Victor H. Fuchs

July 29, 2003

This is Ted Brown. I'm here in Dr. Victor Fuchs's home in Palo Alto, California, and we are beginning our interview on the morning of July 29, 2003.

TB: Let me begin, Dr. Fuchs, with some biographical information about your early career. I've looked at your resume closely and tried to construct from that a chronological sequence. Let me just run through that quickly and tell me if I've got it right.

Your first item on your CV of chronological priority would be your service as a 1st lieutenant in the U.S. Air Force, 1942 to '46. You then returned and you graduated from New York University, cum laude, in 1947. And the next important item is your work as an international fur broker from 1946 to 1950. Then, subsequent to that, you enrolled in the graduate program at Columbia University in economics, receiving your M.A. in 1951, your Ph.D. in 1955. You were a lecturer in economics and assistant professor from 1953 to '59. You were associate professor of economics at NYU from 1959 to 1960. You were a program associate at the Ford Foundation from 1960 to '62, and in

1962 you began an association at the National Bureau of Economic Research, which I believe continues to this day. After that, you seemed to hold several concurrent positions. You were professor of community medicine at Mt. Sinai Medical School; you were professor of economics; you were vice president of the National Bureau of Economic Research, the first two of those appointments in the years from 1968 to 1974. Then in 1974, you became professor in the Department of Economics at Stanford University and also in the Department of Health Research and Policy. And in 1988, you were named the Henry J. Kaiser professor at Stanford, a position from which you retired, now as emeritus professor, in 1995. Is that accurate?

VF: You've got it.

TB: Anything to add that would give your story, simply laid out chronologically, special color, and nuance? Were there any interesting turns?

VF: Well, just that I would emphasize again that my association with the National Bureau has been since 1962. From 1968 to 1978, I was vice president for research at the National Bureau. Before then and since then, I've been a part-time associate. I had some other administrative responsibilities at the National Bureau, but I think you basically got it.

TB: Could you tell me something about how the National Bureau worked when you first were associated with it, and perhaps if it's changed over time?

VF: Well, it started in 1920. It's a private, nonprofit organization. It has a board of directors, which includes representatives from industry, from labor, from government, from all the major professional associations like the American Economic Association and the Historical Association and Statistical Association, and also some directors-at-large. It also has representatives on the board from many of the major universities. Originally it was in New York, and there was a small staff carrying out a limited number of research programs mostly having to do with business cycles, national income estimation, and economic growth.

For the first 26 years or so, the leading force, or the director, was Wesley Clair Mitchell, a professor at Columbia. Subsequently, it was led by Arthur Burns, who was also a professor at Columbia. And during the time that he was in Washington, Sol Fabricant was the leader, while he was director of research. Geoffrey Moore also played a role in leadership at the time, until 1958, I believe . . . Let me check that date. No, it was until 1968. In 1968(7?), John Meyer became president of the National

Bureau. He expanded the bureau geographically quite a bit, opened up offices in several different locations, including one at Stanford.

TB: When did that one start?

VF: It started in 1974.

TB: Because of the sponsorship?

VF: That's correct, yes. I came out here to be the co-director of that office and also to take up the appointment at Stanford.

Meyer served for 10 years. He was succeeded in 1977 by Martin Feldstein, who continues to be the president to this day.

The focus of the Bureau changed dramatically, first under Meyer, expanding into a lot of different fields. I personally was heading up a mini-center, which focused on law and economics, health economics, the family, labor problems, income distribution, things like that.

It also expanded greatly under Feldstein, not only in the range of subjects covered, but the number of people who became research associates all over the country, and it's a very different organization than it was when I first joined.

TB: Well, I've got some very good framing for the next set of questions, which is about your move to health economics.

VF: Right.

TB: It seems from things you've indicated in articles and acknowledgements you've given in some of the work you've cited that the Bureau itself was beginning to move in the health economics direction in the middle '60s with some interesting comparisons of age-adjusted mortality. I may have this very wrong. I'd be interested to know what this move towards health economics was about from your profession both in the Bureau and out.

VF: Well, sure.

First, within the Bureau, I directed a major project on the services industries in the 1960s, culminating in two publications, two major publications, one called *The Service Economy*, in 1968, and the second, *Production and Productivity in the Services Industries*, in 1969. That was still in the spirit of the former Bureau work with its emphasis on measuring output and measuring productivity. And, of course, the growth of the service sector made it an important new area to look into.

In the course of that work, I became quite interested in the problems of measuring output and productivity in

health care, so about 1965, I began a program of research in health economics at the National Bureau, running concurrently with the major project on the service industries, and that was the beginning of that work.

TB: May I just interrupt for a second?

VF: Yes.

TB: From '62 to '68, are you a full-time staff member?

VF: I was, I was - that's right. I may have done some part-time teaching at CUNY, but I was basically a full-time researcher.

So I started a health economics program there. Jacob Mincer, of course, had been doing important work in labor economics all along in the 1960s, and Gary Becker was a major intellectual influence over a wide range of subjects, and so that all sort of came together in about 1968, when I was made a vice president and I took, sort of put together a package of programs, including law and economics, which was, I think, the first law and economics program. That was headed up by Richard Posner, who's now a very famous judge out of Chicago, and Bill Landes. And we also had people like Finis Welch in that program, Jacob Mincer, of course, and Bob Michael, and Michael Grossman came along. They were research assistants and then became investigators

on their own. Jim Heckman was there, and a number of outstanding people. We had about 20 people working in the supply-related areas.

TB: You mentioned various people either by citation or by acknowledgement in your early work in health economics, and I'll just run a series of names by you and you can comment on them.

VF: Yes.

TB: Here's just a short list. Rufus Rorem.

VF: Rufus Rorem, very important, yes. This goes back to my work with the Ford Foundation, where the president, Henry Heald, asked me to look into the health field and recommend to him what, if anything, the Foundation should do in health. And I appointed a number of consultants to assist me in that, and Rufus Rorem was one of them. Others were Walsh McDermott, Colin MacLeod, and Leona Baumgartner. Rorem was a very significant person in the development of the health field in the U.S., and I gave a lot of attention to what he said. He was a very wise man, a very knowledgeable person.

