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ECONOMIC BOUNDARIES OF HEALTH POLICY: FACTORS INFLUENCING 1993-1994 REFORM PROPOSALS

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This article offers a theoretical framework for understanding the crisis of the U.S. health care system and the mainstream debate on restructuring health care financing and delivery subsystems. The author argues that the crisis of the health care system is a cause and a consequence of the long cycle of structural changes in the U.S. economy since World War II. The article distinguishes between the level and the rate of growth of health care expenditures. It is possible to moderate the level of health care expenditure by adopting measures in the direction indicated by the historical experience of other advanced capitalist economics. However, in the long term the rate of growth of health care costs will exceed the rate of growth of gross domestic product, thus any attempt to limit it will result in deterioration in the quantity and quality of health care services. The 1993-1994 mainstream debate is revisited to show how these proposals were a part of the overall effort to resolve the long-term problems of the U.S. economy. The defeat of the Clinton plan was due to its concerns with efficiency of the health care system in the face of the demand by a majority of the U.S. capitalist class to cut costs.

There is a large literature dealing with many aspects of the U.S. health care system from a radical point of view, much of it first appearing in this journal (1). However, very little in this literature analytically links the dynamics of health and health care to the dynamics of the capitalist mode of production (for a recent sample, see 2-4). This article delineates the economic boundaries of health care policy as a necessary step to evaluating health care reform proposals. The premise of such an approach is that health and health care are influenced by the process of economic development. Indeed, production, distribution, and use of health care resources and their attending social relations have increasingly become integrated into the economic dynamic of the advanced capitalist countries (5-7). That is to say, health care has developed into a capitalist industry.

I will show how the current crisis of the health care system has its roots in post-World War II prosperity and how it is both a cause and a consequence of the long-term crisis of profitability in the U.S. economy. I will further argue that the mainstream debate on how to reform the health care system has been dominated by the relentless effort to overcome the economic crisis. The Clinton plan aimed to combine cost containment with increased access to enhance the efficiency of the health care system in order to boost profitability in the U.S. economy. Its conservative rivals focused mostly on cost reduction.

The first section of this article offers a summary of how rapidly rising costs, diminishing access, and relatively poor health outcomes pose a threat to capitalist accumulation and reproduction in the United States. The following two sections then explore the key question of health care costs by distinguishing between their level and rate of growth; the literature on health care costs generally concerns itself with the former. After suggesting that the high level of costs stems from the postwar structure of financing and delivery of the health care system, I put forward the argument that the high rate of growth of health care costs can be best understood from the perspective of the labor theory of value. Next I explore how the fast rate of growth of health care costs poses a definite limit on health care policy in the context of the long-term profitability crisis.

After outlining the relationship between efficiency of the health care system and the extent and quality of access, I then revisit the mainstream health care debate and offer an analysis of liberal and conservative reform proposals as part of the overall attempt to resolve the long-term crisis of the U.S. economy. My argument is that the failure of the Clinton plan was due to its concern with the problem of inefficiency of the health care system in the face of the demand by a majority of the U.S. capitalist class to cut costs. The article ends with a summary and some conclusions.

A FAILING SYSTEM: COSTS, ACCESS, OUTCOME

The mainstream health care reform debate was motivated by concerns about rapidly rising costs, diminishing access, and relatively poor outcomes-that is, the gross inefficiency of the health care system. In 1990, over $666 billion, or 12.2 percent of the U.S. gross domestic product (GDP), was spent on health care. By the year 2000, health care costs are expected to consume 19 percent of the GDP. Currently over 40 million persons are uninsured. In the 1980s, the total number of uninsured grew 24 percent and the number of uninsured children grew 40 percent (8, 9). Since employment is the chief source of health care insurance in the United States, the jobs crisis of the 1980s and 1990s has translated into a severe instability of health care insurance coverage. A U.S. Bureau of the Census report (10) indicates that over 60 million people, about one in every four persons, were without health care benefits at some point in a 28-month period between 1986 and 1988. The rise in health care costs, which is much faster than the rise in the national income and each of its components-wages, profits, and government revenues-has contributed to the growth in the number of uninsured and underinsured. At least 20 million persons with private insurance are considered underinsured (11). In addition, because the rate of growth of federal and state contributions to the Medicaid and Medicare programs has been slower than the rate of growth of health care costs, the provision of care for about 65 million elderly, low-income persons, and those with disabilities has suffered in the face of growing needs.

The interaction between rising costs and diminishing access has contributed to a situation where U.S. health and well-being outcomes compare poorly with those of other countries. Table 1 shows that health care expenditure, both as a share of GDP and on a per capita basis, has been substantially higher in the United States than in its economic rivals in the Group of Seven (G-7), while in terms of health outcomes the United States has not fared as well.

The overall inefficiency of the health care system undermines the international

position of U.S. firms and industries. In 1990, health care costs added an average of $1,086 to the cost of every car produced in the United States, a figure substantially higher than for U.S. auto makers operating abroad, and also higher than that for their Japanese and German competitors. In 1988, for example, Chrysler paid over $700 per car produced in the United States for health care costs compared with $223 in Canada (12).

