PASSIVE INTERVENTION

by Paul Starr and Gosta Esping-Andersen

How government accommodation of powerful private interests produces inflation in housing and health care.

It is hardly a secret—although it is often forgotten by those eager to blame "government" for all of life's misfortunes—that public policy in America rests on the accommodation of private interests. To secure social programs, as well as other legislation, reformers commonly find they have to offer inducements for cooperation to the most powerful interests in the sectors that the programs affect.

Such compromises occasionally not only impede the programs, but also distort the way in which whole sectors of the economy are run. This has been the case with two sectors now experiencing runaway inflation—health care and housing. In health care, public policy has been obliged to accommodate the interests of the medical profession, the hospitals, and the insurance industry. Housing policies have had to accommodate the interests of banks and other finance institutions, builders, and developers. The pattern has been to leave the interests of these parties at the very least unimpaired, while pumping in money through expanded insurance, subsidies, or credit. Tax policies aimed at improving the supply and distribution of housing and medical services have been especially important in their overall impact on these sectors. Today we are paying the delayed price of accommodation, in the form of rapidly escalating medical and housing costs and the growing inability of families and the economy as a whole to cope with the inflationary pressures generated by these sectors.

Conservatives, of course, say much of the current inflation, like most other problems, is due to excessive government interference in the economy. The problem, in our view, has nothing to do with the *amount* of government intervention, but rather with its *nature*. Or to put it another way, the problem is not too much governmental activism, but too much passivity. Political compromise in America has repeatedly produced a type of policy that might be called *passive intervention:* typically, there is enough support to get social programs passed, but not enough to challenge established interests. The results are expensive, and seem to fulfill dire conservative predictions. But a comparison with policies in other Western countries shows the U.S. inflationary pattern was not inevitable. It could have been avoided had the alignment of political forces been different, and it can be limited in the future if those who favor progressive policies understand the long-term costs of redistribution without reorganization.

Policies of passive intervention—or accommodation policies—take private institutions as they are and attempt to work with and around them.

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In general, the clamor over rising medical and housing prices does not come close to the public agitation over inflation in food and energy. Yet the problems are no less serious.

When there are inefficient forms of production, as there are in housing and health care, accommodation policies reinforce them and reduce the incentive to reorganize on a more rational basis. The alternative to accommodation is structural reform. Such reform need not involve centralized state control; instead it may mean reorganizing the structure of private interests. Structural reforms may change power relations, such as between banks and home buyers, or health care providers and patients; they may create or promote alternative institutions, such as cooperatives or employee-owned firms, to meet otherwise neglected interests; or they may force existing private organizations actually to compete with one another. Policies of structural reorganization require more political effort than accommodation policies because of the opposition they arouse. But by eliminating the expensive practice of providing incentives and subsidies to the dominant private interests, they may actually cost less.

The idea of more audacious government action to deal with inflation and other problems runs against the conservative repudiation of government, so popular in American politics today. But the conservative position has a weak foundation, and the policies it suggests are unlikely to succeed in controlling inflation. The conservative case against government intervention usually has two distinct targets: spending and regulation. The attack on government spending enjoys particularly wide support: witness the huge margins by which Americans apparently support a balanced-budget amendment to the Constitution. Most people probably favor a balanced budget because they would just like to pay lower taxes, but a good number probably also believe the conservative argument that we could reduce the general rate of inflation if government deficits were eliminated. There is no reason to believe this is so. As of early 1979, when inflation was running at an annual rate of about 13 percent, the government as a whole, as Lester Thurow of MIT has pointed out, was in fact running a balanced budget: $26 billion in net annual surpluses from state and local governments more than compensated for a $22 billion federal deficit.* Even if out of conservative piety one wanted to eliminate the deficit of the federal government by cutting its expenditures, the effect on inflation in an economy as large as ours would be negligible; the Congressional Budget Office has estimated it at about .1 percent.