TB: I'll mention another name. Kenneth Arrow.

VF: Kenneth Arrow. That also came out of my Ford Foundation work. I had an idea for a Foundation administered project that would focus on the economics of

health, education and welfare, because the Ford Foundation at that time, in line with the profession generally, was focusing on things like productivity and unemployment and economic growth and so on, and it seemed to me that these areas were becoming very important. So I got a self-administered grant of $25,000 in order to commission a series of studies.

There were three monographs to be done by people who were knowledgeable about the institutions that were in the crux of the matter, and then three theoretical essays, one for each field. On the empirical side, the essay was done by Herbert Klarman, and it was a very useful contribution. It was a summary basically of all the research that had been done in health economics up to about 1965

TB: His was another name I was going to mention.

VF: . . . 1965. So that was a big success.

Even more successful was a little book that Ted Schultz did on the economic value of education. That was an enormous success, went into many different languages, many different editions. And Margaret Gordon did the one on the economics of welfare.

When it came to the theoretical side, it turned out to be more difficult and more problematic. The one on the economics of welfare never materialized. The one on the

economics of education, for a different reason, never materialized. But the one on the economics of health was a real blockbuster. That was Kenneth Arrow's paper.

TB: In 1963.

VF: It appeared in 1963 in the *American Economic Review*. I considered it to be the foundation stone for modern health economics and it continues to be very heavily cited right up until this day and is still a significant influence for anybody who wants to think about health economics.

TB: My colleagues in health economics at Rochester usually assign that as the first paper for students to read.

VF: Absolutely, absolutely, yes. And so I feel very good about having gotten Arrow to write that. At the time, I just knew him by reputation, but it turned out to be just great. And since going to Stanford, I've become very friendly with Arrow, a close personal friend, and enjoy that relationship.

TB: Let me just mention as an anecdotal footnote, of my connection to a few of the people that you knew at the time - Morris Silver and Kenneth Arrow.

VF: Oh, yeah.

TB: In 1972, I joined the president's staff at City College, and Bob Marshall had become president of City College. He did a review of all the departments. The chair of the Economics Review Committee was Kenneth Arrow, and the chair of the Economics Department was Morris Silver.

VF: Okay, very good.

TB: That's the connection. I noticed with interest your work with them.

VF: Very interesting. Of course, Arrow was a graduate of CCNY.

TB: I'd like to mention another name: Eli Ginsberg.

VF: Eli was great. I got to know Eli mostly because when I started the health economics program, I appointed an advisory committee, and this advisory committee consisted of physicians and also economists, and one of the people who played a big role in that advisory committee was Eli Ginsberg because he was so wise and so knowledgeable and so willing to share his knowledge and his wisdom. We became great personal friends. We stayed in touch, of course, all the time that I was in New York. And then even after, when I came out here to California, we were in touch right up until the time he died. And I would send him papers, and he would give me very thoughtful comments on them. He was

very encouraging of my work. My work was much more empirical and econometric than his, but nevertheless, he liked it.

TB: I'll mention one other name, and that's Paul Feldstein. I was particularly struck with a very enthusiastic review of Paul Feldstein's doctoral dissertation.

VF: You mean Martin.

TB: I'm sorry. Martin, yes.

VF: Martin Feldstein. There is a Paul Feldstein down at UC-Irvine.

TB: I did mean Martin. Can you say something about his early work on health economics?

VF: Well, Martin started out as a graduate student at Oxford and started to write a blazing series of papers out of the British National Health Service. When I decided to enter the field in a serious way in the 1960s, I made up my mind to go and visit him, not at all realizing that he was a young graduate student, but he was a very mature scholar. In fact, what I usually say now when we get together on social occasions and things like that, I say that I thought that there was a Feldstein Bureau of Health Economics Research because his dissertation, I think, consisted of

nine or 10 already published papers, which must be a record for any Ph.D. dissertations that I know of.

He was a very significant factor in the development of the health economics field, partly his own work, partly the fact that he trained a number of people at Harvard and supervised a number of dissertations in health economics at Harvard. We've been very good friends ever since those early days. In fact, we met his wife of one week at Oxford. They had not yet even gone on a honeymoon. They'd just gotten married.

TB: Were there any other individuals you can think of from that period who were very influential in the early days of health economics?

VF: Well, the most influential people were Arrow, Feldstein, and Becker, although Becker didn't work in health economics directly, but his works on the family and on human capital and household production and so forth were influential. And, of course, Feldstein was a student of Becker's at Columbia. I'd say those were the three most important influences in the development of modern health economics: Becker from his own particular theoretical formulations; Arrow from his -- his were very different; and Feldstein from the point of view of applied econometrics.

TB: Would you say that other people in economics were resistant to this new field, that there were barriers to overcome?

VF: Oh, yeah. Oh, sure, sure.

TB: Can you say a little bit more about that?

VF: Well, you know, it wasn't a very well-developed field. It wasn't very well recognized. It wasn't . . . You know, until Arrow came into it -- I just was recently giving the Arrow Award at the World Congress of Health Economics, and I mentioned the fact that in Hollywood they say that Fred Astaire gave Ginger Rogers class, and Ginger made Fred sexy, and Arrow did both for health economics. He suddenly elevated it to a new level of intellectual prestige, and he also made it sexy and interesting.

So, did you say were there other people? Is that what . . .

TB: I asked also were there other people, but the things that I'm interested in are the primary barriers you were.. .

VF: Oh, the barriers. Well, I'll give you an idea of the barriers.

In the 1960s, I came to Arthur Burns, who was the head of the Bureau and who had been my professor at Columbia, and I told him that I wanted to start a program on health

economics. My idea was that if I worked on it for about three years, I would really get my arms around it, I would understand it, and then I would move on to something else. But at the moment it seemed very challenging and very interesting. Arthur tried to discourage me. He said he didn't think that this was very good for my professional development and my professional future, that I should pick a field like business cycles or economic growth, something that was more respected and acknowledged as an important field to work in. And I was, I guess, a pretty stubborn kind of person.

