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Prologue: American business plays a curious role in the health policymaking activities of the United States. Its degree of involvement falls well short of the magnitude of its massive commitment to financing the medical care of its employees. The reasons for its limited involvement are multiple. Corporate chieftains have been slow to engage the complex issues of health financing because such issues are usually not central to their businesses. They prefer to wield the limited influence any individual or institution can bring to bear on public policy making on matters that seemingly affect their respective bottom lines more directly. Beyond this point, American corporations have been ambivalent about promoting a more pervasive role for government in health financing and delivery because of their general philosophical distaste for regulation. In recent years, though, one argument has resonated with chief executive officers who have been exorted by their employee benefits managers to become more heavily involved in health policy making—the notion that America’s soaring medical bill is making corporations less competitive in world markets. In this paper, Uwe Reinhardt of Princeton University challenges this argument, asserting that it is unlikely that high health costs per se render American business noncompetitive at home or abroad. Reinhardt, who was born in Germany, was educated in Canada and the United States, and is now a naturalized U.S. citizen, is a familiar figure in health policy circles. He plays multiple roles: as a policymaker, who employs his international perspective to influence the directions of American policy; as a speaker, who uses humor to educate and inform; and as a writer, who effectively marshals his argument on behalf of whatever case he is striving to build. Reinhardt was a very active participant in the National leadership Commission on Health Care (see exchange with J. Bruce Johnston in Health Affairs, Summer 1989), and has also been an influential voice on the Physician Payment Review Commission.
Public policy responds to widely shared folklore that is sustained by visible symbols. One such symbol in recent years is the much-cited statistic that an automobile produced in Detroit now contains between $500 and $700 of health care costs, paid for by the auto companies on behalf of their employees. This familiar statistic has nourished the thesis that increases in health care costs have pushed up the retail prices of American automobiles or, conversely, that reductions in this component of manufacturing costs would lead to reductions in these prices.

The belief that increases in health care costs translate themselves directly into higher product prices seems to be a commonplace in the American business community. It supports the argument that employer-paid health care for active and retired employees renders American producers “noncompetitive” in the global marketplace. Thus have health care costs slipped onto the agenda of thinkers who worry about this nation’s future place in the world economy.

A second, more circuitous linkage between health spending and “competitiveness” is sometimes made at the macroeconomic level of the economy as a whole. This particular linkage is thought to operate through the negative impact high health spending has on the nation’s savings rate and, thus, on its rate of capital formation. Since capital formation is generally thought to enhance labor productivity and the latter influences unit manufacturing costs, one can construct from these linkages a hypothetical relationship from health spending to product prices and thence to “competitiveness.” That relationship, incidentally, is thought to touch all our economic activity—even enterprises that do not pay for their employees’ health insurance coverage.

At first blush, these beliefs and the arguments they support have considerable intuitive appeal, which may explain their popularity even among observers outside the business community. Further thought on the matter, however, leads me to a set of propositions very much at variance with the prevailing folklore. At the risk of being dismissed as just one more impractical academic “who has never met a payroll,” I state these propositions below and defend them in the remainder of this essay.

Three propositions. First, it is unlikely that high health care costs per se render American business noncompetitive at home or abroad. Second, it is just as unlikely that the relatively large percentage of the American gross national product (GNP) devoted to health care, by itself, adversely affects the nation’s competitiveness. Third, if high health care expenditures do affect this nation’s international competitiveness, they are likely to do so through the following combination of circumstances: (1) over 40 percent of health care is now being financed through public budgets; (2) American taxpayers and their political representatives want to keep the
percentage of GNP going through public budgets constant; which means that (3) public funds spent on health care may well come at the expense of our investment in human capital (education) and the nation’s infrastructure, both of which are largely publicly financed.

The last factor is likely to be the most important direct link between our high health care expenditures and our competitiveness. One could base on it an economic rationale for shifting health care costs from the public to the private sector, although it is not clear that such a shift is actually feasible. After all, American business may yet decide one day to greet these attempted cost shifts by following Nancy Reagan’s famous dictum: “Just say no!”

None of the propositions I offer here should be viewed as a case against vigilant cost controls in health care. They merely are meant to suggest that such controls had best be defended on grounds other than competitiveness. Chief among these other grounds is the question whether, at the margin, additional spending on health care would enhance social welfare as much as would additional spending on other goods and services.

