Irving Fisher, Victor Fuchs, and the Health-Government Tangle

By RICHARD ZECKHAUSER

ABSTRACT. A comment on the article by Victor Fuchs in this volume.

Victor Fuchs alerts the modern world to Irving Fisher's deep and abiding interests in health. To most of us trained in Fisherian models of money, index numbers, and capital markets, this will be a revelation (see Barber 1997). But disappointment will be just a step behind. As Fuchs points out in this volume, Fisher seems to have set his economics aside when approaching health issues. His tubercular condition, more than economists' marginal conditions, appears to have spurred Fisher's health interests. In sharp contrast to the leading health economists of the modern era, whose health commentaries derive from their professional expertise, Fisher was a social crusader on health issues, who happened to be an economist. Fisher's reluctance or inability to apply his extraordinary economic logic is most telling in his failure to capture health promotion as an investment problem with a significant time dimension, an area where his contributions to economics endure.[1]

Irving Fisher endorsed active government participation in the health sector. The government should be a public health scold and enforcer

*Richard J. Zeckhauser is the Frank Plumpton Ramsey Professor of Political Economy at Harvard University's John F. Kennedy School of Government. Zeckhauser pursues a mix of conceptual and applied research. The primary challenge facing society, he believes, is to allocate resources in accordance with the preferences of the citizenry. Much of his conceptual work examines possibilities for democratic, decentralized allocation procedures. His ongoing policy investigations explore ways to promote the health of human beings, to help labor and financial markets operate more efficiently, and to foster informed and appropriate choices by individuals and government agencies. Zeckhauser's current major research addresses the performance of institutions confronted with inadequate commitment capabilities, incomplete information flow, and human participants who fail to behave in accordance with models of rationality (for example, by engaging in herd behavior). Financial markets and health risks are the subjects of his major empirical investigations. He thanks Miriam Avins, David Cutler, and Victor Fuchs for helpful conversations.

The American Journal of Economics and Sociology, Vol. 64, No. 1 (January, 2005).

(prohibiting alcohol, for example) and a provider of national health care insurance. And Fisher had strong views of how health might be promoted, ranging from diet to eugenics. Fuchs, though a kind man, is not kind to Fisher's analysis of health issues. The explanation, I believe, is that Fisher's approach to health promotion is about as far from Fuchs's as one could imagine. Fuchs is a data man who takes delight in drawing straightforward empirical insights about what works and what does not. And the delight is redoubled when the insights diverge sharply, as they often do, from the conventional wisdom. Fisher, by contrast, though believing himself driven by evidence and urging the development of better health data, often eschews empirical analysis of health issues but makes pronouncements nevertheless. Fuchs the careful researcher, it seems, is offended.

I

The Health-Government Tangle

FISHER'S ATTENTION TO the government's role in health spurs much of Fuchs's analysis. Were brevity not a concern, I would urge Fuchs to retitle his paper "Health and Government, and the Prescriptions of Irving Fisher." Fuchs, in his usual deft manner, identifies simple truths about the distinctive role of government in support of health. Fuchs is a devout economist, and he shows the discipline's explanatory powers. But he is also a realistic economist, and he makes it painfully clear that in the real world many of the government's actions regarding health have little to do with the information asymmetries, redistributional efficiencies, and physical externalities that comprise so much econobabble about why health and government are linked.

My commentary looks at the central issue that Fuchs addresses: the health-government tangle. I chose the word tangle for two reasons. First, there are a dozen strands to the government's involvement in health care, from subsidizing the training of medical students (a rapidly declining subsidy), to supporting biomedical research (an area of rapid growth), to operating veterans hospitals, to running and significantly supporting health insurance systems for the poor and elderly. Second, the nature of government involvement, at least to the eyes of an economist, is more tangled than neat.

Fuchs mentions a number of economic justifications for government participation in health care. I shall mention some others. But however many are included, Fuchs is correct that economics is not able to explain most of the variation over time and space in the way governments support health care. For example, if the purchase of drugs by the elderly merits government support in the year 2005, as a number of current policy initiatives seem to suggest, why did it not in 1990? Psychology and politics—more specifically prospect theory and the 2000 and 2004 presidential elections—both explain the "rapid escalation in costs, government must do something" rationale and the program that Bush put in place. Economics can only contribute that risk spreading has become more important. But if risk spreading were the major factor underlying insurance provision, our nation, much less the developed world, would hardly have so much first-dollar coverage for health care.

Why is so much government assistance delivered in the form of health care, as opposed to cash transfers? (Our nation spends roughly eight times as much on Medicaid, a program paying for health care for the poor, as on welfare.) James Tobin (1970), our fellow participant in this celebration, alas, now deceased, provided much of the economist's rationale for in-kind transfers in a famed essay now reaching its 35th birthday. What follows adds to Tobin's classic array some arguments that are particularly germane to government-supported health services. Despite their substantial normative merit, I recognize that much of what happens in health care is not explained by such factors.

