

**Consumer Interest and Health Reform:
The Logic of Withdrawal from Managed
Competition Physicians for a National Health Program¹**

We propose six tasks Colston Warne would urge in addressing health care reform: 1) skepticism about advertised claims, 2) independent testing and appraisal, 3) minimizing barriers to consumer access and choice, 4) maximizing quality, 5) evaluation of fairness and, 6) assess consumer empowerment potential. Such an exercise would likely have led him, and should lead us to advocate single payer health reform. Consumers are the key to breaking through the gridlock blocking health reform, and single payer is the key for unlocking the democratic dialogue needed for moving forward. Thus we need to stop "fighting over the bill," and instead begin building a better health system.

Gordon D. Schiff, M.D., Cook County Medical Center²

Today we will talk about truth in mending-- mending broken bones, broken budgets, and broken bargains. Mending our ailing health system is, according to a Harris poll, the number one issue on consumers' minds.

At Cook County Hospital, I have encountered mothers who will not let their kids go out and play, lest they break a bone for which they had no health insurance coverage. I took a cab to the airport in Chicago yesterday and when I told the cab driver I needed to stop at Cook County Hospital he said, "I hate Cook County Hospital. You go to the Emergency Room early in the morning and don't get out till late at night." While coming as no surprise (I began working at Cook County in the Emergency Room as a volunteer twenty five years ago) such comments nonetheless always strike a painful chord, a reminder of shortcomings that are hard not to take personally. The cab driver told me he now goes to a private hospital and uses a false name to avoid being billed. I've met mothers who have to go to court to get legal custody of their own children; they delivered their babies under a false name using a neighbor's Medicaid card.

In my clinic, the General Medicine Clinic, there are over 10,000 people on the waiting list, all sick people with medical problems referred from our emergency room (and contributing to the delays there). We hear stories about supposed

waiting lists in Canada for high tech procedures. In the U.S., we ration primary care.

Mending broken bones, helping to heal diseased bodies, what I was trained as a physician to do, in theory the simplest and most straightforward of tasks, thus has turned out to be a much more complex and challenging job than I was prepared for in medical school. What a physician quickly learns, once he or she tries to apply medical skills to effectively impact on patients' and populations' health, is that the interrelationships between medicine and the social science disciplines represented in this room today ultimately have more influence on our citizens' health than 99% of what was learned in medical school. This realization has led me down a variety of paths that you as consumer advocates and academics have cleared for us to meet and travel together. And for that reason, it is with a great deal of honor and trepidation that I will speak today on subjects highly relevant to my day to day work, but ones for which my expertise is inferior to that of many in this room.

Broken budgets refers to the crushing burden of health care costs on governments, especially the states (their leading and fastest growing costs), corporations (whose expenses for health costs in 1965 equaled only 14% of their profits, whereas 1990 health expenses exceeded total

profits)(Himmelstein & Woolhandler, 1994, p. 41), and most importantly consumers for whom health bills are an important cause of personal bankruptcy, poor credit ratings, and financial hardship. The average household now spends 10% of its household income on out-of-pocket health expenses, up from 6.6% in 1965. For seniors this number approaches 20%, rising to the same level as before Medicare was enacted (Himmelstein & Woolhandler, 1994, p. 35).

The broken bargains I will be addressing are the failed promises of our political leaders to bring about meaningful and effective national health reform--to accurately weigh and portray the alternatives and give leadership towards optimal solutions. This broken promise I fear is again being repeated in Washington, unless we can educate and activate consumers, and thereby break apart the political gridlock that appears will block real reform this year.

Mending Our Ailing Health System

How should we mend our ailing health system. The simplest approach for a consumer might be to turn to *Consumers' Reports* for the answer. And it's right here in last month's issue (Karpatkin, 1994). I hope they won't sue me for citing what Rhonda Karpatkin CU President rates/advocates as our best buy--"the single payer plan cosponsored by 98 members of Congress." The reason I fear not being sued is the same reason we're unlikely to have single payer reform this year. Single payer is not a product consumers can go out and buy. Single payer is not even a particular piece of legislation to be voted up or down, although that's clearly one important aspect of its implementation. Rather, as I will argue in this talk, it is an expression of a commitment--to efficiency, to fairness, to quality and to consumer empowerment. It entails a deepening of our understanding of the problems, so that we many help educate consumers and thereby permit them to better evaluate and implement health reform as a means to these ends.

