
INTERVIEW

Physicians As Agents Of Social Control: The Thoughts Of Victor Fuchs

A leading health economist airs his views on a variety of today's pressing health policy issues, including the tensions between market forces and medical professionalism.

by John K. Iglehart

Q: You have been an analyst and an observer of the U.S. health care system for more than three decades now. What trends do you find most troubling, and what trends encourage you to believe that we are moving toward the widely agreed upon goal of ready access to affordable medical care for the American people?

A: I will start with the second part first. I'm not sure that that goal is widely agreed upon in the sense that the public is willing to support the policies necessary to reach it. For example, to achieve universal coverage there must be subsidization for those who are too poor or too sick to afford health insurance, and compulsion for those who are unwilling to acquire it. The debacle of health care reform efforts in 1994 showed that the American public is not yet ready to embrace subsidization and compulsion.

The trends that I find most troubling are too much commercialization of health care, the erosion of professional norms, and the stampede to mergers and acquisitions. An encouraging trend is the growing recognition that no nation can afford to give all of its citizens all of the health care that might do them some good.

Q: Give me several examples of why you are encouraged about people's greater appreciation for the limited resources that are available to finance medical care.

A: One landmark is the First International

Conference on Priorities in Health Care held in Stockholm in 1996 and sponsored by Sweden, Norway, Finland, the World Health Organization, and the European Union. Participants came from more than fifty countries and every continent except Antarctica. A second conference on priorities is scheduled for 1998 in London. In addition, there is heightened interest in shoring up the scientific base of medicine. That goes under different names in different countries. In England it's called evidence-based medicine. In the United States it's called outcomes research or clinical guidelines. In other countries it's called technology assessment. Whatever the name, the idea is the same. The practice of medicine will always be partly an art. But now, with information technology, with more research, and with professionals who combine clinical and quantitative skills, it is possible to ground medical practice more in science as well as in art.

Q: Who's driving this second trend in the United States most directly? Is it the profession? The payers? Government?

A: In the United States, and all over the world, the pressure is coming primarily from those who pay for health care. Unfortunately, they are doing it partly for the wrong reason: because they suspect that much of current medical practice will not stand up to scientific scrutiny. They hope that this new kind of research will save money. In part they're right.

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In part, however, they're going to be disappointed because we will also find a great deal of care that doesn't do the patient harm and, at great cost, may do some good. Such care will meet the test of effectiveness, but not of cost-effectiveness. Then, the government and employers will face a hard question: Will they pay for medical care that may help some patients, but only at tremendous cost?

Q: What about the disturbing trends that you mentioned?

A: I have always advocated the development of an integrated approach to delivering health care, but I visualized it as being led primarily by physicians and other health care professionals. Instead, it now takes the form of commercialized ventures run by people who have a business approach and who make decisions much as they would if they were in any other business. This frightens me considerably. Why would the business executives running health care organizations behave any differently than those running securities firms or real estate investment schemes behave? Business executives try to maximize profit—that is the business ethic. We risk losing sight of medical care as the expression of a professional ethic. The corporate mentality judges success by profit growth. Physician-led systems also will have to pay attention to costs, and physicians also will be interested in making a good income. In my opinion, however, there is a vast difference between a profit-maximizing corporation and physicians who strive to balance their obligations to patients, the organization, and themselves.

Professionalism In Medicine

Q: You have written about professionalism as a system of control. In the context of this transformation, how is the role of the physician changing?

A: Professional power is eroding in two ways, at least. One is through intense competition. Another is through the transfer of power and control from the physician to managers. To some extent, that was inevitable because physicians (with some exceptions) were not will-

ing to step up to the plate and try to deal with the problems of exploding costs and managing the delivery of reasonably good quality care. It was almost inevitable that power would shift away from them. But that doesn't mean that I'm happy about the shift. Nor am I happy about intense competition between physicians or between physician groups. Medical care can suffer from too much competition, just as, in the past, it suffered from too little. The conditions that make the textbook model of competition so appealing are often lacking in medical care. Physicians and patients possess very different information; honesty and trust on both sides are extremely important; and patients often benefit from cooperation among physicians.