II

Economic Rationales for Government Involvement in Health

MARKET FAILURES ARE where economists start when considering a role for government policy. Informational asymmetries play a major role in health care. The agency problem, moral hazard, and adverse selection are three asymmetry-related problems that plague health care. Government policy can do little in the first area and a modest amount in the second; a range of government insurance-related policies can help with adverse selection.

The agency problem is hardly new in the health care realm. As Plato presented the faithful doctor: "No physician insofar as he is a physician, considers his own good in what he prescribes, but the good of his patient; for the true physician is also a ruler having the human body as a subject, and is not a mere moneymaker" (Plato, *The Republic*, Book 1: 342-D). Alas, many doctors, at least in the modern era, are not perfectly faithful to their patients' needs, and the rise of third-party payers has made the agency problem much worse in health care. Such payers trace a new route of accountability, from provider agents back to insurance plan principals. These insurance plans, whether for profit or nonprofit, have a responsibility to their insureds to constrain costs, but this pathway is often ignored. Recently, the government, the preeminent third-party payer in America, has squeezed the health care system. In response, many doctors have struggled to maintain their incomes; hospitals to stay afloat. For some, Mammon has competed effectively against Hippocrates as a figure to guide action.

Moral hazard means those whose care is paid for by a third party demand more care; and those whose services are paid for by a third party provide more services, assuming the price exceeds the marginal cost. The government, where it is the payer, has dealt with moral hazard, at least by providers, in precisely the manner economists would prescribe. It uses the contingent claims approach. When a Medicare recipient gets sick, the hospital is paid a fixed amount, independent of the service delivered. The danger is that the hospital may skimp. However, the fact that the physician is the predominant decisionmaker, and that the patient is quite interested in his or her own welfare, diminishes this danger.

In a book preoccupied with love and adventure, Lord Byron addressed adverse selection: "Tis said that people living on annuities/Are longer lived than others" (Lord Byron, *Don Juan*). The potential for adverse selection—high-risk individuals selecting more generous and expensive coverage—creates a prospect for government activity. Government can provide insurance directly, as it does with Medicare; standardize insurance or make it mandatory, two cornerstones of the Clinton health plan; or subsidize insurance suffi-

ciently to induce purchase by virtually all parties, as it does by not taxing employer-paid premiums.

Surprisingly, many of Fisher's arguments for a public role in health care revolve around asymmetric information, but none deal with these three classic arguments. As Fuchs points out, Fisher simply thought he had better ideas about such areas as diet, physical exams, and the prohibition of alcohol, happily relying on his own assessments of causal relationships, a number of which proved unreliable. Moreover, though he recognized the tradeoffs implicit in policies in each of these areas, he prescribed numerous policies, using his own weights to make tradeoffs within and across individuals. Fisher deserves credit for identifying the importance of lifestyle on health, an area explored much more systematically subsequently by Fuchs ([1974] 1998), but should be chastised for severe overconfidence and for tossing aside the methods of his own discipline.

Turning from informational asymmetries, government's role in funding public goods helps explain why we have an NIH budget, and why its burgeoning collaborative programs with the pharmaceutical industry make sense. It also suggests that it is worthwhile to have a government-supported effort to assess best practices in medicine. Traditional externalities, such as limiting the spread of contagious diseases, explain little of modern government involvement with health. Even in the AIDS epidemic, apart from exhortation, government—with a strong and contemporary concern for privacy and civil liberties—is doing little to control the disease's spread.

Fiscal externalities come next. An individual's income provides a fiscal externality to the government; as he or she earns more, the government collects more taxes. Thus, the government, acting for us all, has an incentive to keep the individual healthy. This provides a justification for government-subsidized health care, at least for potential workers.[2] At the margin, the government is a 40% beneficiary from our richest citizens' incomes, and a 15% beneficiary from less affluent taxpayers. Efficiency demands that a party that shares in the benefits should share in the costs as well. But this fiscal externality principle, though meriting extra credit on public finance exams, is not part of the political debate; indeed it is rarely discussed anywhere,

and assuredly does not explain the government's significant policies in the health arena. Risk spreading provides another potential explanation for a government role. But since most insurance plans cover initial or early dollar coverage, where the financial risks to the insured are small, this explanation is not convincing.

Paternalism does help explain why our redistributional policies focus on health. We do not trust the poor to spend their money wisely, on medicines, say, rather than lottery tickets. A complementary argument applies in this realm: Redistributing health dollars rather than green dollars makes the donors feel better. That is, there is a good-specific externality. Health care is a red flag for conscience. If poor people lack health care, the whole system seems unjust. From the donors' standpoint, and frequently all of us are donors as citizens, better the poor person receive a vaccination than a VCR, a mobile checkup than a mobile phone. His lack of Sonys and Nokias doesn't bother us; it doesn't trumpet the inequities of our society. Sometimes the issue is less how the money is spent than in who gets to spend the money. Target efficiency is lost if Grandma gets a general support check, which is cashed and used to pay for a family trip to the movies; it is preserved if her health checkup is paid for by Medicare.

