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PROFITS, POVERTY, AND HEALTH CARE: AN EXAMINATION OF THE ETHICAL BASE OF ECONOMICS

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Introduction

Economics involves the allocation of scarce resources to competing ends. The main way by which resources are allocated in economies is through private markets. Markets perform their allocative function by highlighting where scarcity exists. Prices will be high when shortages exist. High prices indicate that profits can be earned by producing more of the scarce good. Profit, therefore, is the reward for removing the shortage. In this way, the market price system and the profit motive are inextricably linked.

Although profits perform this positive function, there is also an inherent problem with how the poor gain access to resources within a market system. High profits are reflections of a strong willingness to pay for a good or service by consumers. However, the poor have a low ability to pay, which constrains what they are willing to pay. In the end, it seems that profits respond only to the shortages of goods demanded by the rich.

The fact that the poor are not able to consume a particular good need not necessarily imply that there is a social problem with how markets function. Much depends on the type of good or service being denied. It need not be a social problem that the poor cannot buy Rolls Royces. There would be social concern, however, if something considered vital, like health care, is involved. Hence, it is important to examine, in the context of health care, the ethical base[1] of the profit motive. Then, one can try to understand the extent to which the profit motive can, with and without the help of the government's visible hand, be responsive to the needs of the poor.

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1. By ethics I mean the code of morality which is to decide what is right and wrong. This paper discusses ethics as related to profits, markets, consumers and physicians, in the context of the health sector and the economy as a whole.

I. The Ethics of Profits in the Context of Market Efficiency

Ethics can be thought to apply to both the means by which healthcare resources are allocated and to the end result of the allocation. This section lays out this dual analysis of ethics as it relates to profits and market efficiency. The next section looks at ethics with regard to market incomes and poverty.

A. The Ethical Base of Markets as a Process

From the perspective of viewing ethics as a process (a means to an end), markets would seem to be ethically neutral. Markets use profits to reward producers for supplying the output that is demanded. The output demanded can be "good" or "bad." The market functions equally well in either case. Profit can be earned from producing a drug that cures cancer just the same as it can be earned from tobacco that causes cancer. It is up to society, not market forces, to set the legal and social environment in which the market operates.

B. The Ethical Base of Markets as an End Result

In the introduction I mentioned the role of the profit motive as a reward system. From the viewpoint of ethics related to the outcome itself, we need to ask what exactly is being rewarded. The answer reveals the ultimate value judgment that underlies the market system, because everything is to be validated by the assumption that the individual is the best judge of his or her welfare. This individualistic ethic is called the assumption of "consumer sovereignty." Under this assumption, the fact that the individual would be willing to pay up to $x for something means that s/he is better off by $x if the good or service goes to that individual.

Having established the basis of willingness to pay, it is straightforward to explain the main virtue of markets. What the individual actually has to pay on a market (the market price that is the same for all individuals) is usually much less than the maximum amount that the individual is willing to pay. The excess of what a person is willing to pay over what they have to pay is called "consumer's surplus."[2] Economic theorists have devised theorems that can demonstrate that at market equilibrium, one is maximizing the to-

2. Alfred Marshall was one of the first to explain the theory of consumer's surplus. *See* ALFRED MARSHALL, PRINCIPLES OF ECONOMICS 103-14 (8th ed. 1920).

tal possible consumer surplus.[3] This is what is meant by the claim that competitive markets are "efficient." Departures from the market equilibrium caused, for example, by government price controls, would be inefficient because they would cause a reduction of the consumer surplus.

Gavin H. Mooney argues that for consumer sovereignty to be valid, three questions must be answered in the affirmative:

(i) Are individuals *able* to judge their own welfare?

(ii) Do individuals *accept* that they are the best judge of their own welfare?

(iii) Do individuals *want* to make the appropriate judgments?[4]

We will discuss each of these questions in turn.

