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Policy Analysis Or Polemic
On Oregon’s Rationing Plan?

To the Editor:

In his article entitled “The National Politics of Oregon’s Rationing Plan” (Health Affairs, Summer 1991), Lawrence D. Brown appears to have misunderstood what is most fundamental about what Oregon is doing. The article contains numerous errors of fact, which could have been avoided through a proper review of available reports. Several points require correction in the interest of keeping the debate on solid footing.

(1) Oregon will not actually “exclude services deemed to be insufficiently cost-effective.” Instead, cost was less important than net benefit of the service as measured by predictable improvement in health; relative importance to the entire population to be served; and social values derived from an extensive public outreach process, including “town hall” meetings and a random sample telephone survey. As the Oregon Health Services Commission report clearly indicates, cost was not the driving factor in rank-ordering services.

(2) No “list” of services was discussed “at eleven public hearings and forty-seven town meetings across the state.” Instead, these discussions focused on the values Oregonians want their health care system to support and formed a part of the basis for the commission’s work from the outset.

(3) There are no “revised estimates of the number of new Medicaid eligibles” predicting 200,000. Instead, the estimate made in early 1990 still stands: approximately 120,000 new Medicaid recipients are projected by 1995 as a direct result of expanding eligibility to all those with family income below the federal poverty level.

Beyond these factual errors, Brown’s article contains other problems. Citations and sources are often missing for the most interesting quotations. Rationing and prioritizing are confused throughout the article. Perhaps most telling, Brown appears to embrace the premises behind Oregon’s plan and then to reject the plan at the same time, while offering no cogent reason not to proceed with the plan nor any alternative. His position is sadly similar to the federal government’s neglect of the impoverished uninsured.

Brown offers for consideration three definitive categories of rationing: rationing as social allocation; rationing as principled rationalization; and rationing as cost-effective retrenchment. Then, in attempting to fit the Oregon process into this construct, he claims, “The broad significance of Oregon’s plan lies in its determination to embrace rationing in the sense of cost-effective retrenchment and then use it as a vehicle of principled rationalization of health insurance coverage.” This claim is false and misleading; it has the Oregon process backwards. What Oregon actually has done is, first, to open Medicaid eligibility to all impoverished people; second, to use marginal benefit analysis as one tool for getting as much good as possible out of available resources. The objective is to cover poor Oregonians who have no health insurance and to treat all poor Oregonians equally; prioritizing health services is a way to rationalize the benefit package that defines coverage.

Although Brown often misrepresents the
Oregon health plan and its development, he is surprisingly effective at stating a key premise in Oregon’s case: “Expansions in Medicaid mean little if states respond by cutting eligibility for benefits or by reducing payments to providers, thereby diminishing access.” This is a compelling argument in favor of the Oregon health plan.

No responsible critic of the Oregon health plan can make light of the fact that hundreds of thousands of Oregonians are without health coverage today, or that approximately 120,000 of these are impoverished uninsured who will finally gain access to basic health services under the plan, or that over half these impoverished uninsured are women and children somehow forgotten by those who say the Oregon health plan must be stopped because it is not perfect. There is certainly no perfection, but there is great inequity in the present system, which provides some impoverished women and children with very complete Medicaid benefits while providing other impoverished women and children with nothing.

Blindness to this inequity is widespread among critics of the Oregon health plan, as is exemplified in Brown’s essay by the quotation from an anonymous aide to Sen. Albert Gore (D-TN): “Imagine a hospital room with two beds and two children, one a Medicaid recipient, one the child of a state employee. Each needs a very costly procedure or he’ll die, and the procedure is below the line. For the Medicaid child, the state spends only 38 cents on the dollar, but Oregon would say, ‘Gee, sorry, we’d like to do it but we’ve gotta let you die so we can provide basic care for others.’ For the other child, with the same diagnosis, prognosis, and procedure, the state pays 100 cents on the dollar and it says, ‘Of course you can have it’.”

The aide’s scenario reveals two common misunderstandings of the prioritization process and of the actual list. The list is a priority list. It places reasonable and effective lifesaving interventions at the top. Care for the Medicaid-eligible child in the scenario would be funded in Oregon since the scenario implies that the child’s life would surely be saved with full recovery. Cost of treatment would not control the decision. That is the second misunderstanding. The prioritization process finally gave cost a secondary role, a point carefully spelled out in the commission’s report, which the aide clearly did not consult or understand.