These economic arguments about the rationales for government-supported health care make for lively debate about the appropriate role of government, but primarily among economists. Economists just see these issues differently than the world at large. They tend to see little special about health care, apart from its economic properties, whereas many policymakers and citizens believe that health care, unlike even housing, is a right, something God-given. And what God gives, it seems, in a form of double provision, the government must pay for. (Many agnostics and atheists concerned with a just society also feel the government should pay for health care.)

Whatever the rationale for government involvement in health care, the natural question arises about what happened between Irving Fisher's time and today that so many developed nations today believe that government should simply pay for the bulk of health care. Fisher was well ahead of his time in two respects: identifying national health insurance as a priority, and reaching this conclusion on the basis of limited economic analysis.

III

Appropriate Government Roles in Health Care

THE BACK PORTION of Fuchs's essay looks at the causes and consequences of government involvement. Though we all know there should be a government role in health care, it is much less clear what the role should be. Three decades ago, government policy increased the number of medical specialists and hospital beds. But today it pushes in the opposite direction, in part because we think underutilized resources create their own demand, rather than fostering competition that reduces prices.

Medical technology has marched smartly forward in this era with strong support from government. Though theory suggests improved technologies may save monies on net, they have not. The burgeoning NIH budget must therefore be justified for the knowledge it brings, for the cures of Alzheimer's and cancer that may be just around the corner. In assessing the potential contributions of emerging medical technologies to both health and cost control, Fuchs has often been a sober voice. I am more Pollyannaish. The pathways to production of new medical technologies are much more complex than economists have imagined. Anti-angiogenesis provides an intriguing example. It is a technology that seeks to starve malignant tumors by shutting down their ability to stimulate new blood supplies. Dr. Judah Folkman conceived of this approach 35 years ago and received initial support from the nonprofit American Cancer Society in the late 1960s. Subsequently he received some support from the government. Now the technology is on the brink of a test in humans, and it is commercial biotech and pharmaceutical firms that will be conducting the work. If the results are promising, the government will step in again, to decide whether to let the anti-angiogenesis agents on the market, and for which patients. And the government-run patent system will at all times be in the background, spurring new medical developments by protecting intellectual property, but perhaps discouraging their spread by allowing monopoly pricing.[3]

Even when the goals are clear, what the government should do is not. Consider tobacco regulation. Whatever the role of Joe Camel,

neither the government nor the tobacco companies know how to effectively curb tobacco use, beyond raising the price through taxation.[4] But since cigarettes are disproportionately purchased by the poor, using price as a discouragement works against distributional goals. And leaving distributional considerations aside, should we set the tobacco tax way above the fiscal externalities tobacco imposes?[5] Moral arguments and great pots of money appear to be motivating our nation's tobacco policies, not analytic thought. As a perusal of Fisher's arguments against alcohol make clear, strong moral views do not always lead to sensible policies.[6] Fuchs aptly cites Stigler on the dangers of linking reform and research.

IV

Conclusion

Irving Fisher has been more than discovered as a health economist. He has been dissected by Victor Fuchs, a master anatomist. One of Fisher's greatest contributions is his systematic thought about time and the future. On health issues, he was assuredly future-minded. His emphasis on personal habits, as opposed to health care, as contributors to well-being appears prescient. His strong support for national health insurance was well ahead of his time. Will government begin to emphasize individuals' responsibilities for their own health? Will the U.S. government initiate national health insurance for significant new groups? The answer to these questions will emerge primarily from political considerations. To recognize that policy reality is not to welcome it. The discussion will be less well informed, our health policies less sensible if the economic foundations are not understood.

Irving Fisher was no role model with his analysis of health policy, long on self-assurance, short on economic reasoning. Economists seeking sustenance on health issues should look elsewhere in his works. Fisher bequeathed them a substantial legacy in his pioneering studies at the core of economics, ranging from optimal capital accumulation to the construction of index numbers. On such solid foundations—the first on dynamics, the second on evaluation—sound economics and wise policies in health will be anchored.

Notes

1. See Nordhaus in this volume for an exemplary application of economic logic to the analysis of health.

2. Of course, if health care enables the individual to live longer, to collect more Social Security and Medicare benefits, that creates a fiscal externality cutting in the opposite direction.

3. Economists have a neat solution to this problem. When important technologies become available, have the government buy the patent and make the technology available at marginal cost. This recommendation only holds sway in public finance classes.

4. Recent studies found that the highly regarded, well-established, and widely employed D.A.R.E. Program, intended to curb drug use by the young, is not effectual (*Boston Globe*, August 2, 1999: 1.)

5. Manning et al. (1989) estimated the net fiscal externality of smoking to be roughly zero at a 3% discount rate. The cigarette taxes just covered the difference between smokers' increased medical costs and lower expected Social Security payments, which is below current taxation levels, much less levels that are being contemplated.

6. See Phillips and Zeckhauser (1996) for an assessment of the value of the cardiovascular benefits of moderate alcohol consumption. Should government publicize such benefits, at the risk of increasing problem drinking?

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