How would Colston Warne have

approached this question? Based on my reading of his writings, especially a newly published collection of his lectures on the history of the Consumer movement, I believe he would urge a six part mission in evaluating health reform.

Table 1 What Would Warne Want

Six Steps Colston Warne Might Urge of Consumer Advocates

1. Skepticism About Advertised Claims
2. Need for Testing and Credible, Independent Appraisal
3. Minimizing Barriers to Consumer Access, Understanding and Choice
4. Maximizing Product Quality
5. Evaluation of Whether It Is Fair
6. Assess Potential for Consumer Empowerment/Make Politically Feasible

Skepticism About Advertised Claims

We are in the midst of the largest advertising and lobbying campaign in the history of the U.S. While Colston Warne felt that advertising rarely served a useful social purpose, he was particularly scornful of ads that blatantly misrepresented corporate interests and activities. As noted by Richard Morse (in his postscript to Colston Warne's book) (Warne, 1993), the very companies that fought successfully, at the cost of many lives, against air bags now are taking out full page ads lauding their dual air bags. Likewise we are witnessing full page ads from insurance companies warning consumers of restriction of their choices if health reform is enacted. Restrictions on patient's choices, to choose a physician or follow through with physician treatment recommendations have been the mainstay of mechanisms private insurers have used to control costs.

Especially confusing and pernicious is the fact that there is not one but two insurance industry contingents. One contingent is the 270 smaller and middle sized insurers, represented by the Health

Insurance Association of America (HIAA). These insurers, the source of the Harry and Louise ads, have in turn been the target of Bill and Hilary Clinton's counterattacks. Their \$6.5 million HIAA advertising campaign disguised as a message from concerned farmers, consumers seniors, businesses, and the so called Coalition for Health Insurance Choices, has lured 228,000 consumers to a toll free number, of whom 18,000 have filled out response cards asking to become supporters of the coalition ("Health Care Hucksters," 1994). However, this is really a side show, deflecting understanding from the role of the larger private insurers. Meeting over in Jackson Hole, Wyoming over the past several years, pitching in up to \$100,000 apiece to sit at the table, with no consumer input, this contingent representing the larger insurers, drafted the managed competition plan which is the basis for the Clinton health plan (Priest, 1993). It is a plan that gives private insurers a central, and ultimately controlling role, rather than moving them to the sidelines as a single payer system seeks. The managed competition plan channels \$300 billion addition dollars to the private insurers' revenue streams.

The Clinton administration and private insurers make a number of claims that must be seriously examined. The first is that the current employment based private insurance system is working well for most people, and thus we should (in the President's words) "build on what works today in the private sector to expand employer based coverage." It is well known that 37.4 million people are uninsured, a jump of nearly 2 million from 1991 to 1992. However this is just a snapshot at one point in time. This number rises to 63.3 million if we look over a 28 month period studied by the Census Bureau. Furthermore, 50 million Americans are underinsured with such inadequate coverage that a major illness would lead to financial ruin (Himmelstein & Woolhandler, 1994, pp. 25, 33).

A profound recent statistic, exposes not just cracks but gaping holes in this employer based private insurance foundation. In 1991 only 52% of American workers were employed

in jobs that provided private health insurance (Inglehart, 1994). Because one in seven of these employer-provided insured workers works in public sector jobs (AFL-CIO Public Affairs Office, 1994), their "private" health insurance is actually being provided at public expense. Thus the notion of a publicly-funded single payer alternative, as opposed to trying to patch up a private employer-based system, appears to be much less radical a suggestion. Also, this statistic helps us understand why resistance to "employer mandate" is so sizable.

A second claim of managed competition advocates is the ability of competition between managed care plans to hold down costs. If we compare the rate of premium increase from 1982 to 1991 for traditional indemnity plans vs. HMO's, we can see no evidence to support this claim (in fact the cumulative increase HMO's premiums was slightly higher) (Himmelstein & Woolhandler, 1994, p. 216). Contrary to the Clinton administration's attempt to put a rosier spin on potential savings from competing managed care plans, is managed competition's architect, economist Alain Enthoven (whose theories were originally developed for and failed in the military) (Waitzkin, 1994). Enthoven's (1993) recent article "Why Managed Care has Failed to Contain Health Costs" urges stricter free market measures to address this failure.