Table 1

Comparative economic and health data for Group of Seven countries, 1988[a]

	Per capita GDP spent on health care, 1985 U.S.$	Percent of GDP spent on health care	Life expectancy at birth		Infant mortality per 100 live births	Perinatal mortality per 100 births
			Males	Females		
Canada	1,624	8.7	73.0[b]	79.7[b]	0.72	0.76
France	1,475	8.6	72.3	80.6	0.77	0.92
Germany	1,723	8.9	71.8	78.4	0.76	0.65
Italy	1,094	7.6	73.2	79.7	0.93	1.23
Japan	1,587	6.7	75.5	81.3	0.48	0.62
United Kingdom	851	5.8	72.4	78.1	0.84[c]	0.91
United States	2,145	11.4	71.5	78.3	1	0.97

[a]Source: Organization for Economic Cooperation and Development. *OECD Health Data: Comparative Analysis of Health Care Systems*. Paris, 1991.
[b]1986 data.
[c]1985 data.

Table 2 shows how corporate profits have been squeezed by rising health care costs. Corporate health care costs rose from 8.4 percent of before-tax and 14.0 percent of after-tax profits in 1965 to 61.1 percent and 107.9 percent in 1990, respectively. Health care costs are a major cause of business bankruptcies and labor disputes; 75 percent of recent strikes included trade union attempts to preserve health care benefits (13). Corporate owners and managers who find explosive health care costs and rising labor disputes incompatible with their need to compete effectively in the world market have been demanding reform (14).

According to Organization for Economic Cooperation and Development (OECD) data, government (federal, state, and local) health care expenditures as a percentage of total government expenditure in the United States increased steadily from 5 percent in 1960 to 15 percent in 1990. During the same period, the ratio of public revenue to gross national product (GNP) increased only from 28 percent in 1960 to 33 percent in 1990. Meanwhile, federal, state, and local deficits have been mounting (15). Most of government health care expenditure goes to Medicaid and Medicare. The former is a state-run program for the "poor" financed by general federal and state tax revenues. The latter is a federally run program for the elderly, disabled, and persons with end-stage renal disease that is financed through mandatory contributions from employers and employees, general tax revenue, beneficiaries' premiums, deductibles, and copayments.

Table 2

Health care costs of U.S. businesses
(spending for health services and supplies)[a]

	% of business receipts[b]	% of gross private domestic product[c]	% of labor total benefits[d]	% of labor wages and salaries[d]	% of labor fringe benefits[d]	% of corporate profits before tax[e]	% of corporate profits after tax[e]
1965	0.4	1.0	2.0	2.2	22.4	8.4	14.0
1970	0.7	1.7	3.1	3.5	29.2	19.8	36.1
1975	0.8	2.1	3.9	4.5	28.5	21.3	34.3
1980	0.9	2.7	4.9	5.8	31.7	27.3	42.6
1985	1.2	3.3	6.1	7.2	38.9	51.3	89.9
1990	N.A.	3.9	7.1	8.5	45.5	61.1[f]	107.9[f]

[a]Source: Iglehart, J. K. The American health care system: Private insurance. *N. Engl. J. Med.* 326(25): 1715–1720, 1992. Data are from the Health Care Financing Administration, Office of the Actuary.
[b]Indicates business receipts for sole proprietorship and total receipts of partnerships and corporations, as derived from Internal Revenue Service data.
[c]Reflect health costs embedded in the unduplicated value of intermediate and final goods; based on data from the Department of Commerce national income and product accounts.
[d]Applied to employee in private industry.
[e]Based on July 1990 data from Department of Commerce national income and product accounts. A similar concept of "profits" for sole proprietorships is not available.
[f]Estimate.

HIGH LEVEL OF HEALTH CARE COSTS

The literature on health care costs does not generally distinguish between the high level and fast rate of growth of costs since it actually deals with the former--that is, specific institutional causes of high per capita health care expenditure (16-18). Given the complexities of the health care market structure, such explanations are many. They are generally divided into demand-pull and supplypush theories of health care cost inflation. Among the demand-pull theories, the most prominent is the orthodox moral-hazard model: perverse physician and patient demand for health care resources (19, 20). The most prominent supplypush argument points to the high costs of ever-emerging medical technologies which are not usually money saving (21). Weisbrod (22) combines these two approaches to offer an interactive demand and supply model of health care cost inflation. An insurance system that covers many types of conditions without any limits on the type of technologies used promotes demand-induced medical research and development. Expensive new technologies in turn spur demand for health insurance. This sets up a vicious cycle of rapidly rising health care costs.

The task of exploring the merit of these theories is beyond the scope of this article. It is sufficient to note that their concern is with the level of costs, explaining why per capita health care costs are significantly higher in the United States than in other similar economies.

In this literature, empirical studies of health care costs have generally proved superior to theoretical discussions of the issues involved, which usually rely on imperfect competition models of price. Finally, it has proved very difficult to explain the variation in levels of health care costs across countries.

I suggest that the totality of the U.S. health care financing and delivery system, itself a product of the postwar evolution of the U.S. economy and society, is responsible for its higher level of health care costs. Its most relevant characteristics, as I will discuss later, are the retrospective, fee-for-service, thirdparty payment system and physician-centered, high-technology, curative health delivery system.