There is more to be said for the argument that government regulation increases prices. Environmental protection, occupational health, and consumer product safety laws, among others, undoubtedly raise costs to business and push up prices; the question is whether the costs are justified by the benefits. Sometimes they may not be, but it is difficult to make any simple, across-the-board judgment. The conservatives are not always wrong about regulation, but they are wrong to identify the problem as regulation. Behind the regulations stand a host of private interests, which have, among other things, limited government action to an approach that is merely regulatory. Regulation, after all, grows out of a commitment to limited government and the maintenance of private interests. Conservatives draw the wrong conclusions from their critique. They think it argues for releasing private interests from all control, as if the perfectly competitive markets their analysis presumes would then exist. But the answer may be to rely less on the regulation of private interests and turn increasingly to their reorganization. At least that is the case we propose to make in regard to health care and housing.

Four major sectors, each producing economic necessities, have led the way in the recent period of inflation: energy, food, housing, and health care (see Table 1). Most people feel a direct and immediate impact from price increases in fuel and food, but higher prices for health care and housing hit them less often and less equally. People generally don't worry about rising medical costs until they are faced with a serious illness. The costs of medical care are also fragmented: consumers pay partly in higher insurance premiums, partly in higher taxes, and only partly in direct fees.

Rising housing costs affect different classes of people in different ways. On the one hand, the costs of purchasing and maintaining a house have soared. But on the other, homeownership has the character of an investment, and those who already own their own homes have a stake in inflation since it increases their assets and makes it cheaper for them to pay off old mortgages. Inflation does, however, lead to increased property taxes, which have

* Thurow observes that the federal government was giving state and local governments $77 billion in grants-in-aid. "Theoretically," he continues, "a $26 billion cut in grants-in-aid would have balanced state and local government budgets and left the federal government with a $4 billion surplus" (*New York Times,* March 9, 1979).

been the target of homeowners' discontent (though the movement to roll back property taxes is a protest against the costs of government, not of housing). The one major protest against housing costs has been new rent control laws, but rents have until recently risen more slowly than homeownership costs. In general, the clamor over rising medical and housing prices does not come close to the public agitation over inflation in food and energy.

Yet the problems are no less serious. The proportion of family budgets and of national income spent on health care and housing has significantly increased, leaving less money for other purposes. Medical care, which absorbed about 4.5 percent of GNP in 1950, now soaks up about 9 percent. The per-capita cost of health care in 1977 was $737, up from $334 in 1970.[1] From 1970 to 1976, the monthly cost of homeownership (taxes, mortgage payments, maintenance, fuel, etc.) rose by 102 percent for new homes, while median family income increased by only 47 percent. Homeownership costs have jumped from about 26 percent of median family income in 1970 to about 36 percent today. Close to half of America's families could afford to buy a median-priced new home in 1970; today the proportion has dropped to a quarter.[2] For young families, the costs are rapidly becoming prohibitive.

To be sure, the increase in health care and housing costs is due to improvements in quality as well as to inflation. Yet some of the ostensible improvements in medical care, such as new forms of medical technology, do not appear significantly to improve health and well-being. Rather, they seem to reflect professional demands and institutional interests. Because of the peculiar structure of medical financing ("third-party" insurance), the costs nonetheless get passed on to consumers. Thus much of the cost increase in medicine attributable to improvements in quality represents a diversion of capital from potentially more productive uses.

Some of the rising costs of owned housing are also due to improvements in quality induced by financing arrangements. As inflation erodes the earnings of families but pushes them into higher tax brackets, home buyers have a strong incentive to behave as investors. So they go deeper into debt and buy higher priced (and higher quality) homes both to take advantage of the tax deduction and to shield themselves from further inflation. They might not choose to "consume" housing of such high quality if the tax code did not make it such a good investment. In addition, because of legal obstacles to large-scale, low-cost housing developments in areas like northern California, home builders have been constructing fewer but higher cost units, catering to the upper end of the market. In other words, there has been a shift upward in quality and price in new residential construction as a result of the combined impact of tax incentives, inflation, and legal impediments from zoning and environmental laws. Very little housing these days is being built for low and moderate-income families.

