some credit for the way she or he turned out. Parents have that same reward, but in those cases the pride is sometimes mixed with a certain inability to deal with the fact that the son's or daughter's salary exceeds one's own. That problem doesn't arise in the academic community, as presumably our satisfactions derive from psychic rather than monetary income. Academics can just sit back or, as in my case, stand up and enjoy.

The invitation suggested that I speak about “health policy and health services research and values” and I assure you I'll get around to some of those topics, but first I want to say a few things about Harold Luft. I note that I cannot use the famous words we now find at the end of many articles “no potential conflict of interest relevant to this article was reported.” If I did not report any conflicts I would not be telling the truth (which, of course, may occasionally be the case when the statement is found in print). Transparency requires that I report a very real conflict of interest: I have every incentive to say good things about Hal since in doing so I validate what I wrote to Phil Lee in 1978. Let me quote the last paragraph from my letter responding to the request that I “evaluate Harold Luft for the available position in the Health Policy Program at UCSF:” I wrote “Aware that my enthusiasm is great, I am also aware that

Editor's note: This essay is based on an invited presentation at a “Festschrift” held on September 18, 2008 to honor Harold S. Luft upon the occasion of his retiring as Director of the Philip R. Lee Institute for Health Policy Studies, School of Medicine, University of California, San Francisco. It has been altered slightly for publication at HSR. This essay honors Dr. Luft's roles as health economist.

you might misinterpret it thinking that Fein writes letters of high praise about all former students. That is not the case. I sincerely believe that if I were permitted to gamble only on one younger medical economist, Hal would be the individual I would gamble on. More importantly, I would not consider it much of a gamble. That is the case because I place a very high value on the abilities that I know Hal has: he can separate the trivial from the important in selection of topics; he can be imaginative and rigorous in his use of data; he knows his economic theory and yet has not lost sense of the importance of returning to the real world; he understands the need to translate his findings to the noneconomist and the importance of inferring policy implications instead of standing paralyzed in the face of uncertainty. These attributes are valuable, perhaps in part because they are in such scarce supply.” In saying all that I assure you I was not prescient, only smart. Hal had already exhibited all those qualities.

As you can see I wrote about some of the very same topics I am supposed to speak about today: health policy, health services research, and—implicit in the selection of topics to study and the way they are studies—even a bit about values. I suppose I could sit down at this point—and Hal might even wish I would stop while he’s ahead—but I won’t (and he can relax, I assure him he will not fall behind). I want to stay up here a bit longer and live in Hal’s reflected glory.

The first time that anything related to the health sector enters onto Hal’s resume is in the summer of 1970 (though clearly he had been involved even earlier with what Harvard had to offer in health economics—a lot by the standards of the late 1960s and very little by today’s standards). It would be hard to call health care economics, health economics, or medical economics a field when Hal began. I will not list the individuals who were doing health economics lest I forget someone, but I doubt there were more than five economists over age 40 who had made a long-term commitment to that area. If I include those few who defined themselves as in “public finance” or “labor economics” while doing some health care research, I can get the number up to 10. Part of the explanation, of course, lies in the relatively small role that health care played in the American economy (that is, if we exclude the impact of ill-health on productivity and on the GNP and, typically, that was excluded). Part of it lies in the lack of interest by economists in what can be termed

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“applied economics”—with the exception of agricultural economics and labor economics.

For reasons that need not be explained, I own all the Economic Reports of the President and of the Council of Economic Advisers from the very first one issued, as required by the Full Employment Act, in January 1947 to the latest in February 2008. We can trace the development of the field that Hal helped build as reflected by the attention paid to health issues over those 60 plus years. It is worth doing so in order to more fully appreciate the changes in the attention played to health and health care issues over that period of time. Importantly, we can also note the changes in perspective on health and in policy recommendations and discern the relationship between what the Reports spoke about (and how they spoke) and ideology, values, and health services research.

During the Truman presidency, Reports either totally ignored the subject of health or, at most, made passing reference to it. At the maximum, there were a few sentences about the importance of public health to help prepare people who are suffering from physical unfitness to earn a living, a few sentences that the health sector could help create jobs, and a few sentences on the need to insure individuals against the loss of income from illness and disability and in order to increase access to “essential preventive and curative medical services.” The President urged “early consideration” of his program on medical care; in 1949, he called for the enactment of national health insurance “this year” (The Economic Report of the President to the Congress 1949). As defined in and by the Reports, economics was about monetary and fiscal policy, productive capacity of capital, interest rates, balance of payments, and so forth.