In 1950, only 14 percent of the U.S. population had any type of health insurance. Total private expenditure on health care was $8.7 billion (1950 dollars) (23). During World War II, faced with a government-imposed wage freeze and rising demand, U.S. corporations competed for workers by offering health benefits. After the war, federal tax policy spurred private health insurance by making employer-financed coverage nontaxable income to employees and partially taxdeductible to employers. This encouraged employers to offer health insurance to their employees and prompted workers to buy into company-sponsored plans instead of insisting upon additional wage earnings (24, 25). Thus, U.S. health insurance today is primarily an employer-based system. In the mid-1960s, Medicaid and Medicare legislations were passed as a part of the Great Society program in the midst of massive social protest movements.

Thus, the long-term, postwar economic boom created the material preconditions for both capital and labor to benefit from the expansion of the health care sector. A minimum level of health care became a part of the "moral and historical wage." When Medicaid and Medicare were won in 1965, these publicly funded and privately provided programs substantially enlarged the health care market. The state systematically promoted health care as au arena of investment and accumulation. Health care suppliers-physicians, hospitals, insurance and pharmaceutical companies, medical technologies and medical supply firms-have experienced a boom. Today, health care expenditures constitute one-seventh of the GDP.

Initially, health insurance covered hospital services to ensure payment. The hospitals were reimbursed on a cost basis calculated retrospectively subject to endogenous decisions by physicians as to length of stay and the resources used for each patient. It is well-established that hospitals and physicians have favored higher health care expenditures even when they were not strictly for medical reasons. Thus, for such services, demand has not been cost sensitive. Insofar as patients do not directly pay for health care services, demand for them seems to be inelastic. As Weisbrod (22) explains, medical technology suppliers, including the pharmaceutical industry, have benefited from the escalating levels of health care expenditure. The curative (as opposed to preventive) approach, high technology, and the craft character of U.S. medicine have also contributed to the higher levels of costs.

Beginning in 1983, Medicare introduced the diagnosis-related group (DRG) reimbursement system which paid hospitals predetermined fees for 468 specified diagnoses. Similarly, private firms have embraced managed care systems which integrate financing and delivery services in a variety of ways. These include contracts with selected physicians and hospitals that furnish a comprehensive set of health care services, usually for a predetermined monthly premium; utilization and quality control of the contracting providers; financial incentives for patients to use the providers and facilities associated with the plan; and the

spread of financial risk to the physicians, hence altering their role from serving as agent for the patient's welfare to balancing the patient's needs against the exigency of cost control.

Prominent managed care structures include preferred provider organizations (PPOs) and health maintenance organizations (HMOs). They enjoy economies of scale, scope, and transaction costs. Enrollment in HMOs rose from 9.1 million in 1980 to 41.1 million in 1992 (26). The rising predominance of HMOs has effected a major shift from a fee-for-service, cost-based, retrospective payment system to a prospective fixed-fee system-that is, a cost-conscious health care system. Despite these efforts, there has not been a dramatic change in health care expenditure in the United States; hence the tendency for health care policy proposals to focus on an overall reform of the health care financing and delivery system.

FAST RATE OF GROWTH OF HEALTH CARE COSTS

Despite its high level of health care expenditure, the long-term rate of growth of health care costs in the United States is not significantly higher than in other OECD countries. Seven OECD countries-France, Greece, Iceland, Italy, Japan, Norway, and Spain-have had a faster average annual rate of growth of health care expenditure than the United States in the 1960-1990 period. The United States ranked third, after Spain and Switzerland, in its ratio of the average annual rates of growth of health care expenditure and of GDP in the same period. But, this ratio was consistently higher than unity for 21 OECD countries for which comparative data were available (Luxembourg, Portugal, and Turkey were excluded because of the lack of consistent time series). Table 3 shows the relevant information for the G-7 countries. Thus, the fast rate of growth of health care costs in industrial capitalist economies must be explained in terms of factors common to all of them and not specific features of individual health care systems.

Table 3

Average annual growth rates of health care expenditure and GDP for Group of Seven countries, 1960–1990[a]

	Average annual growth rate of total health care expenditure[b]	Average annual growth rate of GDP[b]	Ratio of rate of growth of health care expenditure to rate of growth of GDP
Canada	5.98	4.23	1.41
France	6.29	3.71	1.70
Germany	4.94	3.06	1.61
Italy	6.51	3.66	1.78
Japan	9.25	6.30	1.47
United Kingdom	4.00	2.47	1.62
United States	6.12	3.15	1.94

[a]Source: Organization for Economic Cooperation and Development. *OECD Health Data: Comparative Analysis of Health Care Systems.* Paris, 1991.
[b]Adjusted for GDP deflator, base year 1985.

One explanation may be based on the neoclassical theory of price and Engel's Law. As economies develop, the rate of growth of demand for health services increases faster than the rate of growth of demand for primary and manufacturing goods. Together with supply constraints, this will account for price inflation of health services, hence a faster rate of growth of costs. In the final analysis, the orthodox explanation will have to depend on supply rigidities and market imperfections (27).