The health care and housing sectors are obviously quite different, but they share some important similarities. In both medical services and housing development, the mode of production has remained relatively unchanged: small-scale producers continue to survive and prosper outside the corporate sector of the economy. Because of the nature of their products, both industries are also immune from import competition. And in both, special financing arrangements—tax incentives and subsidies for homeownership; third-party insurance for medical care—not only serve to stimulate demand, but stimulate the consumption (especially among the well-off) of higher quality services than people might choose solely on the basis of their personal preferences.

TABLE 1

PRICE DEVELOPMENTS IN ENERGY, FOOD, HEALTH CARE, AND HOUSING IN THE UNITED STATES, 1967-1976

	Consumer Price Index	Energy	Food	Health Care	Housing (rental)	Housing (home-ownership)	Median Family Income
1967	100	100	100	100	100	100	100
1970	116	107	115	121	110	128	124
1976	170	191	181	185	145	192	183

Source: "Understanding the New Inflation: The Importance of the Basic Necessities," by Leslie Ellen Nulty. Exploratory Project for Economic Alternatives, 1977.

The pattern of passive intervention common to government policies in both sectors is responsible for these fundamentally inflationary financing systems. Unlike Great Britain and Sweden—two countries we will use as counter-examples in regard to health care and housing—the United States has had little publicly controlled production of housing or public operation of medical facilities. Instead, the federal government has offered tax incentives and subsidies to encourage or enable people to purchase privately produced housing or health care. Basically, it has confined itself to bandaging or boosting the private market mechanism. The tax incentives permit individuals to deduct interest on home mortgages and exempt employers' payments for health insurance from taxable income. Homeowners who sell their homes after a year deduct 60 percent of the profit under the capital gains exclusion, and, if within 18 months they buy another house for a larger amount, they need never pay taxes on the profit at all. These incentives plainly favor Americans who own homes and have private insurance—that is, the middle and upper income groups and higher paid workers.

For lower income people, the government has made available a variety of housing and health programs, such as subsidies for home mortgages and Medicaid; generally, these have attempted to help low-income households buy their way into the market, without disturbing the basic structure of the industries. That these programs have benefited banks, builders, and developers as well as doctors and hospitals is certain; that they have dealt adequately with the problems of the poor one may doubt.

Housing and health care differ in one important respect that involves their relation to the state. The housing industry is far more prone to periodic fluctuations because of its usual sensitivity to interest rates and its use by the government as a tool for speeding up or slowing down the whole economy. Health care rarely shows any fluctuations at all. Payments for health insurance are generally deducted from employees' paychecks before they receive them; few cut back on medical expenditures in a recession since they themselves could save little from foregoing services. Whereas housing prices vary with general economic conditions, medical prices rise almost inexorably. Only during the period of direct government price controls in the early 1970s have they been held back. Otherwise they have been growing at about twice the general rate of inflation. For housing, what needs to be explained is why inflation accelerated in recent years, even in the face of high interest rates. For medical care, what needs to be explained is a continuously high rate of inflation that is apparently almost impervious to changes in the economy.

American housing policy took shape during the years immediately following World War II, a time of exceptionally severe housing shortages. Both policy makers and business interests, fearing that the economy might slip back into a depression, saw a vigorous housing sector as a critical tool in boosting overall economic activity. The chief issue was whether the government should get involved in producing public housing directly, or rely more fully on stimulating the private market through tax policies and loan guarantees.