Had the aide been better informed and sought a factually based scenario, the case might have involved two children born without developed brains (anencephalic) for whom life support is a technical possibility. Medicaid funding would not be available for such treatment, even though it might be available through private insurance. This scenario accurately reflects the significance of setting priorities for health care. But it does not support the easy judgment, assumed by the aide, that the Medicaid-eligible infant and its family would be unfairly treated.

One has to believe that Brown thinks the aide has a valid point, leading us to wonder whether he also has not carefully examined the actual priority process and list.

Another scenario describes something that happens daily across the nation. Imagine a hospital room with two beds and two children, one a Medicaid recipient who is eligible simply because she was born after 30 September 1983 and one whose family income is equally below the federal poverty level but who has no health coverage because she was born before 30 September 1983, and is therefore not eligible for Medicaid. The first needs immediate medical attention or she will die, and she gets that attention under her Medicaid coverage and lives. The second cannot be saved because effective care was deferred until too late in the absence of any health coverage, and she dies when she could have lived. It is especially ironic that a child not eligible under current Medicaid rules may go without care that is eminently affordable and effective, such as antibiotics for an infection.

Brown’s article ends on a curious note. He discusses briefly the health care systems of those countries where rationing is more by queuing than by deliberately set priorities. This calls for two comments. First, Oregon has had visits or inquiries from the following countries that are considering the need to prioritize health services in the future: Great Britain, Sweden, Denmark, Australia, New...
Zealand, and Canada. Second, a fundamental result of the Oregon health plan will be that no one, including publicly insured people, will be at risk of losing basic benefits; on the contrary, thousands who now have no benefits at all will enjoy coverage under the minimum benefit package. What Brown fails to realize is that prioritizing is not a substitute for universal access to basic health care; it is a reasonable, affordable, equitable, and ethical way of achieving and maintaining universal access.

In general, Brown is quite thorough in cataloguing various objections to the Oregon health plan voiced by a selection of Washington, D.C., interest groups. However, he misses a great opportunity to explore and evaluate the reasoning of these critics. Such an analysis would be useful since these critics make up an important part of the Washington health policy power structure and therefore bear considerable responsibility for the current system.

Furthermore, critics of the Oregon health plan were evidently not asked to explain why they prefer to ration health care by categories of people, thus denying virtually all care—even the most effective care—to millions of impoverished families, to grant nearly unlimited benefits—even the most marginally effective—to other impoverished families. Nor were they asked to explain why, given their apparent distaste for what Oregonians have proposed, they have not acknowledged how unfair the status quo system of Medicaid is. They fault the Oregon plan because it falls short of the ideal of rationing health care for everybody, not just for Medicaid clients. Brown also propagates the myth that rationing is not needed: “American policymakers have not earned the right to ration health care, and the very policies that would earn it would eliminate much of the urge to exercise it.” This approach ignores the injustice of leaving the status quo unchanged while attempting to leap directly from the current state of affairs to a radically reformed system.

The efforts in Oregon to improve the lot of hundreds of thousands of uninsured citizens are not an impediment to more radical reform. Rationalizing the system in pursuit of greater equity is an appropriate goal of state health policy. The gross inequities of the status quo make it imperative to move forward, even by small steps, as long as they lead in the right direction. Brown and others surprisingly discount the severity of harm that the status quo inflicts on those in need who can be helped both by short-term reform and by steady work toward more equitable major reforms.

A final note. Brown includes in his essay a caricature, once again by an anonymous critic, of Oregonians as “Marlboro people” in a “Shangri-La setting” with “above-average kids,” who “limp stoically off to the sidelines to down a draught of hemlock” at the appropriate time. Simply quoting these clever images without analyzing their contribution to the debate is evidence of the author’s departure from the work of policy analysis into personal polemic. That is the most serious problem with Brown’s approach. He offers the article as a piece of political analysis, but he fails to respect the line between analysis and commentary. One expects more scholarly distance from the debate, more effort to analyze its substance. There are far too many instances in which unanalyzed material is used to convey Brown’s personal objections to the Oregon plan. At times the text resembles the script for a puppet show—the characters’ “lines”
advance the argument of the puppeteer, who himself remains hidden behind a screen. The account of the “national politics of Oregon’s rationing plan” deserves a more adequately informed, scholarly, and objective treatment than Lawrence Brown gives it.