This explanation confronts serious difficulties. On a theoretical level, the notion of perfect competition that underlies the orthodox theory of price has been discredited in favor of competition as an evolutionary process. Indeed, it can be argued that capitalist development reduces barriers to competition, including in health care services. Except for special situations, such as newly invented drugs or organ transplants, the bulk of health services is easily reproducible and increasingly available upon effective demand. On an empirical ground, as the data in Table 3 suggest, countries with a high degree of state intervention in the health care market, such as Britain, do not exhibit a faster rate of growth of health care costs than those with the least degree of state intervention, that is, the United States. This defies the central assumptions of the neoclassical theory.

The relevance of the classical cost-of-production theory of price-specifically, the labor theory of value-to corporate pricing has been recently stressed (28). In a tradition beginning with Locke, through Smith, Ricardo, and Marx, the value and relative price of commodities are determined by their cost of production and, in the case of the last two theorists, the socially necessary labor time. Because production costs depend on labor productivity, the value of reproducible commodities, including labor power, is a function of technical change: mechanization, improvements in technical division of labor, and specialization. Two conclusions follow. First, it is reasonable to expect prices of reproducible commodities to decline over the long run due to economic development and associated productivity gains. This means a long-term tendency toward a rise in the standard of living.

Second, the price of commodities with production processes that do not easily admit technical change and productivity gains, such as personal services including health care, will rise relative to that of commodities with more dynamic production processes. These two developmental tendencies combine to explain an increasing level of health care expenditure and a faster rate of growth of health care costs as an economy matures.

The relevance of the classical theory of price for the health care industry has been admitted even by prominent mainstream economists. Baumol and Bowen (29), for instance, have argued that the performing arts, as well as a number of services including health care, are labor-intensive activities that do not readily lend themselves to mechanization. In these activities, the quality of the product is closely tied to individual personal attention; they therefore have a low propensity for productivity growth, and their relative prices will tend to rise over time. Thus health care costs tend to grow faster than the national income. Baumol (30) extended this argument to formulate his model of unbalanced growth to explain the chronic fiscal crisis of cities, educational systems, and so forth.

HEALTH CARE COSTS AND PROFITABILITY CRISIS

However, Baumol (31) has also argued that corporate and government concerns with rising health care costs are misguided. In real terms, it is still possible to prosper and provide ever higher levels of health care if the rate of productivity growth of the past several decades continues. This is so because a slow, but nonetheless positive, rate of growth of productivity in personal services, including health care, as well as a fast rate of productivity growth in the rest of the economy will provide the means to afford more goods and services. Table 2, however, shows how corporate profits are indeed squeezed by increasing health care costs. The same may be said of government revenues. Are these merely monetary illusions?

Baumol's optimism is misplaced even on his own grounds. If the relative size of sectors with a low propensity for productivity growth is increasing in a mature economy, would it not follow that the overall rate of growth of productivity and income will slow down? In fact, the average annual rate of growth of productivity and GNP did slow down from 3.080 and 3.837, respectively, in the period 19481969 to 1.355 and 2.499 in 1970-1991 (32).

Indeed, Baumol's analysis is limited to the material (technical) aspects of economic life and largely ignores its social-that is, capitalist-character. The problem of the fast rate of growth of health care costs must be placed within the present reality of the long-term capitalist crisis. A majority of industrial capitalist economies, including the United States, have faced a long-cycle crisis of profitability since the early 1970s. At the core of this crisis is a fall in the average rate of profit in a large number of industrial capitalist economies (33, Chapts. 1-4).

Shaikh (34) has shown that a faster rate of growth of the organic composition of capital relative to the rate of growth of the rate of surplus value has been responsible for the fall in the average rate of profit in the United States in the postwar period. Moseley (35-37) has convincingly argued that this explanation must be augmented to explicitly take into account the substantial growth of unproductive economic activities, chiefly in the supervisory and circulation spheres. This argument has been corroborated by Shaikh and Tonak

(38).

I have further argued that the spread of unproductive activities in the U.S. economy may be correlated with the shift from a dynamic economy, with a relatively large manufacturing base, to a relatively stagnant economy, dominated by a large service sector (39). This hypothesis attempts to merge two aspects of capitalist development: the social dimension emphasized by Marx, as reflected in Shaikh and Moseley's explanation for the U.S. economic crisis, and the material aspect emphasized by Smith, as developed by Kaldor (40) in his model of growth.

The substantial growth of the health care industry in the postwar period offers a case in point. While I know of no study of productive and unproductive labor in the health care industry, there are studies that shed some light on the pervasiveness of potentially unproductive activities. Himmelstein and Woolhandler (41) report that between 1970 and 1982 the number of administrators increased 171 percent, compared with 48 percent and 57 percent for physicians and health care personnel, respectively. Administrative costs stood at 22 percent ($77.7 billion) of the total health care expenditure in 1983. In another study, Woolhandler and Himmelstein (42) report that in 1987 administrative costs were between $96.8 billion and $120 billion, or between 19.3 percent and 24.1 percent of the total health care expenditure. Such costs rose 37 percent between 1983 and 1987. The rise in administrative personnel primarily occurred in the insurance industry, hospitals, nursing homes, and physician practices (billing). While not all increases in administrative personnel can be identified as unproductive labor, Moseley's (43) research indicates that throughout the U.S. economy a majority of such supervisory and circulation activities were indeed unproductive.