1. Are Individuals Able to Judge Their Own Welfare?

The assumption that the individual is the best judge of his or her own welfare is clearly a bad one given all the social problems that occur daily, such as crime, life threatening sexual practices, unhealthy eating habits, and parental abuse. This assumption, however, still may be the best one given the alternatives. If the individual is not the best judge, then who is? Not many people in the United States and in the West generally are willing to accept that the government knows better. This does not mean that there will be no role for the government in the economy; only that the government must (a) act as "referee" for individuals as they decide their own interests in the marketplace and (b) correct any market imperfections that may exist.

While this limited role for the government can be accepted for most goods, is it valid for health care? Of course, to the extent that market imperfections are rife in health care, the government's role may not be so limited. What about the area of serious mental illness, where the assumption of consumer sovereignty can clearly be questioned? A person with hallucinations and delusions is not in a position to make rational economic choices. In addition, persons with serious mental health problems are less likely to be in paid employment and therefore more likely to be indigent. For example, average annual earnings for someone with schizophrenia were

3. This is the basis of the second efficiency theorem of Welfare Economics. *See, e.g.*, JEAN-JACQUES LAFFONT, FUNDAMENTALS OF PUBLIC ECONOMICS 2-4 (1988).

4. *See* GAVIN H. MOONEY, ECONOMICS, MEDICINE AND HEALTH CARE 60-61 (1986).

only $10,761[5] in a national survey of mental illness and only 43.4 percent were employed.[6]

In any one year, the number of people with schizophrenia and affective disorders (such as depression) may not be large. However, we need to add to that number those with alcohol and drug dependency. Moreover, lifetime prevalence rates are significant for serious mental illness. For example, one in every five or six Americans will suffer (severe) depression some time during their lifetime.[7] Effective treatments for depression do exist. Many people with depression, however, do not seek treatment by a trained mental health professional. Markets cannot function properly when consumers are not aware of (or deny) their demand for a good or service.

2. *Do Individuals Accept That They Are the Best Judge?*

Even if the individual is the best judge, s/he may not be in the best position to judge what should be decided. The more complete statement of the consumer sovereignty assumption is that *well-informed* individuals are the best judges of their own welfare. The problem in health care is not just that consumers are not well-informed. For example, outcomes are not always known and much uncertainty abounds for the consumer. Rather the issue is one of asymmetric information.[8] Doctors are trained to know more about health outcomes and alternative treatment options than consumers. In this context, as is also the case when individuals get involved with the legal system, individuals need an agent to help them further their interests. The agent that individuals usually rely on in the healthcare field is the physician. Consumers here accept that the doctor is the best judge of the individual's welfare.

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5. Epidemiological Catchment Area Study (1981-1983), *cited in* D.M. O'Neill & D.N. Bertollo, Work and Earnings Losses Due to Mental Illness: Some Broad Perspectives from Three National Surveys (1997) (unpublished paper presented at the Sixth National Conference on State Mental Health Agency Services Research, on file with the author).

6. O'Neill & Bertollo, *supra* note 5, at 18.

7. *See* Jeffrey H. Boyd & Myrna M. Weissman, *Epidemiology of Affective Disorders*, 38 ARCH. GEN. PSYCHIATRY 1039, 1041 (1981) (estimating lifetime prevalence rates for depression to be between 9-20 percent). *But see* Myrna M. Weissman & J.K. Myers, *Rates and Risks of Depressive Symptoms in a United States Urban Community*, 57 ACTA PSYCHIATRICA SCANDINAVICA 219 (1978) (estimating rates of 16-20 percent).

8. For the pioneering paper on the problem of asymmetric information, see George A. Akerlof, *The Market For "Lemons": Quality Uncertainty and the Market Mechanism*, 84 QUARTERLY J. ECON. 488 (1970).

The doctor-as-agent relationship with their patients fundamentally strikes at the heart of the market mechanism. The "invisible hand" property guaranteeing market efficiency, whereby consumers are separate entities from producers and each follows their own interests independently, interacting only through the price mechanism, is now absent. If the producer is to be the consumer too, how can one ensure that the doctor is going to be a reliable agent, and not demand unnecessary treatments just because they will increase physician profits? The issue of "supplier-induced demand" is a heavily researched area in health economics.[9] The jury is still out as to what extent this actually takes place.