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NOTES

1. As defined by the Health Services Commission, net benefit means benefit with treatment, versus benefit without treatment.

Settling The Score On Oregon

To the Editor:

My modest efforts in Health Affairs seem to bring out the worst in commentators—or perhaps they simply bring out the worst commentators. I had just concluded that the comments by George Stiles and John Dunlop on my paper with Catherine McLaughlin in the Winter 1990 Health Affairs had locked up the ignoble prize for asinine and insipid intellectual exchange, when along come Michael Garland, Harvey Klevit, and Bob DiPrete to make it a dead heat. Unfortunately, the Marlboro people have lit up, blown smoke in their own eyes, mounted their hobby horse facing rearward, and galloped off in the wrong direction.

The Oregon authors charge me with numberless impurities, chief among them sins of fact, interpretation, and motivation. As for facts, they decry “numerous errors” but manage to cite only three; all of these would be trivial even if real, which none is. They think that my shorthand reference to “cost ineffectiveness” as a rationing criterion convicts me of mistaking cost for the “driving factor” in the state’s decisions. Apparently these sophisticates do not understand that in cost-effectiveness analysis, cost is one variable, not necessarily the dominant factor, to be weighed against others. My usage is presumably consistent with John Kitzhaber’s when, for example, he told a committee of the Oregon State Senate that focus groups would review priorities to see if “rearrangement is indicated based on consideration of cost-effectiveness,” and remarked elsewhere that “by ranking health services according to effectiveness and cost, Oregon will establish powerful incentives now lacking in our health care delivery system.” Anyway, on pages 32–33 in my published paper, I dutifully noted that longevity and quality of life were considered along with cost.

The authors complain that I wrongly cited an estimate of the number of Oregonians eligible for Medicaid at as high as 200,000. The figure came from the office of a member, supportive of the plan, of the Oregon congressional delegation. The estimate was a minor datum in the Washington debate, which is, after all, what I was writing about. If it clashes with the authors’ preferred figure, that is their problem, not mine.

Most remarkable is their charge that I wrongly had the priority list discussed at public hearings and town meetings across the state. The factual error is theirs, not mine (page 32). It is a whopper, a classic in the sorry annals of incompetent commentary. Evidently, they quoted from a draft manuscript—from which this language was deleted after Norman Daniels corrected me. These paragons of pomposity, who preach about “a proper review of available reports,” apparently failed to read that most available and primary of sources, the published article they attack. (Could it be that, among their other problems, they do not subscribe to Health Affairs?)

Having sunk in factual quicksand, they take to impugning my interpretation of the scheme. I fail to respect the line between analysis and commentary, say they, an odd allegation from a trio that serves up several pages of commentary containing no analysis at all. The heart of their complaint is that I
supposedly confuse prioritization with rationing. Baloney. The Oregon plan embodies a list of priorities through which a line is drawn to eliminate services that do not pass muster, that is, to ration. Their “argument” is useful mainly as a vivid vignette of a disingenuousness that shows up too often among the plan’s proponents. When the state’s loudly proclaimed intention to make hard choices by means of rationing attracted a rational and international spotlight, advocates powdered their hard noses and preened for the cameras. When analysts began, inevitably, to expose the conundrums about who, what, and how that I discussed in my paper, proponents smiled sweetly and said not to worry: What all this was “really” about was not rationing but universal coverage.

Oregon did not win everlasting fame by assuming its place alongside forty-nine other states with notions about universal coverage. Its renown rested squarely on its claim to achieve universal coverage in an affordable, fiscally responsible fashion, and its mechanism for doing so was rationing. When this was pointed out, proponents would sometimes grow testy, snapping that Medicaid is so obviously a mess, the state’s alternative clearly must be better. When critics persisted, pointing out that this was less than intuitively obvious, that the issues raise complex arguments about which reasonable people could disagree, and that the logical and political connections between universal coverage and rationing are problematic, some proponents would grow agitated and start blubbering about how misunderstood they are. The laudable goals and many genuine insights in the plan are poorly served by this petulance, so evident in the authors’ clumsy polemic.