I can now summarize the causes of the fast rate of growth of health care costs and outline the implications for the economy. The postwar economic boom made it possible for the standard of living to rise in the industrial capitalist countries. With the increase in per capita income, demand for services, in particular health care, increased faster than demand for primary and manufactured goods. This led to a substantial rise in the level and rate of growth of health care costs. The level of health care expenditures has been a function of the rise in per capita income and the specific character of the health care financing and delivery system as discussed earlier. We can now add that it is also a function of the rate of growth of health care costs. The latter is primarily a function of a productivity differential between the health care sector and the rest of the economy.

Over time a larger portion of per capita income went to the less dynamic service sector of the economy, which includes health care; in this sector it is difficult to reduce the necessary labor time by innovations. The relative size of the dynamic sector continued to shrink and its contribution to overall productivity growth diminished. In the United States this process has coincided with a significant rise in unproductive activities and the faster rate of growth of organic composition of capital relative to the rate of growth of the rate of surplus value. These factors resulted in a secular fall in the average rate of profit. By the late 1960s, the mass of profits began to stagnate and a long cycle of crisis began.

Capitalist solutions to the crisis include attempts to boost profitability by reducing unproductive activities and bringing noncapitalist production-use-value and value-producing activities-into the sphere of capitalist-surplus value-production. Still, the main source of a recovery lies in speeding up the rate of growth of the rate of surplus value relative to the rate of growth of the organic composition of capital. This will require a faster rate of growth of

surplus labor time (surplus value) relative to necessary labor time (the wage bill). Marx distinguished between production of absolute and relative surplus value. The former is associated with efforts to increase surplus labor time either by speed-up or by lengthening the working day or by reducing the necessary labor time by a cut in the real wage. There are clearly definite limits to such methods of production of surplus value. Production of relative surplus value, however, depends on technical change and productivity gains. Such methods will increase surplus labor time and reduce necessary labor time by lessening the value of goods and services that make up the wage basket. Production of absolute surplus value historically belongs to preindustrial capitalist accumulation. However, these methods are frequently adopted by capitalists in backward firms and industries and, at a time of crisis, even by leading firms and industries. The industrial capitalist dynamic of division of labor, technical change, and productivity growth is associated with the production of relative surplus value, which requires a measure of labor cooperation. These two approaches to boost profitability are reflected in the conservative and liberal debate on health care. While the former insists on straightforward cost-cutting measures, the latter argues for a need to enhance the efficiency of the health care system to contain costs.

THE PROBLEM OF INEFFICIENCY

The problem of (static) efficiency of a health care system deals with maximization of access and outcome variables for a given level of per capita expenditure. As Table I shows, it should be possible to moderate the level of health care expenditure and enhance access and outcome in the United States if the totality of the health care financing and delivery system is radically changed in the direction indicated by the historical experience of other OECD countries. In particular, inadequate access to health services, especially primary care, and a neglect of public health and preventive medicine are responsible for unsatisfactory outcomes in the United States.

Access to health care in the United States is primarily through employment (63 percent) and government (23 percent). The crisis of profitability has forced employers to cut costs. Firms that had traditionally offered insurance policies have attempted, with a measure of success, to reduce coverage. New job openings in small companies and in industries with no unions typically do not offer health benefits. Medicaid has been in decline almost since its inception: it covered 76 percent of the "poor" in 1965, 63 percent in 1975, and only an estimated 36 percent in 1991 (44, p.42). Meanwhile, physician reimbursement has become increasingly meager so that Medicaid patients lack adequate access to health services. Medicare, a more successful program, has been reducing physician reimbursement fees (which now stand at 59 percent of private insurance fees), shifting more of the costs to the elderly, who pay on average $2,400 out of pocket each year, an estimated 18 percent of the annual income of an average person over 65 years old. The erosion of the real wage in the United States has also meant a decreasing ability to purchase private insurance. The market mechanism in the context of institutional discrimination has rationed access to health care according to employment status, income, race, gender, age, geography, and health status (45).

There is an interesting paradox here. Most economic theories hold that capitalist

growth is associated with inequality of income. Public policy to redistribute income in the interest of workers would cut into profits, hence potential and actual investment. So equity and efficiency are counterposed. If the state were to divert private or public funds to provide health care benefits, would it not reduce the national investment fund, slowing the rate of growth, hence national income and future potential for more and better care?

It depends. While redistribution of income may reduce the total pool of funds available for investment, it would increase the level of effective demand for consumer goods, hence the incentive to invest. It is not so much growth itself but the path of capitalist development that would be affected. Further, private or public expenditure on health care may be viewed as enhancement of "human capital," which may be conducive to accumulation and growth. Moreover, advanced capitalist economies require functionally healthy workers to boost productivity. Loss of workdays due to illness translates into a net loss in corporate and national income.