That did not change appreciably under President Eisenhower. The absence of any attention to the health sector is perhaps highlighted most dramatically in the 1955 Council Report, which contained a section on “Building the Floor of Personal and Family Security” (Economic Report of the President 1955). This section discussed such topics as meeting the hazard of unemployment, extending economic security in retirement, augmenting low incomes, protecting workers’ savings, and improving homes and neighborhoods. It did not include health. Nor does anything related to health appear in the list of 33 specific legislative recommendations by the Council. Again, in some Reports there was a sentence or two that stated better health was a good thing, that America needed some form of catastrophic health insurance and/or greater access to health insurance for retirees. In 1957, three full paragraphs told us that we’d made a lot of progress in conquering disease and extending

life expectancy. Thus, "The struggle for better health and longer life is a continual one, however, and huge returns are still to be expected from relatively small outlays for additional research on crippling and killing diseases" (Economic Report of the President 1957). This was followed by a long paragraph extolling the various initiatives of the administration: more funds for the NIH, for construction of hospitals and research and water pollution facilities, for health personnel training, and for periodic health surveys. Finally, a sentence on the need to encourage expansion of voluntary health insurance through a form of pooling arrangements. Apparently, three paragraphs were more than enough. During the remainder of President Eisenhower's term the Council referred to health again only in passing and then only to extol the administration's accomplishments, which were defined as providing more dollars for the NIH, veterans' care, and other existing programs. Nevertheless, there is nothing to suggest that health and medical care were viewed as relating to the economy.

Enter Jack Kennedy, a president who believed that economics had something to say on every subject and a new Council of Economic Advisers and staff which (and here as a member of the staff of that council, I am very biased) had more credentials than any council or staff before or since: three future Nobel prize winners in economics, numerous chairmen of prestigious economics departments, and so on and so forth. Though the staff was very small (some 19 economists and statisticians), one slot (which I filled) was allocated to the broad field of health, education, welfare, and other "do-good" programs. This Council's first Report in 1962 focused attention on the issue of economic growth and within that domain devoted more space to health care than any previous Report. It is of more than passing interest to note that it was the first Report to explicitly address the issues of racial discrimination when it stated, "Racial discrimination is a national disgrace. In this respect, above all others, practice in the United States is a standing affront to professions of democratic principle. Discrimination inflicts immeasurable human and social costs on a large number of our citizens. In addition—and this is why it deserves particular mention in this Report—it inflicts an economic loss on the country" (Economic Report of the President 1962). I am proud that we devoted more space and more analysis to the subject "the elimination of racial discrimination" than to "health." In my judgment we had the right priorities.

The over a page on health spoke of the days of work lost because of illness (which, even in those days of union strength, exceeded the number of days lost because of industrial disputes by a factor of 20), emphasized the loss of productive capacity (which exceeded the cost of treatment), and—following

tradition—called for more: more dollars for research, more physicians, more teaching facilities, more, more, more. Note, however, that we did say that we would need more physicians “even if needed improvements [not spelled out] are made in the organization and financing of medical care” (Economic Report of the President 196 pp. 120–121). We knew what we meant; Washington had heard about Kaiser-Permanente. Nevertheless, the words “prepaid group practice” were not permitted to cross anyone’s lips and Paul Ellwood had not yet invented the acronym HMO (which in those days, therefore, were taken to refer to the Hadassah Medical Organization).

Yet the emphasis on health in an Economic Report was short lived. Health did not appear again until the 1965 Report and then it did so in the context of a chapter on the economic tasks of a Great Society. I note, however, that the discussion was hardly analytical: the Report extolled accomplishments, paid attention to chronic disease and to heart disease, cancer, and stroke, emphasized the need to improve availability of health services for children, and called for “enactment of hospital insurance for the aged under Social Security” (Economic Report of the President 1965). Put simply: the words changed from year to year, but the message remained quite the same. This is not surprising: the world was much simpler and so, too, was America’s health care delivery system. The pressing issue was health insurance (especially for the aged and other vulnerable populations). But the world was changing (and not merely because Hal was now studying economics at Harvard: after all, correlation does not imply causality).

In 1966, the economic Report devoted some seven pages to its discussion of health. It talked about the costs of ill health, disparities in access to health care and in health status, medical research, and the dissemination of knowledge, medical facilities, and manpower, fragmentation in the administration and organization of public health services, and the financing of health care (Economic Report of the President 1966). Though the emphasis still was on the reporting of data, shortcomings and accomplishments, and had little analytic content, the fact is that one could have built a course around the issues discussed in the Report. The agenda was broadening.