But still, I pursued the idea, and I met a fellow named Quig Newton at a conference, and I told him some of my ideas. He was the president of the Commonwealth Foundation, the Commonwealth Fund I guess it's called. And he said, "Well, why don't you write me a letter about it." I did send him a letter. I think it must have been about maybe four or five pages long. About three weeks later, there was an envelope on my desk at the Bureau with a check in it. I think the check was for $150,000. It was certainly a very large amount of money at that time. And I showed that to Arthur, and he withdrew all his objections. He was a practical person. He understood that, somebody

willing to put money into this. Who was he to say don't do it?

That was the start, in a sense, of my work on health economics. It was that check from Quig, and I've always been very grateful to him, because it's easy to get money once you're established and once the field is well established. But if you're an unknown and the field is an unknown, it takes a little imagination sometimes.

TB: I imagine there were also some conceptual issues, definitional issues, and measurement (unclear) of analysis.

VF: Yes. But that's still there, that's still there. I mean, if you ask, for example, to compare the productivity of health-care systems around the world, such as those you see sometimes from the U.N. or the World Health Organization -- this is a (bogle?), in my opinion. I don't know of any credible comparison really of this, of a system that you can say the British system is better than the American system or the American system is better than the Canadian system or something like that. It's very, very hard for conceptual reasons and for value considerations.

TB: I'm going to come back to this later, but I just wanted to anticipate one of the directions in which I'd like this conversation to go.

There seems to be a development of the field and a focus on certain issues and problems. You yourself later on, in papers of the '80s and early '90s, talk about, for example, the need for a technology assessment or ...

VF: Yes, yes.

TB: So there is a shift, at least in the problem focus, of what can the Congress do over the next several decades?

VF: Yes, right. I mean, one way to look at it is to say that we're confused at a much higher level than we were before. But if you break the problem down into smaller bites and you say, for example, how should we assess a new technology, I think the old technology assessment was rooted in a very narrow, almost biological view that you assess something in terms of its safety and its efficacy without any regard to its cost, without any regard to the utility that it might bring to people independently of changing their life expectancy, things like that.

I want to give you a mixed message about economics if that's where you're going. I think that we have brought a certain set of questions and a certain perspective of looking at phenomena which was very badly missing from the health-care field and which was very badly needed. And this is not just a sort of subject of assessment, because

objectively, one of the things that I observed as I came into the field was that, within a very, very short period of time, the economists came to dominate the discussion.

You know, there was this field of health services research, for example, and I joined a study section that gave out grants.

TB: When did you join the study section?

VF: In the 1960s, in the 1960s. There were good people there. There were good physicians, smart physicians. There were psychologists; there were sociologists; there were anthropologists and epidemiologists. They had been working in this area for quite some time. Within a very short period of time, the economists tended to dominate that.

TB: So you would say that the two fields were essentially separate at first. It was health economics emerging from economics. There was, briefly, existent but ongoing field of health services research, a joining, an overlapping, and then, by the '70s, dominance on the health economists?

VF: I would say so, yes.

TB: That's my view of events.

VF: I don't think . . . I make a sharp distinction of whether _____ field between a discipline and a field.

Economics is a discipline, has been for more than 100 years or so after it sort of sprung up in … philosophy … and so on. Health services research, in my opinion, is still a field where economists can work, psychologists can work, sociologists can work, statisticians, and whatever, and they still make very useful contributions. But what I'm observing is that within a very short period of time, the entry of economists into health services research changed the discussion very significantly.

TB: Let me shift now. I'd like to look at things a bit later.

VF: Sure.

TB: Let me shift to the reaction of physicians and medical journals to your early work. You published fairly soon in the *New England Journal of Medicine* and others, the *Journal of Joint and Bone Surgery*, etc. What was the reaction like for example?

VF: Very interesting. For the most part excellent. For the most part, I really had very little to complain about. The physicians -- I had the advantage of, from the beginning, working with top-notch physicians, very smart physicians. In fact, some of my early work on questioning the efficacy of some medical interventions and so forth was largely based on things that I learned from physicians.

These were sort of the cream of the crop, and they knew what was going on and what wasn't going on.

We had one classic article on surgical workloads, which basically had been accepted by Franz Inglefinger for the *New England Journal of Medicine*, and then someone up there -- I believe a surgeon, a very influential surgeon -- got him to essentially cancel the acceptance. And that article was published in *Surgery*, which is, of course, a surgeon's journal. And it didn't portray surgeons in a particularly favorable light because it showed basically how low the average workloads were of the general surgeons and how, let's say, minor were most of the surgeries that they were performing.

So if you take something like *Who Shall Live*, which came out in 1974, the reaction from physicians overall was very, very good, surprisingly good, so much so that I, because I feel that economists who work with people in other fields, the environmental and so forth, they run into difficulties. I say, though, while being critical, I try to understand how things look from their point of view, and they seem to appreciate that.

TB: In fact, a theme that emerged to me in reading the papers sequentially was just how supportive you are of the physicians' role, physicians' autonomy. You call at

one point -- it's about 1990, I think it was 1988 in the journal *Health Affairs* -- for a revitalization of professional norms, worrying about the managerial takeover.

VF: This is a larger theme of my work in general, and I guess at some point maybe we ought to mention that my work in health economics is only part of my larger research agenda, and it's always been part.

I guess my main thought ever since the work on the service industries was to try to understand post-industrial society and to understand the new kind of society that was emerging when now 75-80 percent of the labor force is engaged in the production of services, and to understand the economics, in the broader sense, that would be appropriate for that kind of society, because if you look at the economics textbooks, they're still either talking about agriculture and diminishing returns to agriculture or they're talking about the manufacture of widgets and what the marginal costs look like and so forth. And I didn't feel -- and to some extent I still think it's true -- that even economics has not engaged a revolution that has occurred comparable to the industrial revolution in the way our economy functions. I saw health care and health as a kind of heuristic device to try to understand these larger sets of issues.