Business interests, such as the Mortgage Bankers Association and the American Bankers Association, together with building industry organizations, like the National Association of Home Builders, were instrumental in vetoing a strong commitment to public housing. They pushed instead for the GI bill and the Federal Housing Administration (FHA), which gave banks a government guarantee that mortgages issued to veterans and other home buyers would be repaid. No conspiracy was necessary to persuade Americans that the single-family home—and a policy that promoted it—was desirable. Thanks to the huge expansion of mortgage credit made possible by federal guarantees, two-thirds of American households now own the home they live in. Transportation policy, with its emphasis on highway construction, and the availability of relatively cheap land also contributed to the spread of single-family homes in suburbs.

By 1960, as Anthony Downs argues, the previous shortages of housing had been alleviated.[3] But during the first half of the sixties the market apparently lost its equilibrium. As a result of migration, rising minority populations, and residential displacement due to urban renewal policies, inner-city areas were becoming more overcrowded. Simultaneously, the volume of newly built, privately owned, suburban units went down. President Lyndon B. Johnson's Kaiser Committee (a special commission, composed mainly of leading business representatives, appointed to develop long-range plans for the housing sector) called for 26 million units to be constructed between 1968 and 1978, with particular attention to the needs of low and moderate-income households.* A major aim of the plan was to alleviate inner-city decay and overcrowding by giving those with lower incomes better access to the private market. During the 1969–1971 recession, the Nixon administration expanded the FHA mortgage guarantee program for moderate income households. Subsidized construction tripled between 1968 and 1971.

* Such a large volume of new construction was deemed necessary to meet the needs of the coming "baby boom" generation and the urban population, which was growing due to migration. The goal of 26 million new units was achieved.

With a stock market that has remained fairly stagnant since the late 1960s, the new incentive structure of the mortgage market, and the steady growth of land values, it is no wonder that capital flowed rapidly and heavily into housing and real estate, particularly in growth regions such as southern California. Between 1970 and 1973, major pension funds, trust funds, and large corporations funneled billions of dollars into this sector.

The Nixon administration, to avoid a major imbalance in investment, applied the brakes in 1973 by curtailing mortgage subsidies and stopping urban renewal. The housing sector experienced a short recession between 1974 and 1975, which has been followed by a period of unprecedented demand and cost inflation. Enormous capital investments in real estate have continued while popular demand for housing has been unusually strong. This has left its mark on skyrocketing land prices, sales prices of new and existing homes, and mortgage interest rates.

No evaluation of American housing policy can fail to recognize its sensational success. A very large proportion of the population enjoys higher housing standards than are found anywhere else. As of 1970, more than 90 percent of American households had one, or fewer, occupants per room. The vast majority lived in what officially is labeled "sound quality housing."

Still, foreign visitors are usually struck by the squalor in which millions of Americans live, slum conditions that one is hard pressed to find in similarly wealthy European countries. Then too, housing statistics disguise the fact that millions of Americans have been purchasing mobile homes (one of the most rapidly growing sectors of the housing industry), not attractive houses in the suburbs.

Moreover, federal housing policies, by stimulating private homeownership, have had a regressive effect on the distribution of income. The federal income tax deductions for homeownership produce a substantial net redistribution from renters to owners, which amounts to a transfer of wealth from lower to middle-income Americans.* While federal housing policy has succeeded in giving the middle class and much of the working class access to good quality housing, its distributive effects have not been wholly egalitarian.

Public housing projects, rent subsidy programs, and mortgage subsidy schemes for lower income families were attempts to compensate for the middle-class bias of other housing policies. But, by and large, quotas for the volume of public housing production set by Congress have seldom been met (public housing production has rarely exceeded 1 percent of all new construction). The rent subsidy, or housing allowance, program was never large enough to affect the market significantly; additionally, low vacancy rates and persistent discrimination against "welfare" families prevented tenants from moving into better housing. And while homeownership subsidies stimulated a huge increase in low-income homeownership, there were some disastrous consequences as well. Although the number of homes purchased under the program tripled between 1968 and 1971, the number of defaults quadrupled by 1973. Many low-income families had been lured into a market that was simply beyond their means.**

Today housing is a problem not only for the poor. It is also a problem for a growing number of middle-income families because of the explosive increases in the price of new and existing homes and the rising costs of homeownership.