They just know that I set out to do a hatchet job on the plan and craftily conducted my interviews accordingly. I find such long-distance psychologizing offensive and wonder how these three acquired such impressive powers of clairvoyance (probably from the same package that brought their Quality of Well-Being Scale decoders and their deed to the Brooklyn Bridge). As a matter of fact, I set out with no strong opinions about the plan; indeed, I agreed to write the article largely because I thought the Oregon effort important and wanted to figure out what it meant. I reviewed stacks of “available reports,” interviewed both proponents and critics of the scheme, and asked each side the hardest questions I could formulate. In my interviews and the article, I tried to identify the best arguments on each side and to confront these with the toughest counterarguments. I believe that the piece offers an accurate, fair, and reasonably thorough account of what the fuss in Washington is about and that the concluding comments are of some value to readers who can rise to the challenge of serious intellectual debate. The authors lament that the plan deserves an “informed, scholarly, and objective treatment.” That is exactly what I gave it. With Garland, Klevit, and DiPrete as friends, the plan needs no enemies.

More troubling than the absurd charge that I manipulated my interviewees like a puppeteer is the implied corollary that Henry Waxman, Ron Wyden, Gail Wilensky, and others are puppets amenable to maneuvering by mischief makers like me. This strange, contemptuous image of the public officials from whom Oregon is now seeking its waiver seems to reflect an arrogance and impatience with policy debate that serves them, and their cause, poorly.

In the middle of their sad little diatribe, the Oregonians don the mantle of the provincial glamorpuss and recount, Blanche DuBois–like, the many foreign admirers who trekked to Mecca-on-the-Willamette to listen and learn. Since they missed all my other points, it is no surprise that they also misconstrued my argument about foreign systems. That nations that enfold their health care institutions in a coherent policy framework might make use of rationing as one strategic tool among others, and therefore might be curious about new ways of doing rationing better, does not imply that those techniques ipso facto make sense in an undisciplined, weakly regulated system such as we have in the United States.

The really interesting question is what use the foreigners make of Oregon’s model once they go home, and about this we know little. I propose that Oregon commission an
informed, scholarly, objective investigator, for example—to visit London, Stockholm, and the rest to study this question thoroughly. Of course this would take some money, and Oregon will naturally want to make hard choices about the most effective use of its resources. So I move that this research be funded by reducing salaries in the Center for Ethics in Health Care, the Oregon Health Services Commission, and the Oregon Office of Medical Assistance Programs. This socially optimal outcome would much enhance everyone’s well-being scale, for it appears that at least three incumbents of these units are generating little net benefit and much gross nonsense.

Lawrence D. Brown
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Give Oregon A Chance

To the Editor:

The four papers appearing in the Summer 1991 issue on Oregon’s rationing plan collectively represent the finest exposition on a health policy issue I can recall reading in one place. Health Affairs and the Milbank Memorial Fund could render no higher service. I only add the following observations.

First, as I have argued elsewhere (Healthcare Management Review, Summer 1991), an engineer would describe the health care system as a nonself-limiting system, unlike, say, feeding the poor, which is self-limiting—when stomachs are full, expenditures are inherently bounded. This follows inexorably from the following dilemma: (1) continually advancing medical technologies will always offer still more marginal extensions of life for still more cost, and (2) everybody dies. Thus, short of suppressing science or discovery of immortality, the health care system must be externally constrained. If it is not, it will grow to consume any level of resources made available to it and then once again demonstrate characteristics of unsatisfied demand. Rationing (which Webster defines as “to distribute equitably”) is inescapable. We can only debate where to place this unsatisfied demand: how, with whom, for what.

Second, unstated by opponents of Oregon’s rationing plan (although perhaps implied by Amitai Etzioni) is fear of its inherently contagious nature. Denied a “below-the-line” procedure in Oregon, one need travel only a short distance down Interstate 5 to California, whose only defense will be to invoke a like limitation exporting the problem over I-80 to Nevada, and so forth.