TB: (unclear) have a check on that in the 1968 program of services.

VF: I do?

TB: Yes.

VF: Yes, that's right. I was already talking about it then. Yes. Now, that's not been a completely successful enterprise because it's a very difficult problem, and the health-care field swallowed me up to a much greater extent than I ever imagined or ever wanted them to do.

Sometimes I feel like Al Pacino in *Godfather 3*. Did you see that movie? At some point he says, "Every time I think I'm getting out, they keep pulling me back in." So that's my feeling about health care because I have worked in recent decades on the family. I've got a book called *How We Live*, and I've worked on things like women's quest for economic equality. It is one of my continuing interests, which came out of a book that I edited a few years ago, on individual and social responsibility. Now, you see how that plays in with health care, but it plays in in a lot of other areas besides health care. And my view of the good society is one that nurtures and gives expression to both individual responsibility and social responsibility. We might as well get that in, that health

care is only part of the picture, and in a way, it's, at least to some extent in my mind, it is never an end in itself, but an instrument for trying to understand a larger set of issues.

Now, you mentioned the role of professional norms in medicine. That's part of a much bigger issue of, how do we continue to use and recognize the importance of integrative systems as well as market-exchange systems and as well as government and threat systems. And, again, I think that our society suffers greatly because of its neglect and its decline of integrative systems like the role of professional norms in medicine.

TB: Let me just interrupt. According to my watch, we should be near the end.

VF: And mentioning physicians who had an influence on me, I would mention David Rogers, who was related to me for a considerable period of time because his sister was married to my brother. I can remember conversations with him, telling him about getting into health economics and his not understanding at all why an economist would want to get into this field, and then he promised to humor me. But later on, especially after he became head of the Robert Wood Johnson Foundation, he had a very broad appreciation of not only economics but a whole range of other things

besides the scientific medicine that he had been trained in.

A brilliant physician at Mt. Sinai was Dr. Popper, who had been trained both in internal medicine and in anthropology.

TB: Hans Popper.

VF: Hans Popper. And I believe that he knew more medicine than any other physician at Mt. Sinai and maybe all the others combined.

Now, in an entirely different way -- was the president of Mt. Sinai and the dean of the medical school, George James, who came up instructed in the public health point of view.

TB: You mentioned Kurt Deuschle.

VF: Kurt Deuschle was chairman of a department. He was an able fellow and good intentions and so forth, but I wouldn't put him in the class with . . .

Walsh McDermott was a very outstanding person because, more than any other physician in America, for example, he combined knowledge and expertise in personal health services. He was, after all, co-editor of one of the major textbooks in internal medicine.

At the same time, he understood the public health dimensions, the population aspects of health. There are

very few people who combine that at the level of sophistication that he combined.

TB: Thinking back to what you labeled the Al Pacino *Grandfather 3* phenomenon, I would think that a great deal of that can be attributed to the success of *Who Shall Live* the book which had …

VF: Yes.

TB: … enormous impact on articles in *Health Affairs* in the last 10-15 years [unclear]general a reference to that as [unclear] impact. So let's focus on that book for now.

VF: Okay.

TB: Can you tell me something about your reasons for writing it, the principal messages you were trying to communicate, and why you think it had such enormous impact.

VF: All right. I had never had a sabbatical in my entire academic career until 1972-73, at which time I was teaching at the City University of New York and Mt. Sinai Medical School, and I had an opportunity to come to the Center for Advanced Study in Behavioral Sciences at Stanford. I'd never gone away from New York. I was very committed to my family and to my family's needs and so forth, and I never could convince myself that going someplace else had that much advantage for me over the

disadvantages that it would have for them. But this seemed like a tremendous opportunity.

I had been doing research on health economics for several years, and I felt that I'd reached a stage where it would be possible to synthesize it and bring it all together in a way that would be accessible to non-economists, primarily physicians and other people in the health field, but even a wider audience than that. The Carnegie Corporation had then very generously put up some money to help facilitate my stay at the Center and to enable me to bring a research assistant out with me.

Coincidentally with that was John Meyer's hope to start an office at the National Bureau out at Stanford because Stanford had offered land and offered help and financing ability and so on, and he wanted me to head that up. I had no interest really in leaving New York, but that would be another thing to just sample that and see how we felt out there and whether that was something we wanted to undertake.

I felt that I could write that kind of book, although it was the first book of mine that was intended for a general audience. By that time I had developed some facility in writing, clear writing at least, and not particularly stylistic. And so I said that's what I'll do.

I'll come out here and I'll spend that year writing a book. I was able to draw on my research; I was able to draw on the research of other people at the National Bureau who had been working in the health area; and then I was able to draw on the other work that I knew about, not only in economics but some other fields.

Also, while I was out here, I was able to visit places like the Kaiser operation and the Group Health care operation up in Puget Sound and places like that, and all of that went into the book. And what emerged was what is often referred to as the little book because it's not a very long one, and I believe strongly that an author can spend some additional time trying to make things succinct and clear and that the payoff, that there's a wide readership. The rate of return is very high. Most people laugh at me, but I say, "Look, suppose you spend an extra six months on a book and you have 10,000 readers, and each reader saves an hour or two because you spent an extra six months clarifying and simplifying, and so look at the rate of return. It's huge." But most people don't think of it that way.

But anyway, I did work on the book, and the themes that emerged were . . . Well, first of all, from a health point of view, one of the themes was the tremendous

importance of non-medical factors in explaining health differentials across populations at any given point in time, and behavioral factors, social factors, even economic factors, things of that kind.

A second theme that emerged was the importance of the physician as the major influence on medical expenditures because a physician decides you go into the hospital, the physician decides when you come out of the hospital, the physician prescribes drugs, orders tests, etc., etc., and that was another very important theme. Most people had it reversed. They thought, at least the economics, they thought it was the individual who determined the expenditures, and they thought it was the physicians who determined your health status.