Ethics, and not just efficiency, is at stake with the agency relationship. This time it is the ethics of the physician that is involved. The medical profession from the outset has recognized the physician's dilemma and its intended resolution was embodied in the physician's Hippocratic oath: a physician must "so far as possible, do no harm." The profession set out to pre-empt the situation by ensuring that professional standards be adhered to, whereby patient interests are given priority over the physician's personal interests. This is one characteristic, first identified by Kenneth J. Arrow,[10] that makes health care different from most other goods. The expected behavior of the producer is that self-interest is to be subordinate to professional standards of appropriate care. By contrast, one does not expect that a used car salesman will give an accurate description of the product offered.

Markets are also threatened in a second way by information asymmetries in health care; this time when the consumer knows more than the producer. The existence of uncertainty is not in itself a cause of market failure. The desire to reduce uncertainty simply sets up a demand for insurance. If there is a one in 1,000 chance of someone contracting AIDS and a year of AIDS treatment costs $500,000, then an actuarially fair insurance policy (one that ignored administrative costs of writing the policy and sufficiently covered the expected claims) would set a premium of $500 per year. The individual may in fact know they have AIDS, however, while the insurance company only knows the national

9. The origins of supplier-induced demand can be found in Max Shain & Milton I. Roemer, *Hospital Costs Relate to the Supply of Beds*, 92 MOD. HOSP. 71 (1959), *cited in* SHERMAN FOLLAND ET AL., THE ECONOMICS OF HEALTH & HEALTH CARE 205-206 (1993).

10. Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 949-51 (1963).

probabilities. The end result is likely to be that only those with AIDS are willing to pay the premium. For every insured person, the premium is $500, the claim is $500,000, and the insurance company goes bankrupt. This so-called "adverse selection" would mean that private markets would be unable to satisfy the desire for insurance and some form of market intervention would be required.[11]

One interesting implication of the asymmetric information problem involves an explanation for why private non-profit organizations are so prevalent in the healthcare field.[12] Take the case of nursing homes. A person with a single elderly parent is considering what nursing home to choose for the parent. Often there is no point in asking the patient what home to go to because s/he would say that none of the homes offered were suitable (in order to avoid going to a home). Clearly, this violates consumer sovereignty. The focus here, however, is not on the validity of the consumer sovereignty principle, but the consequence of its non-adherence. This non-adherence would cause an information problem to the family member making the nursing home decision. The son or daughter will probably never really know what it is like for the parent to be in a particular nursing residence because s/he will not be living there. The suspicion will be that a home seeking to maximize profits may try to take advantage of the fact that the payer has limited information and provide low-quality, low-cost care at high prices. A non-profit home, on the other hand, may be thought to have less of an incentive to cut corners, and therefore be more trustworthy.

3. Do Individuals Want to Make the Appropriate Judgments?

Assume that the individual has the mental facility to make market decisions and that s/he is fully informed. Could it still be rational for the individual to surrender decision-making authority to someone else? In the healthcare field, there are reasons to believe this proposition. Many decisions are of a life or death nature. For such decisions, just going through the calculus of comparing benefits with costs can cause much stress and unpleasantness for the individual. For example, the decision whether to pull the plug on a life support system for a brain-dead loved one is not one that eve-

11. The problem of adverse selection follows directly from the asymmetric information problem identified by Akerlof. *See* Akerlof, *supra* note 8, at 490-94.

12. The theory distinguishing for-profits from non-profits on this basis was developed by David Easley and Maureen O'Hara. *See* David Easley & Maureen O'Hara, *The Economic Role of the Nonprofit Firm*, 14 BELL J. ECON. 531 (1983).

ryone wants to make. It may be far easier to ask the doctor instead: "What would you do in my position?" or even say: "Do whatever you think is best."

To summarize, when individuals are not able, willing, or knowledgeable enough to be the best judge of their own welfare, which is often the case in the healthcare field, either physicians or the government must step in and intervene in the market mechanism.