The Boston University School of Public Health Access and Affordability Monitoring Project plotted the relationship between the proportion of a state's residents in HMOs and the per capita health cost rise during the 1980's. Rather than demonstrating that HMO's hold down costs, there was the opposite correlation. States with the highest HMO penetration had the highest cost rise (Himmelstein & Woolhandler, 1994, p. 217). Such findings are consistent with other findings that competition raises rather than lowers hospital costs, (in addition to increasing aggregate costs for the community) as hospitals engage in "medical arms races" duplicating expensive services as they try to compete with each other to market

their services (Himmelstein & Woolhandler, 1994, p. 126).

A third set of claims centers around alleged failures of alternate systems such as the Canadian system. There are many bona fide problems that the Canadians are grappling with, such as how to decrease persisting social class health disparities, over reliance on fee-for-service providers reimbursement, how to maintain a life-saving tobacco tax in the face of tobacco industry abetted smuggling and a black market, and the economic impacts of a serious economic recession. But, by almost every measure the Canadian system is superior at achieving high quality care for all of its citizens at a cost 40% (and recent data suggests perhaps 50%) per capita less than the U.S.

Canadian consumer satisfaction with their health is the highest among the ten nations surveyed by Harvard's Robert Blendon with Harris polling; the U.S. was the lowest (Himmelstein & Woolhandler, 1994, p. 117). Contrary to perennial rumors that the system is in crisis and that consumer satisfaction is plummeting, a recent Gallup poll showed Canadians' satisfaction with their care increased from 71% in 1991 to 89% in 1993. Tales of dissatisfied doctors are likewise contradicted by a 1992 survey of more than 3,000 Canadian physicians. Eighty-three percent rate the Canadian health care system as good or excellent, and 85% preferred their system to the U.S. system. A study of 147 physicians (75 Canadian, 72 US) who had worked in both systems (an average of 10 years practicing in each country), showed physicians currently practicing in Canada were three times more enthusiastic about their system as physicians working in the U.S. were about ours (Hayes, Hayes, & Dykstra, 1993).

Finally real outcome data refute erroneous claims about delays in care and unavailability of care and high tech procedures. Patients from both U.S. and Canada enrolled in a joint breast cancer registry were compared. U.S. patients experienced longer delays from symptoms to diagnosis, and from diagnosis to surgery (Himmelstein & Woolhandler, 1994, p. 100). Paul Tsongas when

running for President in 1990 dismissed a Canadian-style single payer option saying that his lifesaving bone marrow transplant would be unavailable in Canada. Ironically such transplants were pioneered in Toronto and as this slide shows, the citizens of Canada have comparable equal or better access to transplantation technology (Himmelstein & Woolhandler, 1994, p. 99).

Need For Testing and Credible, Independent Appraisal

While there's obviously no way you can haul managed competition, or single payer for that matter, into an independent test lab, Warne might be distressed to learn that the managed competition approach is completely untested. As opposed to the demonstrated workable single payer financing for insuring universal coverage along with cost control, we must rely on the best guess judgments and calculations of independent expert sources.

Although, unknown to consumers probably even to the consumer minded academics in this room (and contrary to the message that the AMA has tried to project), both of the two most respected medical journals, the *Lancet* and the *New England Journal of Medicine* have editorially endorsed single payer reform. In February after months of study, the leadership of the American College of Surgeons, courageously risked the ire of their conservative members, concluded that the single payer approach was the best way to preserve patient choice and physician professionalism. And this week's issue of *Business Week* offers an amazingly favorable review of the single payer approach (Symonds, 1994).

Even more impressive are the consistent conclusions from nonpartisan governmental studies. Six recent studies, 2 apiece from GAO (General Accounting Office), CBO, (Congressional Budget Office) and the OTA (Office of Technology Assessment) have been released related to the managed competition vs. single payer approach. As shown in Table 2 the message from these reports is that managed competition is uncertain to hold down overall costs, inferior in

coverage afforded, and is unable to approach the administrative savings achievable under a single payer system.

Minimizing Barriers To Consumer Access, Understanding, and Choice

I would like to tell you about 3 patient problems I've recently encountered.