What Is The Price Of Labor?

In a competitive market economy, labor is treated as simply one of many productive factors for which there exists a market-clearing price; that is, the price at which industry’s demand for labor just equals the quantity of labor potential workers are willing to supply. According to the theory apparently popular among much of the business community, the market-clearing price in the labor market is the cash compensation paid employees. Any fringe benefits laid on top of that cash compensation are assumed to come out of the hide of the two other stakeholders in a business firm: its customers and its owners.

If all producers competing in the market for a particular product offered workers the same fringe benefits, much of the cost of these benefits might be passed on to customers through higher product prices, particularly if the overall market demand for the product were relatively insensitive to price. If market demand were highly price-sensitive, however, the cost of fringe benefits could not be shifted to the customer so easily, even if all producers offered the same fringe benefits. Buyers of the product would threaten to stop buying if producers sought to raise their prices. Customers could carry out this threat more easily if they could turn to foreign producers blessed with lower production costs and willing to undercut domestic producers. Under these conditions, according to popular theory, the cost of added fringe benefits would have to be borne by the firm’s owners in the form of lower profits.
Because financial capital is globally mobile, however, management could expropriate the firm’s owners in this way only occasionally and for a short time. In the longer run, a firm can attract equity financing only by offering potential investors the going global rate of return. The growing cost of fringe benefits, according to popular wisdom, therefore puts management between a rock and a hard place: either to price the firm out of its product markets or to destroy the firm’s access to the market for equity capital. Either way, according to the theory, the rising cost of health care (and of other fringe benefits) can kill the proverbial goose that lays employees’ and shareholders’ golden eggs.

A major flaw in this argument is that it completely overlooks the firm’s third major category of stakeholders to whom the cost of fringe benefits can be passed, namely, the recipients of these fringe benefits themselves. To be sure, in the very short run, sudden increases in the cost of fringe benefits may act as mere add-ons to a prevailing level of compensation and be at the expense of shareholders. In the longer run, however, the market-clearing price that brings the supply of and demand for labor into equilibrium will be the total compensation package paid labor, not just the cash compensation. Therefore, in the longer run, the various components into which total compensation can be packaged must be viewed as merely interchangeable. It is not meaningful to single out one particular component of this total compensation package, to divide that component by the number of units of whatever output the firm produces, and then to argue that the amount of this one component per unit of output makes a manufacturer noncompetitive in the product market.

**Regional disparities.** A factor that might appear to aggravate the problem of health care benefits in the United States is the American practice of tying the health insurance premiums payable by the individual firm strictly to the demographic composition of that firm’s own labor force, rather than to the morbidity of a larger community. Under this system of financing, a firm with a relatively older work force will, of course, pay higher average health insurance premiums per employee and unit of product than would a firm with a younger work force, and that may be judged “unfair.”

In this connection, for example, auto executives in the Rust Belt typically complain that, quite aside from foreign competition, they cannot compete even with manufacturers located in the southern United States, where competitors’ work force tends to be younger and not unionized. Thus, an automobile built in Tennessee is said to contain several hundred dollars less in health care costs than one built in Detroit—which, it is argued, makes automobiles produced in Detroit noncompetitive with similar automobiles produced in Tennessee.
One can offer two observations on this line of reasoning. First, significant cost differentials of this sort would be manifest even if overall national health care costs amounted to only 9 percent of GNP rather than the current 11.5 percent. Reductions in overall national health care spending would have only a small impact on the differential.

More importantly, the argument implies that workers in the Rust Belt cannot be made to understand that, to keep the products they produce competitive with products produced by American workers in the Sun Belt, total compensation in the Rust Belt must be competitive with that in the Sun Belt. This implies that cash wages in the Rust Belt may have to be lower than those in the Sun Belt if Rust Belt workers continue to demand the generous health benefits they have always commanded. Presumably, an ability to impart this fundamental lesson in economics to employees is part of the managerial competence for which business executives are hired and handsomely paid.