And a third theme, of course, was that there's no free lunch, that if you're going to have medical care, it has to be paid for, and you can have a lot of different financing systems and you can have taxes, you can have fees, you can have insurance, and so forth, but the basic thing was to understand that somehow the money has to flow out of society into the hands of the people who are providing the medical care. This is not to say that the financing system doesn't matter, but it is to say you can't conjure up a health-care system which doesn't have a financing system.

And I guess, you know, throughout the book, I'm trying to get non-economists to understand some of the basic ideas about economics, the scarcity of resources, that you have to make choices, that there are ways of thinking about those choices to make them more sensibly or less sensibly, but also to recognize that this economic framework is embedded in a larger framework of values, social values, and individual values. That's why I think the subtitle in the book is ***Health, Economics, and Social Choice***.

And the book -- I did a quite thorough first draft during that year. When I came back . . .

Oh, just an interesting side story about the [unclear] that I put going in. The Carnegie Corporation was very eager that this book should have a wide audience, and therefore, before I even went out there, they took me around to a major publisher -- I guess I should mention the name: Random House -- and to one of their senior editors, a very distinguished man whose authors have won many prizes, and they had me show him my outline and what I intended to do. And he spent about five or 10 minutes looking at it and laughed and he said, "Who in the world would want to read a book about this?" And I didn't care, but the Carnegie people were very embarrassed.

VF: That was his comment: Who would read a book like this?

The Free Press picked it up, so it was a trade publication as opposed to . . . Previously I'd published with Yale University Press and Columbia University Press, Princeton University Press, all the university press.

TB: It was the timing as well as the message you speak about. The beginning of the downturn of the American economy in 1978, '79 already worried about health service.

VF: It's always timing, too. In fact, one of my themes that I always push is that there's something called a market for messages. The way I think about it is this. At any given time, academics and intellectuals are doing all kinds of studies. They're throwing in all kinds of theses, all kinds of messages, and some get picked up and some don't. And which ones get picked up depend in part on what the . . .

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VF: . . . the world or the medical world and the others were ready for. I was very fortunate to get a number of very excellent reviews, which certainly helped to start with. And I think that physicians appreciated the fact that I was trying to understand things from their

point of view as well as from the point of view of an economist.

And other than that, I think the other thing that helped it along a lot was the beginning of the spread of courses in health policy and health economics. In fact, you told me you took . . .

TB: Yes. I taught a course. When I moved to Rochester from City College, one of the first assignments was Bob Berg's Introduction to Community Medicine, and he used your book as the first book in the course.

VF: And that certainly helped to spread it.

The funny thing is that, again, the publisher, or the editor, Kessler, after a year or two said, "Well, it's time to bring out a second edition," and I said, "I don't have any interest in that. If I'm going to write another book, it'll be another book. I have no particular interest in just revising this one." He said, "Well, if you don't do that, the sales will fall." And then after about four years, he said the same thing. And after about six . . . And the sales just kept going on and on and on. And now, a couple of years ago, an expanded edition of it came out by a different publisher, World Scientific. And then last year, an Italian publisher published it in Italian. We

went over to Italy to give some lectures at the university medical school. So it has had a continuing influence.

TB: Let me move forward to some other issues.

VF: Yes, sure.

TB: And one has to do -- what I'm currently concerned with now is the development of health economics in association with the Rand Health Insurance Experiment, and then some related work done by people who I think really began the campaign to eliminate barriers to competition. Your 1979 review of Newhouse's book in which you seem to criticize him for being excessively enthusiastic about the potentials of the competition and then eventually your very public statements about the failures of the competition revolution perhaps 10 years later. Let's move through that decade. What was happening in health economics, and what feelings have you developed about both of these developments?

VF: Well, I think that that doesn't lend itself to a simple answer. I think, to start with, some people from outside of economics discovered economics, particularly lawyers. Bill Baxter here at Stanford, Charlie Fried up at Harvard, and so forth. And I think they overbought. They saw something here which was elegant, which was, you know, led to logical conclusions, and so forth, and I think

that they overbought in the sense of . . . And their instincts were right, namely that a market method of allocating resources up until now has proven to be superior to the other two main alternatives. One would be a command-and-control centralized decision-making system, and the other would be a reliance on custom and tradition in the religious ritual, which is fine if you want to have a simple society but won't do anything for you if you have a complex, highly developed society. So in that sense, the intuition was correct.

The notion that you therefore can and should apply a market solution to every conceivable problem I think is an overreach, and . . .

TB: Do you think Newhouse was guilty of that overreach?

VF: Not in the same sense because he has not, he's not at the forefront of political recommendations and political things. Within his framework, he works as an economist and he analyzes things as an economist and he comes out with inferences that are appropriate within the framework that he . . . But I don't think of him as being at the forefront of leading any particular policy initiatives. He goes along with a lot of different things and has had a major influence on the field through his

editorship of the journal, through his editorship of the *Handbook of Health Economics* and so forth, but I don't see him up at the forefront of some political charge.

TB: What about Enthoven?

VF: Alain is much more interested in policy, coming at it from a business school perspective and trying to analyze it from the point of view of companies that are providing health insurance and -- not providing it -- let me say -- I hate that word -- employment-based insurers as something that has developed in a very large way in the United States, and trying to figure out how could we make the employment-based insurance be more efficient, more effective, and so on. And for the most part, I've been supportive of his analysis.

Now, where Alain and I will differ maybe is the extent to which he gets behind a particular idea and then feels a crusader mission to go out and sell it. But basically, if you're going to have an employment-based system, I think most of the things that he's recommending make a lot of sense both from a point of view of efficiency and from a point of view of equity. As a matter of fact, even in a non-employment-based system -- let's say we have a government-financed system -- I see in Europe, for example, many countries are edging toward bringing in various

elements of managed care, managed competition, and so forth.

