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ABSTRACT

First in a series which offers educational resources and teaching techniques related to major social issues to high school social studies classroom teachers, the guide focuses on political and economic aspects of health care in the United States. The document is presented in four major chapters. Chapter I explores how economic and political science frameworks can be used to analyze policy issues. Chapter II presents an overview of health care in the United States. Topics discussed include costs, availability of services, advantages of private and public health care, policy choices, and health care insurance rates. Chapter III outlines objectives for the health care unit, including that students should be able to interpret health care cost data, assess alternative policies, and understand values involved in the controversy over a national health care policy. Chapter IV presents instructional activities which involve students in defining terms, comparing data, discussing issues in groups and in class, analyzing insurance rates, analyzing filmstrips, role playing, and answering questions based on reading assignments. For each activity, information is presented on grade level, sequence within the unit, time and material required, rationale, concepts, instructional objectives, teaching strategies, and pupil activities. (DB)

ECONOMICS-POLITICAL SCIENCE SERIES (EPS)

Analyzing Health Care Policy

A Resource Guide

Prepared by:
Laurence E. Leamer
Paul A. Smith
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1977

Joint Council on Economic Education

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Foreword

Economics-Political Science Project

Although by its very name the Joint Council on Economic Education is obviously committed to improving the teaching of economics, it has developed this Economics-Political Science Series as a contribution to the teaching of the broad social studies field. We believe that each publication will enable teachers to achieve multiple purposes which rank high among the goals for the social studies, and the production procedure for the series demonstrates effective steps and use of personnel to develop social studies instructional materials.

The series is an outgrowth of the Economics-Political Science Project which was undertaken in 1973. The project came into being from a recognition that most social issues were becoming increasingly complex and multidimensional and yet social studies teachers were generally unprepared to handle the teaching of such issues. As a result, students were not being prepared to understand and act upon crucial matters either through default or ineptitude on the part of their teachers. The J. M. Foundation had a strong commitment for many years to improve the quality of our nation's citizenship education and it provided the JCEE with the initial grant to launch the Economics-Political Science Project.

The core of JCEE strategy was to draw heavily from the experiences and judgments of outstanding social studies teachers in diagnosing what needed to be done and how to do it. The major program recommended to lay a foundation for the project was to conduct a national workshop in which strategic social studies teachers could be prepared to teach complex, multidimensional social issues effectively. With this experience as a beginning, it was anticipated that comparable training programs could be provided within states for other teachers. Furthermore, the experience of the national workshop could establish a basis for developing materials for teaching the social issues.

As a preliminary step, pilot programs were held for social studies teachers in North Carolina and Oregon to gain experience and advice regarding the purposes, personnel, content, materials and procedures for the national workshop. Among the key recommendations which emerged were the following: (1) participants should include outstanding high school teachers with backgrounds in economics and political science; (2) the workshop should focus on the analysis of major social issues that involve economics and political science; (3) the workshop should focus also on the techniques and resources for teaching the social issues selected; (4) the staff should include personnel capable of providing the essentials of economics and political science, an analysis of the social issues drawing upon and interrelating the pertinent economics and political science, and leadership in

demonstrating and developing teaching techniques and materials; and (5) the entire workshop should be conducted in an exemplary manner so as to serve as a model for workshops to be held in the future within states and school districts.

The National Economics-Political Science Project Workshop was conducted during the summer of 1974, using the campus of Haverford College as the site and the adjacent city of Philadelphia as a resource for relating realistically the social issues to the real world. Attending were teams of high school social studies teachers from 30 states who had been selected carefully by Affiliated Councils on Economic Education in their states. Evaluations of the Workshop reflected that the purposes were achieved to a very high degree.

During the following year, mini-workshops dealing with social issues were conducted for social studies teachers in five regions of the nation. These programs were patterned after the national workshop and made use of teachers and materials from that workshop. Funds for the national workshop and the regional programs were provided by the J. M. Foundation, Exxon Corporation (USA), and the Lilly Foundation.

It was at this stage that the Economics-Political Science Project turned to the production of teaching materials. With continuing grants from the J. M. Foundation and Exxon Corporation (USA), the JCEE employed four writing teams to develop resource units for teaching major social issues. The resource units were to be designed to teach the social issues analytically, integrating economics and political science in the process, and they were to provide diverse examples and suggestions of units, methods, and resources for classroom use. In order to achieve these aims, each team consisted of an economist, political scientist, two social studies teachers, and a social studies curriculum specialist. Team members had demonstrated their abilities in various phases of the Economics-Political Science Project.

The writing teams were convened by the JCEE for an intensive planning seminar in August 1975 and, drawing from the experiences and output of the national and regional workshops, they developed the focus, format, and procedures for the Economics-Political Science Series.

It was agreed that resource guides were to be developed for analyzing the following: Health Care Policy; Taxation Policy; Economic Stabilization Policy; Government Regulation; Environmental Policy; Housing Policy; and Crime Control and Prevention Policy.

Each resource guide was to contain the following elements: (1) a delineation of the core concepts of economics and political science and their interrelationships; (2) a Topic Overview, providing background information for teachers and an in-depth economic-political science analysis of the problem area on which the guide focuses; (3) a statement of the rationale and significance of the problem area, emphasizing its present and potential place in the lives of students; (4) an identification of the objectives and outcomes from study of the problem area; (5) diverse examples of classroom activities, each designed to achieve one or more of the objectives.

Another major decision reached at that time was that there should be extensive exchange, review and testing throughout the developmental process. All the economists and political scientists would react to each other's analyses and they would also receive reactions and suggestions from the high school social studies teachers. The economists and political scientists would review the content of the methodology prepared by the high school teachers and the teachers would exchange their materials among themselves. Beyond all of this and of crucial importance, it was agreed that the resource guides should be field-tested extensively in classrooms throughout the nation.

All of these procedures have been followed and now the Economics-Political Science Series is available. We believe the series is unique not only in the separate features it embodies but more so in its composite emphases and contributions: (1) a focus upon social issues of major interest and consequence to students; (2) an emphasis upon the teaching and learning of analytical skills; (3) the development of an understanding of the fundamentals of economics and political science, the interrelationship between them, and the application of both disciplines in analyzing and acting upon social issues; (4) the use of diverse, proven teaching

strategies and resources that aim clearly at achieving significant, measurable outcomes.

Another quality of uniqueness that can be attributed to this series is the range of people who have been involved in a close, working relationship: college professors and high school teachers; economists and political scientists; specialists in academic disciplines and specialists in methodology; teachers from school systems with varied sizes, location, and student populations. We believe all of this has proved to be effective and bodes well for the development of social studies materials in the future.

Each publication of the series identifies the people who have contributed to its completion and we extend our appreciation to them for their dedication and competence. On behalf of myself and the Joint Council on Economic Education, I extend a special message of appreciation and commendation to Ms. June Gilliard of the JCEE staff for the most praiseworthy ways in which she has coordinated the development and production of the Economics-Political Science Series. She is recognized to be one of the nation's distinguished social studies educators and her role in this project should provide her with additional distinction. Throughout the project valuable assistance has also been provided by the following members of the JCEE staff: Dr. George Dawson; Anthony F. Suglia; and S. Stowell Symmes.

Although the support of the J. M. Foundation and Exxon Corporation (USA) has been mentioned previously, we acknowledge again our gratitude for having been provided the means to carry out the project and produce this series.

Of course, the Economics-Political Science Project which led to this series is not completed nor is it ever likely to be. Now will come further use, adaptation, modification, and improvement. Social issues are dynamic and there will be need for different resource guides in the years to come. We encourage such ferment and shall welcome suggestions that will enable us to join you in doing what is needed to improve the teaching of the social studies.

Dr. George L. Fersh
Associate Director, JCEE
and Director
Economics-Political Science Project

Preface

Organization and Uses of Unit Resource Material

Policy decisions affect everyone. Consequently it is important that students acquire the knowledge and skills necessary for understanding the major policy questions facing our society and for participating effectively in the processes of public debate and public decision-making.

A Resource Guide for Analyzing Health Care Policy is the first in a series of resource guides focusing on economic-political analysis of contemporary public policies and issues. The topics for this and other units in the series were selected not only because of their current relevance, but also in the belief that these issues will continue to be the focus of public debate for some time to come.

In developing the Economics-Political Science (EPS) resource guides every effort was made to make the material as widely useful as possible. Material contained in individual guides was designed to be used by high school teachers with instructional responsibilities for Economics, Government, United States History, Problems of Democracy, or other social studies courses dealing with contemporary social issues.

The resource guide on health care policy consists of four major components, each designed to serve specific curricular or instructional purposes. The introduction provides a general explanation of the conceptual framework used throughout the series for analysis of policy problems and issues. Hopefully, it also provides a model that teachers may use for extending the study of health care policy or for developing additional units dealing with economic-political analysis of other areas of public debate and concern.

The purpose of the *topic overview* is twofold. First, it provides for the teacher background information on economic and political issues involved in the formation of a national policy on health care. Secondly, it serves as a concrete example of how the conceptual framework described in the introduction is applied for economic-political analysis of policy issues.

The *unit rationale and objectives* and *instructional activities* deal specifically with instructional questions pertaining to the *why*, *what* and *how* of teaching about health care.

When used in their entirety and in the sequence presented, the suggested instructional activities comprise approximately three weeks of study. It is not anticipated, however, that every teacher will wish to use the material in this manner. For this reason the activities are designed so they may be used singly or in various combinations, depending upon the amount of time one wishes to devote to the topic and the needs of the particular student group for whom instruction is to be

provided. To assist teachers in determining which activity or combination of activities is more appropriate for his or her students each instructional activity has been keyed to the objective or objectives it is designed to achieve.

We wish to express our appreciation to the writing team that prepared the material for this our first unit in the EPS Series. To George Dawson for his consultation and untiring effort as team coordinator we owe a special debt of gratitude. We are also grateful to the following teachers for their review and classroom trial of the material in its experimental form: Alison Carter, Norwalk School System, Norwalk, Connecticut; J. K. Hollenshead, Riley W. Bratton, and Penny T. Claudis, Caddo Parish School System, Shreveport, Louisiana; James W. Armstrong, Veronica Moore, and Doris Washington, Norfolk City Schools, Norfolk, Virginia. We found their advice extremely helpful, and to the extent possible, their suggestions have been incorporated in the published material.

June V. Gilliard
EPS Project Coordinator and Associate, School Services Program

Contents

Introduction

Laurence E. Leamer and Paul A. Smith

A central purpose of this series is to help students in learning to view society and its problems from both economic and political perspectives. This can best be done through study of specific questions, each of which offers an economic and political analysis of a distinct social problem.

Economics and political science are complex intellectual "disciplines," each having an extensive body of theory and methodology. As such, their applications in the diverse areas of policy decision-making may leave the teacher searching for certain "essentials"—certain core ideas—with which to explain matters to the student. Such essentials can be found in a modest number of basic concepts that mark each discipline. These are presented in separate statements below, followed by a brief discussion of how concepts may be combined to provide an integrated approach to the teaching of economics and political science.

1. An Economics Framework for Analysis of Policy Issues[1]

It is useful to think of the concepts that form the basis for economic understanding in terms of several broad "concept clusters." The diagram provided in Figure 1 (page 2) illustrates how these clusters and various subclusters are combined to form a schematic framework for economics curricula and instruction.

Every economy, however it may be organized, faces the fundamental problem that economic resources (natural resources, human resources, capital goods) are limited relative to the practically unlimited wants of people in the economy. How people allocate these resources among many competing human wants varies greatly among different economic systems. One broad class of systems solves this complex problem largely by reliance on tradition (e.g., some "underdeveloped" economies), another one by "command" (e.g., the centralized economies like China and the U.S.S.R.), and a third class by a decentralized market mechanism (e.g., the U.S. and most Western European nations). In reality, most economies are mixed in their use of the three approaches and in the economic institutions they have developed; and the approaches and institutions change with the passage of time. We focus primarily on the American economic system, but it is important to recognize that other systems face the same central economic problem of *scarcity*, although they deal with it differently.

When examining any economic system it is helpful to look both at its parts (microeconomics) and the whole (macroeconomics). In microeconomics independent elements can be explored such as what products are produced, how much a firm produces, how much income a family earns, or why corn prices are what they are. But some problems require an analysis of the economy as a whole and thus proceed from a macro perspective. Here economists examine aggregates such as general price levels, gross national products, employment levels, and other phenomena from a total economy perspective.

In our largely private enterprise economy (leaving government aside for a moment) competitive market prices are the dominant mechanism used to allocate scarce resources. Perfect competition rarely exists in the real world, but the competitive market provides us with a model of how markets "should" work when no individual is a big enough part of the total market to have any personal influence on market price.

[1] Adapted from the January 1977 unpublished report prepared by W. Lee Hansen, Chairman, Framework Committee for the Joint Council on Economic Education Master Curriculum Project.

FIGURE 1
Framework for Analysis of Economic Policies and Issues

Systematic analysis of economic policies requires:

IDENTIFICATION OF ISSUES

- Issues Pertaining to Relative Role of the Market vs. Government Action
- Issues Pertaining to the Overall Performance of the Economy
- Issues Pertaining to Distribution of Income

KNOWLEDGE & APPLICATION OF BASIC ECONOMIC CONCEPTS

The Economic Problem

which arises from scarcity and the need for choice, and necessitates the development of

Economic Systems

for resolving problems and issues dealing with what to produce, how to produce, how much to produce, and how to distribute the fruits of production:

Microeconomics: Resource Allocation, Income Distribution, etc. and Macroeconomics: Economic Stability and Growth, etc.

KNOWLEDGE OF ECONOMIC INSTITUTIONS

which provides the factual and behavioral background needed to apply economic concepts

EVALUATION OF ECONOMIC ACTIONS AND POLICIES

which necessitates distinguishing between

Questions of Fact or Prediction vs. Questions of Judgment or Values

applying

Measurement Concepts

for assessing economic performance;

identifying

Goals/Values

to be used as criteria for evaluating policy alternatives

and

weighing policy choices in terms of

Trade-offs Among Goals

Businesses, in striving to make profits, try to produce at the lowest possible cost those goods and services that consumers are willing and able to buy. In some cases they also seek to influence consumer demands through advertising and other selling activities. Producers, in trying to maximize profits, draw productive resources (such as labor, land and machinery) into those enterprises where they will contribute most to meeting consumer demands. While doing so, businesses pay out incomes to workers, landowners, and other suppliers of productive services who are also trying to maximize their economic returns by getting the best possible value or price for what they have to offer. These incomes, in turn, make it possible for income-receivers to bid for goods they want. Thus markets, in which prices rise and fall in response to changing demands and supplies, provide the mechanism which links together consumers and businesses, each seeking to make the best of their positions and abilities, yet each dependent upon the other. In economics, this is described as a circular flow model of the economic system. Individuals and businesses who save part of their income and make these savings available for investment in new productive facilities or in human beings, increase society's capacity to produce in future years. As a result another circular flow exists connecting those having funds to invest and those seeking investment of funds.

Individual freedom of choice is central to the way the largely decentralized, market-directed American economy defines its goals and allocates its limited resources. But these individual freedoms, of the consumer, wage-earner, investor and businessperson, are limited by laws and by social institutions for the protection of the individual and society. Thus, markets and prices, reflecting shifting demand and supply conditions, are the main regulators of the allocation of scarce resources in the production of the most desired goods and services; but governments, unions, trade associations and other institutions help to set and enforce the rules under which competition takes place, and sometimes participate actively in the processes of production and distribution.

There are two general types of queries fundamental to understanding policy issues. One concerns questions of fact or prediction: *What is known* about economic behavior? Or, if we undertake some action, what will be the predicted effects? The other type concerns questions of judgment or values: *What ought to be done* to alter economic behavior? Should we undertake a particular policy or not, given that various people and groups may be differently affected? The failure to distinguish between questions of *what is* and *what ought to be* is the cause of endless confusion and can lead to inappropriate policy analysis.

As we sort through the vast array of questions and issues coming at us from newspapers, television, political campaigns, and our involvement in economic life, we find that most of them can be grouped into the following three broad categories:

One major set of issues concerns the relative role of private market forces and collective governmental actions. On these issues we are interested in knowing "what happens," or what is likely to happen, in response to a change in the demand for, supply of, and the resulting price of individual goods and services. To changes in the supply and demand for labor and capital? To new developments in technology? These questions call for a description of how the total economic system or its parts behave under conditions of free competition and varying degrees of restriction. Another, related set of questions pertains to "what ought to be done." What ought to be done when people don't like the higher prices they must pay for individual products (e.g., oil, gasoline, sugar or coffee)? This involves thinking about whether to rely upon the operation of market forces or to rely upon collective action via government policy such as price ceilings, rationing, special taxes, regulation (e.g., truth-in-lending, environmental controls), and the like. Another way of phrasing the question is: When "should" direct government action be used to allocate resources differently from the way the price system would allocate them? For example, should local government act to allocate energy sources, such as oil or gas? Should government continue to subsidize shipbuilding, farming? Most of these questions concern economic efficiency. To consider appropriate public policy about such questions, one first must identify the consequences of choices, analyze them relative to desired results and values, and then make what is believed to be the most favorable policy decision. But other questions of collective action relate closely to economic equity. For example, should government raise gasoline taxes or use a direct quota rationing system to allocate relatively limited gasoline supplies? The former means that people with lower incomes will be made relatively worse off while the latter provides equal amounts of gasoline to everyone, irrespective of their need or ability to pay.