Q: Is physicians' loss of power a permanent consideration? Do you envision that doctors will rebound in the future, reclaiming some of their lost authority?

A: I hope so, but physicians won't reclaim their authority simply by turning their backs on managed care. If it is to happen at all, it will happen through physicians' and other health professionals' taking a leading role in managing health care. I believe that government policy should look favorably on this kind of development rather than inhibiting it. Even then, the power of the individual physician, the autonomy he or she enjoyed under solo fee-for-service practice, will never return. That doesn't seem to bother younger doctors; applications to medical schools are running at record highs. I am troubled, though, that younger doctors are not more aware of professional norms as an instrument of social control, along with competition and government regulation.

Q: Would you discuss at greater length these three instruments of social control?

A: The economist Kenneth Boulding wrote about three kinds of control systems in society. There's what he calls the exchange system, which means you do something for me because I do something for you. That's how the market works. Second is the threat system, which is when you do something because I tell you to do it and I have the power to make

you do it. That's the way the government works. Third is what Boulding calls an integrative system, in which people do things because of who they are and what their relationship is to others. A family is an integrative system. Schooling can be an integrative system based on a relationship between teacher and pupil, which is neither governed entirely by an exchange mentality nor by a threat mentality, although both may be present. Medical care, at its best, is clearly an integrative system, with reciprocal rights and responsibilities between

patient and physician. Health is produced by physician and patient working together. Good medical care requires an integrative relationship. Neither competition nor government regulation can deal adequately with the complexity of medical care. That's why I keep stressing the importance of professional norms in governing the physician's role.

Q: Has professionalism as a controlling force lost its punch as purchasers become more dominant and commercialism assumes a larger role in our emerging market-driven system?

A: The short answer is yes. But the longer answer is that I see this trend as part of a widespread trend in modern society away from integrative relationships in general. The erosion of professionalism is actually being applauded by large elements in society. It reflects a decline in hierarchical relationships that stems from a desire to have everyone on an equal basis. That is not only true in medical care, it's true up and down every avenue of life. But when it comes to something like medical care, I don't think there is going to be a satisfactory solution short of invoking professional norms and integrative relationships.

Revisiting 'Who Shall Live?'

Q: Almost twenty-five years ago you wrote *Who Shall Live?*, a noteworthy little book that served to educate a generation of stu-

dents of health services research, medicine, and nursing. If you were writing that book today, would its basic conclusions be any different?

A: The most important themes of that book seem to be as relevant today as they were twenty-five years ago. The first one has already been alluded to: namely, that no nation can provide all of its citizens with all of the medical care that might do them some good. Choices must be made. That was the emphasis of the book. Economics provides a framework for thinking about those choices.

Another theme of the book was that health depends a great deal on what we do or don't do to and for ourselves. I think that is still true. Indeed, we now have firmer scientific evidence about how important nonmedical factors are in health outcomes, whether they're genetic factors, or environmental factors, or personal

behavior having to do with cigarette smoking, alcohol, diet, or exercise. That theme stands up well.

It's important for people to realize that when we observe differences in health outcomes between different countries or between groups in the same country, it's more likely that those differences are related to the factors I've mentioned than to differences in medical care. That was a very difficult thing for people to accept twenty-five years ago. It's still difficult for a lot of people to accept. But I think the evidence is quite persuasive.

On The Prospects For Reform

Q: You have written critically of the recent debate over health system reform. Given the values that Americans hold most dear—limited government, low taxes, and freedom for the individual—was the debate doomed from the start, in light of what the Clintons were seeking to accomplish?