II. The Ethics of Profits and its Relation to Poverty

Although economists usually characterize the market mechanism as working through the profit motive, it is in fact more accurate to talk about the market mechanism as a wage determining system because employee compensation is around 73 percent of national income in the United States.[13] The ethical base, however, is virtually the same as with profits. One can again argue that high wages are the reward for producing goods that consumers want. To make the point a different way, economists say that the demand for labor is derived from the demand by consumers for the goods that labor is being used to produce. The only difference between the two types of rewards is that profits involve some risk-taking, whereby the firm needs to anticipate what consumers want.

A. The Ethical Base of Market Income as a Process

Economists, especially those from the "Chicago School," consider the market process as being far more ethically neutral than government intervention in the income generating process.[14] If the weather is bad one year, this would cause farm incomes to fall. This misfortune cannot be blamed on anyone. If farm incomes are low because the government banned agriculture exports, however, this would not have been an unavoidable loss and, in this sense, would be considered an unfair process. That is to say, incomes determined either randomly or in response to consumer preferences are much more acceptable than incomes that are set arbitrarily by government decree.

What is assumed up to this point is that markets are competitive. In such markets, firms can expect to receive in the long run a return that is just sufficient to keep them in business. However, when markets have, for example, a single seller (a monopoly),

13. U.S. DEPT. OF COMMERCE, ECONOMICS AND STATISTICS ADMIN., STATISTICAL ABSTRACT OF THE UNITED STATES 449 (Table No. 693) (Oct. 1996).

14. *See* MILTON FRIEDMAN, CAPITALISM AND FREEDOM 22-36 (1962).

which is often assumed to be the case with physicians' activities, the seller can earn excess returns that do not disappear over time. Monopolies, therefore, are inequitable as well as inefficient because they keep output below optimal levels in order to raise prices and obtain excess profits.

B. The Ethical Base of Markets Income as an End Result

Low income may be a penalty for not satisfying consumers, but may also result from completely unrelated reasons (e.g., economists usually stress the existence of monopoly, bad luck, lack of inheritance, and discrimination). On top of this, there is the simple fact of life that some are sick and disabled and thus unable to seek paid employment.

The problem of low incomes would seem to be another manifestation of uncertainty, with insurance again being the remedy. However, as we saw above with the adverse selection problem that prevents private health insurance from operating, private markets cannot provide income insurance when would-be insurers have some control over whether their incomes are low or not (by not working or getting fired). If markets cannot provide income insurance, then the government must get involved (by using the tax-transfer system). What then would be the ethical base for this intervention?

The justification for the government's redistribution of incomes would, at heart, be exactly the same as was used to justify market outcomes as related to goods and services (i.e., consumer sovereignty). Individuals have preferences about the incomes and consumption of others (i.e., the poor) just as they care about their own income and consumption. If the individual is the best judge of his/her welfare, then this distribution preference should be recognized.

1. Consumer Response to Poverty in the Context of Health Care

Consumer preferences about the poor have policy relevance through voluntary contributions. However, for these contributions to take place on a significant scale, a collective and non-market way of doing this must be undertaken. Private charities can operate, but they usually will not be efficient.

Assume that an individual taxpayer values one dollar's worth of income that he/she receives to be worth $1. If that person values $1 given to a poor person as worth, perhaps, $1.50, then the individual would be happy to contribute to a private charity. For every dollar transferred, the rich person gets $1.50 worth of "psychic"

satisfaction, gives up $1 worth of personal income, and has a net gain of $.50. Transferring income privately would make the rich person better off.

When the psychic satisfaction is as strong as just considered, then government intervention would be unnecessary. More realistically, let us assume that the rich get only $.01 worth of satisfaction for every dollar received by the poor (and continue to assume that they value a dollar to themselves as worth $1). Now, transferring a dollar privately would not be worthwhile, as there would be a net loss of $.99 for every $1 transferred. What the private solution ignores is that every rich person gets the psychic satisfaction of $1 transferred to the poor, even if some other rich person does the donating. Economists would call the dollar transferred a "pure public good," one that is equally consumed by all. This means that everyone consumes each unit of the good simultaneously (e.g., an early warning missile detector for one U.S. citizen is also a missile detector for everyone else living in the U.S.), which is unlike a private good, such as bread (where if I consume a loaf of bread, and you consume a loaf, we must have two loaves to satisfy both our demands). Thus, if there are 101 rich persons, and each values the dollar transferred to the poor at $.01, then aggregate benefits would be $1.01, the cost would be $1, and the transfer would potentially be worthwhile because the net gain would be $.01.