Another important category of issues relates to the economy's overall performance as reflected by the rates of inflation, unemployment and economic growth. What "causes" inflation? What "causes" unemployment? What "should be done" about inflation or unemployment? What policies should be pursued when unemployment and inflation exist simultaneously? There is an obvious overlap between these issues and those mentioned above in explaining recent inflation and unemployment. What "causes" economic growth? What are some of the benefits and costs of economic growth? What is the long-run relationship between economic growth and resources? Between economic growth, population and employment? Between economic growth and the environment? What is the "appropriate" rate of growth? Should we attempt to speed up or slow down economic growth, or pursue a "no-growth" policy? What is the best way to implement our policies?

A third major category of issues relates to the distribution of income produced by the operation of market forces and the redistributive effects of government action. Again, it is important to separate "is" from "should be" issues. What "is" the current distribution of income? What produces this distribution? To what extent does this distribution perpetuate itself? What is the effect of existing and of proposed government policies on income distribution? "Should" policies be adopted that are designed explicitly to change the distribution of income or economic well-being? "Should" the tax structure be made more or less progressive? "Should" schools continue to be financed largely by property taxes? Should policies designed to improve economic efficiency be adopted if they affect the distribution of income? Should government subsidize the housing of elderly and low-income renters? These issues appear to be, either openly or submerged just below the surface, critical to virtually all the questions posed above. They come up in any evaluation of how the market system works, in determining whether collective decisions alter individual economic decisions, and in assessing the extent to which inflation, unemployment and growth affect the general well-being of the population. Who gains and who loses, and who should gain and who should lose, best summarizes what is at stake here.

There are several reasons why unequivocal answers to these and similar questions are not readily available. Economic systems are complex, and an understanding of these systems requires a conceptual framework, factual and cultural information, the application of analysis, the making of judgments, and the determination of action to be taken. Moreover, our ability to know exactly how effectively the economy and its components function is limited by difficulties in obtaining accurate and timely measurements of economic activity. Finally, a variety of unanticipated events affects economic activity, and thereby makes it difficult to predict accurately the results of specific economic decisions. Unlike the physical sciences, carefully controlled experiments are difficult to undertake in economics.

Even if our understanding of the economy and economic decision-making were vastly improved, we still could not expect all disagreements on economic issues and questions to be eliminated. Certainly, some disagreements will be resolved as our understanding is increased; many disagreements will persist, however, because of differences in judgments about the actual or predicted effect of specific decisions; and still others will remain because individual economists, as do most individuals, adhere to different sets of values.

The heart of economics is decision-making—choosing among alternatives. But economic decisions are not made in a vacuum. Rather, they are made in the light of a set of goals. These goals vary from one society to another, from one group to another within a society, and from one individual to another within a group. Among the goals most evident in the modern world and particularly in American society are freedom, economic efficiency, equity, security, stability (full employment and the absence of inflation) and economic progress.

Economic decision-making entails the *opportunity cost principle*. When decisions are made to use scarce resources to produce particular goods or services, opportunity costs refer to what must be given up, i.e., opportunities foregone. A decision to produce one good means giving up the possibility of producing something else. Thus, the opportunity cost—what could have been produced with the resources instead—is the cost of producing that good. For an individual, the opportunity cost of something purchased is the next best alternative which must be forgone. For a society, it is the alternate uses to which productive resources could have been put.

When a person or a group chooses one good instead of another, it is making a *trade-off*—that is, it is trading off less of one thing for more of something else. Society has to make trade-offs too, e.g., between its need for more energy and its desire to preserve the environment. Essentially this involves comparing the various costs and benefits of each of the alternatives. It also involves determining how these costs and benefits will affect different groups within the economic system.

Goals or criteria provide a means of evaluating the performance of not only an economic system and parts of it, but also of existing programs and new policies under consideration. However, many of the goals conflict and difficult trade-offs have to be made. Examples are farm price supports, which promote security but reduce efficiency; minimum wage laws, which can be thought of as equitable but may increase teenage unemployment; and wage-price controls, which may restrain inflation, but also reduce efficiency and freedom. Economic analysis does not make value judgments in these policy areas, but it does help people to understand the nature of the trade-offs so that they can form their own judgments in the light of their own values. Perhaps, most importantly, it encourages use of a reasoned approach in dealing with controversial economic issues.

2. A Political Science Framework for Analysis of Policy Issues[2]

The political scientist uses certain major concepts to find meaning in the world of politics. These concepts direct attention to the significant qualities of any political system and provide measures for how well it is working. As in other intellectual disciplines, there is considerable disagreement in political science about what things are important and how they should be

[2]The statement of political science concepts was prepared by Paul A. Smith of S.U.N.Y., Binghamton, with the consensus of the other political scientists involved in the project.

studied. Nevertheless, while political scientists might argue about exact definitions and preferred approaches, the following concepts provide us with working tools for political analysis. Each of the problems we shall be addressing in this series is a problem of public policy, and thus its solution—or nonsolution—must involve political decision-making. These concepts will provide us means for understanding this process.

The first concept is *authority*. With this we refer to the legitimacy that a political leader, or procedure, or policy has. A political action is authoritative to the extent that it is accepted as right and proper by the community it affects. Authority, therefore, is a relationship that arises not from the will of governors but from beliefs of the governed. What "gives" a political decision authority is usually its connection with some basic *procedure* or *institution* that the community views as a fundamental value. Often this is expressed by some historical event or document. For example, we say that the U.S. Constitution gives the President authority to command the armed forces and the Congress authority to declare war, while neither has authority to do both.

Of course there are many kinds of authority—in art, science, religion, and so forth—all involving standards of performance or truth. The distinctive aspect of political authority is its relationship to social power. "The state," we often say, embodies the authority to make "final" decisions affecting social values; or, more specifically, to use coercive force. Political authority is a tricky concept because it is often confused with power, and because its exercise almost always means that some members of the community must do things they don't want to do. This complicates the quality of approval implied by authoritative acts. Authority wanes as this complication grows.

Our second concept is *power*. Power is the capacity to get persons to do things they would not otherwise do, with *political* power activating instrumentalities of collective sanctions—customarily the state. Obviously, power has many sources. It can "come out of the mouth of a cannon" or it can rest on such forces as love, money, oratory, knowledge or authority. Like authority, power is a relationship. It rests on shared values and unequal resources. Power is authoritative only when its exercise is accepted as legitimate by the community. When power goes beyond authority, deep conflicts occur in the community and governments must use more force and coercion to sustain themselves and carry out policies. We ordinarily think of democratic government as a model in which power and authority overlap and where explicit procedures of consent are used to determine authority. The distribution (who has how much) and exercise of power are thus key factors in the way problems of public policy are handled in the political system.

Although we have used the term *public policy* as if it were a simple and commonly understood concept, in recent years political scientists have given considerable attention to its meaning and analysis. One reason for this is that it is often difficult to know when an action is or is not part of a "policy," and when nongovernmental institutions actually might be "making" policy. For our purposes, this third concept refers to *patterns* of action by government that are directed at recognized social problems. Thus we think of public policy as not one but a *series* of actions having political authority and aimed at some coherent set of social needs. Policy, therefore, is something that results from what government does, and that reflects the power, values and skills of the political community.

In order to deal with the multiple group and individual actions that go into policy-making, political scientists often use the concept of *process*. This refers to the dynamic relationships—especially the relationships of influence—among those who take part in the various steps through which policy is suggested, formulated, authorized, changed, and so forth. Sometimes the "policy-making process" refers to what happens in the political system as a whole, and sometimes to actions leading a particular policy, or set of policies. In either case, process is always active in nature, and the term emphasizes that governing or policy-making cannot be described adequately with formal structures of authority or power.

This brings us to our fifth concept, *institutions*—well-established and "structured" patterns of behavior through which power is exercised and governmental actions are taken. Congress, the Presidency and the Supreme Court, political parties, elections, regulatory agencies, and city councils—all are political institutions. Each such institution is composed of a distinct structure of rules, procedures, roles, expectations and rewards; and it serves certain functions. In America institutional development is well advanced and policy-making is largely channeled through certain types of political institutions designed to "produce" policy. Since institutions are by definition well-established, and elements of their structure are often defined by formal rules (laws), political institutions tend to embody large amounts of authority in their respective areas of jurisdiction. Indeed, we often refer to persons who hold positions or "offices" in governmental institutions as "authorities." So strong is this institutionalization that political activities outside of them are often viewed with suspicion, if not outright opposition. For example, street demonstrations, or demonstrations in courtrooms, are usually treated as highly controversial and "out of order" in the American community.

Political institutions, therefore, tell us a lot about public policy-making. As embodiments of authority, they are preferred channels for political action and power. They are not only natural targets for those in the community who wish to influence policies, but also are guides to who has power in the community. For example, Congressional committees are the focus of political activity on the part of those community interests over which the committees have jurisdiction, while these same committees usually become biased in favor of these same interests. The same thing happens to regulatory agencies. It is easy to see, therefore, that

most policy processes occur in and around institutions. Moreover, important relationships develop between political institutions and those of other types—economic institutions, for example. Business corporations, labor unions, and markets have close and complex ties to political institutions ranging from committees of Congress and federal regulatory agencies to small-town governments.

Our sixth and last concept is politcal *participation*. By this we mean activities that are part of political decision-making—decisions supported by the power and authority of the state. The first point to be made about participation is its diversity. Voting is probably the form of participation that most Americans would think of before any other, since free elections are an institution in America. But for those of us interested in public policy-making, other forms of participation are more useful—writing letters to Congressmen, direct lobbying, or contributions to political campaigns, for example. Bribing, or assassinating, or providing information to government officials are other examples. These remind us that some forms of participation are more legitimate, more costly, and more effective than others.

A logical result of these things is the second point about participation: some members of the community participate more than others. Although it is not easy to summarize the enormously complicated nature of this point, as a rule those persons who have greater resources of wealth, or skill, or status can and do participate more and with greater effect than persons who have fewer of such resources. The fact that this generalization can be made for every known political system has obvious implications for the distribution of power, the nature of policy-making, and the outcomes associated with policies. Democracies pride themselves on expanding participation, and this is a public value in the United States. Even so, the general relationship between resources and participation remains. Moreover, some areas of policy-making have more participation than others. For example, fewer Americans "decide" the level of defense expenditures each year than where bridges will be built over inland waterways. Participation must be measured and judged not only in terms of amount, but also in terms of quality and breadth. Some men and women might participate with great intensity (and effect) in a relatively narrow area of policy, while others might participate over a wider range and with less effectiveness in any one area. Thus political participation is many-faceted and complex.

Looking back on the six concepts that we have singled out for special emphasis in the understanding and application of political science, we see that each one in itself has a good chance of becoming an arena of controversy in the policy-making process: Does a particular policy represent an "abuse, or a maldistribution, of power"? Did the policy process wrongly exclude deserving groups in the community? Does government intervention constitute a "misuse of authority" or the "abridgment of rights"? for example. The reason for this is that these concepts not only involve the *description* and *analysis* of politics, but the *evaluation* of politics as well. Each carries with it values and standards—How much power is good? What extent of authority is proper? Who should participate, and in what way? And beyond this is the question of political *effectiveness*, the capacity of the political system to act, to work, and get things done. Remember that Mussolini was originally complimented because "he got the trains to run on time." (Which later turned out to be questionable.) So the effectiveness of a governing arrangement, or of a public policy, also becomes (and hardly surprisingly) a criterion of value.

Finally, we are left with the question, "What is politics?" Political (or "public") authority, power, process, policy, institutions and participation all involve conflicts of value. Politics is the working out of these conflicts so that policies are made and governments can function. In democracies politics is marked by bargaining, compromise and accommodation, and it is this meaning of politics that is most common in America. In cases where there is policy unanimity within a political community, there is no politics, while policies that are imposed on a community also have no place for politics. Politics, therefore, occurs where there is conflict over social policies and where these conflicts are resolved with a minimum of value loss to any particular interest. Some members of the community will win, others will lose. Some will get more than others. But the gains and losses will be limited by the process of politics. Politics is often looked upon as a necessary evil, with suspicion and skepticism. But as you consider the different problems of public policy, and the conflicts and controversies over solutions that divide the community, imagine what policy-making would be without politics. It would be policy-making of absolute unanimity or absolute coercion, or both. Neither of these is consistent with our basic ideals of individuality and the free and vigorous expression of ideas.

3. Integrating Economics and Political Science

While economics and political science are separate disciplines, it is important to keep in mind that they have much in common, and that in effective analyses of public policy they almost always must be used together. Indeed, "Political Economy" has a long and distinguished tradition as an intellectual discipline itself. The similarities and differences between economies and political science are summarized in Figure 2.

Both economics and political science are concerned with human values, and with the decisions about these values that have social consequences. Both disciplines are social sciences, which means that both have similar standards of scientific logic, evidence collection, and

FIGURE 2

THE SUBJECT MATTER OF POLITICAL ECONOMY:
A Framework for Analysis of Political-Economic Policies and Issues

ECONOMICS (Economic Science)	POLITICS (Political Science)
FOUNDATION	
THE ECONOMIC PROBLEM (Wants > Resources → Scarcity, i.e., our wants exceed available resources and therefore scarcity exists)	THE POLITICAL PROBLEM (Conflicts of interest)
THUS	
I. Political economy is the study of the **methods** by which society—	
employs its resources (human, capital, natural, time) productively for the fulfillment of human wants.	resolves conflicts of interest over the authoritative allocation of values; thus a study of power.
Toward these ends	
Economics is a study of how a society decides—	Politics is a study of how a society decides—
a. **What** to produce (i.e., what wants to fulfill) and **how much** to produce	a. **What** goal values are to be sought and given authority
b. **How** to produce most efficiently (i.e., how to allocate resources most productively to their alternative possible uses)	b. **How** societies are to be organized for the pursuit and use of power and authority (i.e., mechanisms for resolving conflicting values, achieving social goals)
c. **For whom** to produce (i.e., who is to get what and how much and how is this to be decided)	c. **For whom** the organization exists (i.e., who gets what; whose goals are served?)
II. Political economy is the study of **social problems** relating both to the functioning of the organization as a whole and to its particular institutions.	
Both Economics and Political Science usually employ a problems approach involving three steps—	
a. **Definition of the Problem**—What desired goals are believed to be inadequately served by existing institutions? How does "what is" conflict with what many think "ought to be"?	
Economics is concerned with problems relating particularly to the goals of—	Politics is concerned with problems relating particularly to the goals of—
1. Efficiency and productivity	1. Justice in the exercise of power
2. Growth	2. Equity in the distribution of power (income, deference, security, influence)
3. Stability (both full employment and general price stability)	3. Freedom (both limits on the use of power and access to resources needed to realize individual potential).
4. Security	4. Effectiveness
5. Equity in the distribution of income	
b. **Understanding of the problem**—What concepts, what analytical tools, what facts do economics and political science have to contribute to an understanding of the problem and its proposed solutions?	
What do we know about how productively resources are being employed for the fulfillment of human wants related to the problem and the consequences for other values?	What do we know about value conflicts (i.e., conflicts of interest) related to the problem, how they are being resolved, and the resulting allocation and use of power?
c. **Public policy alternatives**—What are their economic and political implications? How may citizens, as individuals and groups, influence policy decision-making?	
What will be the probable consequences, both in the short run and long run (the seen effects and the unseen), for the economic goals stated above?	Who is proposing what and why? How does private interest relate to public interest? What are the probable consequences for the political goals identified above?
Thus what policy alternatives will bring the greatest net realization of values?	
I.e., a more optimal allocation (use) of resources (so that their marginal value products in all alternative uses are equal).	I.e., resolution of the problem with a minimum value loss to any participant and a maximum value gain to all.
Which policy alternative is most compatible with one's economic philosophy (i.e., one's view of the proper role of government in relation to the economy)?	
Should government's role in the economy be expanded or contracted. If so, where?	Can government be effectively organized to serve the roles assigned to it? How?
d. **Action**—How may one implement one's views?	
How does one act as consumer, producer, as a member of an interest group to bring about desired changes?	How may one as a citizen or leader participate in politics to be most effective in bringing about desired changes?

the construction of theory. In short, they share a common emphasis on verified explanations of patterns of social life. Both, therefore, are concerned with social problems. See Part II in Figure 2 for a summary of the four steps in a rational approach to the study of social problems.