A: Absolutely. Absolutely. Many books and

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articles have been written trying to explain what happened, criticizing the Clintons for political ineptitude or for poor design and so on. Some of those criticisms are valid. I wrote a piece for *Health Affairs* in which I laid out some criticisms of my own.¹ Having said all that, in my mind there was never a chance of comprehensive health care reform. I said so in *Health Affairs* in 1991.² I said so again in the *Journal of the American Medical Association* in early 1993.³ The reasons are much the same as those that I put forth in 1976.⁴ First, Americans have always had a great distrust of government, which you mentioned. Second, we're very heterogeneous; we don't feel that same empathy across the whole population that you might find in countries such as Sweden, the Netherlands, or Japan. Third, Americans have a very weak sense of *noblesse oblige*. In fact, when I mention the term now to undergraduates at Stanford, many of them aren't even familiar with the concept. But in Europe this is a well-established concept that came down from feudal times.

The one thing that has changed since 1976, but not enough to make a big difference yet, is that we used to have very strong private, nonprofit voluntary institutions that performed quasi-governmental functions in health care. There were Blue Cross and Blue Shield plans that used community rating and, in effect, provided a kind of social health insurance. There were nonprofit hospitals that did a tremendous amount of cost shifting to cover the expenses of caring for the very sick and the uninsured. They were, in effect, picking up the slack and making the community as a whole bear the cost for the poor and the sick.

These institutions have changed greatly, and that reason is weaker now, but the other three reasons are stronger now than they were twenty-five years ago. In my judgment, the enactment of comprehensive reform could only occur in the wake of some major political upheaval such as often accompanies a war, a depression, or large-scale civil unrest.

Q: You talk about the erosion of community rating and the changing nature of the

Blues system and nonprofit hospitals. Are they caught up, essentially, in this drive to commercialize and the forces there are so strong that these institutions simply have no choice but to play that game?

A: That's correct. They have virtually no choice. Certainly, they have no choice about abandoning community rating. If they maintain community rating and the competing companies do not, the competing companies will pick off the good risks with low premiums and the Blues will constantly have to raise their premiums. The better risks will leave Blues plans because their premiums are high relative to those of other companies. The dynamics of the insurance market says that once some companies depart significantly from community rating, the others will find it impossible to maintain it.

Q: In a letter to President Clinton at the beginning of the health care reform debate, you asserted that the United States must disengage health insurance from employment. You said that labor market efficiency suffers because workers' choices of jobs, decisions about job changes, and timing of retirement are frequently influenced by health insurance considerations. Do you see a continued erosion of the employer-based system in terms of the number of people with coverage?

A: There is a small amount of erosion by individual employers, but there also are attempts to apply Band-Aids to keep the employer-based system going. Many individuals and organizations have a stake in maintaining an employment-based insurance system. This system cannot deliver universal coverage, and if that's what we want, sooner or later we will have to change to a different system. Right now, however, there are benefits managers, insurance companies, and others who want to perpetuate—and improve slightly—the employer-based system rather than taking their chances on some totally new system.

Q: You also asserted in that letter to President Clinton that "we must tame but not destroy technologic change because such

change is the most important force behind the escalation of health care expenditures.” The question is, will a market-driven system of allocating health care resources be more effective at taming technology than was our traditional system of delivery and financing?

A: It probably will be. But a lot will depend on the incentives and the cues that the system gets from the government and others who are funding care. For example, if there is an emphasis on insurance for catastrophic illness, that means more money for the technologies used by patients with catastrophic illness. There would be a diversion away from research and development (R&D) for, let’s say, preventive medicine. It is a mistake to imagine that research priorities come down from heaven rather than to recognize that the character, shape, and pace of medical innovation are influenced by market forces—by where we put our money. If there is an increase in funding of health care for the elderly, you’re going to see a lot of new technology for the elderly. Boost funding for premature babies, and you will see new technology in neonatal intensive care units. Sometimes the developments are dictated entirely by scientific advances. But there’s often a big step between a scientific discovery and the transformation of that discovery into an effective technology. Money talks, and in the world of medical R&D, sometimes it even screams.