It is not till 1967, 20 years after the first Report, that the tone of the discourse changes. For the first time the words “group practice” and “prepaid medical care” appear, account is taken of the shift to specialization, the decline of general practitioners, and the increasing utilization of hospitals. There is an increased emphasis on racial disparities. Furthermore, for the first time we see a section called “cost factors” and reference to the fact that the costs of medical care have been rising about twice as rapidly as average consumer prices over

the previous decade. Under the heading “prospects for the coming decade” we find the following: “With both costs and demand rising strongly, it seems likely that public and private health expenditures, which increased from 41/2 percent to 6 percent of GNP in the past decade, will continue to command an increasing share of the Nation’s resources. The bulk of these outlays will be made by consumers, as they have been in the past. Public expenditures will be particularly important to break supply bottlenecks, and to close gaps in health care associated with poverty” (Economic Report of the President 1967). If one reads carefully one will see that for the first time the Council is beginning to look at the health sector’s organization and not simply take it for granted and is beginning to show concern about rising costs. The sentence “Considerable private and public effort is needed to hold down costs” introduces a brief discussion of “new arrangements to make better use of scarce skills and facilities . . . and incentives for more efficient operation and distribution of health services.” As a final harbinger of things to come, the council stated: “It is essential to avoid any tendency to control costs less carefully as a result of the increasing scale of insurance and prepayment” (Economic Report of the President 1967).

These various themes were referred to and elaborated upon in the Economic Reports in the Nixon administration. There was a rising level of concern with the rapid increase in medical care prices, a rejection of the long-standing and simplistic supply–demand theory that the increase reflected a shortage of resources and would be taken care of by increasing the number of doctors and hospital beds, an increased emphasis on “the fact that many patients no longer have to pay their own medical bills” as an explanatory factor, and a much more explicit endorsement of group practice and the productivity results associated with that form of organization. I believe that the fact that so many Health, Education, and Welfare and other officials came from California helps accounts for the phenomenon. They knew and respected Kaiser. Earlier administrations may have known about HIP in New York and Group Health in Washington, DC, but these were not viewed as favorably as Kaiser. Those prepaid group practice arrangements had difficulty in overcoming the stereotype that they were some form of second-best “clinic medicine.” Nevertheless, much of what was written about prepaid group practice was based on pure economic theory and casual empiricism. We did not know very much more about group practice in 1972 than we had known in 1967 when I wrote my book on the doctor shortage and extolled group practice almost as an article of faith (with a tinge of ideology). In 1972, we were still almost a decade away from the first edition of Hal’s landmark—and I do not choose that word

lightly—book: *Health Maintenance Organizations: Dimensions of Performance* (Luft 1981). Thus, the basis for the Council Report's words about group practice was not all that different from other statements made in the field of health economics. In the precomputer (certainly the pre-desktop-computer) age few of the positions taken were based on sophisticated data driven analysis.

Lest this sound too critical of Council Reports, let me make clear that, important as the Council may have been at various times in helping to explain economic events and trends, it inevitably reflected the agenda of the profession and of the nation. The 1972 Report paid more attention to health because health expenditures had risen rapidly as a share of GDP and of total federal expenditures (Economic Report of the President 1972). Similarly, in 1973 the Council recognized social change by devoting a full chapter to the economic role of women—though this perhaps also reflected the fact that for the first time one of the three Council members was a woman—who says female economists haven't made a difference and for the better (Economic Report of the President 1973).

The final Economic Report issued under President Nixon ends on a somewhat wishful and wistful note. I quote "higher deductibles and coinsurance . . . would increase out-of-pocket cost of medical care for the aged and the poor. A mechanism is needed that will provide adequate medical care for the aged and the poor and reduce the strong inflationary pressures built into medicaid [sic] and medicare [sic], but that will do so without direct Government provision of medical care or extensive regulation of the medical care sector" (Economic Report of the President 1974).

Enter Alan Greenspan, Chairman of the Council under Gerald Ford. The 1976 Report is interesting in two respects. The first is the unusual statement at the beginning of a chapter on income security and health issues. "This chapter relies heavily on the research of economists and statisticians employed in government, universities, and private nonprofit research firms. Although the policy of not citing individual authors and research papers in the *Economic Report* . . . is being continued, documentation may be helpful. Therefore, on request, the Council of Economic advisers will send interested readers a bibliography of the external sources used for the preparation of this chapter" (Economic Report of the President 1976). Those of us who have worked in government recognize how unusual that statement was.