One possible objection to the above may be that many of the Rust Belt industries that are most seriously burdened with employer-paid health care costs do not procure labor in the perfectly competitive labor markets envisaged by textbook theory, but instead procure it from powerful unions, technically known as labor monopolies. From the viewpoint of union members fortunate enough to be employed, the great virtue of a labor monopoly lies in its power to impose upon employers a private minimum-wage floor in excess of the market-clearing level of total compensation. It may be thought that this power enables a labor monopoly to force fringe benefits upon employers as a genuine add-on to cash compensation, rather than as a mere substitute for cash wages. Not so.

If the customers of a unionized firm are highly price-sensitive—that is, if they can readily turn to foreign suppliers of the product—that firm has no more leeway to shift the cost of added fringe benefits forward to customers through higher prices than would a similarly situated firm that procures labor in perfectly competitive labor markets. Nor would the unionized firm find it any easier to shift those costs backward to potential suppliers of equity capital. Instead, in the longer run, a unionized firm faced with a relatively higher compensation level (including fringe benefits) will find it relatively more economical to replace labor with labor-saving equipment. Thus, increases in the cost of the fringe benefits enjoyed by employed union workers would be shifted backward by the firm to newly unemployed union members.

Alternatively, if the union’s leaders were sensitive to the plight of potentially unemployed rank and file, they might be cautious in pushing up the total level of compensation too exuberantly and be willing, during wage negotiations, to trade off cash income for fringe benefits, and vice
versa. Recent negotiations in the American labor market suggest a willingness on the part of union leaders to contemplate such trade-offs. To illustrate, in November 1989, the Nynex Corporation (New York’s telephone company) settled its long strike with the Communications Workers of America over health care benefits with a package that, according to a Nynex statement, “is approximately $125 million less—or about 25 percent—than the comparable [cash] wage settlements at other former Bell companies.” The union had refused to accept direct contributions by employees to their health insurance coverage; evidently, however, it was willing to settle for commensurately lower cash wages.

That union leaders may be a bit ahead of business executives in their study of basic economic principles may be inferred also from a fascinating remark offered by Douglas Fraser, past president of the United Auto Workers union. Responding to an auto executive during a recent debate on American health policy, Fraser observed:

> Before you start weeping for the auto companies and all they pay for medical insurance, let me tell you how the system works. All company bargainers worth their salt keep their eye on the total labor unit cost, and when they pay an admittedly horrendous amount for health care, that’s money that can’t be spent for higher [cash] wages or higher pensions or other fringe benefits. So we directly, the union and its members, feel the costs of the health care system.

It is certainly true that, if a unionized industry finds it technically difficult to substitute labor-saving devices for labor, a recklessly managed labor monopoly could push the price of labor so high as to help price the industry out of the competitive global product market altogether. The causal factor in this case, however, is not high health care expenditures per se, but an overall compensation package that is excessive relative to the compensation paid similarly skilled labor elsewhere.

### The Burden Of Postretirement Health Benefits

The preceding analysis applies only to the compensation of active workers. A quite distinct problem arises out of the growing burden of so-called postretirement health benefits.

During the past several decades, many American business firms have taken it upon themselves to operate sizable private social security systems for their employees. They have done so by promising employees health insurance coverage during retirement for costs not covered by the federal Medicare program, on top of defined private pension benefits. Exhibit 1 indicates the prevalence of this type of coverage among retirees age fifty five and older.
Exhibit 1
Employment-Based Health Insurance Coverage Of Retired Americans, 1987

<table>
<thead>
<tr>
<th>Age cohort</th>
<th>Policyholder only</th>
<th>Dependent coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>55 and over</td>
<td>38.8%</td>
<td>9.9%</td>
</tr>
<tr>
<td>5–59</td>
<td>50.1</td>
<td>20.6</td>
</tr>
<tr>
<td>60–64</td>
<td>51.9</td>
<td>15.0</td>
</tr>
<tr>
<td>65–69</td>
<td>40.3</td>
<td>11.1</td>
</tr>
<tr>
<td>70–74</td>
<td>37.1</td>
<td>4.9</td>
</tr>
<tr>
<td>75 and over</td>
<td>28.1</td>
<td>4.9</td>
</tr>
</tbody>
</table>


A total of twenty-two million Americans age fifty-five or over are estimated to be retired.

