

sired reduction in low-benefit, high-cost procedures. However, global budgets may not be the best mechanism for encouraging efficiency in hospital operations. The use of some form of prospective payment system (such as Medicare's diagnosis-related groups), instead of or in conjunction with global budgets, may prove more effective.

Also, while other systems have been more effective than the U.S. system in controlling costs, the U.S. approach has excelled in encouraging institutional innovations. Many European analysts are interested in figuring out ways to incorporate innovations such as health maintenance organizations into their insurance systems. The Dutch are now moving cautiously into a major reform that they hope can combine universal access and expenditure limits with greatly enhanced institutional flexibility. Many serious problems in the new Dutch system must yet be resolved, but if successfully implemented, it may provide a useful model for others.

**Aaron's plan.** Aaron is convinced that, despite the drawbacks of many of the alternatives, flaws in the current U.S. system can only be addressed through comprehensive reform. He concludes by describing his plan: (1) require employers to finance health insurance through either direct provision or payment of a payroll-adjusted premium; (2) create a national program to pick up all costs

in excess of a fixed amount per insured person; and (3) channel provider payments through a network of regional fiscal agents. These agents would negotiate fee schedules for physicians and global budgets for hospitals, control the locations at which different medical services are delivered, and influence which procedures are made available under specified circumstances.

Aaron sets out his own proposal "less to urge one approach . . . than to fuel the debate." I agree that more debate is needed before any particular approach is adopted nationally. Experience from abroad suggests that costs can be controlled and access broadened if the two objectives are linked in a system that features coordination of payers and some mechanism for limiting expenditures. But that experience also suggests that much remains to be learned about the advantages and disadvantages of various reimbursement strategies.

The United States is a large and diverse country, and the particular health financing model best suited to one part of the country may not be best suited to another. It may be possible, therefore, to develop a national structure within which different models can evolve in different areas of the country. However the reform debate turns out, *Serious and Unstable Condition* provides both important analyses and a useful framework.

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## The Gender Gap In Wages And Health

by Elizabeth Fee

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### *Health Care and Gender*

by Charlotte F. Muller  
(New York: Russell Sage Foundation,  
1990), 258 pp., \$34.95

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Feminist analyses of the health care system have raised many questions of gender inequality in medical education, science, and practice. The earlier feminist critiques

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of some twenty years ago tended to come from the point of view of relatively affluent patients who were willing or able to pay for medical care but expected their concerns, ideas, and feelings to be treated with respect. Such women complained of physicians' arrogant and dismissive attitudes, their excessive enthusiasm for surgical procedures, their tendency to define all aspects of life in medical terms, and their unwillingness to share responsibility for decision making. These critics wanted woman-centered care that would be more responsive to the social, psychological, and emotional context of health and illness; less oriented to maximizing physicians' incomes; and more con-

cerned with patients' rights and interests. The collective voice of the women's health movement, supported by hundreds of small feminist health organizations, would become an important influence in changing attitudes and sometimes policies.

In *Health Care and Gender*, Charlotte Muller evaluates the changes of the past twenty years, the growing body of research on gender and health care, and the evidence of continuing gender-related discrimination. She is most effective when addressing the economic basis of gender inequalities in health care, a subject given far too little attention in the earlier feminist writings that focused so intensively on attitudes and ideology. Muller argues convincingly that the single biggest contemporary problem of women's healthcare is the problem of paying for that care. Women are more likely to be in the low-paid, nonunionized sectors of the economy, to have interrupted careers or to work part time, and to be members of the "working poor." In a system in which high-wage workers usually receive good benefits, including health insurance, low-wage workers often lack any insurance coverage whatsoever. In addition, since women's wages tend to peak early whereas men's wages tend to rise throughout their careers, men are likely to receive far more generous retirement benefits.

For all of these reasons, the system of employer-based health insurance discriminates against female workers and reproduces the inequities of a still largely sex-segregated labor market. Muller argues that women will be ill-served by the health care system as long as health insurance is tied to employment, as long as women receive lower wages, and as long as they continue to carry the major burden of caring for children, the elderly, and, indeed, for all family members. Only universal coverage could avoid the discriminatory structure of the labor market and thus guarantee equal access to care.