But the two disciplines differ in their framework for analysis, institutions, fundamental concepts, and the type of evidence or "data" they most commonly employ. Economists and political scientists have therefore developed different areas of expertise. Economists are experts on the vast array of stable and changing conditions that are related to the distribution and exchange of goods and services. They concentrate their attention on the institutions or arenas where these economic decisions take place. The most notable of these are what economists call "markets," with their component buyers and sellers. Their data are commonly in the form of units of economic value—*money*—units that have the great advantage of precision and comparability.

Political scientists, on the other hand, are experts on the distribution and use of social power, and on the institutions through which that power is mobilized and made authoritative. Most notably, these are institutions of government, political parties, and elections. Since there are no measures of power or authority comparable to that of money and market values, political scientists use various forms of data to study politics, including votes, opinion surveys, laws, and judicial decisions. It is also true that just as economists recognize that actions of government affect economic conditions directly and indirectly, political scientists know that economic resources are resources of social power, and that economic issues are a major element of politics.

Insofar as alternative social goals can be assigned economic values, and markets exist in which these values can be expressed and measured, economic processes and analyses are effective means for achieving social policies. Cost-benefit analysis remains a classic way to choose among alternative human values and policy goals.

When, however, human values cannot be measured as "economic goods," or when markets are for some reason (such as monopolies) not effective in their pricing and distribution functions, then policy decisions tend to be moved from the economic to the political arena. The realm of politics can encompass conflicts among alternative human values and social goals of all sorts, with the resulting policies being enforced through the power and authority of government. For each of the social problems treated in this series, you will find it interesting to observe how both economic and political factors contribute to both the causes and possible solutions of the problems, and how economists and political scientists analyze, in their own ways, what the problems are and how they might be solved.

While we recognize the importance of the other social sciences and the extent to which they enhance one's understanding of public problems and issues, our aim here is to combine only two of these disciplines, economics and political science. The teacher resource materials contained in this and other units in the series provide concrete illustrations of how economics and political science may be combined for purposes of enabling students (1) to analyze and understand policy issues and (2) to participate effectively in the political process through which policy alternatives are examined, promoted and acted upon.

Topic Overview

Health Care for Whom?

Laurence E. Leamer and Paul A. Smith

Definition of the Problem

A social problem exists when "what is" conflicts with what many people think "ought to be," when the facts of our living differ from our values, when many think something is wrong with society or its institutions. Although some people think that health and health services in this country are satisfactory or even excellent, many think otherwise. Whether a serious problem really exists or not, our students will live in an age in which health care is certain to be one of our major political-economic issues.

The study of any problem should begin with trying to see clearly what is wrong in the eyes of those who are disturbed, including certainly our own students, their families and community. This we will briefly do next. Then we will turn to economics and to political science to help us further to clarify the nature of the problem as viewed from their unique perspectives. Finally, before delving more deeply into the background of the issue, we shall try to clarify further just what our goal is, i.e., what is this health we aspire for?

The Problem from the Perspective of the Layperson (and probably also our students)—Many people feel that a national health crisis is upon us. It is composed of many personal and family crises when serious sickness or infirmities strike. Even the healthy often live in fear of unexpected medical bills not covered by insurance. The following are some of the facts on which the layperson's sense of crisis is based. You and your students will probably be able to add concrete personal evidence, especially on the first two points.

1. *Health care is very costly and is becoming more so.* A short routine visit to a doctor's office is likely to cost $10 or more and a thorough physical exam perhaps up to $125 or more. In 1975 hospital costs rose 18.2 percent in just one year to a national average of $128.26 a day for each patient, or approximately $1,000 for a typical stay of eight days.[1] What does it cost in your community? Add to the figures above the physician's fees, special drugs, perhaps a needed private nurse, and so on. Your medical and hospital bills may well mount to many thousands of dollars, and health insurance at its best will probably cover only part of this. Each of us consequently faces the possibility of a medical bill that could wipe out a year or more of earnings, perhaps a lifetime of savings, or that might impose such a cost on our families or community.

2. *There are many shortages of medical services.* Try to find a doctor to make a house call, even in an emergency. Indeed in many communities, try to find a general practitioner at all (while the number of physicians has been increasing, the percentage providing the primary care of the generalist has been declining). Or if you live in one of the less affluent states, try to find a specialist. Or in many rural or inner-city areas, try to find a physician of any kind. Medical services are poorly distributed in relation to the people who need them. Shortages are common, while there are surpluses of doctors in some suburban areas. What is the situation in your community?

3. *The cost of publicly provided medical services is mounting rapidly.* From World War II until 1966 government expenditures for health care rose along with private expenditures. Publicy provided medical services cost slightly over 20 percent of all health expenditures. Then in 1966 came Medicare and Medicaid. Government expenditures mounted. Indeed, in 1975 Medicare expenses rose 30 percent over the prior year and

[1] For the most up-to-date figures on this and other statistical facts that follow see the latest issue of the February *Social Security Bulletin* of your library or a nearby Social Security office.

Medicaid 25 percent. In 1975 all government expenditures for health had risen to 42 percent of total health expenditures. As a result, almost 10 percent of all government expenditures, federal, state and local, were for health. This means higher taxes and/or higher payroll deductions.

4. *Our total national expenditures for health are mounting.* In 1950 4.6 percent of our GNP was devoted to health services. This rose to 8.3 percent in 1975 and is expected to rise to perhaps 10 percent by 1980. We as a nation are spending over $100 billion a year for health care; in 1975 we spent $118 billion for an average of $547 per capita or $2,188 for a family of four. Inflation is part of the explanation for these mounting expenditures. But in 1975, for example, the cost of health care services rose more than twice as fast as the rise in the overall cost of living. It is high time for us to try to see what is happening. Are we demanding and getting a rapid increase and improvement in the health services? Or is this a "sick" industry absorbing an increasing share of our national product but doing little more to earn it?

Enough, then, of this preliminary review of the nature of the problem nationally, and also in our community and in the homes of our students. Is all the furor over the high cost of medical care simply another episode in the persistent human quest of something for nothing and of scapegoats for the fact of scarcity? Is it a problem blown all out of proportion by politicians seeking issues to win votes? Is it a problem brought on by self-seeking interest groups out after more of the national product for themselves? Or is it a crisis which is inevitable whenever a nation changes its priorities and employs the political process to develop new and better organizational means to serve emerging goals? Indeed, is it a problem which should concern our young people at all? If there is a problem, have the social sciences—economics and political science in particular—anything to contribute to its understanding, and ultimately to its solution or alleviation? As the Introduction states, it is the central purpose of both economics and political science to help us to use analytical concepts to understand —and thus to act upon—problems of public policy.

The Problem from an Economic Perspective—Economics is the study of the economy, i.e., of the organization of society to cope with the *basic economic problem*. The economic problem arises from the fact that, given the state of technology, our wants are greater than can possibly be satisfied using available resources: natural resources, man-made capital resources, human resources, and time. *Scarcity*, i.e., limited resources, is a fact of life. We must therefore choose among the alternative uses to which resources may be put. Somehow societies must operate within an economy, an *economic system*, to try to make the best use of their scarce resources in the fulfillment of human wants. You will recall (or if you do not, you should review) that the concepts italicized above are ones stressed in the Introduction to these units as the basic concepts of economics. A central goal of your instruction should be to assist your students to understand and use them in the context of this problem.

One of our very important wants is for health and thus for goods and services (doctors, nurses, health teachers, hospitals, clinics, etc.) which help to preserve or improve ourselves. It would be great if health were a free good, if we could all be and remain healthy without even trying. Sometimes we can. Among the free gifts of nature (if we do not contaminate or misuse them) are the sun, the outdoors, the air, our generally healthy bodies—all of which can contribute to our physical and mental health. Indeed one of the problems of interesting many students in health is that they are of an age in which they are probably enjoying these free gifts without much concern for their potential loss.

But in part good health is not free. As civilization advances, we find that we use more of our scarce resources to preserve and protect the health we have. We try to improve our knowledge of our physical and mental selves. We spend more on technologies and facilities to improve and make more broadly available our health services. Therefore, a large and growing sector or our economy is devoted to the satisfaction of our wants for health.

The several basic questions around which we study economies as wholes have their counterparts in the study of a sector of the economy such as health.

- *What shall be produced and how much*? What health services do we want? How much of our national effort should be directed to meeting our wants for health? (always remembering that scarcity dictates that more and better doctors, hospitals, public health facilities, health education, free services for the aged and/or poor are usually provided at the "cost" of other highly desired goods and services and each other)—Review the *opportunity cost* principle as described in the Introduction.
- *How shall these goods and services be produced*? How are health services best organized—by individual family doctors, by clinics, by joint practices, through hospitals, by health maintenance organizations? What is the most efficient use of resources within the health industry? How can our resources best be used to produce the health goods and services we desire? What is the optimum balance of alternative and competing ways to produce what we want, e.g., of health research vs. health service, improved and expanded medical education vs. health education in the schools, more hospital rooms vs. more clinics, more aid to the aged vs. more preventive medical services for the young?
- *For whom shall the goods and services be produced*, i.e., how shall the output be distributed? Who should have access to health services? Who should be served by the most skilled people and in the best facilities? Are there people who should

receive no services at all? Is there a human right to health? (If so, why?) How much? What quality? And if there are not enough resources for all (there will not be), who shall be served, and ultimately who shall live and who shall die? Another side of this third question is how much should be paid to doctors, nurses, medical aides, pharmacists, health teachers, or those in another health care role? This determines what share of our total national product each will receive as compensation for his or her services, and how much health care will be available.

The problem of health thus relates to several economic goals identified in the Introduction. First and perhaps foremost it relates to the goal of *efficiency*. Are we making the best use of our available resources? Are human resources (doctors, dentists, nurses, teachers, aides) employed where they are most needed and in ways in which they are most productive?

Second, health relates to the economic goal of *progress and development*. A sickly people cannot be as productive as they might be. A growing economy is more likely to have the resources to devote to better health.

Third, this problem relates vitally to *economic security*. The threat of sickness and its costs endangers the security of many households, not only because of possible medical costs but also due to the possible cost of one's very employment.

Fourth, and related to all three of the goals mentioned above, the question of "health care for whom?" relates also to the goal of *equity*, i.e., justice, which is also a political problem. Is adequate health care a human right? Are we providing adequate care for all? If not, are we sharing it fairly? What is fair or equitable? How much should those who provide medical services be paid? Should those who render a very valuable service be paid more or do they have an obligation because of their skill to serve their fellows more?

Finally, the problem of health relates to *freedom*. The ill are not effectively free to work, to develop themselves, to enjoy the opportunities of life. Should the well or the young be free from having to contribute to the health care of the less fortunate? This issue is a component part of the political concept of freedom.

Throughout all these questions the basic economic problem identified above and its corollary, the opportunity cost principle, pervade. There is a scarcity of resources for health. More health services are at the "cost" of other desired goods and services: education, housing, recreation, etc. More preventive medicine may be at the "cost" of improved therapeutic health care. Our interdependent economic world is so often a cruel world. Almost every good seems to cost another good. Everywhere there are trade-offs among goals. Every solution seems to activate other problems. We must choose. We cannot have our cake and eat it too! We may not be able to devote all the resources to health care we would like and also have the many other goods and services we value.

The economic perspective exists to alert us to our choices and their consequences. Since we cannot have the very best of free health for all, the problem is to develop the health service sector of our economy so that the best use is made of the resources that are employed there rather than in other desirable ways. An important aim in teaching should be to help students to see and understand the health service sector of our economy in the context of the many other desirable goods and services we seek.

The Problem from a Political Perspective—The provision of health services is basically an economic problem, i.e., it concerns making the best use of our resources for the rendering of desired health-related goods and services. But conflicts of interest are involved in any attempted solution to the problem, as are concepts of freedom and equality. Political science provides an indispensable perspective for seeing and understanding these conflicting interests and values, and for understanding the process by which solutions are to be sought and the roles in this process you or your students may play.

Let us review very briefly, in the context of this problem, the several basic political concepts explained in the Introduction. They will be italicized when first used below. Vitally involved in every problem are people and groups with different interests, and probably different values. *Politics* is the process by which these value conflicts are resolved through *authority*, i.e., through procedures and institutions that the community accepts as proper channels of social power. *Power* is the prime mover in politics. It is seen when individuals and groups get others to do things they would not otherwise choose to do. When power is exercised so that authoritative units of government act to achieve recognized social goals the result is public *policy*. The involvement of individuals and groups in these political processes is called *participation*, and stable patterns of authority and action that emerge in the exercise of power are called political *institutions*. All of these concepts are applicable to problems of health.

While we are all in broad agreement on the value of health, we are not in agreement on its value compared with other competing goals. (How many of your students would give up a car or drive more slowly or stop smoking in order to have a clinic at school?) We disagree on the relative importance of different emphases on health. (Should there be fewer doctors in your community so that more are available where needed more?) We disagree on how much we should pay for health services and on how much those who provide these services should be paid. (Should a short visit to the doctor cost so much?) The healthy and the young probably see less need for health care than the sick or aged, especially if health care for others will "cost" the healthy and young goods and services they value. (Would your students gladly pay higher

taxes so that the aged and poor might be better cared for?) Likewise, the rich, who are now able to buy quality health care, may object to the cost of providing care of the same quality for all. (Do your students think that we should make new expensive medical technologies freely available to all if to do so means much higher taxes on all, including the young?) Thus conflicts of interests abound in the area of national health policy. Politics is the process by which these conflicts are resolved and authoritative public policy formulated.

One view of politics is that it involves private interests being rationalized in terms of the public good. The "public good" thus legitimizes a decision or policy. For example, teachers should be paid more (our private interest) because thereby our society will have better schools (public good). Or young people should not be taxed to pay medical costs of the poor (possibly your students' private interest) because such a system will foster a nation of irresponsible and lazy individuals (public cost).

Employing this perspective, we shall see the conflicting interests involved in the problem of health care (those of the doctors, the medical specialists, the nurses, the public health agencies, the patients, the public). Many of these or their spokesmen will be busily engaged in politics, i.e., in rationalizing their interests in terms of the public good and then participating in public policy-making, exercising power within the agreed-upon framework of authority. It is important for students to see that self-interest is not merely something that *other* selfish interest groups espouse; it is part of their own (and even your and my) human nature. Most of us are blind to this fact since we becloud our own self-interest by our belief that what is good for us is really good for society.

Thus a central goal of our instruction should be to alert our students to see themselves as political creatures. The political perspective should help us to understand ourselves and society better, and help us to play a more constructive and understanding role in the political process by which our conflicts of value are resolved and the general welfare and real interests of most individuals are best served.

Finally, and very importantly, the political perspective should assist us and our students to discover how we personally fit into the political process and thus how we may be more constructive and effective participants in public policy-making to implement the values we stand for. What organized interest groups (if any) really are employing political power effectively in the service of our goals? What roles may each of us play in the political process, as an opinion leader, as an opinion follower, as a citizen? And perhaps the ultimate and hardest question of all regarding political participation, how may the layperson recognize the competent and responsible authority on matters of public policy related to health care? Are there guidelines by which the great majority of us, who necessarily know less about national health problems and policy, can be guided by specialists and leaders who really know more?

Neither economics nor political science can provide final definitive answers to the questions above. Our goal in instruction can therefore be only to activate our students' interest in these matters. We hope that as a result they will be more understanding, more demanding of the economists, political scientists, and political and public leaders who specialize in the study of national health policy. For it is they who must lead in the formulation of better ways to implement our emerging and often conflicting goals regarding health services.

Health as a Goal: Its Meaning and Determinants—Sometimes the simplest concepts turn out to be the most complex. What initially seems self-evident we find we really do not understand. Probably it is this way with the concept "health." Thus as we conclude our preliminary formulation of the problem we should ask ourselves just what we mean by "health" as a goal.

The World Health Organization (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of distress or infirmity." The customary view of "health" is probably the latter, i.e., absence of distress or infirmity. A merit of the WHO definition is that it reminds us that health as a goal may be much more.

Health as a goal may concern not only physical health but also mental health. If we accept the WHO definition, we will be concerned not only with physical and mental well-being but also with social well-being. So defined, our goal is broadened to be almost equivalent to the good society.

Similarly, means to this end, whether narrowly or broadly defined, are more varied than first appears. Disease and infirmity are most directly attacked by curative or corrective medicine. Basically and minimally, health as a goal involves an attempt to provide resources for the cure of our typical ills and accidents. But another strategy, and probably a better one if possible, is to use resources for the *prevention* of disease or infirmity. Their prevention may involve more than medical palliatives. The physical environment is an additional source of poor health: environmental pollution, dangerous cars and highways, slums, poor sanitation, for example. So also is our cultural environment: poverty, cigarette smoking, drugs, overeating, drinking, careless driving, passive spectator sports and TV viewing, etc.