Alas, while it is difficult enough to estimate the actuarial value of future defined pension benefits, an employer offering future defined health benefits generally has no idea just what these service benefits might be, let alone what they might cost, because technological advances are so rapid in health care. Exhibit 2 suggests something about the potential fiscal consequences of such promises. As is shown in the exhibit, average annual per capita health care expenditures for Americans under age sixty-five currently run at about $1,287. For the aged, these costs average $5,360 per capita and rise steeply with age. Medicare pays on average less than half of the health care costs incurred by the aged. Private sources, American business firms prominent among them, pay about 37 percent.

One may charitably view the widespread offering of postretirement health benefits as benevolent—albeit financially reckless—paternalism on the part of American executives and labor leaders seeking to act with

Exhibit 2
Per Capita Expenditure On Health Care, United States, 1987

<table>
<thead>
<tr>
<th>Age cohort</th>
<th>Spending per capita</th>
<th>By source of funds</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65</td>
<td>$1,287</td>
<td>$ 947</td>
<td>$ 41</td>
</tr>
<tr>
<td>65 and over</td>
<td>5,360</td>
<td>2,004</td>
<td>2,391</td>
</tr>
<tr>
<td>65–69</td>
<td>3,728</td>
<td>1,430</td>
<td>1,849</td>
</tr>
<tr>
<td>70–74</td>
<td>4,424</td>
<td>1,564</td>
<td>2,234</td>
</tr>
<tr>
<td>75–79</td>
<td>5,455</td>
<td>1,843</td>
<td>2,685</td>
</tr>
<tr>
<td>80–84</td>
<td>6,717</td>
<td>2,333</td>
<td>3,023</td>
</tr>
<tr>
<td>85 and over</td>
<td>9,178</td>
<td>3,631</td>
<td>3,215</td>
</tr>
</tbody>
</table>

social responsibility. In a less charitable interpretation, this practice may be viewed as a dubious method of procuring labor and securing industrial peace, for the long-run cost of this practice has always been carefully hidden from a firm’s owners.

Under our Generally Accepted Accounting Principles (GAAP), business firms must accrue as part of payroll expense the present (actuarial) value of the pension liability triggered by the employee’s service in the year that service is rendered, and not just when these benefits are paid out in cash. Furthermore, under the Employment Retirement Income Security Act (ERISA) of 1974, it is generally required that employers fund these future liabilities in the period the employees’ service is rendered.

Remarkably, neither stricture has hitherto been applied to promised postretirement health benefits. Most corporations have booked outlays on such plans on a pay-as-you-go basis, charging them to income only in the year when the required health expenditures were made on behalf of the then retired employees. One may fairly label this form of financial reporting practice as Louis XIV accounting ("Après moi, le déluge"), for it permits management teams in one period to shift expenses for which they are obligated to future periods presided over by different management teams.

Offering defined benefits of this sort, on a pay-as-you-go basis, without full disclosure of their approximate actuarial cost, may have been a seductive idea in the pastoral years following World War II, when the United States was free to dictate the world economic order and when the typical American corporation could assume that its economic position was secure forever. Unless such promises are substantially funded when they are made, however, they are usually highly reckless. They are certainly reckless in today’s uncertain, highly competitive world economy that exposes the revenue stream of even giant American business firms to managerial decisions made in faraway Asia and Europe.

To be fully responsible, American industry and labor should shift away from defined health benefit plans toward the more viable defined-contribution plans. Ideally, one would like to see Congress enact compulsory, defined-contribution plans for acute and long-term care. Such savings plans should be fully vested, should come out of pretax earnings, and could be managed either by the public sector or by approved private plans, as is the custom in Europe. Finally, they should be supplemented with public subsidies for low-income employees who could not under any circumstances accumulate sufficient savings to finance their retirement.

**Unfunded liabilities.** But even if American business did shift away from defined-benefit to defined-contribution plans for retiree health benefits, what of the enormous unacknowledged and unfunded
postretirement health benefit obligations soon to be highly visible on the books of American business? Under a proposed new ruling by the Financial Accounting Standard Board (FASB), employers will be required, after 1992, to report the estimated future cost of postretirement health benefits on an accrued basis, just as they now must report the actuarial cost of defined pension benefits. The Employee Benefits Research Institute (EBRI) recently estimated the total amount of unfunded liability for benefits already promised at about $170 billion for American business as a whole, although other estimates have put the number multiples higher. For some individual firms, this hitherto unacknowledged and, unfunded prior service obligation equals substantial portions of net worth.