The second matter of note is that the part of the chapter on "Income Security and Health Issues" that is devoted to health is quite comprehensive. It discusses the various relationships of health to economic and social variables, the importance of insurance, and the rising costs of care. It amplifies the

discussion of what it sees as “the problems of insurance:” such matters as reimbursement policy and the absence of incentives for economy, the purchase of too much insurance because of the tax benefit, the lack of sufficient cost-sharing (Economic Report of the President 1976). Given the make-up of the Council in the Ford administration, this is not a surprising view of insurance—just as we’ve been told that there are knee jerk liberals I am here to tell you there are knee jerk conservatives. Nevertheless, there are glimmers of analysis in addition to the rhetoric. Even so, we should be clear that health had not yet advanced beyond a relatively small walk on part in the economic drama. Health affairs and health policy remained the domain of other branches of government. The CEA and others might wade into policy discussions, but if so it was behind the scenes. The bulk of the Report had reverted back to the traditional concerns: the state of the economy, the battle for price–wage stabilization, and the concerns about the balance of payments. There was the obligatory discussion of government regulation—whether too much or not enough depended on which party was in power. In the applied economics area attention was paid, and almost for the first time, to energy and especially to oil policy.

The first Economic Report under President Reagan discussed the control of health care costs, contrasted the administration’s approach with that of earlier ones, and provided the rationale for its efforts. Nevertheless, there was little new and even less that was definitive. Thus, the following: “A proposal is under consideration which would require medicare [sic] beneficiaries to pay a part of the costs for each day they are in the hospital. In addition, a catastrophic health insurance plan which would guarantee that annual costs to the patient would not exceed a certain amount is also being considered. . . . Other proposals aimed at increasing competition in the medical care system are currently under development. Some analysts have suggested replacing medicare [sic] with a voucher system” (Economic Report of the President 1982).

The 1985 Report marks a significant change in the concern about health in the Economic Reports. Previously the applied areas were agriculture, housing, transportation, energy, education, and income maintenance (especially in retirement). Now, for the first time there is a full chapter (of some 30 pages) devoted to health status and medical care (Economic Report of the President 1985). The chapter poses what it considers “the central problem of public policy toward medical care.” How do we resolve the inherent conflict between the goal and the means of health insurance? The goal: reduce the risk that consumers will face large out-of-pocket expenditures for care; the means by which this is accomplished is the third party, but that leads consumers to

purchase more care and this demand increases the cost of care of insurance. This poses the central problem of public policy toward medical care as the Reagan administration saw it.

The section headings are instructive: health status of the American population; trends in medical care spending and use; factors responsible for rising medical care expenditures; does more medical care produce better health?; the effects of lifestyle on health; public policy to encourage health behavior; health insurance and medical care costs; the tax subsidy for private health insurance; reforming the tax treatment of health insurance benefits; indemnity insurance and preferred provider organizations; public policy toward discounts; the role of information in medical care markets; Medicare: public health insurance for the elderly; Medicare background information; Medicare physician reimbursement; Medicare hospital reimbursement policy; care for the dying; coverage for new medical technology; Medicaid: public health insurance for the poor; Medicaid background information; aid to families with dependent children Medicaid; long-term care Medicaid.

While there were no footnotes to the literature, there were numerous (nonspecific) references to academic research and, of course, quite specifically to the RAND health insurance experiment (Economic Report of the President 1985). I can testify to the thoroughness of the discussion: my marked-up copy served as collateral reading and as the basis for lectures in my course on the organization and finance of the medical sector that was an elective for Harvard medical students. One may disagree with some, perhaps many, of the policy prescriptions—Republican initiatives are not the same as Democratic ones—but one cannot quarrel with the completeness of the topics covered in the presentation, with the obvious omission of any discussion of universal insurance and the problems of the uninsured and underinsured.

The next time health appears upon the scene is six Reports later, in 1991 when the Council wrote: “The most dramatic illustration of the growing importance of the health sector is its rising share of GNP. In 1960, health care accounted for 5.3 percent of GNP, its share rose to 11.6 percent in 1989. To put these numbers in perspective, total health care spending in 1989 was twice as large as Federal spending on defense, and more than six times larger than the value of U.S. farm output” (Economic Report of the President 1991). The Council then discusses and welcomes changes in the supply and demand conditions and states: “... *increases in the amount of resources devoted to health are not necessarily bad, since to a large extent they represent an investment in health, the changing preferences of a wealthier society, and the extra cost of a longer lived population.*” [Italics in original] (Economic Report of the President 1991, p. 136).