Patient #1:

An elderly woman, whom I was evaluating for medical risks before a scheduled surgical operation, appeared visibly upset. When I asked her why, she told me that "the doctors at that private hospital used up all of my Medicare, so I won't be able to have the operation." I tried to reassure her that this could not be the case, Medicare insurance did not work like that. She then took out a letter she had received from Medicare which stated that "You have used up all of your Medicare deductible for 1993." She had obviously misunderstood the meaning of the term "deductible." So, I turned to the 4 medical residents working with me to share the example with them. All of them, although more highly educated than our poor patient, understood the letter exactly as she had; each interpreted the letter as meaning she had used up her insurance benefits.

Patient #2:

A middle aged woman whom I had been following for ten years developed worrisome chestpain. Although she was reluctant, I convinced her to be admitted to the hospital. As a result: A) she refuses to return to my clinic, stating "they are going to put a lien on my house," (which turns out is not true, but was her interpretation of the requirement to disclose this asset), and B) a supervisor from the Illinois Department of Public Aid is manually searching records in the County Assessors Office to look up the value of her home, because the Medicaid application form requires verification of this data. The amazing thing is that such assets are not even used in calculations for eligibility related to acute hospitalization (only income counts).

When I asked why spend taxpayer dollars needlessly looking up property records, the Medicaid supervisor could only reply that "this was required."

Patient #3:

A 71 year old woman came to our General Medicine Clinic also with a letter from Medicare. It stated she was not eligible for Medicare. Again I reassured this patient that this was not possible, all citizens over the age of 65 could be eligible for the Medicare program. It turns out that I was wrong. The patient, due to not unusual although somewhat complicated circumstances related to nonmarriage and being on disability, did not have enough "units" from Social Security to qualify for Medicare Part B. I confess that I still don't completely understand this, but our clinic social worker insists that there's little that can be done to remedy her situation, that Medicare was not in error to exclude her.

What do these three examples have in common. Superficially one might view them as illustrating the complexities, inefficiencies, even absurdities of public bureaucracies, providing yet another argument for privately administered health insurance. That would be a mistake. What they illustrate for me are problems inherent in cost barriers, means testing, and multiple separate programs for different types of patients. All of these mechanisms are features of both the current system and the proposed reforms (with the exception of the single payer proposal).

The Clinton, Cooper, and Republican plans all rely primarily on two mechanism to hold down costs-- competition, particularly between competing managed care plans, and so called patient "cost sharing." Cost sharing means additional patient fees for insured patients such as copayments, coinsurance, and deductibles. Unlike managed competition, there is good evidence that cost sharing requirements can decrease costs, by reducing the rate of medical encounters by as much as 40%.

Critics note however that such "taxes on the sick" have been shown

Table 2
Summary of Government Studies

Source	Date	Title	Conclusions
GAO	6/91	Canadian Health Insurance: Lessons for the U.S.	Provides universal access w/ no cost sharing More efficient at cost containment than U.S. Spend 1/5 on insurance billing Good Access to Primary Care No Waits for Lifethreatening Needs, rarely for others Cost savings permit covering those now uninsured
CBO	5/93	Managed Competition: Its Potential to Reduce Spending	Uncertain if claimed spending reductions would occur Depends on various uncertain assumptions Contingent on various practice changes
OTA	6/93	An Inconsistent Picture: Economic Impacts of Competing Reform Approaches	Single Payer could decrease costs \$241 billion/yr Managed Compt could decrease costs \$22billion/yr Wide range of estimates; worst case: Increases of \$21 billion-Single payer; \$47 billion-Managed Compt
GAO	10/93	Managed Care: Effect on Employers' Costs Difficult to Measure	Little empirical evidence of savings from Managed Care since tends to attract healthier patients Actual Premiums Range 2% less to 7% more
CBO	12/93 2/94	HR1200/S 491 Administration's Bill CBO	Administrative savings Single Payer \$100 billion Administrative savings Clinton Plan \$7 billion Total Potential Savings \$225 billion -Single Payer Total Potential Savings - \$150 billion - Clinton Plan Clinton Plan underfinanced: adds \$74 billion to deficit

to have little affect on expenditure decisions once a person enters the system, where physician decision making drives the major costs in health care. This, along with the substantial administrative costs associated with collecting these illness tolls, led the OTA panel, on which I participated, to conclude in its report released last month, that there is no evidence that cost sharing will decrease overall medical costs (U.S. Congress, OTA, 1993).