For myself, I've never, again, felt that my role was primarily one of a crusader or a polemicist, but much more an analyst and researcher and a teacher. But if you look at the recommendations in the back of *Who Shall Live*, which, after all, goes back now 30 years, you'll see a small section in the back, not very prominent, not my main purpose in writing the book, but speaking personally, saying that we ought to have a universal health-care system, that it ought to be organized into essentially large groups that are paid on a capitation basis. So it has the germs of managed-care, managed-competition idea in there. But I don't see my role primarily that way, and I don't think Joe sees his role primarily as a crusader.

TB: Were there others perhaps, then, some who worked with Joe at Rand, others, a newer generation, a generation of perhaps ideological differences? I'm thinking of Chuck Phelps, someone who I knew reasonably well at Rochester.

VF: Yes, yeah. Well, Chuck did some very good work early on, but for the most part, except for this excellent textbook, really has largely moved out of health economics because of his administrative responsibilities. And Chuck -- I guess it would be hard to say because he just hasn't

written that much about things recently. He's picked up on the small-area variations and tried to talk about the welfare losses, because in some places doctors do a lot of this kind of operation, and in other places they do a little bit. But right now, Chuck is not really playing a significant role in health economics except for his textbook. And he did have a paper with Alan Garber a couple of years ago, a sort of conceptual-foundation paper about cost-benefit analysis, which is a controversial area.

You know, academics thrive on controversy, to some extent like any other field. This one writes this paper and the other one writes this paper showing what was wrong with that paper, and then the next one comes back and shows what's wrong with that paper, and so on. I don't want to minimize that because that's the way a field develops, but it hasn't been my own particular interest.

TB: I'd like to continue this discussion into the '80s and early '90s, and I'm very interested in what I, as a historian, took to be the continuities and some shifts in emphasis of your work. Continuities I would identify in philosophical and political terms as your emphasis on balanced approaches, both the government and markets, or identification of a third wave and revitalization of professional norms. And that work seems to be in

opposition to what I take to be a very strong push for competition in markets.

VF: Pushed by me?

TB: No, not by you, but I'm trying to identify who are those who are pushing that both intellectually and as health economists, and then, of course, organizationally, and your falling back from that position and emerging in the '80s as a consistent critic of some of what people have been saying and also a worried observer of some of what's been happening.

VF: Well, I think I would agree with everything except the idea of a drawing back. The only reason why you might get a drawing-back impression is because, in *Who Shall Live* and some of the earlier writings, I was trying to call attention to the fact that you can't ignore market considerations and that you can't ignore incentives and constraints. So it wasn't a drawing back so much as a question of which audience are you addressing at which particular time, because I don't feel that my own position in that regard has changed substantially from 30 years ago. But, depending on what you're reading when, you might see a different emphasis in my work.

Let me also mention that a big part of my work, probably more maybe than any of the other health economics

people, except for Michael Grossman, who worked with me for many years, is my interest in health, my interest in the determinants of health, as well as my interest in medical care. In fact, I sometimes say that if I'm known for one thing, I would like to be remembered as the person who changed the field from medical economics to health economics, because I've never understood why one would spend a lot of time worrying about medical economics without realizing that you've got to ask what's happening to health and what is the goal of medical care in health. So I've done a lot of work.

Right now, my major project has to do with the decline in mortality in the second half of the 20th century, which is really a health thing. And then I mentioned this piece I'm writing on the socioeconomic aspects of health and so on. So I think that's one thing that has distinguished my work in a lot of the work that you're referring to.

TB: A lot of that work was very focused on specific delivery of medical services and the outcomes of that service, let's say very focused analysis on the medical sector rather than on a variety of global factors as they contribute to health.

VF: Last year, with my research assistant, we published a paper in ***Health Affairs*** on air pollution and

its effects on the utilization of medical care. And John Iglehart said that this paper got the most press coverage of any paper they published last year.

TB: Even though your work remains focused on these larger issues and broader concerns, it seemed to me that in at least three of your papers, and probably others that I haven't had a chance to read as carefully, the paper in 1990 *Health Affairs and New Technology Assessment*, two papers in the *New England Journal*, one in 1990 and one in 1993, on the Canadian versus U.S. expenditures for physician services and hospital services, and it was something of a closer focus than your earlier or other work on medical services or hospital services per se that makes it feel, as you read it, more like other work in health economics done by that generation. I'm trying to get a flavor.

VF: You may be right. I would say, though, that it is a little tricky to answer that question because I see what you're driving at. But I would put it differently, that in the beginning I was trying to weigh out very broad frameworks for thinking and broad themes, and that as these became very well known and well accepted, if I were going to continue to make a contribution, I can't just keep on repeating those things, and therefore I have to go into

more detailed work, more specific problems, to continue to make a contribution. So in that sense, I think I understand what you're saying.

TB: Let me put it in a slightly different framework as well. When we talked before about the difference between health services research as a field and health economics as a discipline, the question that I have is --

VF: I would say economics is a discipline.

TB: Economics is a discipline, with health economics as a special area.

VF: Health economics has only a few things to warrant calling it a discipline.

TB: As I look at the development of health services research as a field -- and as a trained historian of science who studies fields and emerging fields and so forth -- I'm looking at patterns of institutionalization, separate journals, various forms of legitimacy, funding, etc.

VF: Yes, yes.

TB: And it seems as if there are two separate entities, health economics and health services research, at the beginning of the '70s, and perhaps a convergence or overlap or takeover of one by the other, health services research by health economics, by the latter '70s or the

'80s, and one way to understand the new contributions in the late '80s, early '90s is as a kind of response to the evolution of what is now combined within both fields, that there's a discipline which has brought health economics into it combined with medical appropriate sorts of studies, and that it really is a new and exciting intellectual adventure that evolved in that emerging development field.

VF: I think that's a fair statement, that I think health services research has grown, it's grown in size and respectability, and so on, in important ways, and I think economists have played a major role in that development, particularly people like Joe Newhouse and Mark Pauly and so on -- Uwe Reinhardt.