Although transfers would be worthwhile, they would not take place without government involvement. Each rich person has a rational incentive to under-reveal his or her preferences and try to get a "free ride" (get the benefit and leave others to do the paying/transferring). The solution is that each rich person would vote for every rich person to be taxed $1, including him/herself, and in the process, each would be better off. The taxes would be voluntarily imposed and would not require government coercion.

Note that this argument for public provision would be true for other goods also, such as national defense or the preservation of endangered species, where the equal consumption property existed. In all cases, the desire to get a free ride means that markets fail completely. When people do not pay the price, profits cannot be earned, and no output will be forthcoming. Within the health-care field it would particularly apply to public health (e.g., to justify public inoculation programs). What does not follow from this argument for public provision, however, is public production. Privately owned laboratories can develop and produce serums on par

with publicly owned laboratories as long as they receive the tax revenues from the government as payment for the services.

This argument explains why income redistribution would be desirable and can account for programs such as Aid to Families with Dependent Children ("AFDC").[15] It also can be adapted slightly to explain why the poor in the United States today get most of their assistance in-kind.[16] For example, the government provides Medicaid and does not give cash assistance to pay for the health care of the poor. Assume that the rich care how the poor get assistance. One dollar's worth of assistance to the poor could be spent on something that does not give the rich any psychic satisfaction, such as alcohol or illegal drugs. If the rich want the poor to get food, education, and health care, then cash transfers would be inefficient (the rich as a group would be better off if the poor are assisted in-kind).

To see some empirical support for the claim that government intervention is necessary for income redistribution, refer to a recent study of the sources of income for homeless people by Cheryl Zlotnick and Marjorie J. Robertson.[17] The median income was $376 from any source for a sample of 564 homeless people in California,[18] only 266 of whom had neither a major mental nor a substance disorder.[19] The main sources of income were from work, entitlement programs, and other sources.[20] There were three private voluntary sources: panhandling, gifts from relatives, and gifts from friends.[21] Most homeless people did not get income from these sources, and when they did, the amounts received were small.[22] Thus, 104 received a median income of $30 as gifts from relatives; 94 received a median of $20 as gifts from friends; and 82 received a median of $10 from panhandling.[23] On the other hand,

15. *See* Larry L. Orr, *Income Transfers as a Public Good: An Application to AFDC*, 66 AM. ECON. REV. 359, 369-70 (1976).

16. For the redistribution in-kind argument see H.M. Hochman & J.D. Rodgers, *Is Efficiency a Criterion for Judging Redistribution?*, 26 PUB. FIN. 76 (1971).

17. *See* Cheryl Zlotnick & Marjorie J. Robertson, *Sources of Income Among Homeless Adults With Major Mental Disorders or Substance Use Disorders*, 47 PSYCHIATRIC SERVICES 147 (1996).

18. *Id.* at 149, 151.

19. *Id.* at 148-50 (Tables 1-3).

20. *Id.* at 149 (Table 2).

21. *Id.*

22. *Id.* at 150.

23. *Id.*

entitlement programs provided the most monthly income ($340) and was the second most common source (for 243 individuals).[24]

The Zlotnick and Robertson study also highlights the fact that, in order to get government assistance, someone had to act as an agent for those with severe mental illness or substance abuse. Those with either (or both) of these disorders were four to nine times more likely to report entitlement income if they had received case management services in the previous month.[25]

2. *Producer Response to Poverty in the Context of Health Care*

Traditionally, markets in health care have had their own way of resolving the conflict between profits and the needs of the poor. The markets have deviated from the "law of one price." Instead, price discrimination was rife, whereby different consumers were charged different prices for the same good. In order to satisfy the physician's Hippocratic oath, which requires that all sick people be treated, the rich were charged prices well above costs in order to provide a margin which could subsidize free care for the poor.