Lessons From Europe

Q: You recently spent an extended period in Europe lecturing and discussing social trends and health systems with a number of intellectuals, physicians, and government leaders. What struck you most about these conversations, in terms of the status of the European health care systems and their future directions?

A: One striking thing is the widespread fear of rising health care expenditures, even in countries that have not experienced much of an increase in the health sector’s share of the gross domestic product (GDP) in recent

years. I found this fear in every country. As soon as you get into a discussion with health policymakers, they talk about health expenditures’ being too high and what can be done to constrain further growth. I think that this stems from the fact that the government has such a big stake in health care spending in these countries, and there is overall concern about the size of budgets. This is also related to discussions about creating a European Monetary Union, which would put constraints on all government expenditures, including health care. Another theme that I encountered was the desire to put the practice of medicine on a more scientific basis. This theme is closely related to the concern about expenditures.

Q: Did you sense an erosion of the solidarity of values embedded in the social insurance systems in Europe? Or are Europeans holding to defending those values?

A: That’s a tough call. If I were to speculate a little, I would say that these values are eroding a bit, but there is still a tremendous attempt to preserve them, to preserve the rhetoric, and to preserve the symbolism. For example, we normally think of Germany as a capitalist country. But when it comes to health care, “market” is a four-letter word there. You can’t talk about the market and health care. That doesn’t mean that market forces aren’t at work. It just means you can’t talk about it.

You’ll probably see a similar change in England now that the Labour government is in power. The Thatcher reforms there called for the creation of internal markets among the financing, purchasing, and delivery of care. I think that the new arrangements are likely to stay, but they won’t be described—certainly not approvingly—in market terms the way they were in the Thatcher era. The Labour government will abolish the term “internal markets” long before it does anything to the markets themselves.

Q: Are there lessons to be learned from the study of foreign health care systems? Your views on this question seem to have waxed and waned over the years.

A: You’re right about the waxing and waning. My first view was, yes, we could learn a lot

from them. My second view was, no, we couldn't learn much from them because every country has to develop a health care system that's consistent with its own political, social, and cultural foundations. I now think that the second view is correct if you mean by learning that you can automatically copy things that other countries do. But my first view has merit if you mean that you can draw some general principles about health care and health policy from the experience of other countries. One thing is very evident: No country does or will treat health care like an ordinary commodity, subject simply to the interplay of supply and demand in market fashion. Not even the United States will do that. Economics provides several explanations for this.

Another lesson to be drawn is that if you want to limit the rate of growth of expenditures, you will probably be more effective in doing it from the supply side of the equation than from the demand side. This is one of the big differences between the United States and other countries. Many Americans seem to feel that if we can only get the demand side right, everything would be fine. I don't deny that making patients more conscious of cost would have some effect. But when you're talking about 14 percent of GDP versus 8 percent of a smaller GDP, I think that the big difference is the effectiveness of supply-side constraints—constraints on facilities, personnel, specialists, and technology. It's these constraints that hold down the rate of growth of expenditures in other countries.

Mergers And Consolidation

Q: Along with commercialism has come consolidation of systems, particularly in California. What are the implications of this consolidation for patients, providers, and purchasers of care? And, I might add, in your recent JAMA paper entitled "Managed Care and Merger Mania," you suggested, if I remember correctly, that the mania was behind us—that is, many or most of the mergers had taken place by then.⁵ Anyway, the question is, what are

the implications of consolidation?

A: Let me say first that I was not making a prediction that there wouldn't be many mergers in 1997 or anything like that. What I was suggesting is that, in the fullness of time, I believe that many of these mergers will be found not to have a solid economic efficiency base. They may become undone, and we will see spinoffs, breakups, and contracting out. That's been the experience in other industries that go through these merger waves. We're in the midst of a huge merger and acquisition boom, which is not by any means limited to medical care. We see it throughout the economy. And the experience of previous merger booms is that, subsequently, many of them turn out to be economic mistakes.