Still, much of health care expenditures goes for relatively stagnant personal services. If the dynamic sector is still dominant and the economic system robust, then the net effect may be positive. Better health care will improve capital-labor relations and the quality of time spent in the production process. However, if the economy is in decline or the dynamic sector is no longer dominant, it may be that further diversion of social surplus to health care or other relatively stagnant activities will only deepen the crisis. Thus, in a long-term expansionary phase of capitalist development, improvement of real wages and social services coincides with the overall process of capital accumulation. However, in a long-run contractionary period, both real wages and social benefits are subject to cuts. Efficiency and equality are less counterposed in periods of long-term expansion than in periods of long-term contraction.

THE 1993-1994 HEALTH CARE REFORM DEBATE REVISITED

The central issue in the health care reform debate was the gross inefficiency of' the U.S. health care system. As Clinton put it in his presidential address on health care to the joint session of the U.S. Congress on September 22, 1993: "Our competitiveness, our whole economy, the integrity of the way the government works, and ultimately our standard of living, depends upon our ability to achieve savings without harming the quality of health care." (46) Clinton's assessment reflected a large degree of consensus among capitalist owners, managers, and policymakers on the importance of a more efficient health care system for restructuring the U.S. economy. However, the inability of the 103rd Congress to agree on any reform proposals reflects important divisions within the U.S. capitalist class on how to proceed in the face of the long-term economic crisis.

The debate was dominated by the Clinton plan and the (usual) conservative and liberal arguments regarding the role of private ownership, the market, and the state in policy formulation.[1] All health care reform proposals fell within these general policy prescriptions.

[1] The terms "conservative" and "liberal" have changed their meaning many times since the 19th century. Today they are largely context dependent. In this article I define them as follows. Conservatives maintain that an unhampered private enterprise market system is necessary to achieve economic and social development. Liberals argue that sectional interests of some branches of the

The major difference between the conservative and liberal plans lay in whether to focus on cutting health care costs for businesses or to aim at an enhancement of the efficiency of the health care system to contain costs. The mainstream debate therefore did not address health care as such but dealt with costs and efficiency of the health care system from the point of view of restructuring the capitalist economy.

It is sufficient to review the relevant aspects of six prominent congressional bills as summarized by the Congressional Research Services Report (47). For the purpose of our analysis, these can be grouped into three categories. The McDermott-Wellstone single-payer proposal presented a left-liberal alternative. It radically altered the health care financing system by requiring federal and state governments to provide universal health insurance. The Clinton plan represented a center-liberal proposal aimed at regulation of the insurance and health provider markets, achievement of near universal coverage, and an employer and individual mandate to finance the system. The other four bills (Cooper-Breaux, Michel-Lott, W. Thomas-Chafee, and Stearns-Nickles), all conservative in approach, used different mechanisms to oil the health insurance and delivery markets and limit state intervention to the most blatant cases of market failure.

The difference between the liberal and conservative approaches can be discerned in their handling of the problem of the high level and fast rate of growth of costs. The Clinton plan used a three-pronged strategy to increase efficiency and contain costs. It aimed at establishing a prospective payment system emphasizing the economies of scale, scope, and transaction costs associated with managed care, especially HMOs; (near) universal coverage; and an emphasis on prevention and primary care.

Since the 1970s the process of concentration and centralization of capital in the health care industry has given rise to managed care, especially the vertical integration of health care insurance and delivery into the HMOs. This process has enhanced productivity and undermined the craft nature of the health care industry by bringing into the sphere of capitalist (surplus value) production activities that were previously carried on in the sphere of petty-commodity (value) production. The Clinton plan attempted to speed up this process and foster its early predominance to contain costs.

Universal coverage can contribute to the process of moderating the level of health care costs. Currently, the uninsured end up as high-cost users of the health care system since the law requires hospitals to admit all patients on an emergency basis regardless of their ability to pay. The uninsured are forced to seek expensive emergency room services either for lack of access to inexpensive primary care or for treatment of an acute, often advanced disease. Hospitals pass on such costs to the insured patients in the form of higher prices for supplies and services or they receive government subsidies. The cost of the uninsured then shows up in the form of higher insurance premiums or taxes. There is, therefore, an economic incentive to cover as large a section of the population as possible. Universal coverage also simplifies the task of rationalization and standardization of health insurance and delivery

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economy may conflict with the overall capitalist optimum. As such, free competition may not always result in overall efficiency. They therefore favor a measure of government intervention to adjust for such cases of market failure. Some left-liberals Would even argue that private ownership itself must be restricted or altogether abolished in certain sectors to affect changes conducive to better accumulation of' social capital.

systems and thus reduces waste and paper work. There are also ideological-political reasons for universal coverage.

The Clinton plan emphasized preventive medicine and primary care, as the HMOs and some corporations are already doing. The aim was to help lower health care costs by reducing disease occurrence or gaining early diagnosis through the standardization of health plans and regulation by health alliances.

The Clinton plan contained provisions to regulate prices of health care inputs, such as pharmaceuticals, office visits, hospital stay, and insurance rates. More importantly, it also contained a provision to limit the rate of growth of health care costs to the rate of growth of GDP.

The Clinton plan would have been largely financed by employers and employees paying 80 percent and 20 percent of insurance premiums, respectively. Limits would have been placed on liability for small firms and low-income individuals. The shortfall would have been paid by the federal government through savings in Medicare and Medicaid, assessments on corporate alliances, tax code changes, and a tax on tobacco. The bulk of such revenue would have come from working people (48).