Property taxes, contrary to a widespread misperception, are not a leading cause of higher homeownership costs: higher purchase prices, interest rates, and fuel costs have been more significant (see Table 2). Many people blame the increases in purchase prices on higher construction costs. But only 5 percent of homes purchased annually are newly built, and prices of old homes have soared as

* Homeowners can deduct state and local property taxes as well as interest payments on home mortgages from the federal income tax. Since their "imputed rent" is not taxed as income, homeowners pay about $9 billion less in taxes than if they had followed rules pertaining to other investors. The redistributive benefit of these tax arrangements is, of course, highest for those who have recently purchased (or remortgaged) a home.

** There were 600,000 defaults between 1973 and 1975. The annual default rate during these years corresponds to about 10 percent of all new homes built. The Department of Housing and Urban Development has been forced to repossess hundreds of thousands of low-income homes. We can only guess at the magnitude of frustration and disarray in low-income families generated by this program. The rising costs of homeownership suggest that default rates are likely to remain high for several years.

Whereas housing prices vary with general economic conditions, medical prices rise almost inexorably.

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quickly as those of new homes. The dramatic jump in purchase prices in the past decade is primarily due to the ways in which federal tax benefits to property owners during times of high inflation and economic stagnation distort the system of demand and supply in the housing market.

Policies that worked well prior to the 1970s are now producing a rising rate of inflation in housing and real estate because they have new effects on consumers under changed economic circumstances. The tax advantages and the new rules allowing lower down payments keep demand at a high level despite rising prices. Rather than letting themselves be priced out of the market, households take advantage of the availability of mortgage loans and favorable tax provisions. Both spouses work, they dig deeper into their savings, cut back on other consumption, and go heavily into debt because they are convinced that in the long run the investment will pay off. Assets invested in property are, as people say, a "hedge" against inflation. Under current income tax rules, property ownership serves as a tax shelter for earners pushed into higher tax brackets by inflation. Corporations, trusts, and speculators also have found real estate investment to be an attractive alternative to the sluggish stock market. Thus, federal tax provisions in a stagflationary economy simultaneously motivate housing consumers to behave as investors and capital owners to shift resources into fixed property. As a result, demand already heightened by the maturation of the "baby boom" generation has reached feverish proportions. Housing prices are driven up and the volume of residential mortgage debt increases—it doubled between 1970 and 1976, and currently exceeds $880 billion.

On the supply side several factors contribute to higher housing costs. The suburban homeownership policy was based on the availability of cheap land, but land is no longer cheap in most metropolitan areas. Rising fuel costs and already long commuting times make it difficult to build suburban developments farther out from urban centers. Established homeowners are using zoning ordinances and environmental regulations to keep out large housing developments. As Bernard Frieden has recently pointed out, such local resistance induces builders and developers to concentrate on a smaller number of high-priced units instead of large-scale, moderate-cost projects.[4]

To make matters worse, inflation in housing is self-perpetuating. The higher the prices, the greater the tax advantages, and the more families feel they must own their own homes to stay ahead of inflation. The government, instead of attempting to restructure this system, gives in to it, and actually helps promote its continuation. In recent years government action has liberalized capital gains taxes, reduced the required down payment, and changed mortgage repayment schedules to permit lower payments in the first several years. The politics of accommodation now threatens to destroy the earlier accomplishment of widespread homeownership at moderate cost.

The soaring inflation in the homeowner market is now spilling over into rental housing. Because of higher profits from owned housing, high interest rates, and rent control or tenant resistance to rent increases, developers are building fewer rental units and landlords are converting apartments into condominiums and cooperatives for sale. In the last three years, the *New York Times* reports, there has been a net loss of 2 percent of rental units annually.[5] If this trend continues, a serious shortage will develop, dramatically pushing up rents. The groups to suffer most will be the elderly, single people, and the poor. As rents follow the price spiral in the homeowner market, the net result will be that most American families, whether renters or owners, will have to devote a larger share of their income to shelter.* So the politics of accommodation not only threatens the principle of affordable homeownership; it threatens to make one of life's necessities a heavy burden for most Americans.