The question arises whether the sudden accounting recognition of this obligation, and its eventual amortization through the payment for retiree health benefits, will not by itself erode the competitive position of American industry in the world economy. Here we must distinguish between mere accounting entries and future cash flow.

Technically, the recognition of this hitherto unacknowledged prior service obligation in the firm’s books is just an accounting formality. There will be a debit (or a time-phased series of debits) to the firm’s net worth accounts (that is, shareholders’ equity) and a corresponding credit (or series of credits) to an account labeled “Unfunded Liability for Postretirement Health Benefits,” or something like that. This entry by itself does not alter the firm’s current or future liquidity. It merely alerts sleepy shareholders to the fact that a substantial portion of what management had always reported to them as “shareholders’ equity” actually had been quietly given away to labor long ago by the firm’s executives, some of whom may already be happy recipients of these postretirement health benefits by the time the revealing journal entry must be made.

**Impact on shareholders.** And what of the market price of the firm’s stock? Might it not plummet in response to this shocking accounting revelation? Probably not just then. In today’s alert securities markets, there typically will have been an appropriate downward adjustment in the price of the firm’s stock long before the FASB eventually forces this candid journal entry upon management. Indeed, the ongoing lengthy discussion of the FASB exposure draft on its proposed ruling has by now let all of the relevant cats out of the bag. These cats must by now have been fully counted by the nation’s security analysts.

But what of the sizable cash outlays American business firms will have to make in the future, either to prefund their postretirement health benefit plans or to pay for health benefits when retirees receive them? Might not this drain on corporate funds—cash outlays for workers who
do not even work for the company anymore—render American industry noncompetitive in world markets? Here the proverbial two-handed economist can answer with an equally firm “Yes” and “No.”

“Yes,” if American industry insists, against all reason, on seeking to fund these cash outlays through higher product prices, come hell or high water, even at the risk of quiet suicide in the global product markets. “No,” if American industry sees the light, prices its products competitively, and then funds this cash drain out of shareholders’ current cash income, as best it can. After all, it was management in its role as shareholders’ agent who made these commitments to workers on the principals’—the shareholders’—behalf. It is therefore only reasonable that shareholders be made to absorb the cost of honoring these promises. Indeed, it is in anticipation of just these future hits upon shareholders that the market price of the firm’s stock will tend to drop as soon as the extent of this future cash drain becomes known to the financial markets.

The impoverishment of existing shareholders through management practices that had been carefully hidden from these shareholders for so many years may, at first sight, strike one as manifestly unfair. But does lack of candor on the part of earlier managements really entitle shareholders to public relief? One should think not.

Although the ideal of our industrial democracy calls for forthright financial accounting on the part of management, our Generally Accepted Accounting Principles certainly cannot guarantee it, nor does management invariably strive for it. Lack of forthright financial reporting on the part of management is but one of the many risks that shareholders assume when they invest in a company’s stock. In return, shareholders do earn long-run rates of return far in excess of the rates paid on better-protected investments. In a sense, shareholders have already been prepaid for such contingent losses.

Other options for business. Do current and future managements have other options to fund their postretirement health benefits, other than hitting upon trusting shareholders? Perhaps. A desperate enough corporate America may seek to pass the cost of these benefits back to retired employees simply by “modifying” its earlier promises. Management’s ability to do this is currently being tested in the courts. Should those firms seeking that relief prevail and eventually nibble away at the postretirement health benefits they had promised their workers, the retirees who recently celebrated their successful lobby against the Medicare catastrophic legislation may yet come to rue their victory and return to Congress, hats in hand, like prodigal sons (and daughters).

On the other hand, should management lose in the courts, there always remains the option simply to nationalize the private agony. The
growing plea for national health insurance by some American business leaders is one variant of this strategy. For example, business might argue that a Congress willing to cover with taxpayers’ funds the ludicrous and often corrupt mistakes of the savings and loan industry, to an estimated tune of $200 billion, ought also to be willing to foot with taxpayers’ funds a similar bill for the much more nobly inspired, if reckless, attempts by American business to offer employees private, business-financed social security systems. It would not be difficult to develop some sympathy for that line of argument, and, conceivably, it might find a receptive audience in some Congress a decade hence. It is likely to fall on deaf ears now and in the near future.