The Report then discusses what it calls “perceived problems of the existing system: Rising government health care costs; health care price inflation; the medically uninsured.” In turn, the Report addresses the question “Why health care markets perform poorly.” One explanation: “. . . consumers covered by insurance face diminished incentives to minimize the cost of care, since someone else pays the bills.” This is accompanied by a primer on “moral hazard” and an endorsement of deductibles and capitated systems. A second explanation is government regulation with particular emphasis on state mandates. And the third is the characteristic of employer-based insurance and tax-free benefits. Nevertheless, the Report offers no specific solutions to the problem. It does not go beyond the statement “Health care policy reform will not be successful unless it improves the incentives for health care consumers and providers to balance costs and benefits” (Economic Report of the President 1991, pp. 135–143).

The final Report of the first Bush administration in 1993 bequeaths a 50-page chapter on “The Economics of Health Care” and, implicitly, a rich health care agenda for the new President (Economic Report of the President 1993). This is by far the most comprehensive discussion of health care. The chapter’s context is given in the first paragraphs: “Growing concern about rising expenditures and reduced access to insurance has led to the development of a wide variety of proposals for health care reform, from the Administration’s market-based approach to calls for a government-run national health insurance program [i.e., from our responsible and measured response to their “drop the Hydrogen Bomb” approach]. The success of any of these proposals will depend on how well it addresses the reasons behind the increase in expenditures and decline in insurance. Economics is very useful in understanding these developments. It suggests that most health care in the United States is financed and delivered in ways that give both health care providers and their insured patients many incentives to increase the quality of health care but little reason to be concerned about its cost” (Economic Report of the President 1993, p. 119). The discussion of the matters raised in this sentence is comprehensive, if at times incomplete. It, as is the case in the descriptions of the Canadian, German, and U.K. health systems, has the following characteristic: a fairly thorough description of a problem area (quite complete for a document that uses economics rather than health care as its starting point) and then a set of inferences, explanations, and recommendations. The Report compares the Administration proposal with a managed care proposal, a pay-or-play and rate-setting approach, and national health insurance and global budgeting. Not unexpectedly, the

Administration proposal for a market-based reform plan wins in the side-by-side comparison. Of considerable interest is the fact that the discussions (and the proposals) do reflect work in the universities and research organizations. This is perhaps most evident in the attention paid to risk selection and to the need for health risk adjustment, though I believe that the Report was overly optimistic about the speed with which risk adjusters could be phased in. That the chapter does provide a valuable overview should not come as a surprise given the fact that Sherry Glied was a member of the Council's senior staff. The discussions of health care and health care financing in most Reports could have been (and most probably were) written by individuals with no special understanding of or knowledge about the health sector. Nuance was not their strong suit. The 1993 Report was markedly different and, in a sense, so complete that it almost required a response from the new administration.

That it received in the 1994 Report, the first under Bill Clinton. Not surprisingly, its chapter is entitled "Health Care Reform" and states that we face a health care crisis that demands a solution (Economic Report of the President 1994). It divides that crisis into four "separate but interrelated parts." First, the system fails to provide health security for millions of Americans, both insured and uninsured. Shortcomings in insurance—sick people pay more than do healthy ones, preexisting conditions, and limited benefits—are a second problem. The third problem is the lack of effective competition, which means that providers and consumers have few incentives to make cost-conscious decisions. The fourth problem is the burden that the current system places on public sector budgets. The chapter argues that these four problems have to be tackled simultaneously. Each of these problems is then discussed in considerable detail—reflecting the deep knowledge of the health care system that the senior economic staff member with health responsibilities, David Cutler, possessed (the discussion of moral hazard is considerably more nuanced than in prior Reports). The Report then presents a 15-page section on the health security act, its "architecture" and economic impacts. The contrast between this discussion and earlier ones on legislative proposals (e.g., on medicare) is striking and speaks to the expansion in the field of medical economics. Clearly, the study of the interrelationship between health, health care, and economics has come of age. Even so, one may ask how much of all this is the product of the kind of detailed health services research that was being produced in the academy.

That year, of course, represented the high water mark on health care in the Clinton administrations and in their Economic Reports. A year later, with

failure behind them, the chapter was down to a few pages that repeated the diagnosis and explained the need for action (Economic Report of the President 1995). Nevertheless, the battle for health reform having been lost it is no wonder that the Council did not believe it opportune to dwell upon the matter and underline its disappointment.