Such financial barriers to access, absent technically complex adjustments for income, disproportionately affect poor people. There is evidence from the Rand Health Insurance Experiment, a

randomized controlled trial which compared different types of insurance coverage, that low income chronically ill patients experience poorer health outcomes when randomized to a copay or HMO rather than free plan (Himmelstein & Woolhandler, 1994, p. 227). The more widely cited conclusion of the Rand study, namely that the copay cohort's costs were decreased with no measurable adverse health outcomes, on average, overlooks not only this worrisome side effect of cost sharing on the sick poor subgroup but also what I consider the most profound and important finding of the study. Cost sharing was not effective for sorting out needed from inappropriate care.

Visits for serious symptoms such as loss of consciousness, involuntary weight loss of more than 10 lbs during the past month, serious bleeding, etc. decreased as much as visits for what Rand called "discretionary," less serious symptoms (Shapiro, Ware, & Sherbourne, 1986).

Thus the OTA report concluded "that the conventional wisdom, that cost sharing reduces utilization by promoting the use of more cost effectively appropriate care and by discouraging the use of unnecessary services" has "no supporting evidence." The evidence instead suggests that this is a crude and ineffective instrument for matching health care services with health needs. For these reasons the Canadians as well as the Wellstone and McDermott single payer plans reject cost sharing for acute and preventive care. Instead they rely on the mechanism most households use to fix their personal expenditures, and most countries successfully use to control their health costs. They set a budget, and figure out how to live within it. They therefore avoid complex and intrusive bureaucracies. Providers are given both incentives and the flexibility to maximize services within a negotiated and predictable budget. Each provider simply submits one floppy disk to the Provincial government each month; each hospital is sent a check for 1/12 of its annual global budget.

The issues raised by our three patients, related to the administrative complexities associated with means testing and fee collection, financial barriers to access, and multiple confusing classes of patients and programs, multiplied by millions of similar experiences each year, should lead consumers to seek the simplest and most efficient mechanism for health insurance. Again contradicting convention wisdom, the most efficient method for collecting and dispersing health insurance dollars is a publicly administered program such as the Canadian system (.9% overhead) or even Medicare or Medicaid (2.1%) as opposed to U.S. private insurance (13%-a figure that would be even higher if it also included investment credits) (McDermott, 1994;

Himmelstein & Woolhandler, 1994, p. 128).

I'd like to propose and test what I'll call the 60/60 rule. Can the financing of the health plan be explained to and easily understood by the average consumer (or an employer) in sixty seconds, and can they then calculate exactly what their costs will be in another 60 seconds? Since I'm already running short of time, and you are better informed than the average consumer, I'll give you only 30 seconds for each using HR1200/S491 (McDermott/Wellstone) All employers pay a payroll tax or premium of 8.4%, all employees pay 2.1% of their income (in most cases a simple payroll deduction). That's it!. Try doing that with the Clinton Plan. The only small print is that the 8.4% employer contribution is reduced to 4% for small businesses (defined as < 75 employees earning an average of \$24,000 or less) plus a \$2/pack cigarette and 50% handgun and ammunition tax. According to Jerry Anderson, economist at the Johns Hopkins Center for Hospital Finance and Management, 75% of people would pay less for better coverage than they currently have.

Maximizing Quality

Canadian health economist, Robert Evans (1989) presents a culinary parable about what is happening in U.S. health care today. Let's imagine that a group of us decide to go out to eat at a restaurant after the meeting tonight. Evans asks, what is the most economical way to order and pay for the meal? If each person orders and pays for his own meal, standard economics wisdom suggests that each of us will be more prudent in our ordering. On the other hand if the bill is pooled, each person would be less cost conscious since everybody else is sharing the expenses. Thus if each person has to pick up their own tab, there will be less champagne and steak, more chicken and sprite.

But what if, when the bill arrives at the end of the meal we get into a fight. Each person, concerned about not paying any more than they had to, argues about his or her proper share. And what if, in order to resolve the dispute, I bring in my

accountant, and then you bring in your lawyer, and others do the same. Maybe the restaurant owner brings in his lawyer, and even a security guard when we start questioning his charges. Now, which way of ordering is more cost effective?