The auto is a greater killer and maimer of humans than almost any disease. So is the cigarette. So are overeating (in developed nations) and starvation (in most of the rest of the world). So are poorly balanced diets. Poverty, and frequently associated with it, bad nutrition, substandard housing, inadequate sanitation, and poor education are certainly important correlates of poor health. Some may even argue that the medical drama which so permeates our television makes hypochondriacs of many of us and thus harms our mental well-being.

The point of all this is that health as a goal involves

much more than merely keeping physically well. And the maintenance of a "healthy society" and cure of its physically, mentally and socially sick requires much more than merely more and better health services. For example, programs to alleviate poverty or to provide better health education may be better cures for or preventatives of sickness than would be improved or more broadly available medical services. This means that *the economic problem* of health is broader than we first envisioned: It may involve the better allocation and use of all resources for the attainment of many social goals. Similarly with the political problem: Health is related to the resolution of conflicting interests and goals by society as a whole.

Background and Analysis Relating to the Problem

Enough then of the broad definition of our problem. We must not let our knowledge of the complexity and broad scope of the problem become our rationalization for doing nothing, relying on freedom and market forces alone. Knowledge can be at the "cost" of action; rather our goal with our students should be to make knowledge a basis for informed and responsible action. But before turning to proposed policy alternatives and problems of choosing among them, we shall sketch further background. We shall first briefly review our current programs and policies. Then we will in turn review the economics of the health industry and the politics, including the interest groups involved therein. We recommend, indeed urge, that you read along with the materials that follow the JCEE's Economic Topics pamphlet on *The Economics of Health Care.* Part One, "The Health Care System" relates particularly to this section.

Our Current Programs as Revealed by their Financing—In 1975, as we pointed out above, we were in this country spending $547 per capita on personal health care. But for your students and all persons under 19 years of age the average health expenditures were $212 per capita; for those between the ages of 19 and 64, $472; and for persons 65 years of age or older over $1,360. Think about these figures for a moment. In 1975 per capita disposable personal income (i.e., average income per person available to spend or save after taxes) was approximately $4,750. Almost one-tenth of what we have to spend goes for health. And health costs are highest in the later years when incomes are generally declining. Like education for the young, medical expenditures for the aged cannot always be paid for by the recipient when he or she is served. Somehow their costs must be shifted to others or paid for when the recipient has an adequate income. Roughly only one-third of the average per capita annual health costs is paid directly by the patient. Approximately one-third is paid by the average patient's private insurance plan—for this the individual and/or his or her employer have been paying premiums. The remaining third of personal health costs is paid by the government, and thus by taxes. Let us look more fully into these last two-thirds, first the financing of personal health care through private insurance and secondly through government.

Approximately three-fourths of the civilian population have some form of private health insurance. Of these civilian private insurance owners, 42 percent are insured with Blue Cross/Blue Shield, 62 percent with other private insurance companies, and 6 percent with Health Maintenance Organizations (the total is above 100 percent because some have insurance in more than one category). Three-fourths of all these private insurance owners are insured by their place of employment; with the employer paying part or all of the premiums.

Blue Cross covers hospital costs. It employs a *service benefit* approach, i.e., it pays the hospital the total cost for allowed services, e.g., for a semiprivate room. Thus as hospitals charge more for this service, premiums for this coverage rise. Blue Shield covers surgical costs, but on an *indemnity* basis, i.e., paying a specified amount per designated operation with the patient paying the remainder. Thus as surgeons' charges rise, the patient pays the whole amount of the increase.

Private insurance companies usually employ the indemnity approach in covering both a patient's hospital and surgical costs. But in addition to Blue Cross/Blue Shield or private insurance company hospital and surgical coverage, one may also purchase (or his employer may purchase for him) Major Medical coverage. It is to assist in very high expenses not covered by the above policies. For example, it may pay expenses after $15,000-$20,000 per family member. Then it usually provides for deductibles (i.e., for the patient paying a certain percentage of costs above the deductible amount, often 20-25 percent).

The 5 percent of the insured civilian population who belong to Health Maintenance Organizations (HMO's) have a very different arrangement. The HMO has its own staff of physicians and usually its own hospital. Thus it generally fully covers all allowed hospital and surgical costs on a service basis. Physicians are not paid a fee-for-service rendered but rather a salary (like teachers for example). Differing from Blue Shield and most private insurance contracts, nonsurgical physicians' services are also covered, e.g., clinic, office, and sometimes even home visits. As their name implies, HMO's are concered with preventive medicine and thus encourage physical checkups and health maintenance visits by its members by charging no fee-for-service.

In summary, Health Maintenance Organizations are financed fully by sponsoring companies and usually by membership fees charged to the insured. Blue Cross/Blue Shield and other private insurance plans are usually financed jointly by employers and the insured, but with the latter picking up part of the hospital/surgical costs. In general, the insured pay approximately one-third of their total personal medical costs—often around 20 percent of their hospital costs, 60 percent of their physicians' charges, and an even larger percentage of their drug, nursing home, and dental costs.

The third of all personal medical costs that is financed by the government consists of programs particularly for the aged and for the poor. First there is Medicare. Medicare is a government-sponsored social insurance program in which eligibility is based on age, not need. One must be 65 or older. Like Blue Cross/Blue Shield, its benefits fall into two parts. Part A provides for hospitalization and related services. It combines a service benefit approach (e.g., covering hospital expenses for the first 90 days) with cost-sharing. Part B relates to physicians' services. It too combines service-type benefits with cost-sharing. For example, there is a deductible amount the individual must pay, plus a coinsurance provision by which the individual pays 20 percent of the amount above the deductible sum. Part A (hospital) is financed by a payroll tax. Part B (physicians' services) is voluntary and involves a monthly premium paid one-half by the person and one-half from public funds.

Medicaid is a federal/state governmentally supported program of public assistance to persons on welfare. It covers hospitalization, physicians' services, and nursing care. Medicaid, differing from Medicare, applies to all ages. For further and more up-to-date information on Medicare or Medicaid see a recent almanac and yearbook.

Economics of Health—The problem of providing adequate health care is basically economic. We simply do not have enough human and material resources to satisfy all our desires relating to health and also our many other desires. The economic problem of scarcity exists. Also we may not be making the most efficient use of the resources we now devote to health. Efficiency, remember, is the central goal to which economics relates. In this section we will briefly survey our health services just as economists would survey any industry. First we will take an overall view of health services as an industry. Then we will look at the demand for health services, the supply, and finally the resulting prices and the allocation of resources—in other words—at the market. We recommend, indeed urge, that you read along with this section the JCEE's *The Economics of Health Care*, pp. 1-7, where this topic is developed more fully.

Health services are the third largest industry in the United States. Indeed in 1970 one out of every 20 persons employed in the nation was in the health services. It is probably higher today. We tend to think of health services as being rendered by physicians. But actually there are approximately 12 other persons employed for every physician (3 clerks, 3 aides or orderlies, 2 nurses, 1 practical nurse, 1 cleaning person, 1 medical or dental technician, and 1 food preparer). It is probable that many of your students will be so employed. Indeed, they should be alerted to the many skilled and challenging occupational areas in health services: e.g., nurses, medical technicians, dietitians, skilled therapists, paramedics. In addition, there are closely related occupations in, for example, the pharmaceutical industry, health education, hospital administration, hospital architecture, and even medical economics.

Two-thirds of those employed in the health services are employed in hospitals and nursing homes. Thus these plus the many doctors' and dentists' offices, the drug stores, and clinics are the places of business for the medical services. As mentioned earlier, the health services are not only a large industry but a rapidly growing industry. For a more recent and more complete statistical picture of the health industry we recommend that you or your students consult the most recent *Statistical Abstract for the U.S.* Browse through the section on Health in Part I of Vital Statistics.

In economics we are concerned with the market through which an industry serves its customers. Probably the most striking contemporary fact related thereto is the rapid rise in the cost of health care and the large increase in health expenditures in the U.S. Why? In economics we look at demand and supply. Why the sudden increase in demand? First of all, our population has been growing. But most important, the proportion of older people has been increasing greatly; we have seen they are the greatest users of health services. Secondly, as a result of new technologies and new medical techniques we desire types of health care that were not previously available. For example, the aged used to be cared for in our homes; now we usually employ nursing homes. Children were born and cared for at home; now they arrive in maternity wards of hospitals, may be cared for in children's wing of a hospital, and are kept well by skilled teams of medics and a vast array of medicines and therapies. Today when we go to our doctor or the hospital we are tested, kept well, or cured by an amazing battery of new technologies. Health is now much more than a country doctor and an aspirin.

Thirdly, our demand for health services has been growing because our incomes have been growing, but it is the distribution of income that affects the distribution of good health. The poor cannot afford to be sick, and when they are, they may have to rely on letting nature take its course. The more well-to-do spend more on health, not only physical but often mental health as well. Finally, a very important reason for increase in demand has been the rise of new ways of financing health expenses—by insurance and by the advent of Medicare and Medicaid. Because on the average the direct cost to us is only about one-third of the actual cost of medical services (the other two-thirds being paid by government or insurance), some may demand medical services they would not seek if they were directly paying the entire bill. For all these reasons the demand for health services is increasing.

Indeed, the demand for health services differs in several important ways from the demand for most other goods and services. According to conventional economic analysis, the consumer in a free enterprise economy, knowledgeable of the alternatives and knowing that he or she must pay the full cost of whatever he or she chooses to buy, decides whether to purchase a desired good or service. But these conditions are not usually true in the case of most expenditures for

health. The consumer (patient) is largely ignorant about the quality and even the price of the service about to be purchased. Indeed the medical profession generally aims to keep it that way; their "ethics" do not permit them to advertise. Thus efforts of self-designated "public interest" groups to provide consumers with knowledge about doctors' specialties, education, charges, and records have been resisted. Professionals sometimes (and not only doctors) favor competition for others but resist it in their own profession.

Once the patient has chosen a doctor it is usually the physician who decides what the buyer is to purchase in the way of medical care. Since so vital a thing as health is involved, the physician is probably told to spare no expense. Few of us would give our plumber or auto repairman or even our school superintendent such freedom. It is we who will pay the bill but our doctor who influences our demand for his or her services. Our doctor, of course, will probably be concerned about the costs to us. But even his or her judgment may be influenced by the fact that most patients, protected at least in part by insurance, will not directly have to pay the full cost. Also the modern physician, threatened by potential malpractice suits, may be prone to be indifferent to the patient's costs. A less expensive procedure could be at the "cost" of an expensive negligence involvement by the doctor. The opportunity cost principle has unusual applications.

There are likewise complications on the supply side of the market for health services. For example, the limited supply of doctors is in part doctor-made. Why? Although the incomes of doctors are generally high (a situation which should normally increase their supply), their number has been restricted by limited admissions to medical schools. Similarly, the medical profession has established rules that forbid nurses, pharmacists or paramedics from performing services that doctors normally perform. Likewise the medical profession has often opposed innovation in medical organization (e.g., HMO's). Of course in all such cases the profession justifies its position in terms of what it believes to be in the public interest. You remember this practice is a nearly universal "political" act. We as teachers often do the same; so do most professional groups who control a highly valued service or good. There is a potential monopolist in most of us!

Our economic policy alternatives relating to the market(s) for health goods and services become clear. Shall we try to make those markets more effectively competitive? Or if that is impossible, or will have undesirable results, how may we develop effective systems of self-control and/or public control? In general, then, how may we best organize the health service industry and markets so that they will be efficient in the meeting of human wants and equitable in the way they serve? The role of economics as a social science is to assist in this quest.

Politics of Health—Repeatedly in the foregoing paragraphs we have seen economic considerations leading to politics—to the exercise of power and the necessity of utilizing authority for making public policy relating to the health service industry. We shall now identify the prime actors in the political drama concerning health services. Whose interests are involved? Who speaks for these interests? Then with our actors identified, we shall briefly review the history of the politics of this issue. The history, of course, leads to the current political situation including roles and strategies your students (and their teacher) may play in deepening their understanding of this issue and in exercising their own political power for public policies they favor. We hope that we will thus bring concrete meaning to the fifth and final basic political concept described in the Introduction, i.e., political *participation*.

The basis of politics lies in conflicts of value. The working out of these conflicts so that public policies are made and governments can function is politics. Like-minded citizens who organize into groups have more political "resources," and therefore have more influence. In the politics of health services there are several interest groups engaged in the formulation and promotion of policies that serve their interests as they see them and also the public good as they view it.

First of all there are the physicians, approximately 350,000 in number. The most influential organization speaking for this group is the American Medical Association (AMA) to which 175,000 physicians belong. Like most dominant associations of the economically very successful, the AMA has been a strong, conservative force, an agency to preserve the favorable economic status of its members and to oppose most new institutions that might jeopardize or change this status. Thus, the AMA has sought to preserve the fee-for-service system of paying doctors and the right of doctors to be free from government regulation of their fees or practices. For this and other reasons it has opposed most efforts to change (i.e. "reform") the health care industry.

But there have been other spokesmen for other branches of the health industry—the Health Insurance Association of America for the insurers, and the American Hospital Association for the hospitals. The AMA and other organizations are not monolithic associations. Politics is involved *within* a professional group or an association to determine who will speak for the group and what he or she will say. For example, within the AMA, the surgeons, the salaried doctors from universities and clinics, doctors employed by government, and young doctors and interns have at times dissented from the seemingly monolithic voice of the AMA. It is important that our students see these interest groups (particularly those with which they disagree) not as scheming giants opposed to the general interest, but generally as well-meaning associations which are seeking ways by which their self-interest may serve the general welfare. Because people have different values, one man's "special interest" may be another person's "public good."

A second category of interest groups is composed of

those largely outside the health industry but which have a strong interest in the health of the nation (and thus of their members). The AFL-CIO is an example of such a group. It has sponsored studies, published analyses for the general citizen, and engaged in political action related to health. The Committee for Economic Development (CED), an organization of generally liberal business leaders, is another such body which finances serious studies of current issues and publishes reports to influence public policy. The CED's *Building a National Health-Care System* of April 1973 is such a report.

In the politics of health (and many other public issues) there is a third category of actors ranging from persons and organizations engaged simply in the scientific study of the problem, to intermediaries between these scientists and the public or interest groups (e.g., journalists, teachers, advisors and even the JCEE through this booklet), and on further to persons or agencies directly advocating some policy position. For example, health social scientists are to be found in the medical economics departments of medical schools and economics departments in several universities of the nation. Private research agencies sometimes have such members. In many government units, particularly HEW and sometimes in state or local agencies, there are professionals engaged in these roles. Organized "public interest" groups, such as Ralph Nader's Public Interest Health Research Group, engage in study, reporting and advocacy. They concentrate specifically on the nature of the "public interest," but no way has yet been found to reach agreement on what it is—so that too remains a political question. As our students study the politics of health they should certainly become acquainted with all three categories of interest groups.

What has been the history of the politics of health, the history of the conflicts of interest which we now seek to resolve with a minimum of value loss to any particular interest and a maximum contribution to the interest of all?

The value of health and the services of a good doctor have of course long existed. But the idea that the government should do something about it was first expressed in the late 19th century. Compulsory accident and sickness insurance was first enacted in Germany under Bismarck in 1883-84. In the United States the late 19th century reform movements, especially of the Populists, included such insurance on their political agendas. But the Great Depression of 1929-1940 brought the matter to the fore. The Social Security Act of 1935 included old-age assistance and provision for medical expenses for the elderly, jointly financed by the federal and state governments. In 1946 Britain passed a comprehensive national health insurance act; Canada followed in 1958. In 1960 we initiated a series of reforms. The Medical Assistance for the Aged legislation was enacted, and the Kerr-Mills bill, providing public assistance benefits for those not already recipients of welfare aid, was also passed. Then in 1960 came Medicare and Medicaid. In 1970, the Occupational Safety and Health Act provided for additional government involvement in health care. The Occupational Safety and Health Administration (OSHA) sets policy and develops programs to promote safety and health on the job. By setting federal safety and health standards, OSHA tries to reduce the incidence of employment-related personal injuries, illness and deaths among working men and women in the U.S.

The idea that health services are basic human rights, like education, began to be accepted by many people. The consequences of this right, if it is one, are widely discussed. By 1970, or soon thereafter, most interest groups had come to recognize that some form of universal health insurance or health coverage was in the offing. The only question was: what form? The following had their plans: the AFL-CIO, the AMA, the Nixon administration, the Health Insurance Association of America, the American Hospital Association, the CED, and several medical economics scholars (notably Martin S. Feldstein of Harvard and H. M. and A. R. Somers of Princeton).