But the problems would not disappear. In 1997, the Council has a rich discussion of Medicare and of the long-term care component of Medicaid (Economic Report of the President 1997). Health care reform and universality are not on the agenda, but Medicare remained there. Again, the discussion which 20 years earlier would have been limited to data on expenditures and on enrollment, now has a strong analytic component. In 1998, perhaps to provide equal time to that received by the aged and disabled, the Council focused its health discussion on the well-being of children (Economic Report of the President 1998). The Clinton presidency closes out with the annual Report of 2001 and a far different section on health than the one some 8 years earlier. Entitled "Innovation and Access in Health Care" it discusses technological innovations, organizational innovations to control costs (arrangements somewhere between fee-for-service and managed care capitation plans—even so, the Report notes "the ideal incentive structure has not yet been identified"), and what it has accomplished in its attempts to improve health insurance coverage (Economic Report of the President 2001). It is a quiet, perhaps poignant, section.

The final several years (2002–2008) span President George W. Bush's presidency. In those seven Economic Reports, there have been 5 years when the Council Report had a separate chapter on domestic health issues and one year when it devoted a chapter to the global HIV/AIDS epidemic.¹ This is a remarkable change. I believe it reflects the growth in importance of the health sector, but perhaps even more the fact that the administration had a radical agenda for change and wanted to provide the intellectual underpinnings for the changes it sought. The dominant themes in the first such chapter are as follow: (1) reliance on health insurance as a payment mechanism leads to an inefficient use of resources in providing and utilizing care; (2) the uninsured include many who are "effectively insured because they can enroll in Medicaid [and have elected not to], because many who have Medicaid coverage elect not to report they do [a potential stigma effect?], because many may remain uninsured as a matter of choice [32 percent of the uninsured reported household income of over U.S.\$50,000; 25 percent had employer-provided health insurance but did not opt to participate—no data are provided on the definition of "employer provided"—over 40 percent

of the uninsured are between ages 18 and 34 and presumably see themselves as young and healthy and not in need of insurance. Because many persons fall into more than one group, not all those without insurance are accounted for. Perhaps—but the administration doesn't provide data—the remainder are Christian Scientists! In any case, the flavor of the discussion is clear: the problem of the insured is not as real or as large as is often suspected. The Report provides an agenda for improving health care markets. Among the suggestions are coupling Health Savings Accounts with a high deductible policy and providing a tax deduction for those premiums, investment in information technology, and tort reform (Economic Report of the President 2002).

The 2006 chapter has as thorough a discussion of health care costs and what to do about them—from the conservative perspective—as one could imagine. The solutions to the rapid increase in expenditures and to the inefficiencies within the sector are expanded health savings accounts and providing more information (on prices, quality, and value of medical care) in order to have more informed and, therefore, “better” consumers, and practice guidelines and cost-effectiveness studies to help providers to help patients in making their decisions (Economic Report of the President 2006). In 2007 and in 2008, additional ways to strengthen private markets (with special emphasis on the problems of Medicare) are elaborated. It will be interesting to see what the Council chooses to emphasize in next year's Report, the last by this administration.

What does all this add up to? What summary conclusions do I draw? (1) For reasons that are obvious—the impact of health expenditures on the federal budget (as well as on state budgets) and the share of the GDP devoted to health expenditures in total and personal health expenditures in particular—the CEA has devoted more and more attention to health care in its annual Report. When I entered this field that was not yet a field, and even when Hal entered, health care was not a big deal for economists. Today it is. (2) Paul Samuelson once quipped that you can turn a parrot into a learned economist by teaching it to say “supply” and “demand.” Reading the 60 plus Economic Reports convinces me that the Council of Economic Advisers believes that the parrot could become a learned health economist by learning to say “moral hazard, moral hazard.” But Paul was joking. In contrast, the various Councils attribute so much of what is wrong with our health care system to this one idea that I do not believe they are joking. (3) Whatever one thinks or thought of the significance of the RAND experiment, of its strengths and of its shortcomings and of its policy implications, surely there is something odd in relying on it even as