Of course, even if the present health insurance system were replaced with a tax-financed national health insurance system of the sort recently advocated by David Himmelstein and Steffie Woolhandler, the cost of health care would not necessarily vanish from the income statements of American business. Such a system might be financed wholly or in part with payroll taxes, as is the case in West Germany and in many other European nations. Alternatively, the system might rely partially on corporate income taxes as a source of financing. Such a system, however, might still relieve business firms encumbered with huge unfunded liabilities for postretirement health benefits by shifting part of these liabilities to other business firms and, in the end, to those who bear the ultimate incidence of taxes levied upon the business sector.

### Competitiveness From A Macroeconomic Perspective

Quite aside from this analysis at the microeconomic level of the individual firm, it is sometimes argued, at the macroeconomic level, that the overall percentage of GNP devoted to health care in our economy is too high for the nation’s long-run competitiveness, because it comes at the expense of capital formation. This argument goes as follows:

A nation can allocate its GNP to current consumption or to investments in productive capital. (The portion of GNP that is not consumed represents the much-discussed “national savings ratio.”) It is generally agreed that capital formation enhances the productivity of labor. It can thereby lower the labor cost per unit of output and, thus, product prices.

The United States has traditionally exhibited one of the highest ratios of consumption to GNP in the industrialized world (that is, one of the lowest savings ratios). Our relatively high spending on health care is part of that high consumption (low savings) ratio. Japan, for example, spends only about 6.5 percent of its GNP on health care. The United States now spends about 11.5 percent. Relative to the United States, Japan therefore could spend about four percentage points more of its GNP on research, product development, and other productivity-enhancing capital investments than we
do, and still leave the same percentage of GNP as we do for all other things. Indeed, it is precisely its traditionally high rate of national saving and capital formation, rather than cheap labor, that makes Japan so price-competitive in the global market today.

An alternative macroeconomic argument couches its reasoning not in terms of an assumed inverse relationship between national health spending and the national savings ratio, but on the allocation of scarce productive resources to competing uses. This version of the macroeconomic argument proceeds as follows:

Our health sector now absorbs many scarce real resources (scientists, engineers, doctors, other labor at various degrees of skill, brick, mortar, equipment, and so on) that could be deployed in the production of superior consumer electronics, cars, cameras, and supercomputers, and is so deployed in Japan and in other countries that spend a smaller fraction of their GNP on health care. To remain competitive with these other nations, we had better divert scarce human talent and other real resources away from health care and into other economic sectors that make import- or export-competitive products.

For example, instead of drawing so many good minds into medicine and allied health professions, we should persuade young people to become scientists and engineers who devote their life to making better consumer electronics, cameras, computers, and the like, that could then be produced more cheaply in the United States and competitively priced in the world market.

There clearly is something to these macroeconomic arguments. It is not so clear, however, why they should focus strictly on health care as the chief culprit, particularly when there are so many highly intelligent Americans who spend all of their energy and intellect merely redistributing claims to the nation’s useful output, rather than creating net additions to useful output themselves. One thinks here, for example, of the huge tax-avoidance industry that helps Americans pass their tax burdens around like hot potatoes, of the huge legal industry that helps Americans sue one another in strictly negative-sum games, or of the equally huge advertising industry, some of which may well disseminate useful information, but much of which simply moves customers around in negative-sum games.

Indeed, the question can be broadened further. In 1987, Americans spent a total of $194 billion on hospital care, $102 billion on physician services, and $34 billion on drugs and sundries. These are sizable outlays. On the other hand, in the same year, Americans were willing and able to spend $35.6 billion on tobacco products, $61 billion on alcoholic beverages, $24.2 billion on jewelry and watches, and $26.2 billion on toiletries and preparations. It can be asked why, if reduction in the national consumption ratio is the objective, or if scarce resources are to be channeled to superior economic uses, we should not divert real resources
away from yet other economic activities—for example, from the entertainment industry or from our large transportation industry—all of which absorb human labor of varying skills and other resources that might be put to better uses? But therein surely lies the crux of the matter: the key words are “better use,” and we must ask, “better” in whose eyes?