Although President Nixon sought to initiate a program in 1971, only discussion and debate, but no action, ensued. While there is wide agreement that something should be done, the conflicting interest groups are far apart on method. Senate and House Committees continued occasionally to hold hearings. Prodded by the explosion of medical costs, popular magazines continued to run articles (be sure to consult the *Readers Guide to Periodical Literature* for citations). The political parties select issues that will win votes, and medical care is among them, since almost no one is against some form of health care. In 1976 both major political parties dealt with health care in their platforms. It seems almost certain that some health plan will be voted on and implemented in this decade. Thus there will be politics—bargaining, compromise and accommodation. There will be leaders exercising persuasion in efforts to get others to follow their will. And there will be institutions, such as the political parties, and the Congress and the Presidency, through which policy will be made. Our goal as teachers is to prepare our students to observe and understand this political-economic process, this contemporary experiment in public policy-making, and probably to exercise their own power intelligently and effectively if they choose to. For the practical aim of the study of politics is to improve political participation.

Policy Alternatives

What then are our policy choices? What is being proposed to solve or alleviate the problem? Finally, how does the layperson choose among them? Having chosen, how may one make oneself politically effective in support of the preferred course? And since the "winner" which emerges from compromise is unlikely to be yours, how does one respond to the public policy decision?

Major Proposed Alternatives—Four major alternative or complementary types of proposals have

been suggested:

1. Provide incentives for voluntary purchase of private health insurance. Tax and other incentives would be used with employers and employees. For example, the AMA's "Medicredit" plan would give individuals tax credit against their income taxes for health insurance expenditures. The American Hospital Association's "Ameriplan" would employ a benefit payment rather than tax credit. The Health Insurance Association of America's "Healthcare" would provide incentive tax reductions. Note that the stress here is on voluntary action but with tax incentives to individuals and firms to do what is desired. The health care industry is left largely as it is.

2. Mandatory private insurance plus a program of benefits for the poor. Employers would be required to purchase private health insurance for their employees. This was central to Nixon's proposed National Health Insurance Act; employers were to pay two-thirds, and employees one-third. Provision would be made for voluntary purchase of insurance by persons not covered by this scheme. Also in the Nixon plan, the federal government would subsidize coverage for low-income families with children, fully for families of four or more with incomes up to $3,000 a year, and partially for other low-income families.

3. Comprehensive government-operated social insurance under a government-financed system. There would be compulsory coverage of the whole population, financed by payroll taxes and general tax revenue, and administered by government and not by private insurance companies. The Kennedy-Corman National Health Security Plan follows this course. It, however, allows individuals either to join a comprehensive health service organization (e.g., an HMO) or to enter a fee-for-service arrangement as at present. Others who favor this alternative feel that the health service industry must in whole or part become a government enterprise (like the public schools) if it is really to serve effectively and efficiently.

4. Strengthen and extend Medicare to the entire population. The program would be financed by payroll taxes as at present but with federal revenue added. But differing from the plan just above, private insurance companies would be retained and employees might opt out of the program if they privately purchased adequate insurance. We suggest you review our policy alternatives as developed more fully in JCEE's *The Economics of Health Care* pp. 7-10.

Major Policy Issues—The differences among these four alternatives should help us to identify the basic policy issues involved. These are:

1. Who should be included? The entire population or only those who do not now have adequate coverage or only the poor?

2. What should be covered? Everything; only selected health care and only to a limited amount; or should individuals and families cover normal medical expenses for themselves thus confining coverage under the legislation to catastrophic expenses (thus to Major Medical)?

3. Should participation be voluntary or mandatory?

4. How should the plan be financed? Privately or by government? If the latter, by general revenue or by payroll taxes on employer or employee?

5. How should it be administered? Should insurance be through government or through private carriers? Should medical services be provided through private enterprises, through HMO's, through clinics and hospitals, or through government enterprises?

But basic to the policy issues are the problems identified at the beginning of this paper, problems as seen by laymen and economists.

1. Just how much of our GNP are we prepared to devote to the health services? We are approaching 10 percent. Should we be using more? If so, what other goods and services do we reduce? One of the major measures of your success as a teacher of economics will be whether you and your students develop a habit of appraising what you want in terms of its opportunity cost. What would be the opportunity cost of more and better health care? What would be the opportunity cost of increased expenditures on accident prevention? What are the direct and indirect costs that a program like OSHA places on employers by requiring them to furnish each employee with a hazard-free environment? How might these costs ultimately affect the price of goods and services?

2. How much of our resources should be devoted to better health services and how much to alleviation of some of the causes of poor health? Should our strategy be to build a more healthy society, or to repair the personal and social consequences of our failures?

3. How can we get a more efficient organization of the health care industry? More emphasis on preventive medicine? Services effectively available to the poor, to all geographic regions? How can we get better use and organization of the resources we have? Will fee-for-services or salaries more likely provide incentives and employment conditions to stimulate the best performance? How can we build incentives for efficiency into our health care system? How can we assure an effective system of accountability?

4. People will be motivated by their self-interest and thus will employ politics (that includes not only doctors but all of us). How can we best build an organization or organizations that will structure the interests of physicians, hospitals, insurance companies, nurses and consumers so that they serve the interests of all or most? Should we try to move toward a more effective competitive free enterprise economy in the health services or should we move toward more government control and operation, and higher taxes? Or should we be developing a mixed system, with private enterprise where it is likely to work but with government operation or other organizational plans where they seem more appropriate? Is it possible to develop an effective system of self-control into the parts of the health industry itself?

How Does One Choose? How May the Citizen Influence Health Policy?—In view of the preceding economic questions, how does one choose among such varied plans? What may one do to be politically effective in support of what one believes? With such questions, political science becomes relevent to us again.

The idealistic view of the intelligent citizen is that he or she carefully studies all alternatives, makes up his or her mind, then casts a vote and abides by the results even though they may be disappointing. A similar simplistic view is often held by those of us who are social studies or social science teachers; we imagine that by "solving" social problems in our classrooms or by showing our students the alternatives we thereby prepare them to vote intelligently. But all this is a figment of the imagination. The closest individuals will probably ever come to voting on this issue will be in a presidential or congressional election in which, if health care is an issue, it will be only one of many issues. How then may your students (and you) become involved?

A few of your students may see health care as an issue which they would like to continue to study (certainly a short unit at school should have taught them how much they still do not know). Later they may participate in a committee of local citizens who continue to study the matter in the League of Women Voters, the Chamber of Commerce, or the regional health care board. Some may become in your community "opinion leaders" recognized for their knowledge of health problems. They may be public representatives on local hospital boards or HMO's. They may organize or lead local forums on the subject. They may write letters to the local newspaper expressing their views on local and national issues relating to health policy. They may become active members of local public interest groups whose general position they support, e.g., possibly Ralph Nader's self-styled Public Interest Health Research Group or a Political Action Committee of their union. Indeed one of your students might even run for Congress some time, making this a major issue.

Probably some of your students will be employed in some phase of the health services; indeed one of your teaching goals should be to alert them to vocational possibilities here. It is certain that all your students will be employed in an industry which will participate in financing health services. Thus they will become members of special interest groups. Probably little you now teach them will determine your students' later stance on this issue. Rather it is the union or professional association to which they belong, the firm in which they are employed, the opinions of their fellow workers or managers or bosses that will largely determine their views.

But within these special interest groups we may exercise leadership. As we choose leaders of our interest groups, we influence whether they provide responsible leadership on our behalf. As we become aware that all of us rationalize our private interests in terms of the public good as we see it, we may become more open-minded participants in the democratic political process. We may be mistaken as to what is to our interest, in the short run and long run; so also with what is really in the public interest. And thus the compromise which is likely to result, while fully satisfying to no one, may become a platform of experiment and experience from which future builders of a better health service industry may orient their reforms.

In addition to our special interests many of us may have our policy views influenced by our social-political-economic philosophy. There will in a free society always be conservatives whose interests and genuine devotion is to the *status quo* or even to what once was. They are indispensible stabilizers of society and challengers of new, perhaps poorly formulated, ideas for change. There will always be persons who advocate change, persons whose interests are usually involved in altering the social structure. Then there will be the great masses of us who ride along with the views of the interest groups to which we belong, or with those with whose general philosophy we agree. We are the "opinion followers."

A central objective in teaching this unit is to make this "ride" more comprehensible to our students, to alert them to the problems of providing proper health care to all and to proposed alternative solutions. But we cannot give them the answer. Another objective should be to assist our students to understand themselves as political persons, to learn how they as members of special interest groups may see that their group is guided by competent and responsible scholarship as its opinion leaders develop policy positions. Finally, our goal should also be as teachers to activate a few to become "opinion leaders" or politicians who will devote their lives in part to the building of a freer, more efficient and more equitable society embodied in the health services.

An Illustrative Case Study

Your own community will probably provide the most useful case for applying the economic and political science concepts defined in the Introduction and employed above. Your students will probably be able to document the problem as defined in the first part from their own experiences and those of their families. Your community may be facing its own difficulties and controversies in health care.

Is yours one of the many communities in the nation without a doctor (or with too few)? Or is your community having problems supporting several competing hospitals with duplicating services; thus are you discussing possible consolidation? Do the poor and the aged have effective access to needed health care? Are your nursing homes overbuilt or inadequate? Is there an HMO? Have your health insurance rates been increased recently? Should health education and basic medical care be provided in your public schools? These are but samples of health care problems that probably are around you.

Remember, as you study your local case, to apply

the basic economic and political questions to it. *What* do we want? *How* efficiently are we organized for satisfaction of our health wants? *For whom* is the organization working and are all those who should be served being effectively served? How could the use of our local human and capital resources in the health industry be improved? More of some desired service will be at the "cost" of what other desired service (i.e., the opportunity cost principle again)?

And as you view a local health problem from a political science perspective, notice the clash of interests involved. Note how interest groups try to exercise power in their behalf—using the power of words, of money and of prestige. Note how the political process is used to try to reconcile these differences, to find a solution probably completely pleasing to none but partly satisfactory to many. Note how individuals participate in the making of public policy. Note how everywhere private interests are being rationalized in terms of the public good. Note the role of scientists, of opinion leaders, of interest groups, of politicians in the process.

In these ways your students should be able to share in your community's effort to answer the question, "Health care for whom?"

A Selected Bibliography for Teachers

JCEE Economic Topic Series, *The Economics of Health Care*. Analysis by N. Tor Dahl and E. David Emery. Teaching Suggestions by Edward Prehn. New York: Joint Council on Economic Education, 1974 (mailing address: JCEE, 1212 Ave. of the Americas, New York, NY 10036). 16 pp., sold singly or as a set of 30 analyses and 1 complete booklet. A filmstrip is also available. This is a nearly indispensible complement to this unit. In particular it supplements our materials on economics and on policy alternatives. Differing from this JCEE Economics-Political Science Series, the analysis part of the JCEE Economic Topic Series is written for students.

Robert D. Eilers, *Financing Health Care: Past and Prospects*. Minneapolis: Federal Reserve Bank, March 1974, *Exponent* No. 7, 32 pp. (mailing address: Federal Reserve Bank, 250 Marquette Ave., Minneapolis, MN 55480). Free classroom copies available. An excellent readable short coverage of the topic. Be sure to get a copy for yourself and perhaps others for your students. It is descriptive in nature; you will need to supplement it by an economic and political perspective.

Committee for Economic Development, *Building a National Health-Care System*. New York: Committee for Economic Development, April 1973, 105 pp. (mailing address: CED, Distribution Division, 477 Madison Ave., New York, NY 10022). $2.10 per copy including postage; a free copy is available to high school teachers who mention course title for which publication is to be used. An excellent booklet with many useful charts. It is a good example of how a business group is trying to contribute to public discussion of the issue and to the choice of a new health care policy.

Social Security Administration of HEW, *Social Security Bulletin*. If this periodical is available in your library, you will find it to be your best source for recent statistical information and charts. You might also visit your local Social Security office to see a copy. Browse through recent issues. The following are two illustrations of recent very useful articles (these two articles are published every year in the months indicated):

"National Health Expenditures, Fiscal Year 1975," February 1976, Vol. 39, No. 2, pp. 3-20.

"Age Differences in Health Care Spending, Fiscal Year 1975," June 1976, Vol. 39, No. 6, pp. 18-31.

AFL-CIO, *The American Federationist* and *Viewpoint: AN IUD Quarterly*. Washington: AFL-CIO (Mailing address: AFL-CIO, 815 Sixteenth St. N.W., Washington, DC 20006). These two publications often have articles expressing AFL-CIO's views on the issue. Free copies are usually available in limited quantity. They are generally very well written and well illustrated. The following are illustrations of recent articles (by the time you read this there will be others):

Representative James C. Corman, "Now More Than Ever: We Need a Health Security Act," *Viewpoint*, 5, No. 1, First Quarter 1975, 29-33.

"National Health Perspectives: 1973," *Viewpoint*, 3, No. 3, Third Quarter 1973.

"Special Issue: National Health Security—The Only Solution," *American Federationist*, May 1973.

"Health Care Cost: A Distorted Issue," *American Federationist*, June 1975.

"National Health Insurance: Diagnosing the Alternatives," *American Federationist*, June 1974, pp. 7-14.

Scientific American, September 1973 issue or its reissue in book form under the title *Life and Death and Medicine*. San Francisco: W. H. Freeman and Co. An excellent, scholarly, though readable study. The following three chapters apply to our topic:

Martin S. Feldstein, "The Medical Economy," pp. 112-119.

James L. Goddard, "The Medical Business," pp. 120-128.

Ernest W. Seward, "The Organization of Medical Care," pp. 129-135.

See also the bibliography on pages 10 and 16 of the JCEE *Economics of Health Care*. For very recent or current information see—

Readers Guide to Periodical Literature under "Medical Laws and Legislation," "Medicare," "Medical Policy" and related titles.

Social Sciences Index under "Medical Care," "Medical Economics," "Insurance—Health," and related titles.

Statistical Abstract of the United States, Part 1, Vital Statistics—Health.

A current almanac (*World, Information Please, CBS News, or Reader's Digest*) for summary of Medicare, Medicaid, or other current legislation.

Watch for hearings on national health policy con-

ducted by Senate and House Committees such as:

Senate Land and Public Welfare Committee: Subcommittee on Health.

Senate Finance Committee: Subcommittee on Health.

House Ways & Means Committee: Subcommittee on Health.

Joint Economic Committee

Also watch for findings concerning the nation's health issues from time to time by the U.S. Department of Health, Education and Welfare (HEW), probably by the Secretary or by the Health Resources Administration or Social Security Administration.

Rationale and Objectives

prepared by
Lawrence W. Bloch

Rationale

Health care has become the third largest industry in the United States, with a total expenditure of well over $100 billion in 1975. Costs of health care have gone up faster than the rising cost of living in the past 20 years. Hospital costs, in particular, have risen even more rapidly, going up almost 10 percent annually between 1960 and 1970. Many health economists feel there is little correlation between health expenditures and the true quality of health care or even lower mortality rates.

One of every 20 persons in the labor force is employed in health service industries today. Being a potential employee, but certainly a consumer of health services, it is vital that today's student has some understanding of the many economic and political factors affecting health care.

This premise is further supported by the confusion surrounding the myriad models of financing mechanisms for medical care by both private and public sectors. The student, as a potential consumer, must learn his or her way through the maze of Blue Cross, Medicare, H.M.O., and National Health Insurance. Many political leaders agree that the present system of financing medical care has glaring defects.

Even though the vast majority of Americans has some sort of private medical insurance, major illnesses or accidents can still bankrupt the middle-class family. For people over 65, who have large medical costs on limited incomes, the government has assumed much of the cost through the Medicare program. Even here, there are still out-of-pocket expenses for the elderly not fully covered by Medicare. The United States remains the only industrialized country in the Western world without some form of National Health Insurance. Various plans have been put forth to meet the problems of the extraordinary rise of medical costs in the United States.

In addition to financing medical costs, another major problem is the delivery of health care services. Health service, being a scarce economic good, is not evenly distributed throughout the country with relatively less service in rural regions and inner city areas. The poor tend to have far less access to medical services than those with higher incomes. In fact, the delivery of health services has changed very little in the last century. It has been described as one of the last "cottage industries." Some critics have suggested a complete reorganization of the delivery of health care in the United States.

The extent of government involvement in health care will be one of the major issues facing legislators, and so in turn, an issue for the voter. The choices to be made regarding health care delivery and financing are difficult and will involve considerable thought and energy in the next decade. Youth must be informed of the issues.