Women's health needs. In addition to the problems of health care financing, provision for reproductive care is remarkably deficient. Muller argues that we need to offer a spectrum of health and social services to help adolescents deal with the problems of

unwanted fertility and to provide coverage of contraception, prenatal care, and pregnancy-related services—including abortion—for all women. The aim should be to aid women in giving birth to desired children, not to force them to bear unwanted babies, she says. The current underfunding of reproductive services extends to specific cost-effective preventive services, such as Pap tests and breast cancer screening, which should be covered by all policies and for all women. Muller states that while maternity leaves are a signal benefit for women, children, and families, they too often bring an interruption in health care coverage.

Muller notes that women use more health care and hospital services than do men, have more acute episodes of illness, experience more need for reproductive care, and need more chronic and long-term care over their greater life span. In midlife, women have more reproductive health problems, while men are at higher risk for serious injuries; in later life, both men and women experience chronic disorders. Muller argues that efforts to measure the costs of illness and death have typically devalued women's lives and women's work; if the value of a life is measured by the value of market-determined earnings, economic analyses of illness merely reproduce the gender inequities of the labor market.

Muller shows that the sources of financing of care differ by gender: Women use more family and personal funds and rely more on Medicaid; men have more and better coverage by private insurance and are more likely to be covered by Veterans Administration programs and by Workers' Compensation. Women, paying more expenses out of pocket than men, are more likely to have unmet health care needs. It is interesting to note that when men and women are given routine examinations for the same conditions, men tend to receive more tests; perhaps this indicates that men's complaints are often taken more seriously than women's.

Muller explores the interesting if fragmented research on different ways of treating male and female patients and the different forms of care given by male and female

providers. Male patients, for example, with the same reported symptoms as women, are more likely to receive coronary bypass surgery. Female doctors provide more preventive care; one study has shown that female gynecologists perform hysterectomies at one-half the rate of their male colleagues.

Medicaid. Muller argues that the burdensome features of Medicaid are both gender and class issues and that the high rates of poverty among women make Medicaid a critical feminist concern. Younger women's health care is shaped by the features of Aid to Families with Dependent Children (AFDC) and by federal and state policies on pregnancy, while older women are most affected by regulations on access to long-term care. Women—the majority unmarried, divorced, or widowed—constitute between 60 and 70 percent of all Medicaid recipients. It is not surprising that female poverty is tied so closely to single status; in a sex-segregated, discriminatory labor market, women's main route out of low-wage work is still through marriage.

Medicaid thus tends to become a program for chronically and severely poor, predominantly single women. Its association with poverty affects the attitudes of providers, clients, and taxpayers. Over 25 percent of the nation's privately practicing physicians currently refuse to treat Medicaid patients, as do even higher numbers of obstetrician/gynecologists and other key specialists. Because women are much more dependent on Medicaid than are men, such refusals are a gender as well as a class issue.

New health care financing mechanisms may unintentionally make women's situation worse. Early hospital discharge and the move to outpatient surgery shift the burden of care to the home setting and to the unpaid services of female caregivers. Men benefit from the unpaid caring labor of women; much more rarely can women count on men for such supportive care.

The elderly. The problems of elderly women were largely neglected in the first wave of feminist analysis of health care. Muller's sympathetic chapter on the elderly partly compensates for this neglect. In dealing with the elderly, she finds that gender is,

in many respects, a proxy for ability to pay, but it is not an exact indicator. The poor (or functionally impaired) male and the poor (or functionally impaired) female are more alike than the poor and the well-to-do, the vigorous and the frail, within each sex.

Again, the problems of elderly women are largely the problems of poverty. Women are repaid for spending time caring for households and families by the loss of retirement and pension benefits. Given the fact that women constitute over 70 percent of the elderly poor, health care deficits among the elderly affect large numbers of women. As the population ages, numbers of women increase relative to men; the oldest, and sickest, part of the population becomes overwhelmingly female. The limitations of Medicare coverage place the highest burdens on those of lowest income, forcing many elderly people to forgo needed care. The burdens of poverty are highest for black and Hispanic elderly women living alone.