Medicare And Graduate Medical Education

Q: For years Medicare has played a central role in financing graduate medical education. Is there any rationale in your mind for the magnitude of Medicare's role in this regard, or should it be reformed?

A: I think that there is no rationale for it—certainly, no compelling rationale. This is a happenstance of political alliances, arrangements to get political legislation passed, to get support from various groups and so on. It seems to me that the issue of how much we want to spend for medical education and how much we want to spend collectively to subsidize medical research should be faced by Congress—society's collective voice. It shouldn't be buried in programs that are clearly designed for other purposes, such as providing medical care for the elderly.

The Consumer's Role

Q: What's your take on the role that consumers are playing? The conventional wisdom about how markets operate is that consumers must be equipped with good information, and that they must understand that information to select the right choice for their particular case. Do you believe, at this point, that consumers are

stepping up to the plate on this, or are we still faced with an average consumer who is largely ignorant about choice and about the changing system?

A: I think that a large amount of ignorance on the part of consumers about medical care is inevitable. I only wish that physicians knew more. Because we're dealing with such complex phenomena and the appropriate technologies change so rapidly, I have never been a big cheerleader for the notion that consumers will be terribly well informed. Add to that the fact that people, when they're well, don't spend a lot of time thinking about medical care, and when they're sick or their loved ones are sick, they are caught up in a variety of emotional problems and pressures. In my experience, most people—even those who are extremely well educated and have more than average knowledge about medical care—want to go to a physician whom they trust to give them good and honest advice. I think that's the way it's going to continue to be. A lot of today's consumerism is being pushed by professional consumerists, consumer advocates, and the media, rather than by any real demand on the part of ordinary people.

The Rise Of New Foundations

Q: Over the years you have derived considerable support for your research from private foundations. As the stock market has flourished, and as new foundations have been created from not-for-profit conversions, the resources commanded by the foundation world have increased dramatically. What is your view of these institutions and the contributions they are making to American society? Are they bold enough in seeking constructive change? Should they be subjected to greater government oversight?

A: Well, I'll start with the last. No. Not greater government oversight. On the basis of all recent experience, governments probably do more harm than good when they get into that kind of thing—just as I think they're doing more harm than good as they now try to

prescribe what should happen at the bedside. I don't think that's a business that the government should be in. On balance, foundations perform a valuable societal function. I'll put it to you very simply: Add up all of the funds that foundations dispose of during a year. I don't know what that number comes to, but I'm sure it's many billions of dollars. The government budget is in the thousands of billions. So ask the following question. Would society as a whole be better off if those funds were added to the federal budget instead of being at the disposal of the foundation officers and staff? In my judgment, it would be no contest. The foundations would win, hands down.

On balance, foundations are an important additional element that not only supplements what government is doing but, in a sense, is in a position to evaluate what government is doing. We desperately need that. We need small-scale experiments and demonstrations. We need to learn through trial and error, provided that the costs of the trials and errors can be kept within bounds. We need the diversity that foundations provide. Instead of one federal government, there are hundreds of foundations with different boards, different staffs, different ideas about what needs to be done. They can support unpopular people and programs. Can they make mistakes? Sure. Can they abuse power? Sure. Are they bold enough? Probably not. But on balance, I believe that they are a useful element in our large, pluralistic society.

NOTES

1. V.R. Fuchs, "The Clinton Plan: A Researcher Examines Reform," *Health Affairs* (Spring 1994): 102-114.
2. V.R. Fuchs, "National Health Insurance Revisited," *Health Affairs* (Winter 1991): 7-17.
3. V.R. Fuchs, "Dear President Clinton," *Journal of the American Medical Association* 269, no. 13 (1993): 1678-1679.
4. V.R. Fuchs, "From Bismarck to Woodcock: The 'Irrational' Pursuit of National Health Insurance," *Journal of Law and Economics* 19, no. 2 (1976): 347-359.
5. V.R. Fuchs, "Managed Care and Merger Mania," *Journal of the American Medical Association* 277, no. 11 (1997): 920-921.