Objectives	Activity Implementing Objective
The student will:	
1. interpret charts and graphs containing data on health care costs and expenditures	No. 1
2. employ cost-benefit analysis for assessing alternative health care policies	Nos. 1, 3, 4
3. apply concepts of supply and demand to explain and/or predict	

price trends in the health care industry	Nos. 1, 2
4. identify practices and policies that have resulted in a modification of the market for health care goods and services	No. 2
5. identify the major interest groups involved and state the position of each on proposed health care policies	No. 3
6. describe and state reasons for the present distribution pattern of health care goods and services	No. 3
7. identify and state value issues involved in the controversy over national health care policy	Nos. 4, 5
8. clarify his/her value position and identify the policy alternative most consistent with this position	No. 5

For ease in duplicating the classroom handouts, all student materials are found at the back of this volume.

Instructional Activities

prepared by

Lawrence W. Bloch

Instructional Activity No. 1

Rising Costs of Medical Care in the United States

Recommended Use: Introductory activity for 11th-12th grade courses in Contemporary Issues or Economics.

Time Required: Two-three 45-minute class periods.

Materials Required: Visuals A-D and Student Reading No. 1

Rationale: To understand the extent of and reasons for the rising medical costs in the United States in the last 25 years.

Concepts: Cost/benefits, gross national product (GNP), index number, amount vs. percentage.

Instructional Objectives: Given charts and graphs containing data on costs and expenditures for health care, the student will:

1. demonstrate understanding of the nature of the data provided by:
   a. defining key terms (GNP, Index Numbers, etc.) used in headings or to label columns and axes,
   b. distinguishing between amounts and percentages.
2. compare costs of medical care for selected years between 1950 and 1975.
3. compare price increases for different types of health care services from 1950 to 1975.
4. state hypotheses as to why costs for certain health care services have risen sharply while the costs for others have remained relatively stable.

5. identify types of health care services paid by the individual, by insurance companies, and by government.
6. through discussion, state and weigh costs and benefits of government expenditures for health care.

Teaching Strategy	Pupil Activity
1. Introduce topic by having students discuss special health care costs they or their families have encountered over the past several years.	Discuss costs of personal health care or health care for their families.
2. Project visuals A and B. Before having students attempt to interpret data, you may wish to review the following terms: GNP, Per Capita Cost, Index Number. *Note:* You may wish to present (or have students collect) data on health costs in the local area and have the class compare these to national statistics.	Using data provided on visuals: a. compare the rising health costs in 1950, 1960, 1970, and 1975. b. identify medical services showing the greatest cost increase between 1950 and 1972 and hypothesize reasons for the rise. Try to account for unusual rise in hospital care and nursing home care and relatively stable costs of prescriptions and drugs. Explain and compare the per capita cost for health care in 1966 and 1975.
3. Follow up discussion of high cost of medical care with Visual C and Student Reading No. 1 in order to give students some idea as to who pays the over $118 billion health bill in the United States. Have students explain main details of the chart. Be sure to include a discussion of the changing quality of health care as a factor affecting costs.	
4. Project Visual D. Initiate class discussion by asking the following: a. Who benefits the most from government expenditures on hospital care? Who pays (i.e., what is the source of government funds spent for health care)? b. Private insurance pays the least for which types of medical service? c. Why are most people not too concerned with the high cost of hospital care? d. What percentage of doctors' services does the patient pay?	Analyze charts explaining the patient's share of costs for various health services and implications of this for consumer demand.
5. After completing analysis of charts, present the following problem: Assume someone in your family has a serious auto accident necessitating a six-month hospitalization at the following costs: Hospital - $18,000 ($100 per day) Doctor - 4,500 Nursing, drugs, etc. - 2,000 $24,500 How would these costs be paid?	Respond to problem by reporting orally how much of high cost of auto accident would be paid by private insurance, and how much paid by patient's family. Check at home how much of this cost would be paid by government, private insurance, and patient's family.

6. *Extended Activities (Optional)*

Divide class into Task Forces, each with responsibility for one of the listed long-term assignments.

Task Force Assignments

a. Compile a list of the different types of health care facilities available in the local region. State the purposes of each type identified.

b. Interview administrators of various facilities and obtain data regarding their objectives, cost of operation, recent changes in policy due to increased costs (if any).

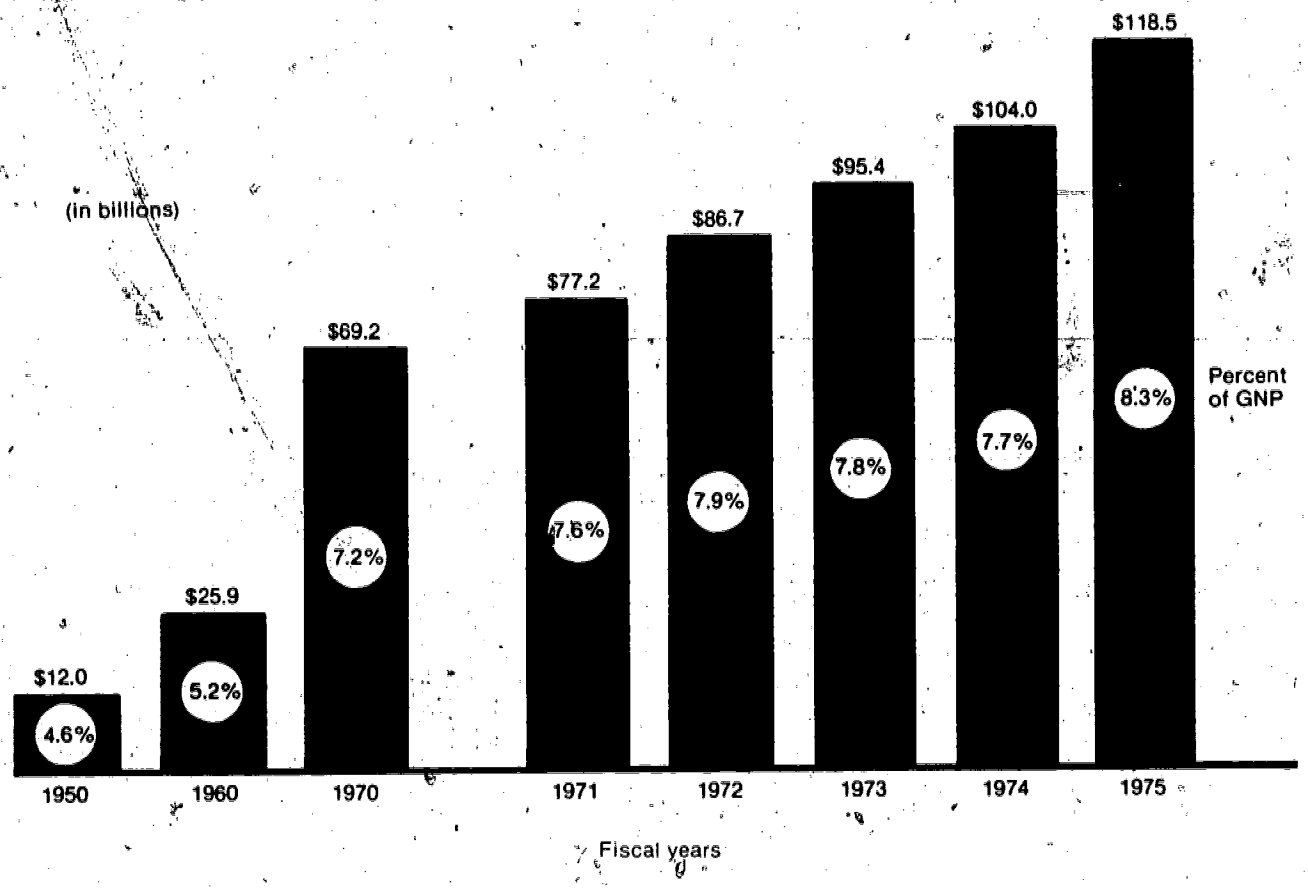
c. Interview members of the community regarding their attitudes towards health care, cost of services and possible solutions to problems of health care.

d. Compare health care practices in the United States with those of other countries.

e. Collect statistical data and develop charts on cost of medical care in the local area.

VISUAL A

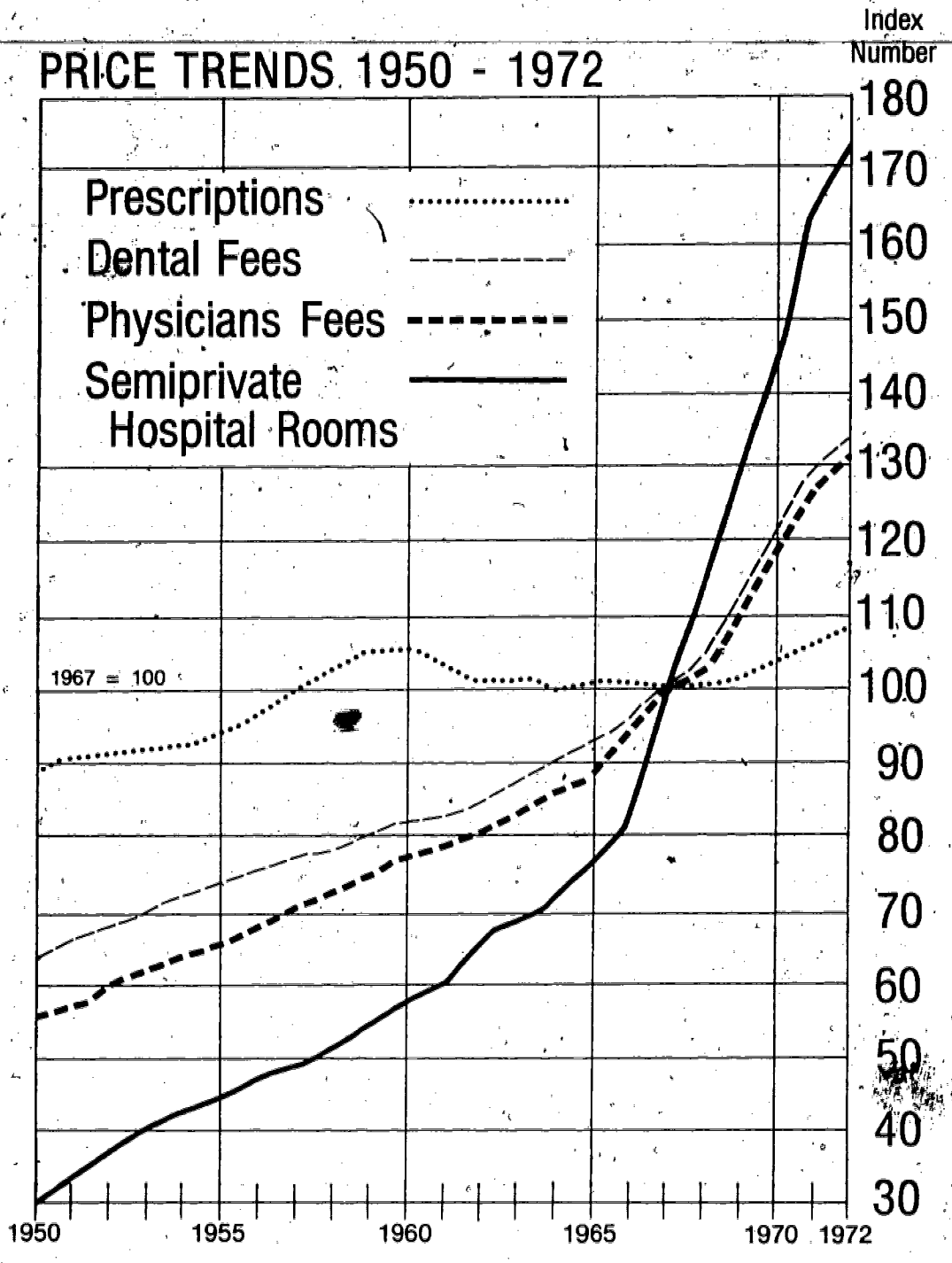
TODAY'S MEDICAL CARE DOLLAR IS OVER $100 BILLION — 8.3% of GNP



Source: *Social Security Bulletin,* February 1976, p. 5

VISUAL B

WHICH MEDICAL COSTS HAVE BEEN INCREASING THE MOST?

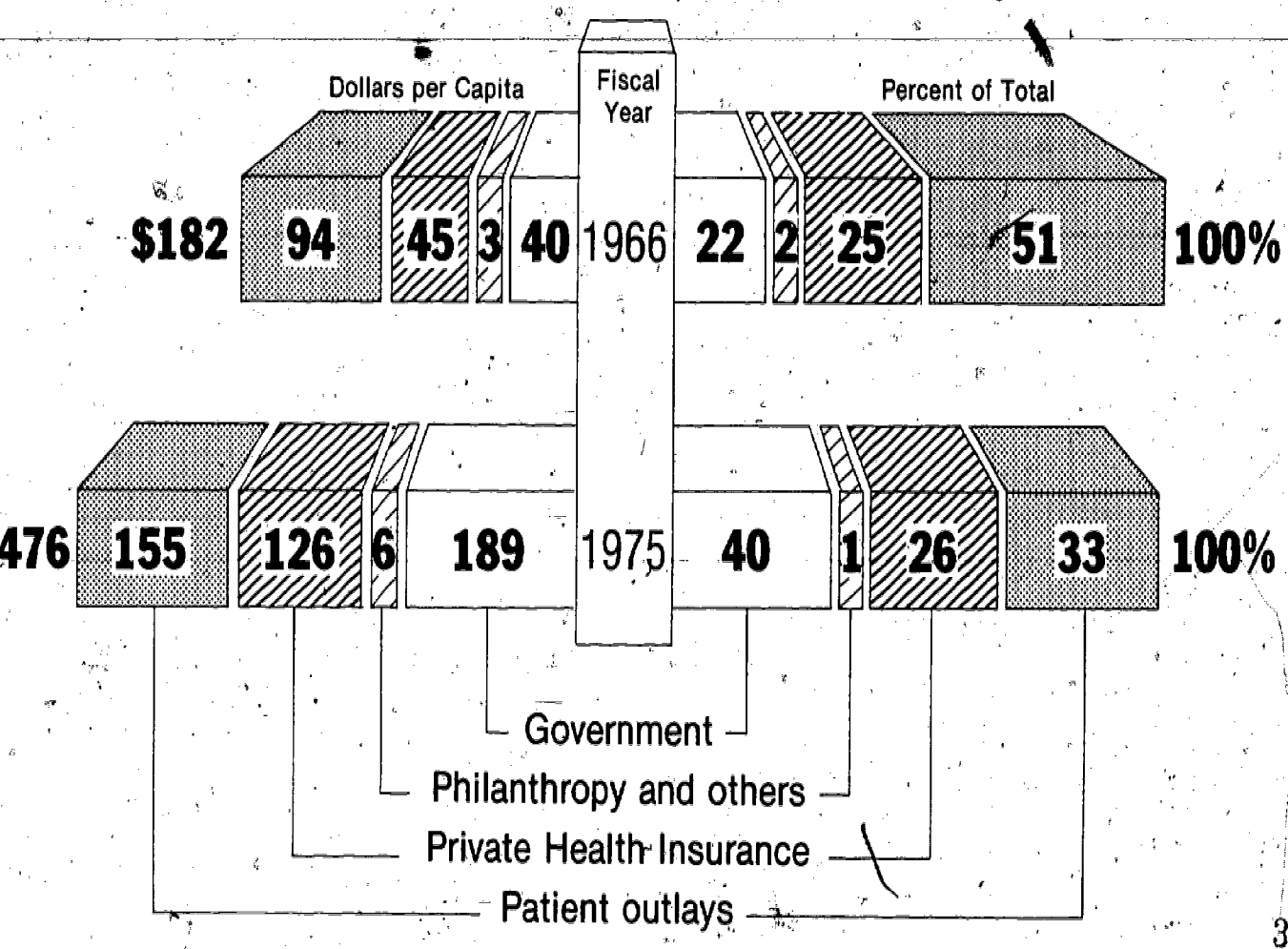


Sources: Dept. of Commerce, Dept. of Health, Education and Welfare, the Conference Board, 1973.

36

VISUAL C

IOW MUCH OF THE HEALTH BILL DOES
'HE PATIENT PAY DIRECTLY?