But at the same time, health economics as a separate field has grown at a pace that I wouldn't have believed possible. We had at this world congress in San Francisco in early June 1,500 people, and 60 percent of them were from outside the United States. Now, 30 years ago, that just would have been inconceivable. You could have gathered all the health economists in the world in a seminar. So this is a development, and these people are doing health economics, and a lot of them are publishing in health economics journals. There's the *Journal of Health*

Economics, there's *Health Economics*, which is edited in Europe, and so on.

As I say, these fields take on a life of their own. People need to publish. They give courses. They need to get promotions and things like that. So both things are happening. Health services research is flourishing, and I believe that many of the other fields have made a comeback to some extent. That initial sort of takeover by economists is probably not as true today as it was 10 or 15 years ago. And health economics has grown also.

Also, there's a . . . I don't know. Do you know the paper I published? It was an address I gave, too, a couple of years ago in Rotterdam on the future of health economics.

There I make a distinction between a twofold mission that I see health economics has. One is to make a contribution to the health and medical care field. That is to say, to use the insights and skills and the methodologies of economics to make a contribution that would include health and medical care; and the other is to use health and medical care as a field of analysis and study to make contributions to economics or, I would say, to social sciences even more broadly.

And so I think that there is good work to be done in either direction, and there are people working in either direction. But I don't see them as sort of in competition with one another or alternatives or anything like that. And naturally, sometimes some things will grow faster and at other times other things will grow faster. But this is the way I see it now.

TB: My image would be of separate lines with some overlap and divergence.

VF: That's right.

TB: In a rhythmic pattern . . .

VF: And there are people who -- it could be both, and there are people who . . . Most of the work, I would say, that comes out of Europe . . . Are you familiar with the health economics group up there? They're probably the best health economics group in Europe - York, England.

TB: Oh, in Europe.

VF: European, yes. And they are mostly doing the studies of the cost-effectiveness of different interventions, things like that. That's the one stream that's feeding into health and medical care, the consumers are health and medical care.

And then there's other work that --- has been doing a little work on health, and some of the other people in

Chicago as so forth, which is addressed much more, I think, through the economics community, published in the economics journals and so on. And that's fine, that's fine. I'm sort of in the middle there.

TB: Just one last question about that, and then we'll turn to other issues.

Do you think there's any relevance to the timing of your recognition by health services research institutions; that is, your 1988 award as distinguished investigator by the Association of Health Services Research or the 1991 Baxter Foundation Health Services Research Prize? The timing seems interesting in terms of what you were publishing about that time as compared to what you had been publishing, say, 10 or 15 years before.

VF: I never thought about that. What do you think?

TB: Well, I think that my sense is that people within health services research did recognize your work as more like theirs than they would have in the earlier period.

VF: Yeah, yeah, yeah. And that's in line with your earlier question as well.

TB: Yes, that's how I developed that hypothesis.

VF: I've never been that much into that kind of thing. You know, because of my background – you understand -- in the army and -- and so forth -- I've always

considered myself to be in some sense a marginal academic. I'm not a purely academic in the sense of one who thinks of himself primarily as an academic and is marching to the tunes that academia plays and so on. I never worried that much about publishing in the right journals or getting the right . . . So everything that has come to me has been almost, if not accidental, but incidental to my own driving thing, which is curiosity and trying to find out about things and trying to express what did I find out really.

I was some years ago elected president of the American Economic Association -- absolutely astounding, not anything I would have ever thought of, you know, that somebody from health economics primarily, although I have worked in other fields, would be chosen for something like that.

And my feeling about the other things is pretty much the same, too. If the people in my firm are doing it, it's great. If I think it's right and if the people who I respect think it's right, that's great.

TB: That's probably the best formula for success of [unclear] care most about.

VF: Not necessarily. Remember that I was 44 years old before I got tenure. That's not exactly a recipe for success for most people who are thinking of academia as their career.

TB: Right. That's certainly correct.

Well, let me -- this will be the wind-down of our conversation -- ask you to reflect about some of the broader political, ethical, moral concerns, which you write about so well, and I found very moving when I read your papers.

I'm thinking of your worries about the competition revolution, a related concern about the erosion of volunteerism, your sense of urgency about writing about these issues, your talking about the need for some national commitment. Could you just comment on those issues?

VF: Sure. You know, every -- many people have a vision of a good society, what makes for a good society, and I have a lot of concerns about the U.S. and the directions that the U.S. is going in. And a lot of them have to do with what I spoke of previously; that is to say, my vision is one that incorporates both individual responsibility and social responsibility. And I've been very troubled by the fact that the debate, if you will, in quotation marks, in the United States seems to be primarily between people who emphasize individual responsibility and people who emphasize social responsibility without any willingness to recognize the value or importance of the other's point of view. And so here we have a society which

for the most part, the people in them are mostly bothered, mostly willing to know all this, and we have a political system that fluctuates very much more widely from one extreme to the other. So we have a Congress that is dominated by extremists and we have a political system which, you know, supports that type of thing. Winning the primary is the main route to getting elected. You win the primary by appealing to the extreme groups in your party, and no seats are safe seats.

I'm very concerned about American society. I think the critique of the right of some of the extremes of the left is correct. I think the critique of the left of the extremes of the right is correct. But I don't see much hope for people trying to get some kind of balance or middle ground, which is where I think most of the American public is. So there's almost a disconnect.

Then there's another thing that troubles me, is the disconnect between politics and policy and the findings of research. I've seen this disconnect in the United States for a long time. We have now a bill, two bills for drugs for Medicare. I hardly know of any pharmas who thinks there's any merit in either of the plans that are coming forward now from an efficiency point of view, or an equity point of view, and yet this is what Congress came up with.

And then I went to England recently, where I felt maybe things were better, and they aren't. The disconnect there between the political initiatives in health care and the research is just as bad as it is here. And that's troubling too.

TB: Would you say that in Europe, there seems to be more of a continuing commitment and that social cohesion is the purpose of a health system -- and you say that in Germany for example [unclear] this country, yet more can be [unclear].

VF: That's right.

TB: This would indicate something about a broader vision.