In the end, then, the macroeconomic argument against spending on health care boils down to the perennial question over the relative benefits and costs associated with shifts of real productive resources among different economic sectors and from consumption to savings. The argument should be styled something like this:

If Americans do wish to constrain their overall spending on consumption for the sake of capital formation or to shift real resources toward more productive activities, such as consumer electronics or computers, it is better to draw away the requisite real resources from health care rather than, say, from the production of alcohol and tobacco, from the advertising industry, from the legal industry, from the entertainment industry, from the media, or from transportation and the like, because all resources in these other sectors are still “more productively used” than are many the resources now devoted to health care, where real resources are so often wasted.

In this context, the term “more productively used” means that, even at the margin, the deployment of real resources in these other sectors bestows relatively greater satisfaction (“social value”) upon Americans than do many of the resources now deployed in the health care sector, even if these other sectors produce alcohol, tobacco, and the like.

A full development of this issue goes much beyond the scope of this essay. It requires one to come to grips with the definition of “social value.” It is customary in our latitudes to let the “social value” of ordinary consumer commodities—such as bread and shoes and gin—be defined by the willingness to pay with one’s own money. By contrast, the “social value” of a medical treatment given to a particular person may vastly exceed the maximum amount of money that person may have been able and willing to pay for the treatment, because a community may wish to see a person receive treatments he or she would not be able to afford with his or her own resources. In the context of health care, benefits and costs are not easily measured.

At this point, we merely note that the macroeconomic case against added spending on health care rests on the allegation that, among the many sectors of our economy, the health care sector is unusually wasteful. It absorbs real, productive resources to produce services whose “social value,” however defined, does not cover their social opportunity costs in terms of the forgone output these resources might have produced elsewhere.
We do not usually make this allegation in connection with ordinary commodities—including handguns, alcohol, and tobacco—because total spending on such commodities is thought to represent the sum of a myriad of individual, voluntary transactions in each of which the buyer makes certain that the benefits yielded by the commodity cover opportunity costs of producing it. Because of the presence of third-party payment (and also because patients tend to be ill-informed, sick human beings and not regular consumers), we cannot assume that each health care transaction successfully passes a proper benefit/cost hurdle. Hence we suspect a large potential for waste, particularly when health care is paid for on a fee-for-service basis.

On this suspicion—and on some supporting empirical evidence that fuels the suspicion—rests one part of the macroeconomic case for health care cost containment. The remainder of the argument has to do with the many demands, and fiscal constraints, Americans impose upon their public sector.

Constraints Posed By Fixed Public Budgets

If there is one macroeconomic link by which high health care expenditures are likely to detract from the nation’s competitiveness in the long run, it probably resides in that portion of total national health expenditures financed through public budgets (about 42 percent at this time). For decades now, the lips of American taxpayers have formed the words, “No tax increases!” Not only have our politicians dutifully paid homage to that wish, they have sanctified and fueled it in every recent election campaign. Total taxes in this country at all levels of government have, in effect, fluctuated very narrowly around a fixed level of 33 percent of GNP since 1970, in spite of an aging population and a growing underclass of poverty-stricken children. With the possible exception of Japan, we still have the lowest overall tax burden among nations in the Organization for Economic Cooperation and Development (OECD), where tax-to-GNP ratios in the mid-to-high 40 percent range are typical.

Given this relatively small, fixed public budget, every dollar the American public sector must spend on health care must come at the expense of other public expenditures—including spending on the nation’s public infrastructure and on education. In recent years, however, we have financed some parts of public spending simply with public debt.

American children now receive an average of only 180 days of schooling per year, compared with 220 days or so in Europe and 240 throughout the Pacific rim. Survey after survey reveal that America’s children lag academically relative to their contemporaries abroad. A good case could
be made, on grounds of both fairness and efficiency, for lengthening the school year in this country by, say, forty days a year to keep our children competitive with children elsewhere. This expansion of the school year would cost money, of course. Alas, as noted, the American taxpayer chants: “No way!” Alas, too, American governments at all levels are under constant pressure to spend more on health care, lest they stand accused of “rationing” care.

It is through this peculiar mechanism—rigidly fixed public budgets and ever-rising claims of health care on these fixed budgets—that health care today may mortgage our nation’s future competitiveness. The end result of this mix of contradictory pressures is likely to be ever more neglect of human capital formation (education) in this country and similar neglect of our public infrastructure that is such a crucial contributor to productivity growth.