However, with the advent of attempts to increase efficiency in health care, fee schedules were set by the government which eliminated the margin that made cross-subsidization possible. In the early 1980's, Medicare introduced a payment system for hospitals that assigned a standard rate for a specific procedure or service. All services were set out as categories ("Diagnostic Related Groups," or "DRG's") and a rate for each category was listed based on what that service cost on average in the past. Thus, if a hernia typically involved two days hospitalization and a battery of associated tests and services totaling $1000, then this would be the sum that Medicare would compensate the hospital for any new patient with a hernia condition. The motivation was to reduce any test or length of hospital stay thought to be unnecessary; any service provision above the norm for the area would be borne at the hospital's expense. The unintended effect was that the cross-subsidization which occurred earlier would no longer be possible.

Government policy has also been strongly behind the development of health maintenance organizations ("HMO's"). These organizations use a capitation system for charging patients, whereby a fixed fee per person is set and all care is to be covered for that one payment. Just like the DRG at the hospital level, the capita-

24. *Id.*
25. *Id.* at 151.

tion fee for physician services replaced the previous fee-for-service system and fixed a limit to healthcare costs. The increase in efficiency again limited the physician's ability to cross-subsidize the poor by charging higher fees for the rich.

Separate from government initiatives, market forces have also been working in the same direction. Increased competition, as measured by the number of firms in an industry, is thought by economists to lower prices and profits and thus increase efficiency. Increased competition, therefore, can be expected to reduce the possibility of subsidizing the poor's services. With so many public and non-profit firms in health care, it is interesting that this expectation of lower cross-subsidization with greater competition was found also in the healthcare field, as we now see.

In many areas, the only source of outpatient care for the poor and the uninsured suffering from serious mental illness are the Community Mental Health Centers ("CMHC's"), which had grown to about 2,200 in the United States by 1989.[26] Robin E. Clark, Robert A. Dorwart, and Mark Schlesinger looked at a sample of 430 such multi-service agencies in 1992 (68 percent were nonprofits, 28 percent were publicly owned, and 4 percent were for-profits).[27] The output of concern (one of three dependent variables) was the number of below-cost visits. The competition measure was the number of community facilities per 100,000 of the population (a service area was a county where 10 percent or more of an agency's patients lived).[28] The main result was that, the greater the number of community facilities, the lower the number of below-cost visits.[29]

What is particularly revealing about this study was the set of variables that were not statistically significant. It did not matter whether the agency was publicly owned or not.[30] More importantly, the number of non-community facilities had no effect on the number of below-cost visits.[31] Thus, the number of HMO's per 100,000 and the number of psychiatrists per 100,000 were not competitors for the community facilities serving the really needy.

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26. *See* Robin E. Clark et al., Competition, Market Structure and Community Mental Health Agencies 1 (1992) (unpublished paper presented to the National Council of Community Mental Health Centers, on file with the author).

27. *Id.* at 9.

28. *Id.* at 10.

29. *Id.* at 13.

30. *Id.* at 16.

31. *Id.*

On the other hand, for indicators of need, the study used *per capita* income and the percentage of the population living in urban areas[32] (epidemiological studies find that urban areas have higher incidences of mental illness). For both variables, the higher the indicator of need, the greater the number of visits at prices below costs (both variables were statistically significant).[33]

Conclusion

It is not profits *per se* that are the defining value judgment behind how markets operate. Rather, the key assumption is that the individual is the best judge of his/her welfare. We have presented many reasons for doubting the validity of consumer sovereignty in health care. Consumer sovereignty, however, is not an all or nothing imperative. First, one can accept consumer sovereignty in some areas and not others. This is what is implied by saying that a legal framework must be set for markets. Individuals are then free to eat themselves sick, but they are not allowed to buy child pornography. Second, one can accept consumer sovereignty for some people and not for others. This is a most difficult issue which would seem to have fundamentally undemocratic undertones, but it is an inescapable fact for some people, especially the seriously mentally ill.