Is there a way to resolve the problems of production and distribution of housing without setting off an inflationary spiral and without getting mired in all the problems of public housing? The example of Sweden suggests there is.

Pressed hard by the labor unions during the 1960s, the Swedish social democratic government

* As rents begin to climb, rental construction may pick up again. Yet, with rapidly rising rents it is likely that tenant militancy will heighten and that rent controls will be imposed in many municipalities. Where this occurs, landlords will have an added incentive to move out of the rental market, thereby reinforcing the crisis. It is also possible that the federal government will respond with more subsidies to rental construction. Indeed, federally subsidized construction accounts for almost two-thirds of all new rental construction today. But to offset the current net decline, the additional federal commitment of funds would have to be massive.

guaranteed the construction of one million affordable new units (in a country with a population of eight million). The demand for housing in Sweden was, if anything, heavier than in the United States. The Swedish policy makers, however, feared that a system based on private construction and finance would encourage speculation and high inflation. Moreover, a bias favoring single-family homes in such a massive building program would absorb too much of the country's economic resources.

So the social democrats followed a strategy based on bringing the entire financial structure under public control. First, the government brought the mortgage interest rate down below market rates, which drove private financial institutions out of the home mortgage market. To fill the vacuum, it channeled publicly controlled pension funds into housing finance. Then the government gradually diminished the role of profit-motivated builders and developers by giving preferential loans to cooperative builders and nonprofit housing societies and, to a lesser extent, to local governments. This strategy succeeded. The Swedes were able to provide rental or cooperatively owned housing of a high standard for most of their citizens.

The Swedish government's politics of structural change were less successful in satisfying demands for equality: higher income families came to enjoy better income-to-rent ratios than lower income families. Since the late 1960s an expanding system of rent allowances has entirely replaced the old rent control system as a means of securing good housing for low-income families, old age pensioners, and families with children. Today most Swedes have very favorable income-to-rent ratios. The average industrial worker, for example, spends between 15 and 20 percent of income in rent.

Ironically, the very success of Swedish housing policy has begun to boomerang. Although the demand for good housing has been met, more Swedish families now want single-family homes instead of apartments. This places the government in a new dilemma: there is growing electoral pressure for tax and mortgage provisions favorable to homeownership; because of Sweden's low rate of population growth, however, if such provisions were adopted, the result would be wide-scale abandonment of new apartments.

While no form of government policy can guarantee a problem-free housing sector or satisfy people's housing preferences once and for all, the Swedish experience demonstrates that vigorous government intervention in restructuring the market can solve problems of shortage and distribution without incurring inflation. Whatever problems exist in the Swedish housing market today, they do not begin to match the current crisis in the United States.

The causes of inflation in medical care are tolerably well understood, as is the part played by government in encouraging higher costs. The key mechanism is the system of financing, and here three elements are crucial.

The first is that payment for most medical care today is made by a "third party." Whether the third party is a private insurance plan, like Blue Cross, or a public agency, like the Social Security Administration, is less important than the fact that

TABLE 2

COST INCREASES IN HOME PURCHASING AND OWNERSHIP, 1970-1976

	Increase (1970=100)
Home Purchasing	
Median sales price of new homes	189
Median sales price of existing homes	165
Construction cost of new homes	163
Home Ownership	
Cost of new homes	202
Cost of existing homes	173
Costs itemized:	
Monthly mortgage payments (new homes)	197
Monthly mortgage payments (existing homes)	173
Monthly property tax	152
Monthly heat and utilities	177
Overall maintenance	161
Total consumer price index	146
Median family income	147

Sources: *Statistical Abstract of the United States 1977,* Bureau of the Census. *The Nation's Housing: 1975-1985,* by B.J. Frieden and A.P. Solomon, Harvard-M.I.T. Joint Center for Urban Studies, 1977.

neither the patient nor the "provider" (that is, the hospital, doctor, or clinic) bears the true cost of treatment decisions. In their use of medical resources, neither party has any incentive to balance costs against benefits. As of 1977, third parties financed 70 percent of all personal health expenses, up from 45 percent in 1960, and 94 percent of all hospital costs, compared with 81 percent in 1960.[6] Over the last two decades, hospital care has seen the most rapid increases in cost.