The McDermott-Wellstone plan used the Canadian model to increase efficiency and contain costs. Government financing of health care would have substantially reduced administrative waste and transaction costs (41, 42). The emphasis on primary care and prevention would have reduced some costs and helped to attain better outcomes. Provider prices would have been directly negotiated with the government on an annual or per case basis, putting in place a prospective payment system. However, this approach runs counter to the recent trend of concentration and centralization in health delivery (49). It would also preserve the craft structure of medicine. As a result some of the savings and efficiency gains might be lost. The fast rate of growth of health care costs is a problem in Canada as well. So, like the Clinton plan, the single-payer bill would have limited the rate of growth of health care expenditure to the rate of growth of GDP.

The McDermott-Wellstone proposal would have raised revenue through a system of taxation earmarked for health care as well as using current monies spent in federal health programs. Increased employer hospital-insurance payroll tax, self-employed tax, and individual (with an exemption for very-low-income persons) and corporate taxes would be needed to pay for this plan. A millionaire surtax, "sin" taxes, user fees for the aged, and premiums would also have to be imposed. It is important to note that such a financing scheme builds upon an already regressive taxation system (50).

The conservative proposals were designed to slow the growth of health care costs by reducing demand. Some proposals would have also increased the efficiency of the health care insurance and delivery markets. They all would have done away with a third-party payment system in favor of various schemes to shift the burden of costs onto the individual. The Stearns-Nickles proposal would have required all employers to convert health care coverage of their employees into higher wages. This would have made the employee and not the employer responsible for the full cost of health care by 1997.

In the conservative proposals there is also a monetary incentive to not use the health care system. Thus, there might have been fewer attempts by the lower-income groups to seek medical attention. As demand for health care is directly linked to the ability to pay, social demand for health care would have declined, resulting in a drop in total health

expenditures.

The conservative proposals, except for the Stearns-Nickles plan, would have actively encouraged the prospective payment system using a managed care approach to increase efficiency and contain costs. All would have regulated the underwriting and rating practices of the insurance companies. They all opposed any employer mandate.

As for the problem of access to care, the Cooper-Breaux and Michel-Lott plans claimed to seek improvements in availability and affordability of insurance. The W. Thomas-Chafee plan would have made it mandatory for every individual to purchase health insurance. However, the mere requirement to purchase health insurance does not automatically add up to more coverage and greater access. Insofar as the current lack or inadequacy of coverage is due to inability to pay, it is difficult to imagine how any substantial improvements in access to care could be forthcoming from these proposals. Moreover, if the current long-term trends in the economy continue, relatively smaller private and public funds will be available to cover a larger needy population. This will result in further cuts in an increasing number of services for the poor.

The role of government and the mechanism offered to help the most vulnerable sections of working people vary in each proposal. Government financial contributions come from the current regressive taxation system and from cuts in existing social programs. Different mechanisms are also offered to induce individuals to pay for their health care costs.

Readers of this journal have had the benefit of some detailed descriptions of the political processes that led to the formation of the Clinton plan and its eventual defeat (51-56). Here, I limit myself to an outline of what happened to various proposals and why.

In the course of the debate, the left-liberal single-payer plan-cosponsored by several dozen Representatives and Senators and endorsed by some trade unions, medical associations, and citizen groups-did not get any serious attention. However, many such supporters, including one of its principal sponsors, Representative McDermott, actually channeled their energies into support for the Clinton plan (54, pp. 24-32).

The center-liberal Clinton plan proved unacceptable to large sections of the capitalist class. The Congressional Budget Office estimated that its cost-containment effect would not kick in until the year 2004 and that it would add to the federal budget deficit until then (57). The owners and managers of big business, including the National Association of Manufacturers, who strongly favored health care reform including an employer mandate, opposed goverrment regulation on health care financing and delivery and demanded the lowering of the employer's share of the insurance premium to 50 percent from the proposed 80 percent. This would have amounted to a major shift of the burden of health care costs onto workers. Labor Department statistics show that public and private employers' health care contributions stood at $258.5 billion in 1992 (58). State and local government paid a total of $54.8 billion, an average of $3,494 per employee, with employers paying 85 percent of the premiums. Private employers spent $203.7 billion, an average of $2,267 per employee, with employers paying 86 percent of the premiums. The employers' share of the premiums in various sectors of the economy were: construction, 89 percent; manufacturing, 89 percent; transportation and utilities, 93 percent; wholesale trade, 85 percent; retail trade, 77 percent; finance, insurance, and real estate, 81 percent; and services, 83 percent. A significant section of big business-for instance the Roundtable, an association of 200 large corporations-opted for the Cooper-Breaux proposal, which resembled the Clinton proposal but without an

employer mandate, a promise of (near) universal coverage, or a significant degree of government regulation. Small businesses, as represented by the National Federation of Independent Businesses, were in the forefront of the attack on the principle of universal coverage and employer mandate (53, pp. 622-626).