Gender and health policy. Muller notes that health policy debates over ways of financing the health care system, including long-term care, are usually conducted without reference to gender. This apparent gender-neutrality may result in further gender inequities when policymakers ignore the real social and economic context of the policies they promote. Muller's focus on these underlying economic inequalities by gender provides a valuable corrective for health policy analysis and highlights the ways in which our policies need to be more sensitive to both gender and class.

This is a valuable, indeed essential, contribution. It is unfortunate that Mullet's book is poorly written and that much of it, despite its great intrinsic interest, manages to be remarkably dull. Health care and Gender was selected for publication as a Russell Sage Foundation book. The foundation's criteria for manuscript selection are "competence, accuracy, and objectivity," qualities that are indeed fully demonstrated here. Would that the "selected expert readers" and editors of this volume had insisted upon a more readable text, less freighted by the compulsion to mention every available research study of the past twenty years, and

upon more of Muller's own perspective on the issues. When her voice does emerge, it is that of a concerned and compassionate observer who knows her subject well. It is a pity that this voice is so often muffled by her style of presentation.

Some other elements are missing. Muller provides little sense of history beyond a vague idea of progress made in the past twenty years in addressing the more obvious sources of gender discrimination within health care settings. Her book also lacks a sense of the specific humanity of the women who are its ostensible subject. Feminist readers will find no voices of female patients here, no reflection on the insights, anger, or resistance of the women whose plight is being discussed. Muller attends to research data, not to subjective experience. Perhaps

because of this focus, she says relatively little about the relationships between gender, class, race, and ethnicity. Her final paragraph concludes with a plea to recognize the interplay of gender with class and ethnicity in conceptualizing and modeling the health care system, yet she avoids many opportunities to address these relationships explicitly or to demonstrate by example the type of analysis she advocates.

Despite its various shortcomings, this is a valuable book, bringing a basic economic analysis to bear on women's health care and providing an indispensable focus on gender to debates on health care financing and health policy. Serious students of health policy will be able to ignore the infelicities of style and glean much of value.

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## Tracing The Roots Of Modern Bioethics

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by James F. Childress

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### *The New Medicine and the Old Ethics*

by Albert R. Jonsen  
(Cambridge, Mass.: Harvard University Press, 1990), 171 pp., \$18.95

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"Medicine and its practice is radically ambiguous, and, in my opinion, ethics is disciplined reflection on ambiguity." With these words, Albert Jonsen states one of the major theses of his book, *The New Medicine and the Old Ethics*. According to Jonsen, a professor of medical ethics at the University of Washington Medical School, radical ambiguity in medicine means that medicine "can go badly wrong even as it aims to heal." Nevertheless, ethics that focus on ambiguity can still come to "closure on certain questions." In this work, drawn from his 1988 George Washington Gay Lectures at the Harvard Medical School, Jonsen focuses on the ethical traditions in medicine. In the language of one of his prevailing images, the new medicine has "hard, sharp edges" (in-

struments, machines, and drugs with technological precision), while "the ethical questions have a blurred outline." In this book, he brings together the "hard, sharp edges" of modern medicine with the "blurred outline" of its ethical traditions.

Jonsen finds reinforcement of his notion of ethics as disciplined reflection on ambiguity in the practical perspective of Aristotle, not in the theoretical perspectives of philosophers such as Descartes and Spinoza. He holds that "ethical understanding comes as much from appreciation of tradition and history as from clarity of concept and rigor of logic." Without denying the importance of appropriate precision in discussions of ethics, Jonsen strives to maintain the variety and richness of personal experiences, historical traditions, and cultural formulations. He argues that because of its ambiguity, the moral life as lived in medicine (and elsewhere) "cannot be delineated in clear, bright lines. . . . It is rather a chiaroscuro in which the shadowy figures from history, myth, and tradition are often more powerfully present than the pallid propositions of philosophical ethics."

Early in the book, Jonsen identifies the paradox of self-interest and altruism that is at the very center of medicine. Through a

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