The second element is that payment to doctors and hospitals is made on an individual "fee-for-service" basis. Under fee-for-service, providers have an incentive to increase the number of services to raise their incomes; they have no incentive to economize. In Britain, by contrast, general practitioners are paid a fixed sum annually for each patient on their lists, and in an American health maintenance organization (HMO), subscribers pay a flat fee for all services during a year. The English GP and American HMO have an incentive to economize, but if they economize too much, they risk losing their patients to other doctors or other health plans. Both the English system and the HMOs have contained costs at dramatically lower levels than fee-for-service medicine in America.

The third element of the inflationary financing system is that reimbursements to hospitals and other institutions under Medicare and Blue Cross are determined on the basis of costs. The greater their costs, the higher their reimbursements. The financing system thus encourages hospitals to solve their budgetary problems not by minimizing costs but by maximizing reimbursements. Indeed, an institution that seeks to minimize its costs risks reducing its income not only in the current year but for years to come, since future reimbursements will reflect the record of past costs, particularly capital expenditures. The hospital that spends wantonly today will reap its rewards in higher rates of reimbursement tomorrow. Such is the logic of cost-plus reimbursement.

The dynamics of the system are simple to follow. Patients want the best medical services available. From the viewpoint of the providers, the more services they give and the more complex the services are, the more they earn and the more they are likely to please their clients. Physicians, moreover, are trained to practice medicine at its highest level of technical quality without regard to cost. Hospitals want to retain their patients, physicians, and community support by offering the maximum range of services and the most modern technology, regardless of whether they are duplicating services offered by other institutions nearby. Insurance companies are able to pass along the costs to their subscribers, while their profits increase with the total volume of expenditures. No one in the system stands to lose from its expansion. Only the population over whom the insurance costs and taxes are spread has to pay, and it is too poorly organized to offer resistance.

The obvious defect in the system is the absence of any effective restraint on its appetite for resources. Yet this is no accidental oversight; it is the outcome of a long history of accommodation in public policy to the interests of private physicians, hospitals, and insurance companies. They have succeeded in blocking any form of control or any alternative form of organization that would threaten their domination of the market.

We can conveniently divide the government's history of accommodation during the twentieth century into a "negative" and a "positive" phase. The negative phase runs more or less to the end of World War II; the positive phase, from 1945 to the present. During the early period, the government accommodated the interests of the medical profession primarily by keeping out of its territory and allowing the creation of a structure of financing and organization highly favorable to the physicians' interests. During the more recent period, the government has had to accommodate the interests not only of the doctors, but also of the hospitals, insurance carriers, and medical research and education complexes. Beginning in the postwar years, it aided capital formation in the medical sector with funds for hospital construction and research and then in 1965, when Medicare and Medicaid were enacted, it moved into the direct financing of services. But here too its policies exemplified the kind of passive intervention that pumps in money without challenging the structure of private interests.