VF: Well, every country has to be analyzed in its own terms and the country's own history. Germany has a history of Nazism, a history of division between the east and the west, so they have to evolve a system which deals with . . . And they have a history of aggression and warfare with Europe. So they support a unified Europe much to their own economic disadvantage – they support the European Union. They support the euro and things like that. But you have to understand that I think in terms of the history of that country. I mean, every country has to be understood, I think, in historical terms.

Actually, I think that people who would like to see the United States move toward a more socially oriented policy of national health insurance or universal coverage, something like that, over-read what's going on in other countries, because beneath the surface and beneath the lip service that the politicians may have, there's a lot of ferment against these things. In Canada, I think the [unclear], and one of these days Alberta or one of the other provinces isn't going to -- will break away from these things, even though the [unclear] report would say, "Oh no, we have to do more in this direction and we have to have the provinces subsidize one another."

England on the surface has an egalitarian system. You don't have to be there more than a week to see how there are all kinds of inequalities built into that system, but they're kept below the surface. And as long as they're kept below the surface, it pleases both sides. They can keep up the appearances of having a very egalitarian system, and the ones who really are not partaking in that sense are also having what they want, too. And I think that's happening in some of the other European countries as well.

TB: Getting back to the United States, do you still believe, as you've written on a number of occasions, that

we will not have confidence of health reform unless we have some major political upheaval?

VF: That's correct.

TB: That's a rather pessimistic view.

VF: It is pessimistic because those things are not desirable in themselves -- large-scale civil unrest. After all, technically speaking, we could have universal coverage next year. It's very simple. You just have to have compulsion and you have to have subsidization of those supporting groups paying their own way. Okay? All of these papers that are written, they only address that very simple thing. Is the public willing to accept compulsion, and are they willing to subsidize the ones who can't pay? I don't see any evidence that they are. Even the ones that might be willing to subsidize aren't willing to accept compulsion, and the ones who are willing to accept compulsion aren't willing to subsidize. And remember, every other system that has universal coverage has compulsion and subsidization

I mean, you know, the Clinton effort went down in flames. But there were 20 other bills, and there were other efforts by other people, and not a single one of them got reported out of committee.

Incidentally, that's an example of where you have a market with a message. In 1991, I wrote this piece on national health insurance revisited. I said my usual thing that I had been saying and others had been saying, and other people would say, "Oh, sure. The public supports national health insurance." I was right. But nobody really wanted to hear that message.

I don't know if you saw my piece that published in the *Journal of the American Medical Association*. I wrote the letter to President Clinton. I think that one was as on the mark as anything I've ever written -- very simple, very easy to understand. You could ask Phil Lee about that because Phil said he was going to try to show that to Hillary. This was at the very beginning of her effort. But there was no market for that message.

TB: You also wrote about the need to disengage health insurance from employment.

VF: Yes. I do. But, there's a lot of opposition to that, obviously, and there's a lot of vested interest in that system. And that's why it would take an upheaval of some kind to break up that system.

Basically, what has to happen is that I think most of the large employers in the country have to see the system

as not being in their interest anymore. That may be very [unclear] system.

TB: [unclear].

VF: Not that. But if costs continue to escalate at a rapid rate, it is possible. But, still, I do think that we need some kind of breakthrough in terms of, that things become so unsettled and in some sense so troubling that people are willing to throw off their previous ways of thinking about solutions and face it.

And it has happened in the past in this country and in other countries, certainly. It's too bad, though, that it would take something like a [unclear] or a large scale civil unrest. But I don't think we'll gain it fast.

TB: One last question that I hope will be open ended.

VF: Yes.

TB: In your essay *No Pain No Gain*, I was a little surprised, unless I missed it, to not discover what [unclear] from the insurance industry as one of those who had a great deal to lose in a national system.

VF: Well, first of all I'm not sure if that's true because even if we had universal coverage, and even if we had financing through some broad-based tax, like a value-added tax or something like that, my guess is that, in the

American context, that system would be administered by the same insurance companies as in today's plans.

TB: Really?

VF: Yes. So since already in the large insurance markets I would say that the bulk of their business comes from administrative services only, they're not in the insurance business because the employer is self-insured. So essentially they would be administrative services only. They would lose some of their underwriting business. But the underwriting business is a different business. The other is a much more dependable business, just being paid for business services. And they would be doing it for a larger population.

TB: They wouldn't have any fiduciary responsibility --- just be an administrative contract.

VF: That's right, that's right. So I'm not so sure it would work out badly for them.

But remember that at any given, any institution will typically fight hard to preserve what they have and what they know rather than to go into the unknown, even if the unknown may actually work out much better for them.

Jefferson put this very well; Machiavelli even before him put it very well. So it's very understandable that the seniors see, you know, I don't want to tamper with Medicare

because who knows if we're going to get [unclear]. The drug companies are not interested in these new things that the government is proposing to buy their drugs. Plus they see problems down the road. So I think that's why the insurance companies oppose it. That doesn't necessarily mean that they're going to be worse off.

TB: Any other reflections that you would like to approach?

VF: About what?

TB: Anything that you would like to say as a continuation of this conversation or as a coda.

VF: I'd say, working with the health field has been a very, very rewarding experience. It's disappointing to me that I couldn't learn more about it sooner so that I could follow my original plan of moving on to other fields as well. But the people in it are mostly, you know, good people to work with. The problems are extremely challenging. We're talking about something that's getting close to 14-15 percent of the total economy. Even beyond that, it involves so much in the way of human values and so forth that if one can make even a small contribution in this area, I think it's an extremely worthwhile thing for somebody like myself, who is trained in economics, who doesn't have the ability to create a great new medical

system that would change the whole economy or change the whole way people think about economics. I think it's been a wonderful field to work in.

My two main concerns within it have been, you know, what determines health, and what determines expenditures for medical care. I continue to be very interested in both of them.

I have really nothing but good to say about the field that's treated me very well, and I continue to find it very challenging.

TB: Thank you very much.

END OF INTERVIEW