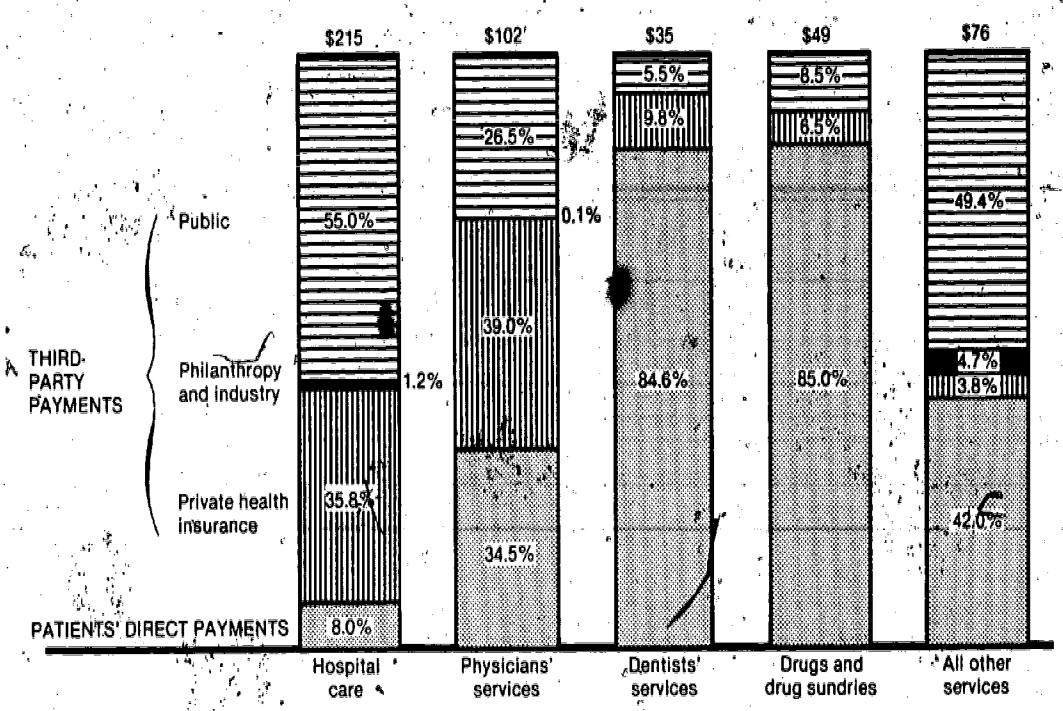


rce: *Social Security Bulletin*, February 1976, p. 14.

VISUAL D

WHAT'S THE PATIENT'S SHARE OF EACH HEALTH BILL?

FISCAL YEAR 1975



PERCENTAGE DISTRIBUTION OF PER CAPITA PERSONAL HEALTH CARE EXPENDITURES

Source: *Social Security Bulletin*, February 1976, p. 15.

Student Reading No. 1

National Health Expenditures

Private and public—1950 and 1975

FISCAL 1950 TOTAL AMOUNT (In Millions)				FISCAL 1975 TOTAL AMOUNT (In Millions)			
Type of Expenditure	Total	Private	Public	Type of Expenditure	Total	Private	Public
Health Services and Supplies	11,181	8,710	2,470	Health Services and Supplies	111,250	65,665	45,585
Hospital Care	3,698	2,008	1,690	Hospital Care	46,600	20,957	25,643
Physicians' Services	2,689	2,556	133	Physicians' Services	22,100	16,245	5,855
Dentists' Services	940	940	—	Dentists' Services	7,500	7,085	415
Nursing Home Care	178	167	11	Nursing Home Care	9,000	3,799	5,201
Other	3,676	3,039	636	Other	26,050	17,579	8,471

Source: *Social Security Bulletin*, February 1976, p. 7.

Instructional Activity No. 2

Supply of and Demand for Medical Services in the United States

Recommended Use: Developmental activity for 11th-12th grade classes in Contemporary Issues or Economics.

Time Required: One-two 45-minute class periods.

Materials Required: Student Reading No. 2

Rationale: To understand how increased demand for health services and a higher standard of living have driven up health costs.

Concepts: Market, demand, supply, price.

Instructional Objectives: Given the reading "The Economics of Health" and classroom discussion of factors that affect the markets for health care goods and services, the student will be able to:

1. list reasons for increased costs of medical services.
2. list ways in which the demand for medical services is different from the demand for other goods and services.
3. describe practices within the health care industry that modify the market for health care goods and services.
4. state effects of governmental programs on the market for health care goods and services.
5. predict price trends in the health care market when factors of demand or supply are changed.

Teaching Strategy

1. Distribute Student Reading No. 2.

Pupil Activity

Read handout and discuss the following:

a. Why is it becoming more difficult to receive service from doctors during the week, at night, or on a weekend? Why is it sometimes easier to see a specialist than a general practitioner?

b. How is demand for medical services similar to and different from demand for other goods and services? The supply of medical services?

c. What effect do these factors have on the *price* of medical services?

d. What effect have the governmental programs Medicare and Medicaid had on the demand for medical services? The supply? Price?

e. If government paid all medical bills in some sort of national health insurance plan, what effect do you think this would have on the price of various health care goods and services (e.g., hospital cost, physician costs, etc.)? Why?

Student Reading No. 2

The Economics of Health*

The problem of providing adequate health care is basically economic. We simply do not have enough human and material resources to satisfy all our desires relating to health and also our many other desires. The economic problem of scarcity exists. Also we may not be making the most effective use of the resources we now devote to health.

Health services are the third largest industry in the United States. Indeed in 1970 one out of every 20 persons employed in the nation was in the health services. It is probably higher today. We tend to think of health services as being rendered by physicians. But actually there are approximately 12 other persons employed for every physician (3 clerks, 3 aides or orderlies, 2 nurses, 1 practical nurse, 1 cleaning person, 1 medical or dental technician, and 1 food preparer). There are many occupational areas in the health service industry, e.g., nurses, medical technicians, dietitians, skilled therapists, paramedics. In addition there are numerous closely related occupations in, for example, the pharmaceutical industry, health education, hospital administration, hospital architecture, and even medical economics.

Two-thirds of those employed in the health services are employed in hospitals and nursing homes. Thus these plus the many doctors' and dentists' offices, the drug stores and clinics are the places of business for the medical services. As mentioned earlier, the health services are not only a large industry but a rapidly growing industry. For a more recent and more complete statistical picture of the health industry we recommend that you consult the most recent *Statistical Abstract for the U.S.* Browse through the section on Health in Part I of Vital Statistics.

In economics we are concerned with the market through which an industry serves its customers. Probably the most striking contemporary fact related thereto is the rapid rise in the cost of health care and the large increase in health expenditures in the U.S. Why? In economics we look at *demand* and *supply*. Why the sudden increase in demand for health services? First of all, our population has been growing. But most important, the proportion of older people has been increasing greatly; we have seen they are the greatest users of health services. Secondly, as a result of new technologies and new medical techniques we desire types of health care that were not previously available. For example, the aged used to be cared for in our homes; now we usually employ nursing homes. Children were born and cared for at home; now they arrive in maternity wards of hospitals, may be cared for in children's wing of a hospital, and are kept well by skilled teams of medics and a vast array of medicines and therapies. Today when we go to our doctor or the hospital we are tested, kept well, or cured by an amazing battery of new technologies. Health is now much more than a country doctor and an aspirin.

Thirdly, our demand for health services has been growing because our incomes have been growing, but it is the distribution of income that affects the distribution of good health. The poor cannot afford to be sick, and when they are, they may have to rely on letting nature take its course. The more well-to-do spend more on health, not only physical but often mental health as well. Finally, a very important reason for increase in demand has been the rise of new ways of financing health expenses—by insurance and by the advent of Medicare and Medicaid. Because on the average the direct cost to us is only about one-third of the actual cost of medical services (the other two-thirds being paid by government or insurance), some may demand medical services they would not seek if they were directly paying the entire bill. For all of these reasons the demand for health services is increasing.

*Excerpt from "Health Care for Whom?" by Laurence E. Leamer and Paul A. Smith, 1976.

How the Demand for Health Services Differs from the Demand for Other Goods and Services

The demand for health services differs in several important ways from the demand for most other goods and services. According to conventional economic analysis, the consumer in a free enterprise economy, knowledgeable of the alternatives and knowing that he or she must pay the full cost of whatever he or she chooses to buy, decides whether to purchase a desired good or service. But these conditions are not usually true in the case of most expenditures for health. The consumer (patient) is largely ignorant about the quality and even the price of the service about to be purchased. Indeed the medical profession generally aims to keep it that way; their "ethics" do not permit them to advertise. Thus efforts of self-designated "public interest" groups to provide consumers with knowledge about doctors' specialties, education, charges, and records have been resisted. Professionals sometimes (and not only doctors) favor competition for others but resist it in their own profession.

Once the patient has chosen a doctor it is usually the physician who decides what the buyer is to purchase in the way of medical care. Since so vital a thing as health is involved, the physician is probably told to spare no expense. Few of us would give our plumber or auto repairman or even our school superintendent such freedom. It is we who will pay the bill but our doctor who influences our demand for his or her services. Our doctor, of course, will probably be concerned about the costs to us. But even his or her judgment may be influenced by the fact that most patients, protected at least in part by insurance, will not directly have to pay the full cost. Also the modern physician, threatened by potential malpractice suits, may be prone to be indifferent to the patient's costs. A less expensive procedure could be at the "cost" of an expensive negligence involvement by the doctor.

The Supply of Health Services

There are likewise complications on the supply side of the market for health services. For example, the limited supply of doctors is in part doctor-made. Why? Although the incomes of doctors are generally high (a situation which should normally increase their supply), their number has been restricted by limited admissions to medical schools. Similarly, the medical profession has established rules that forbid nurses, pharmicists or paramedics from performing services that doctors normally perform. Likewise the medical profession has often opposed innovation in medical organization. Of course in all such cases the profession justifies its position in terms of what it believes to be in the public interest. This practice is a nearly universal "political" act. It is a practice of most professional groups who control a highly valued service or good. There is a potential monopolist in most of us!

Our economic policy alternatives relating to the market(s) for health goods and services become clear. Shall we try to make those markets more effectively competitive? Or if that is impossible, or will have undesirable results, how may we develop effective systems of self-control and/or public control? In general, then, how may we best organize the health services industry and markets so that they will be efficient in the meeting of human wants, and equitable in the way they serve?

Instructional Activity No. 3

Comparison of Private Insurance Plans with National Health Insurance Plans

Recommended Use: Developmental activity for 11th-12th grade classes in Contemporary Issues or Economics.

Time Required: Three-four 45-minute class periods.

Materials Required: Student Reading No. 3. Either of the following sound filmstrips: "The Economics of Health" (Joint Council on Economic Education Economic Topic Series, 1212 Avenue of the Americas, New York, NY 10036) *or* "Health for All" (The New York Times Current Affairs Series, Teaching Resources Films, 2 Kisco Plaza, Mt. Kisco, NY 10549).

Rationale: To assess costs and benefits of private health insurance plans versus proposed National Health Insurance (NHI) plans.

Concepts: Costs and benefits, economic incentives (and disincentives), power, interest group.

Instructional Objectives:

1. After viewing the filmstrip, students will:
   a. recall major factors leading to increased costs for health care goods and services,
   b. state reasons for and give examples to illustrate present distribution patterns of medical services.
2. Students will compare types of coverage provided by different types of private health insurance plans.
3. Given information on the major national health insurance proposals, students will:
   a. state and/or compile a list of the costs and benefits of each,
   b. identify interest groups most likely to support each plan and those most likely to be opposed,
   c. assess each plan in terms of its potential economic and political consequences.

Teaching Strategy	Pupil Activity
1. Show frames 1-47 of filmstrip "The Economics of Health" (or if using "Health for All," show frames 1-30).	After viewing these frames, discuss the following: a. What are the major factors that have led to increased costs for medical goods and services? b. What were the reasons given for the unequal distribution of medical resources in the U.S.? In what areas would you expect to find a surplus of doctors? A shortage of doctors?
2. Show remainder of filmstrip.	View filmstrip.
3. Poll students to see how many of their families have private health insurance coverage.	Indicate whether family is covered by some sort of private health insurance plan.

4. Distribute Student Reading No. 3. While students are reading handout, write the following questions on the board:
   If the government became the sole source of payment of health bills, what would be the incentive to keep costs down?

   What would happen to demand for services if government paid all medical costs? Could our present health service handle the demand? Could the taxpayer handle the cost?

Note: Additional questions for guiding student discussion of costs and benefits of NHI plans are provided on p. 37.

Discuss the following:

a. Types of coverage provided by different private health insurance plans.

b. Strengths and weaknesses of private health insurance plans.

5. Have students select one of the following for research:

   a. Reasons for AMA opposition to national health insurance plans over the past 40 years.

   b. National health insurance plans in other countries (e.g., England or Sweden). For a description of national health insurance in England you might refer students to "The Hidden Cost of Womb to Tomb - Britain's Plan," *Forbes*, October 15, 1974, p. 41.

Select a topic and working individually or in groups conduct research study.

6. *OPTIONAL*: Have students prepare position papers and debate the following: "Resolved, the United States Needs a National Health Plan." (NOTE: An alternative would be to organize the presentation as a congressional hearing and assign students to prepare position papers representative of the different interest groups involved, e.g., AMA, AFL-CIO, etc.)

In preparation for the debate, prepare a position paper including the following:

a. a statement of his/her position on the debate question.

b. the action (or specified plan) he/she thinks should be implemented.

c. costs and benefits of the proposed actions as compared with costs and benefits of other alternatives.

The six key health-insurance plans

BILL	NATIONAL SUPPORT	ESTIMATED COST BY 1980	ADMINISTRATION	FINANCING	BENEFITS
Kennedy-Corman	A.F.L.-C.I.O., Committee for National Health Insurance.	$24.8 billion.	Special board within H.E.W.; regional and local offices will operate program.	Half to come from Federal general revenues, half from special taxes; 1 percent of payroll for employees, 2.5 percent for employers and self-employed.	Institutional services: hospital care, skilled nursing facilities up to 120 days. Diagnosis and treatment: physicians' services, lab and X-ray, home health services, prescription drugs (for chronic illnesses), medical supplies and appliances. Other services: physical checkups, well-child care, maternity, family planning, dental care (up to age 25), vision care and eyeglasses, hearing care and hearing aids. Patient cost-sharing: none.
CHIP	No formal support.	$11.3 billion.	Insurance through private carriers; states to supervise under Federal regulations.	Employer-employee premium payments, with employer paying 75 percent (65 percent first three years); special provisions for small employers and those with high increases in payroll costs.	Institutional services: hospital care, skilled nursing facilities up to 100 days. Diagnosis and treatment: physicians' services, lab and X-ray, home health services (up to 100 visits), prescription drugs, medical supplies and appliances. Other services: well-child care, maternity, family planning, dental care (under age 13), hearing care and hearing aids (under age 13). Patient cost-sharing: annual deductible* of $150 per person; 25 percent coinsurance,** with annual ceiling of $1,500 per family.
Ullman	American Hospital Association.	$25.1 billion.	Private insurance carriers under state supervision, according to Federal guidelines.	Employer-employee premium payments, with employer paying at least 75 percent; Federal subsidy for low-income workers and certain small employers; patients enrolling in a health-care corporation get 10 percent subsidy.	Institutional services: hospital care up to 90 days, skilled nursing facilities (30 days), health-related custodial nursing home care (90 days). Diagnosis and treatment: physicians' services up to 10 visits, lab and X-ray, home health services (100 days), prescription drugs limited to specified conditions, medical supplies and appliances. Other Services: physical checkups, well-child care, maternity, dental care (under age 13), vision care and eyeglasses (under age 13). Patient cost-sharing: coinsurance (20 percent) or co-payments*** (up to $5) on most items; special "catastrophic" provisions become effective when patient's out-of-pocket expenses reach a specified amount.
Fulton	American Medical Association.	$20.3 billion.	Private carriers provide insurance under state supervision; regulations issued by a new Federal board.	Employer-employee premium payments, with employer paying at least 65 percent; small employers get Federal help as do all employers with unusual payroll cost increases; self-employed pay own premiums but are assisted by income-tax credits computed on a sliding scale (the lower the income, the higher the credits).	Institutional services: hospital care, skilled nursing facilities up to 100 days. Diagnosis and treatment: physicians' services, lab and X-ray, home health services, medical supplies and equipment. Other services: physical checkups, well-child care, maternity, family planning, dental care (under age 18). Patient cost-sharing: 20 percent coinsurance, with an annual maximum of $1,500 per person and $2,000 per family.
Burleson-McIntyre	Health Insurance Association of America.	$11 billion.	Insurance administered by private carriers under state supervision; plan is voluntary.	Employer-employee premium payments, the ratios to be negotiated between them; low-income workers pay less; self-employed pay entire premium; all participants eligible for special tax deductions.	Institutional services: hospital care, skilled nursing facilities up to 180 days. Diagnosis and treatment: physicians' services, lab and X-ray, home health care (270 days), prescription drugs, medical supplies and appliances. Other services: well-child care, maternity, family planning, dental care (under age 13, one visit), vision care (under age 13, one visit). Patient cost-sharing: annual deductible of $100 per person; 20 percent coinsurance on all items, with annual family limit of $1,000.
Long-Ribicoff	No formal support.	$9.8 billion.	Employers and employees have two choices: to join Federal insurance program administered by H.E.W., or to buy private insurance from federally approved carriers, under H.E.W. supervision.	Employers pay 1 percent payroll tax and are allowed similar provisions for self-employed.	Institutional services: hospital care, skilled nursing facilities up to 100 days. Diagnosis and treatment: physicians' services, lab and X-ray, home health services, medical supplies and appliances. Other services: None. Patient cost-sharing: first 60 days of hospitalization not covered; first $2,000 in family medical expenses not covered.