Much of what's going on in health care today is arguing about who will pay the bill. Everyone tries to minimize their costs by shifting them onto someone else, sometimes another 3rd party payer, sometimes back to the provider, more often onto the patient. Total costs inflate. The cost of arguing over the bill comprises much of the 25% administrative costs in the U.S. system. The need to account for and bill separately for each aspirin given in the hospital, and accommodate each payers' aspiration to outsmart the others in gaming and minimizing risks, wastes conservatively 10% of our nation's one trillion dollar annual health bill (Woolhandler & Himmelstein, 1991). \$100 billion could be saved simply by reaching an agreement in advance that we'll simply order next years' health fare as they do in Canada.

We're spending so much time arguing about the bill (and here I am halfway through this talk thus equally guilty) that we're overlooking the fact that we're all paying for a suboptimal system. Overlooked during our argument (to extend Evans parable) is the fact that food is of uneven quality, served inefficiently, and lacking in basic nutritional value. The following gives you a taste of some of these quality deficiencies.

Discontinuity-primary care. We hear talk about the impact health reform has on the deficit. Here's another deficit statistic. In Chicago, the Health Summit reported that there is an annual deficit of 2 million ambulatory care visits from the number predicted for our city's population; patient encounters that have simply disappeared from our city's health care ("Summary Report" 1990).

Prenatal care. The percentage of African-American women with no prenatal care before the 3rd

trimester exceeds 10%, and has been rising in recent years (Himmelstein & Woolhandler, 1994, p. 62). Such a phenomenon is beyond comprehension to maternal and public officials in most European countries, where early prenatal care is a given.

Iatrogenic adverse events. Product safety has always been an important concern of the consumer movement. Reliable evidence from the California Medical Insurance study in the late 60's and the Harvard Malpractice Study of Hospitalized patients in N.Y. state in the 1980's suggest a 1% incidence of serious negligent adverse events (Weiler, et al, 1993). This translates into almost 100,000 deaths or serious injuries, making it the leading cause of potentially preventable injury in the U.S.

Failure to provide needed prevention. Many recommended interventions (i.e. flu shots, mammograms) are given to < 50% of eligible people. A complex result of consumer and provider education and behavior issues, coupled with cost and system barriers, these statistics portray a sobering level of disorganization in our health system (Burack, et. al., 1993).

Diagnostic errors. While a few small studies show rates as high as 20-50%, the most disconcerting fact is that we lack any formal mechanisms to track and learn from errors (Williamson, Walters, & Cordes, 1993). Even the time honored autopsy, for centuries the source of the profession's learning about missed diagnosis, has atrophied (the rate has fallen to < 10% nationally) due to public and professional indifference, and competing concerns (Hill & Anderson, 1988). How useful will databases tracking patient outcome be with patient giving false names, or providers being given financial inducements to give a more complex billing diagnosis label (Schiff, in press)?

Unnecessary procedures/surgery. Health services research from large financial claims databases shows as much as three to ten fold variations in rate of certain

procedures. However when the Rand Health Services Utilization study looked at high volume vs. low volume geographic areas they found, to their amazement, the same rate of inappropriate procedures (i.e. 32% for endarterectomy) in both high vs. low volume areas (Chassin, et al, 1987). How can we explain this? Many, such as John Wennberg (1987), have suggested "underevaluated theory." We simply lack the knowledge base to know precisely how and when to optimally use such interventions in a flexible way consistent with patient variations and values.

Sub optimal medication prescribing/information/use. Speaking as an internist, and Chair of the U.S.P. (United States Pharmacopeia) Panel on Consumer Interest/Patient Education this is an area of great importance, requiring a more detailed discussion (Schiff, 1992). We will simply note here that probably half of the medications are either used or ordered incorrectly.

Inattention to quality of life issues. For example according to reports recently released by the Agency for Health Care Policy and Research a quarter of patients have their postoperative pain inadequately treated.

Finally one last quick look at customer satisfaction. The defenders of the status quo are correct when they argue that the majority of patients are satisfied with their care. Unfortunately the data shows that dissatisfaction is rising, with 25% of people somewhat or very dissatisfied with their care, a number that has doubled from 1987 to 1992 (Himmelstein & Woolhandler, 1994, p. 260).

I offer this list as neither a consumerist doctor-basher nor a defensive physician, the two perspectives from which such issues are usually discussed. Rather, I present these problems to impress upon you the serious work we all have ahead of us once we can stop arguing about the bill.