late as in the 2006 Economic Report (Economic Report of the President 2006, pp. 94–95). The RAND experiment was begun in 1971 and completed in 1982. Yet it remains *the* source for data as well as ideas that are cited in discussing the impact of cost-sharing. Is there no other information? Have economists, the presumed experts on the allocation of resources, been misallocating their own by failing to look at real worlds as they exist in the United States and elsewhere? Is it really possible that the RAND experiment was *the* experiment for all time? Even if it was the greatest thing since sliced white bread—and I do not think it was—surely it is time for a change to San Francisco sourdough as represented by Hal’s work before and after coming to UCSF as well as his forthcoming book. (4) Aside from the summaries of legislative initiatives, much of what is written reads as if it is received wisdom, the theory stuff that most of us learned in Economics 101. I recognize that the Economic Report is not the place to report on the rich health services research that the federal government, foundations, and others have funded and in so doing have stimulated. The Report presumably is about big ideas, and health services research often appropriately reflects the comment by “Tip” O’Neill that “all [he really meant most] health care is local.” But the Report is the place to see the ideas that Hal expressed and the research that he summarized in his important article “Competition and Regulation” published in 1985 in the special issue of *Medical Care* on “Planning for the Third Decade of Health Services Research” (Luft 1985). The Reports are the places to see the ideas that have motivated much of health services research and its various findings. (5) I believe that if you examine the Reports you will discover that they read like the rest of economics. They are written in a style that purports to be neutral and scientifically objective and that suggests that economics is value-free. But that is not the case either about the Reports or about economics more generally. That is not merely a matter of which subjects are given priority. It is a matter of analysis and the weights we attach to this effect and to that effect, to this explanatory variable and to that. The real world is messy and in that real world we must balance competing claims and competing values. That balance reflects values not mathematical prowess. Samuelson once wrote, “A good economist has good judgment about economic reality” (Samuelson 1972). If that is true—and it certainly is so in the policy domain and in the domain of analysis of the real world rather than in the mere exhibition of mathematical prowess—we have to recognize what we are talking about. Truth in advertising requires that economists recognize their disagreements often stem from attitudes, culture, and values and it would be helpful if the public recognized that as well. The economic literature abounds with examples, but wonderful

documentation can be found in the 1984 publication by the Subcommittee on Health of the House Ways and Means Committee on the Proceedings of the Conference on the Future of Medicare. The volume contains a 24-page paper entitled "A Medicare Voucher System: What Can It Offer?" (Friedman, LaTour, and Hughes 1984) and a brief 7+ page response by one Hal Luft, entitled "A Medicare Voucher System: Issues and Concerns" (Luft). This may sound like ancient history, but unfortunately there are those who haven't read Hal's rejoinder and haven't learned their history. They, and regrettably we, are doomed to repeat it. The point I make is that the original paper was written by economists and the rejoinder was as well and yet they fundamentally disagreed. I more than suspect those disagreements are related to values.

I have already alluded to health services research and have only a few words to add. My observations are of two kinds: one positive and one at least questioning. The positive is based on two reminders. I have already alluded to the importance of recognizing that much of health care is a local matter at least in the sense that that is often the unit of investigation and, as well, the level at which changes in organization and behavior are implemented. This is important because a failure to recognize it often leads to a shying away from the investigation of important questions with an excuse such as "I can't study all hospitals and what have I gained if I only study one or two" (or, having studied one or two, inferring or letting the reader infer that that one or two are representative of the universe). Small studies *are* important and the more so because they aid in our understanding of economic, organizational, and behavioral reality. The second positive thing to state is that not every study that is undertaken has to be oriented toward policy, or at least toward policy writ large. Policy is made in the hospital, in the individual department, in a host of places and by a host of individuals. Furthermore, some things are worth studying even if they have no immediate (or for that matter long-run) policy implication. I remember a mentor of Hal's and an individual from whom I learned a lot, John Dunlop, once railing against members of the Harvard economics department because they wanted to be funded to do certain studies because, as they claimed, these studies had policy implications. John, who had recently served as the Secretary of Labor, used a few choice expletives to state that they didn't know anything about policy and how it is developed and formulated. "Let them ask for money saying their studies will advance civilization. Then, at least they'll be honest." He added that if advancing civilization were the criterion he'd sooner give the money to the historians who were writing a multi-volume history of the Abbey at Mount Cassini, thus

suggesting that the economists may not have been entirely wrong in not resting their case on the advancement of civilization. My point is that we should not denigrate health services research endeavors that have little or no federal legislative implications. That is a false criterion (a point, perhaps, more readily understood in California than in the Northeast).