Finally, one detects a faint whiff of arrogance emanating from inside the Beltway in Washington, D.C. Oregon, a “million” miles away, has—to use Uwe Reinhardt’s phrase—“broken the policy gridlock,” and Oregon’s freely elected leaders have reached substantial consensus on how to move forward. Having been lectured from afar on the virtues of the spotted owl, perhaps the people of Oregon deserve the right to see to their own without interference. Why didn’t the same overseers of what’s good for the rest of us rein in Massachusetts before it departed on its abortive path?

John Kitzhaber seems to have the makings of a worthy colleague of C. Everett Koop and others in the pantheon of physician/leaders who have truly made a difference in health care.

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Obstacles To Soviet Health Reform

To the Editor:

The article entitled “Soviet Health Care from Two Perspectives,” by Diane Rowland and Alexandre V. Telyukov (Health Affairs, Fall 1991), provides an excellent and much-needed overview of health care financing and delivery in the former Soviet Union. This information is of critical importance to bilateral and multilateral assistance agencies as well as to the U.S. government as they grapple with the difficult issues concerning the technical assistance needs of the troubled region.

We visited the Soviet Union in early August 1991 for consultations on health care financing issues and met with the So-
viet Union Ministry of Health, the Russian Federated Republic Ministry of Health, and the Ministry of Health of Latvia. Even though this visit predated the August coup attempt, we saw that almost all authority for health care financing and delivery had been shifted to the republic level. The shift of virtually all tax and financing authority placed real decision-making power at the republic level and helped to inspire the coup attempt.

However, even prior to the coup attempt, the Soviet Ministry of Health’s staffing level had been cut by 40 percent, with further cuts anticipated. Moreover, even at that time, only minimal residual public health and environmental functions were under consideration to remain at the union level. With the apparent abolition of the Union Ministry of Health in November 1991, it appears that even these residual union-level functions will be transferred to the republics. While the exact details of this transfer of responsibilities are not yet known, it would appear that issues affecting several republics, such as the environmental problems from Chernobyl, will likely be handled by inter-republic coordinating committees.

The proposed health care financing reforms have two purposes: to provide additional nonbudget revenues for the health sector, and to encourage efficiency by separating health financing from provision of care. The intent of the reforms is to establish insurance funds at the republic, regional, and/or local levels, financed by contributions from enterprises, individuals, and government budgets. Efficiency will be established through the introduction of market principles by the insurance funds, which will force hospitals, polyclinics, and physicians—public or private—to compete for patients.

While the republics are at different stages in adopting health insurance laws, both the Russian Republic and now-independent Latvia intend to have insurance-based systems in place by January 1993. However, many of the basic details have yet to be worked out. These concern the extent to which medical practices and facilities can be privately owned as well as the organization and scope of the insurance funds—whether there will be one or multiple competing insurance funds, whether these will be public and/or private, be experience- or community-rated, and cover basic or supplemental services.

To analyze these reform efforts, one must understand the interdependence of health-sector reforms with overall economic and legal reforms, obstacles to reform, and the technical assistance needs of the republics and Baltic states. Unlike the incremental reforms pursued by most Western countries, the Soviet reforms in every area are truly complete departures from the past seventy years. Replacing a rigid, centrally planned system based on quantitative input norms with republic-based systems operating on insurance principles and market forces will be heavily dependent not only on major restructuring of health care financing and delivery, but also on the more general economic and legal changes concerning price liberalization, privatization, and tax policy.

Obstacles to reform. Numerous political, legal, and economic uncertainties could preclude successful implementation of the proposed reforms. For one, the reforms have been vigorously opposed by the trade unionists, who believe that the solution is simply to put more public money into the health sector. Physicians and academicians also fear loss of privileged status and financial support for their national institutes.

The second set of obstacles relates to the interdependence of the health sector with the rest of the economy and the general legal framework. Successful insurance reform will be acutely affected by laws concerning privatization, ownership of property, price controls, joint ventures, the viability of financial markets, the availability and allocation of foreign exchange, and the overall functioning of the economy. Unless the rigid restrictions on prices, property ownership, and the development of financial markets are lifted, it will be impossible to develop a health sector based on market principles. Furthermore, without economic recovery and a convertible ruble, enterprise profits or government revenues will be insufficient to finance the health sector. While the Soviet
Union’s new associate member status with the International Monetary Fund is a necessary first step toward fiscal infrastructure reform, at least in the short term, sufficient humanitarian assistance and foreign exchange must be available to purchase desperately needed equipment, spare parts, supplies, pharmaceuticals, and so forth.