One dimension that really blurs the consumer sovereignty issue is the impact of age. At the upward limit, the elderly are more likely to have Alzheimer's disease than the young, so serious mental illness may be present. However, there are also physical disabilities that are not always acknowledged by the individuals themselves, but nonetheless require care. At the lower limit, we have the young who are forced to go to school. We do *not* ask a seven year old if they want to go to school today and rather play instead. Again the legal system gets involved and sets the rules. It says that at eighteen you can make your own decisions, but not beforehand. The unanswered question is what occurs during the eleventh hour of the 364th day of being seventeen that solves the consumer sovereignty issue.

The need for efficiency in health care is incontrovertible. As Gavin H. Mooney writes:

> It is not a question of Ethics or Economics. Without a wider use of economics in health care inefficiencies will abound and deci-

32. *Id.* at 11.
33. *Id.* at 12-13.

> sions will be made less explicitly and hence less rationally than is desirable: we go on spending large sums to save lives in one way when similar lives in greater numbers could be saved in another way. The price of inefficiency, inexplicitness and irrationality in health care is paid in death and sickness.[34]

But, the problem is that markets are not always efficient in health care. We have seen that the asymmetry of information between buyers and sellers causes market failure. Government intervention is sometimes necessary to provide the finances for the markets to exist in the first place. This is especially so for pure public goods where private markets fail completely. Remember also that it is only competitive markets that are efficient. When competition is absent or diverted, markets need not be efficient.

Aside from issues of efficiency, we have the inherent problem that markets do not automatically respond to the poor. They respond to willingness to pay, as constrained by an individual's ability to pay. One could argue that, in order for markets to accurately reflect individual preferences, incomes should not be so unequal that ability to pay completely swamps willingness to pay. Income redistribution is almost a prerequisite for effectively functioning markets.

If redistribution is required, who is to do the redistributing? Again we are left with the conclusion that it cannot be left to voluntary (private charity) processes. Markets cannot always redistribute income efficiently. Voluntarily imposed taxes by the rich are often needed as part of a collective redistribution agreement.

While redistribution has traditionally taken place within the healthcare system by virtue of the physician's desire to treat everyone who is sick, competition has discouraged this behavior. The reduction in the ability of providers to cross-subsidize health services for the poor due to recent policy changes means that universal health insurance coverage is now more necessary. This point is worth stating in a different way.

Previously, healthcare markets did accommodate the poor. With increased competition from DRG's, HMO's, and even community agencies, the ability to accommodate the poor has been reduced. In particular, in mental health, there exists a "Two-Class System" of care.[35] A 1994 study of inpatient admissions at hospitals in

34. MOONEY, *supra* note 4, at 90.

35. *See* Ethan B. Minkin et al., *An Analysis of the Two-Class System of Care in Public and Private Psychiatric Hospitals*, 45 HOSP. & COMMUNITY PSYCHIATRY 975 (1994).

Maryland found that minorities, men, the uninsured, the unemployed, and those with the severest cases of mental illness (schizophrenia) were much more likely to be admitted by the public hospitals.[36] Any healthcare reform must ask the question whether "public and private hospital systems are prepared to treat new and different populations" than they are currently.[37]

Since there is this tension between efficiency and providing for the poor in health care, we must first recognize this conflict and then try to get policy makers to articulate the "trade-off" between these two social objectives. That is, policy choices that involve the benefit of increased access at the cost of reduced efficiency can only be determined if one knows what the relative weights are for the two objectives.[38]

36. *Id.* at 976.

37. *Id.* at 975.

38. The trade-offs are given practical expression by attaching different distribution weights to the effects accruing to different income groups. For a survey of schools on distribution weights see Robert J. Brent, *Use of Distributional Weights in Cost-Benefit Analysis: A Survey of Schools*, 12 PUB. FIN. QUARTERLY 213 (1984).