*Deductible: Patient's share of annual medical costs before insurance coverage begins.
**Coinsurance: the percentage of a given bill that is charged to the patient.
***Copayment: a flat rate charged to the insured patient on specific items (such as $2 per office visit).

National Health Insurance Plans

Questions for Discussion

1. Would the proposed NHI plan result in more equitable distribution of health care services among the various socioeconomic groups?
   a. Would it increase the quality, amount and types of health care services available to various segments of the population?
   b. Would it result in a reduction of personal expenditures for "catastrophic" illness?
   c. What effect would the plan have on health care for the poor? The non-poor? The young? The aged?
2. Does the proposed plan include built-in incentives or disincentives for:
   a. cost control?
   b. efficient use of resources?
   c. improving the quality of services?
   d. curbing excessive demand?
3. Would the plan result in increased costs to the taxpayer? employer? employees?
4. What interest groups or segments of the population are most likely to support the plan? What groups are most likely to be opposed? What is the relative political power of these groups?
5. What arguments might a Congressman or Congresswoman use in explaining to his/her constituency why he/she supports the plan? Why he/she opposes the plan?

Focus for discussion by June V. Gilliard, Curriculum Specialist, Joint Council on Economic Education, 1212 Avenue of the Americas, New York, NY 10036

Instructional Activity No. 4

"Health Maintenance Organization" A Better Way to Receive Health Care?

Recommended Use: Developmental activity for 11th-12th grade classes in Contemporary Issues, Economics and Government.

Time Required: One-two 45-minute class periods.

Materials Required: Student Reading No. 4.

Rationale: To explore alternative methods of delivering health services with emphasis on prevention and early diagnosis.

Concepts: Costs and benefits, public policy.

Instructional Objectives:

1. Given the reading "Health Maintenance Organization," the student will:
   a. state at least two advantages and two disadvantages of HMO's.
   b. describe actions of the Federal Government for encouraging the growth of HMO's.
2. The student will compare costs and benefits of HMO with those of conventional health insurance plans.

Teaching Strategy

1. Distribute Student Reading No. 4.

2. Have students select one of the following assignments:
   a. Identify and write to a certified HMO plan and ask for information about HMO's in your area or state.
   b. Research and report on activities of the Federal Government for encouraging growth of HMO's. As a start, you may consult the following:

   "Health Maintenance Organization—Are They an Answer to Your Medical Needs?" *Consumer Reports*, October 1974.

   OR

   "One Stop Health Care—How It Works," *U.S. News and World Report*, January 21, 1974, p. 46.

Pupil Activity

After reading handout,

a. list advantages of HMO over the fee for service system.

b. list disadvantages of HMO.

c. list at least two examples of governmental influence on the growth and development of HMO plans.

Working individually or in small groups select assignment and complete tasks indicated.

3. Write the following on the board:

   a. What are the advantages and disadvantages to a doctor in joining an HMO plan?

   b. Account for the following: Subscribers to HMO use hospital facilities less and have fewer surgical procedures than patients who use the Blue Cross-Blue Shield plan.

   c. Why would an HMO plan not help families with incomes under $5,000 a year?

   d. Do you think you would favor an HMO plan? Why or why not?

   e. Do you favor present governmental policies toward HMO plans? Why or why not?

Discuss questions, comparing costs and benefits of HMO's with costs and benefits of private insurance plans.

Student Reading No. 4.

Health Maintenance Organization

An HMO plan assembles a number of health services under one roof for its voluntarily enrolled members. Instead of charging a fee for each service, the HMO collects a lump sum in advance from subscribers—roughly $600 to $850 a year ($50 to $70 a month). For this money, a subscriber to an HMO plan will get:

a. Physician services including consultation and referral to other doctors in the plan.

b. All in-patient and out-patient hospital services including lab and radiation and X-rays.

c. Emergency care when necessary.

d. Health care at home.

e. Physical check ups.

f. Dental exams for children under some plans.

In summary, HMO plans can usually provide all the medical care a subscriber needs under a single roof with one telephone number which can be used 24 hours a day, seven days a week when needed.

Backers of these plans say the cost will be less than the fee of services practiced by most doctors and over the long run will lead to lower health care costs since HMO physicians emphasize preventative care and early treatment.

Two complaints are often voiced in criticism of HMO's. Some people say the HMO's are too impersonal. A patient does not get to know the doctor who is treating him because he may see a different doctor each time he uses the service. Others feel the system is too rigid in the rules it sets up for subscribers.

The government has backed HMO with funding for planning and establishing new HMO's around the country.

The Department of Health, Education, and Welfare announced rules late in October 1975 that mandate employers with more than 25 workers to offer their employees HMO plans as an alternate to standard health insurance.

"The regulation, which would take years to implement fully, would require some 400,000 employers to allow workers to buy insurance coverage in which they pay a set fee for all health care."

"Development of these plans over the last few years, however, has been slow for several reasons. The plans are expensive to establish, premiums are high and enrollment of patients is always very slow. Also, the Federal Government lowered its initial enthusiasm for the plans, many of which had been developed and planned with public assistance.

"In addition, the standards for service that a plan must provide to qualify for Federal endorsement, are very high. Only five plans have received such endorsement thus far" (*The New York Times,* October 25, 1975).

Instructional Activity No. 5

Health Care Values

Recommended Use: Culminating activity, after students have examined health care problems, and various plans for national health insurance.

For 11th-12th grade students in Contemporary Issues, Economics or Government classes.

Time Required: Two-three 45-minute class periods.

Materials Required: Student Readings Nos. 5-10.

Rationale: To enable each student to clarify his/her position on issues pertaining to health care and to examine processes through which policy issues are resolved.

Concepts: Scarcity, opportunity cost, public policy.

Instructional Objectives:

1. Given readings representing different viewpoints on health care needs, the student will:
   a. identify the values on which different viewpoints are based,
   b. state his/her position on proposed policies,
   c. justify his/her position in terms of explicitly stated values/goals.
2. Given alternative uses of limited national resources the student will:
   a. identify and discuss the opportunity cost of increased government expenditures for health care services,
   b. indicate both verbally and in written form how he/she thinks resources should be allocated,
   c. compare his/her response with that of other class members,
   d. compare problems and processes for resolving conflicting views of class members to problems and processes involved in making policy decisions.

Teaching Strategy	Pupil Activity
1. Distribute Student Readings Nos. 5-9 and write the following questions on the board.	Read handouts.
a. "The health care crisis is largely a crisis of money. Under the present system of health financing, *income* often determines the quality of medical care people get in America." (agree or disagree)	Discuss questions, noting the different values on which individual responses are based.
b. Is health care a basic *right* like food, shelter, or just a privilege for those able to pay?	Summarize pros and cons of increased governmental expenditures for health care.
c. How important is it for a patient to have free choice of physician and hospital when ill and in need of medical care?	

d. If the government raises taxes and spends more money on health care, will this guarantee better health for American citizens?

2. Distribute Student Reading (worksheet) No. 10. Direct students individually to rank items on the list, beginning with the item they feel should receive highest priority. This is a "forced choice" exercise; consequently, students are to assume that if the money is allocated for the item ranked number one, they must forego all other items on the list no matter how desirable these may be.

Individually complete ranking exercise.

3. As a means for introducing (or reinforcing) the concept "opportunity cost,"

   a. *ask*: Did you have any problem deciding what should be ranked highest? Were there other items on the list for which you would have liked to allocate funds? If so, what are they?

   b. explain economists' use of the concept.

   c. have individual students indicate the program they ranked as number one and to state the opportunity cost of their choice.

Using responses given on worksheet, state and discuss opportunity cost of government expenditures for health care programs.

4. Direct students to assume they are representatives in Congress and are faced with the problem of deciding as a body how funds are to be allocated. *Ask:* As a member of Congress what would be the major consideration that would influence your decision?

Identify and discuss factors that influence policy decisions.

5. Ask students which of the following is closest to their personal position with regard to national health insurance.

   a. Complete national health insurance (e.g., the Kennedy-Corman Plan)

   b. Limited national health insurance still using private health insurance companies (e.g., AMA-Medicredit)

   c. Keep present system with a few modifications where needed.

Indicate the policy that most closely reflects his/her personal position.

Divide class into groups, placing students taking the same position in the same group.

Using information from previous reading and discussions, prepare a summary of the major arguments supporting the group position.

Select one person to present the group position to the class.

6. Following group presentations provide opportunity for individual students (through discussion or written statement) to indicate if they have changed their position on NHI as a result of the group arguments.

Student Reading No. 5

Agreed, Here Comes National Health Insurance

The growth of public and private insurance in recent years has made national health insurance seem less radical but not less necessary. The current mix of public and private programs is uneven and widely acknowledged to have at least three glaring defects.

First of all, the poor still have very inadequate coverage. In 1970, only 39% of persons under 65 with incomes under $3000 had any hospital or surgical insurance compared to 90% of those with incomes over $15,000. Second, few Americans are protected against catastrophically high medical bills. Most insurance plans have upper limits (the benefits cease after a certain number of days or dollars). Third, the system is biased toward high cost care which discourages preventive medicine and does nothing to promote efficiency. Since many patients are covered for hospitalization but not for other forms of care, doctors have a tendency to order hospitalization in order to reduce bills, even when a visit to the home or the doctor's office would be just as effective. Since check-ups and preventive medicine often are not covered, patients may neglect conditions until they become acute and require costly medical care. These deficiencies in the current system have led people to the position that some kind of national health insurance is needed to accomplish three objectives:

1. to have access to medical care without financial hardships.
2. to protect everyone including middle income and upper income people against catastrophic illnesses.
3. to increase incentives for using preventive medicine and managing health institutions effectively.

Alice Rivlin, *The New York Times Magazine*, July 21, 1974. Reprinted by permission.

Student Reading No. 6

Medical Care for the Underprivileged Population

What is the relationship between poverty, socio-economic class, race and good health?

A recent assessment of poverty and health differences between deprived Americans and those reasonably well off summarizes the situation this way: Heart disease, hypertension, arthritis, mental disease, visual impairment and orthopedic disability are all more common among the poor. Death rates from tuberculosis, syphilis, influenza, pneumonia, and vascular lesions of the central nervous system are twice as high among nonwhites as among whites. With proper adjustment for age, heart disease, stroke and cancer are all more frequent in the ghetto.

For the poor, risk of dying under the age of 25 is four times the national average. Life expectancy among the nonwhite population is 63.6 years as compared to 70.2 years in the white population. The maternal mortality rate among nonwhites is 90.2 per 100,000 as compared to 22.4 per 100,000 in whites. The infant mortality rates of nonwhites in 1940 was 70 percent greater. According to the United States Children's Bureau, infant mortality rises as family income decreases. Fifty percent of poor children are incompletely immunized against small pox or measles. Sixty percent of poor children have never seen a dentist. If they are poor, and if they are black, Jonathan Kozol's *Death at an Early Age* literally applies.

Charles R. Green, *The New England Journal of Medicine*, May 21, 1970. Reprinted by permission

Student Reading No. 7

What Is Good Health?

Any way you look at it, a great deal of money is spent on medical care in the U.S. . . .

Does that mean, then, that Americans are the world's healthiest people? No. In fact, they are embarrassingly low on the totem pole.

Two indicators used to measure quality of health are the rate of infant mortality and life expectancy. In spite of the money spent, the U.S. ranks thirteenth in infant mortality. In short, twelve other nations—including Sweden, Iceland, Switzerland, Japan, Canada, and France—have a better record of preserving human life in the infant years.

When it comes to life expectancy the record is even worse. U.S. Department of Commerce statistics show that in 21 other nations people live longer. An American born in 1971 can, on the average, expect to live to his or her 71st birthday. That's a big improvement over the year 1900, when Americans could count on living only about 50 years. But it is still less than people living in such nations as the Netherlands, Canada, Israel, Japan, Denmark, and Britain.

It is becoming increasingly clear to many people that just spending money on health isn't the only answer. More and more of these people are coming to the conclusion that "good health" is also the result of a way of life: a way of life that includes a good diet, a reasonable pace of life, and a decent environment—one with relatively clean air, adequate living quarters, and tolerable noise levels.

"It is true that the poor do not have as great an access to medical care," says Dr. Peter Isaacson. Isaacson is chief of the department of preventive medicine and environmental health at the University of Iowa College of Medicine.

"But consider the other phenomena to which they are subject: malnutrition, air pollution, poor education, more frequent pregnancies, higher rates of venereal and other diseases, inadequate housing, inadequate sanitation, inadequate rodent control and even inadequate clothing."

"Do none of these factors have any relationship to health?" Of course they do he says. . . .

Senior Scholastic, March 20, 1975, p. 13. Reprinted by permission

Student Reading No. 8

National Health Insurance
Will It Promote Costly Technology?

What impact would national health insurance have on medical practice and medical research? A number of experts are afraid that the side-effects of national plans may be highly undesirable.

Some economists have been predicting that national health insurance will induce more and more people to opt for highly expensive and elaborate forms of treatment, such as extra tests, unnecessary surgery and elaborate terminal care. The trend would then be to bias medical care in favor of expensive technology intensive procedures. And since resources are finite these activities would drain away funds and manpower from lower cost care. An example of high costly technology is a decision by Congress to allow medicare to insure patients on the "kidney machine" (renal dialysis). This machine prolongs the life of end stage kidney disease sufferers at the cost of $10,000 to $40,000 a patient. This provision which costs 135 million the first year could cost one billion dollars to help 60,000 patients per year.

Professor Somers of Princeton (a medical economist) stressed that trade-offs are going to have to be made and coverage limited. Getting people to accept the fact of limited resources for health care has been hard, because you end up saying, "someone has to be allowed to die."

Deborah Shapeley, *Science*, November 1, 1974. Reprinted by permission.

Student Reading No. 9

Health Care for All?

We must ask ourselves, therefore, whether it is worth it to go toward NHI. With the limited resources available to meet our vast needs, we cannot afford huge expenditures on unnecessary medicine. The 1973 budget study of the Brookings Institution pointed out that public funds spend on NHI would not be available to meet "other high-priority public objectives." Unfortunately, the American public seems willing to devote only a slowly growing portion of its GNP to public expenditures. Given the political-economic reality, the value of NHI must be weighed against the value of the social programs eliminated from consideration by NHI's high costs. The loss of social programs will escalate with the cost of the government's commitment to current payment mechanisms.

The poor, whose health is the worst and whose need the greatest, will suffer most from the distortion of social priorities. After a study of the links between poverty and health, Professor Monroe Lerner of the Johns Hopkins School of Medicine, concluded that the poor experience "substantially higher rates of overall mortality, infant mortality, and severe illness" than those in higher income brackets. Lerner suggests that programs designed to alleviate poverty will also improve the health level of the poor.

Lerner's conclusions may surprise us because we are accustomed to assuming that medical care is the only critical determinant of health. But medical sociologists have documented a wide variety of cultural, behavioral, and environmental factors which contribute substantially to health or illness.

Inadequate housing, nutrition, clothing, economic security and education contribute to the total poverty environment and to the ill health of the poor. If the poor lack access to quality medical care, they also lack access to quality housing, good jobs, and nutritious food. Social programs which help alleviate these elements of poverty will substantially improve the health level of the poor; they will also be the programs most likely to go under-funded as escalating medical costs consume available public funds. Rather than march blindly toward some vague and distant goal of national health insurance, we must begin to ask ourselves, "Where are we going, and do we really want to go there?"

—Steve Slade, *Progressive*, April 1974. Reprinted by permission.

Student Reading No. 10

Federal Budget Exercise

Suppose the U.S. Congress were faced with the decision to allocate $100,000,000 for new domestic programs. How would you recommend the money be spent?

1. Food stamps for poor Americans
2. Research on cure for cancer
3. Programs for reducing unemployment
4. Expanded health care coverage for the elderly
5. Research and development of new sources of energy
6. Housing for low income families
7. Grants to local and state governments for crime prevention and control
8. Grants to local governments for education needs
9. Preventive medical services for the poor

Rank the above-mentioned nine items in order according to your priorities, i.e., which program would you give the highest, which the lowest priority, etc.?

	Rank Program No.
Highest Priority	1. _____
	2. _____
	3. _____
	4. _____
	5. _____
	6. _____
	7. _____
	8. _____
Lowest Priority	9. _____

Focus for discussion: by S. Stowell Symmes, Director of Curriculum, Joint Council on Economic Education, 1212 Avenue of the Americas, New York, NY 10036

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