To round out the matter, I will state the one hesitation that I have. All of us have read articles that utilize well-known methodology and document something we of already know. We may not have known the precise quantitative relationship between a, b, c, and f, but we could have guessed it and it really doesn't make much difference (indeed, any difference) whether our guess would be off by 10 percent or more. Surely all of us have wondered whether the quest for "false" precision is justified. As fellow researchers we don't complain, but as taxpayers who funded the work we ought to grouse a wee bit. I don't want to sound anti-intellectual, but some portion of ongoing research, supported by scarce funds and utilizing scarce resources cannot really claim to be intellectual. Let me be clear, they are good studies. The problem is not the quality of the research endeavor, but the importance of the issue being addressed, that is, the quality of the question asked. Perhaps we should use the standard that we call for in medical tests: don't perform the tests if the results will have no operational consequences. If we are perceived as belaboring the obvious or examining the trivial, we run the risk of losing support for really important research activities.

Let me close with a few more words about Hal and generalize from those remarks. Hal spent a year at the somewhat short-lived Center for Community Health and Medical Care at Harvard Medical School. During that year he was in a medical and health sector environment that reflected the belief of those who helped found the Center that to understand the behavior of individuals in a sector one had to study people and understand what happens on a day-to-day basis in their environment. The John Dunlop that I spoke of and the labor economists who were in his circle of mediators and arbitrators handled all kinds of labor disputes, including those in railroads. Among the things they did to equip themselves to do so was ride long distances with railroad men in the caboose of freight trains. They believed that institutions made a difference and that they had to understand the situation on the ground. That is the perspective to which Hal was exposed (and to which he responded by writing 6 of the 11 "occasional" papers the Center published between October 1972 and June 1973).² I believe that it is that perspective, that willingness to immerse oneself in the institutional framework that one is studying that has characterized Hal's

work and that has made it so very valuable. He knows the data, but he knows how they were gathered, what the pitfalls may be, what they may reveal, and what they may hide. You get that flavor in reading his remarkable article “Health Services Research as a Scientific Process: The Metamorphosis of an Empirical Research Project from Grant Proposal to Final Report.” I won’t summarize, because you ought to read it yourselves to fully appreciate it (Luft 1986) (see *Health Services Research* October 1986). I do believe that the year at the Center contributed mightily to his development as a first-rate investigator and as the economist who has most effectively collaborated with clinicians and noneconomists in his research.

We are all very fortunate that Hal chose health economics as his field of work. We are all very fortunate that he was willing to give up some of the fringe benefits of being an economist in a traditional economics department, the conversations on matters of mutual interest, the bandying about of names and the talking about the latest article, and chose instead to be in a different environment and write for a somewhat different audience. I claim no credit for his decision to seek this path. But I do remember some 35 years ago when Hal was sitting in my office and mulling about various job offers. He was a “hot” commodity, a Harvard Ph.D., an education in a department with a reasonable number of luminaries, a concern about important questions and a methodological and econometric versatility. As I remember it the choice had narrowed down to Yale (and an ability to work with a wonderful person and great economist, Jim Tobin) or Stanford Medical School (and the opportunity to develop and carry out an agenda of work in health economics). Most economists would have been thrilled with the opportunity at Yale and that, of course, was what the Harvard economics department folks were pushing for since they viewed things from their self-interest perspective and Yale would have been a feather in their cap. I asked Hal what issues and problems excited him. It was clear that he really wanted to do health economics and, thus, that Stanford made more sense. And so I cautioned him; “Be careful. Don’t go to Stanford, if you are going to spend time feeling sorry for yourself because you’re not having coffee with Jim Tobin.” He concluded that having coffee with Jim would be nice, but that it was not what he wanted out of his professional career. We and U.S. health care and millions upon millions of Americans—patients and prospective patients—surely are the richer for the choice he made. And Professor Luft is also better off. Hal certainly would have become one more among many great American economists. That, however, doesn’t hold a candle to what he became: *the* preeminent American health care economist.

NOTES

1. The “missing” year is 2003.
2. See: No. 3, with Martin Feldstein and Bernard Friedman, “Distributional Aspects of National Health Insurance Benefits and Finance” (October 1972); No. 9, “Effects of Coinsurance on the Use of Physician Services: Comment” (June 1973); No. 10, “The Impact of Poor Health on Earnings” (June 1973); No. 11, “Education, Health, and Labor Force Participation: A Source of Bias in Human Capital Analysis” (June 1973); No. 12, with Joel Kavet, “The Implication of the PSRO Legislation for the Teaching Hospital Sector” (August 1973); No. 13, “Health Economics: An Annotated Bibliography and Course Outline” (August 1973).

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