The myopic political imperatives of the 1980s have placed government in an untenable position. Rightly or wrongly, the American people have promised Medicare coverage to all aged, rich or poor. The implied burden on the public purse can only grow. In addition, however, somewhere between thirty and thirty-five million Americans currently have no health insurance coverage whatsoever. Most of these uninsured are low-wage, full-time employees of small business firms or their dependents. One-third of them are children.

To provide the uninsured with access to mainstream American health care requires that better-off Americans somehow pick up the tab. If this transfer cannot be effected openly through the government, via taxes and public health insurance programs (or public subsidies toward private coverage), then we shall face some stark choices in America. Either we must abandon the low-income uninsured and simply ration them out of the health care system altogether—a policy already under way in many parts of the country—or we must use some forms of indirect taxation to effect the necessary transfer.

One form of such indirect taxation is the practice among providers of health care to shift the cost of uncompensated indigent care rendered by them to paying patients who, in turn, are insured by the business sector. An alternative, somewhat more direct form of such taxation would be simply to mandate employer-paid health insurance upon all business firms, large and small. Mandated employer-paid benefits are taxes in all but name. Finally, the public sector could seek, as it already has, to spread its constrained budgets over more people by paying prices below fully allocated costs for the health care it finances—a practice commonly known as “cost shifting”—leaving private-sector, paying patients and their insurers to pay for the uncovered overhead. Given the large share of
the health care market accounted for by the public sector, it has the market muscle to extract such discounts.

There is something unseemly about these indirect forms of taxation, because their chief purpose is to camouflage their ultimate incidence. But in a nation unwilling to tax finance openly the government’s urgent tasks, indirect taxation through these various forms of cost shifting may well make perfect economic sense from a longer-run perspective.

Concluding Remarks

None of the preceding arguments should be taken to represent a case against efforts on the part of business to control its own ever-growing outlays on health care benefits. On the contrary, business would do well not to pay for health services of dubious medical merit, and also to minimize the money prices it pays for whatever health services it does procure on behalf of employees. After all, every dollar wastefully or needlessly spent by employers on health care impoverishes at least one of the firm’s stakeholders, and, almost always, it is employees who pay the bulk of that price in the form of lower real cash income, at least in the longer run.

Even if every increase in the cost of employer-paid health care benefits could immediately be financed by the firm with commensurate reductions in the cash compensation of its employees—so that “competitiveness” in the firm’s product market is not impaired—it would leave employees worse off unless the added health spending bestowed upon employees is valued at least as highly as the cash wages they would forgo to finance these benefits. Because it is the perceived value of a firm’s compensation package that lures workers to the firm and away from competing opportunities, the typical business firm has every economic incentive to maximize this perceived value per dollar of health care expenditure debited to the firm’s payroll expense account. Therein, and not in “competitiveness” on the product side, lies the most powerful rationale for vigorous health care cost containment on the part of the American business community.

This essay is based on an earlier letter written to the employee-benefits manager of a large American corporation. I thank David E. Card of Princeton University’s Department of Economics and Robert H. Sprinkle of Princeton’s Woodrow Wilson School for their valuable comments on an earlier draft. Mark V. Pauly of the University of Pennsylvania commented extensively on the earlier letter and sent along some pertinent papers of his own that make similar points. Any remaining errors or faulty logic in the present essay are, of course, solely the author’s responsibility.
NOTES

3. Typically, a defined-benefit plan pays future pension benefits that are defined by the worker’s years of service to the company and by the average income during the later stages of the work life. The actuary trying to estimate what sum must be set aside in the current year to own up to the pension obligation generated by the worker’s service in the current year must predict long-time series of future interest likely to be earned on funds set aside in a pension fund, the worker’s age of retirement, future quit rates, future wages and salaries, and future inflation. In short, the so-called actuarial service cost of a pension benefit is at best a rough “guesstimate.”
6. Actually, spending on health care can be one of the more productive investments a nation can make if it prevents future illness or restores sick individuals to a healthy, productive life.
10. Under current tax laws, compensation in the form of health benefits is not taxable income, while cash compensation is taxable income. That tax treatment biases the benefit/cost calculus in favor of employer-paid health benefits.