In the early, negative phase of government policy, the principal interest bloc was the medical profession. It wanted state intervention primarily of two kinds: medical licensing laws, which protected physicians' control of the medical market, and public treatment in municipal hospitals and state mental asylums of those who could not pay for private care. The profession was also willing to accept the state's role in public health, particularly such activities as cleaning up the environment and providing vital statistics. Defining the boundaries of public health, however, was a problem. Public health had emerged in the mid-nineteenth century primarily as a sanitary movement, concerned with sewage, swamps, and other perceived sources of disease, but the discoveries of bacteriology late in the century made it clear that disease was often spread by the sick themselves. Some public health officials, therefore, wanted to attack diphtheria, tuberculosis, syphilis, and other contagious diseases by treating the sick, but to do so was to trespass on the terrain of private physicians. After a series of conflicts in various cities,

public health agencies agreed to limit their work with individuals to diagnostic services and health education. Thus the very concept of "public health," as opposed to private medicine, was partially the outcome of the accommodation of the government to the interest of the organized profession in securing the market for curative services exclusively for its own members.

In what is by now a well-known story, the physicians also successfully opposed government health insurance. Although initially receptive when the idea was first proposed around 1915, the doctors soon decided it might result in controls over their fees; with influential support from the insurance industry they defeated the proposal. The Progressive reformers supporting health insurance were willing to concede to the physicians almost everything they wanted; the doctors still opposed health insurance for fear of what it might become. The first proposal for structural reform in medicine came in 1933 from the Committee on the Costs of Medical Care, a commission underwritten by foundations, which in its majority report called for group practice combined with group payment—an idea later called prepaid group practice or, more recently, health maintenance organization. Such plans might well have limited the power and income of the profession. The American Medical Association (AMA) called the committee's report "communism"; it openly blacklisted doctors cooperating with a few such medical plans—actions that resulted in the conviction of AMA officials for violating the Sherman Anti-Trust Act. Despite the legal verdict, physicians successfully resisted prepaid plans through collegial pressures and were able to convince a number of states effectively to outlaw them. The experience of the few plans that survived, such as the Kaiser Health Plan in California and the Group Health Cooperative in Seattle, suggests that the costs of prepaid group practice are about 20 to 30 percent less than those of fee-for-service medicine.

Until the mid-1930s, the AMA was opposed not only to government health insurance and prepaid group practice plans, but also to private health insurance—in fact, to the very idea of insurance at all—for fear that insurance companies too might restrict medical fees. This position had to be abandoned during the Depression, when there was some threat that health insurance would be included in social security. Private insurance seemed like the lesser evil. Hospitals, many of which had fallen into grave financial difficulty, began to set up Blue Cross plans as a way to help patients pay their bills. The doctors decided Blue Cross was all right if it limited itself to hospital bills; they then established an insurance plan under their own control, Blue Shield, to cover medical fees. Ultimately, the profession's fear of the insurance companies proved groundless. By the early 1950s, commercial firms took a larger share of the health insurance market than the "Blues." But because the market is so fragmented—today the largest commercial health insurer, Prudential, covers only 4 percent of subscribers—the companies do not exercise any countervailing power against the medical profession. Antitrust laws prevent the insurers from getting together to try to limit doctors' fees.

The government aided the establishment of a private, third-party payment system by exempting employers' contributions for health insurance from taxable income. As incomes have risen and workers have moved into higher tax brackets, they have had an increasing incentive to take wage increases in the form of tax-free health insurance benefits. Just as the tax code favors homeownership and thereby stimulates demand, so it favors third-party payment for health care.

The positive phase of the government's accommodation of private interests in medical care began in the period after World War II. During the Depression, the federal government provided funds for hospital construction and medical services, but only on an ad hoc basis through relief measures. The establishment of the National Institutes of Health in 1946 inaugurated two decades of growing support for medical research; the passage of the Hill-Burton Act in 1946 brought subsidies for hospital construction. Other funds expanded graduate medical education. These programs deflected some of the interest in national health insurance. By enlarging the capacity for hospital care, teaching, research, and innovation, they were complementary to rather than competitive with the interests of the medical profession.

These capacity-building programs increased the tendencies toward specialization in medical practice. Whereas in England two-thirds of the physicians are general practitioners, in America today two-thirds are specialists. The difference stems from the American pattern of policy accommodation. In England, the government limits the num-

The hospital that spends wantonly today will reap its reward in higher rates of reimbursement tomorrow.