The Clinton plan was opposed by the health insurance and delivery organizations. The Health Insurance Association of America, representing small and medium-sized insurance firms, found the plan's bias for the large HMOs intolerable. Together with larger insurance companies-Prudential, CIGNA, Aetna, Travellers, and MetLife—organized in the Alliance for Managed Competition, they vehemently opposed government regulation of the industry (53, pp. 593-615). The pharmaceutical companies opposed Clinton's plan to set drug prices (53, pp. 620-622). The American Medical Association was split on the Clinton plan. They opposed it, then supported it conditionally, with a significant section representing those who own small businesses opposing the employer mandate (53, pp. 615-618). Even the owners and managers of HMOs, a major beneficiary under the Clinton plan, expressed concerns with government regulation and insufficient standardization of health plans (58). While hospitals generally supported the Clinton plan, some urban teaching hospitals stood to lose because of it (53, pp. 618-620). The tobacco industry opposed a tobacco tax to partially fund the plan.

While the Clinton plan enjoyed the endorsement of the leadership of the AFL-CIO and major public advocacy groups, such as the American Association of Retired Persons and Families U.S.A., it did not have significant grassroots support. As major sections of the U.S. capitalist class expressed doubts and opposed various aspects of the Clinton plan, the conservative opposition managed to wrestle major concessions from a White House desperately looking for a compromise. The administration began to back down on key aspects of its proposal, including government regulation of health care insurance and delivery systems, employer mandates, and universal coverage. By midsummer 1994, there was no more a Clinton plan. Meanwhile, no alternative proposal managed to get a majority. The attempt to reform the health care system in 1994 had failed.

CONCLUSIONS

The economic boom after World War II created the conditions for the expansion of the health care industry which benefited both labor and capital. However, capitalist prosperity also created the conditions for economic malaise. By the early 1970s a long-term crisis had set in. At its base is the long-term decline in the average rate of profit due to the rapid rise in the organic composition of capital, the expansion of unproductive activities, and the growth of the service sector, including health care, characterized by relatively low levels of productivity. With the advent of the economic crisis, the problems of the health care system-rising costs, declining access, and relatively poor outcomes; that is, its gross inefficiency-have become a major dilemma for capital and the state.

The mainstream debate 'on health care represented the perceived interests of sections of the capitalist class as reflected in typical conservative and liberal approaches to the economy and society. A decisive majority agreed that the postwar health care financing and delivery systems should be reformed but they disagreed on how to proceed.

The Clinton plan hoped to contribute to continued labor support for capital and the state by combining cost containment and increased coverage to enhance the efficiency of the health care system. However, its cost-saving benefits would not have kicked in for at least another decade, and its eventual success would have depended on a significant improvement in productivity and profitability in the U.S. economy. If the rate of growth of the dynamic sector of the economy did not exceed a certain minimum, then financing of health care costs would have become exceedingly difficult. Indeed, the liberal plans anticipated such difficulties when they included provisions to limit the rate of growth of health care expenditure to the rate of growth of per capita GDP. If applied, this provision could have caused stagnation and eventual rationing of health care services on a national scale.

Thus, major sections of the U.S. capitalist class did not support the Clinton plan. They insisted on further cost cutting to boost corporate profitability, as reflected in the conservative proposals that would have shifted health care costs onto the working people. This is a short-sighted view of capitalist development characteristic of a period of decline. The conservative plans would have increased the pressure on government finances and led to increasing industrial and social tensions. The ultimate solution to the health care cost crisis is a dynamic economy with high levels of productivity gain. This may prove impossible without the active cooperation of workers who find health care increasingly beyond their reach. Hence the capitalist dilemma.

The argument presented in this article can be readily extended to other social services, such as education, as all are conditioned by the same requirements of capitalist production, distribution, and consumption. Insofar as the rate of growth of health care costs exceeds that of the GDP in the long run, health care systems in other industrial capitalist economies experience similar difficulties. The perspective presented here may then be useful in understanding recent health care reforms in these countries (59). Thus, the expansion of social services in the post-World War II period has contributed to the decline in overall rate of productivity growth and the average rate of profit. The slowdown in capital accumulation and economic growth has increasingly placed these very same social services outside the reach of the working people. The solution to this problem lies in socialization of these services: that is, making health care a right. Measures along this line have been adopted in all advanced capitalist economies. However, the crisis of welfare state programs since the 1970s attests to their instability within the context of a capitalist economy. The alternative seems to lie in the socialist transformation of the society. One can point to the success of the Cuban socialist orientation where an exemplary health care system has been established and maintained despite many odds and in the face of severe economic difficulties (60). A fundamental threat here is the growth of a state bureaucracy. It was the bureaucratic degeneration or deformation of social revolutions in the Soviet Union and Eastern Europe that created the preconditions for the recent crisis of the economy and society in these countries. The ultimate solution will collie only when direct producers themselves, not capitalists or bureaucrats, plan and carry out social production and distribution.

The 1993-1994 health care debate revealed the contradictions of capitalist social relations in the United States at the end of the 20th century, where capital and the state still have major difficulties to surmount. The crisis of liberalism and the continued attack on the economic, social, and political gains of working people reflect the weakness of the capitalist system. This reality will give impetus to working-class resistance and self-

organization. On such a basis it will become possible to forge the necessary alliance of direct producers to rebuild the society, including the health care system, in the interest of human needs, not profits.

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