Next steps. One fundamental impediment to successful reform of the health care financing system is a lack of basic understanding and experience concerning the workings of insurance. Health officials in both the Russian Federated Republic and Latvia have requested technical assistance to establish and manage health insurance funds, yet technicians in both places have virtually no knowledge of how to implement or regulate insurance. While health officials have legislated an insurance approach to health care reform, they have little practical knowledge concerning operational and administrative issues. Immediate technical assistance in this area is clearly needed.

A second area of concern is the lack of information and expertise to implement incentive-based payment systems for medical care providers. Questions such as whether a diagnosis-related group payment system for all hospitals will best achieve efficiency, given hospitals’ complicated and substantial data requirements, are under debate. Clearly, technical assistance that provides the range of alternative methods for paying hospitals and physicians along with the implementation requirements and likely incentive effects is needed.

A third and related area concerns management information and accounting systems at all levels. National- and republic-level health accounts are needed, to know the level of real resources currently going into the health sector. For example, there is no reliable information on the amount of “informal” payments to medical care providers for better-quality care or for bypassing queues. At the provider level, for market incentives to operate, individual providers must know their costs and volume of services, so that they can operate efficiently.

A fourth area is the need for information about quality assurance. There is a great deal of interest in the structure and process standards used in the United States to assure quality of care. In particular, at all governmental levels, health officials have requested information about licensure requirements for U.S. physicians and requirements for board certification in different specialties. Similarly, these officials have requested information about the specific criteria used by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and state inspectors to certify hospitals and nursing homes. Given the deteriorating physical state of many health institutions and the relative ease of providing this type of information, assistance in this area should be of high priority.

Such technical infrastructure assistance from appropriate international organizations, the United States, and other Western countries can provide the knowledge base for these countries to set their economic and social systems in order.

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Efficiency And Health Services

To the Editor:

In recent years, professional economists have become increasingly interested in the rising expenditures for health services. Their concepts and economic styles of viewing the health services enterprise are pervading the literature on cost containment. It was probably not until total expenditures for health services were nudging 6 percent of gross national product (GNP) that economists as a profession began to take note of the enterprise. There are, of course, exceptions such as Herbert Klarmann, Victor Fuchs, Rashi Fein, and Burton Weisbrod.

As a consequence, the buzzword efficiency inspires a great deal of the theoretical and applied literature. Politicians, administrators, and policymakers in turn have taken up the concept of efficiency with little regard
whatevsoever for its precise meaning in economics. The concept has been borrowed from business and for-profit firms whose products are relatively easy to measure in terms of input and output.

I gather that efficiency to economists means the smallest input for the greatest output. In the purely professional portion of the health services and the knowledge level of the general public, economists’ concept of efficiency is not easily applicable. Not until the cost of an input can be clearly related to health outcomes is the concept of efficiency applicable to personal health services.

The recent issue of Health Affairs (Fall 1991) is replete with application of the concept of efficiency in comparing health services delivery systems cross-nationally. The same can be observed in comparing different delivery systems in the United States.

Obviously, one can apply the concept of efficiency to, for example, catering, housekeeping, and maintenance services in hospitals. However, physician decision making (diagnosis and treatment) is far from precise, as is the range of symptoms inducing a patient to seek services. Hence, it is inappropriate to compare the efficiency and costs of delivery systems, whether it be across nations or across systems within a nation. In essence, the expenditure level of a particular delivery system becomes an equilibrium point between patients, providers, and sources of payment in short, a negotiating system quite pure and simple. The language of efficiency requires more precision than the health care arena permits.

Space precludes developing this criticism further, but perhaps this letter can be a starter. I plead for more sophistication in evaluating a health services delivery system than comparing low and high expenditures. A sociopolitical criterion is the extent to which the degree of access to services converges between income levels.

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