Cost effective health reform requires thinking about the improved quality that is both required for and created by fundamental change. A

shortsighted consumerist approach on this might be to merely call for better inspection, and hail the current rush to "quality report cards." However, as Don Berwick (Harvard pediatrician who has introduced industrial (Japanese) quality improvement theories to medicine) has warned that better quality can not be inspected or selected, it must be induced and produced (Berwick, 1989).

Improved quality must originate with and must be designed to maximize the intrinsic values of health workers to help patients; to build on their desires to work with the health care consumer to better meet their needs. I contrast this approach to the current reality of oversight of medical care.

There has been a shift from what was previously a "more is better" mentality, 180 degrees to a "less is better" paradigm, what I believe are two sides of the same coin, with not even a thin rim dedicated to the idea, that maybe "better is better." Thus in the past decade the quality oversight of medical care has been predominantly focused on monitoring and limiting utilization of health care services.

There has been an unprecedented growth in the number of organizations that perform so called "utilization review," from about 125 private organizations in 1989 to almost 350 in 1992. In 1983 14% of corporate benefit health plans required prior approval for nonemergency admissions, by 1988 this number had risen to 95%. According to a policy paper just issued by the American College of Physicians almost all of these review organization are for-profit, freestanding, and lack any formal relationships with health care providers. They generally use "unilaterally developed, secret criteria to evaluate care" (American College of Surgeons, 1994). These review organizations boast that they can deny 10 -35% or more of claims for procedures by applying their proprietary criteria either before or after the fact.

For example, the current issue of Business and Health describes the efforts of benefits managers at Harris Corporation, a Florida based manufacturer who hired Health

Economics Corp, a data analysis firm based in Dallas to perform detailed review of each service received by their employees in an effort to "micromanage the networks to find the source of suspected problems at the level of the individual provider..."(Torchia, 1994). When provider or specialty profiles so generated show higher than average costs feedback, if necessary, a provider contract termination is implemented.

What's wrong with this? Isn't monitoring and weeding out inappropriate care, thereby getting more value for our health dollars something consumers should welcome? W. Edwards Deming, who died last December, was the American statistician whose quality theories are considered by Japanese to be the source of their ability to produce highest quality autos, electronics, etc. Deming used to cite an article on a study of 970 historians' ratings U.S. presidents. The researchers were pleased to find "we've been remarkably lucky considering the haphazard way we select a president" that 1/4 were considered great, and at least half are above average. (p.57) (Being great was defined as being in the top 25%).

Finding resource utilization outliers via the widespread practice of "economic profiling" is like finding great presidents in Deming's example. Chopping off tails from practice variation curves does little to improve overall quality. Deming's ideas, as I'm sure many of you are aware, go beyond simple statistical common sense. He taught the importance of moving from downstream inspection of the end results of the production process (where defective items were reworked and the workers responsible were sought out for blame), to focusing upstream, redesigning the production process to build in quality.

One last example to illustrate this point. I recently (in the capacity as co-chair of our hospital's quality assurance committee) contacted and reviewed demonstration software from one of these firms engaged in monitoring physicians treatment decisions (Quality FIRST). The company claims to have developed guidelines for 450

diagnoses, representing over 97% of medical practice. Using the guidelines up to 2/3 of selected procedures can be flagged as unnecessary or inappropriate. I was interested in whether we might use their protocols further upstream, as decisionmaking aids for the clinicians, rather than as inspection tools for the insurers. The answer was a bewildered and unequivocal no--the guidelines were not developed to be used for that purpose. (Frankly, I'm not sure how much added value such canned protocols would be anyway for a knowledgeable specialist physician who grapples daily with the difficult individualized patient management decisions). Rather than improving quality such approaches to improve appropriateness by denying claims become merely another variant of arguing over the bill.

How can quality be promoted through national health reform? The Quality of Care Task Force of Physicians for a National Health Program has developed ten quality enhancing principles, which I urge you to critically examine (Schiff, et al, 1994). Each one invites your criticisms and research to better define and apply it to health reform and quality improvement.

Is It Fair?

In Washington each interest group, trying to preserve a piece of the status quo, argues that proposed health reform legislation is not fair, that they will have to pay more. Highly regarded by Colston Warne was a 1963 CU subsidized publication entitled *The Poor Pay More* by David Caplovitz. The current highly regressive reality of U.S. health care financing will probably worsen under the Clinton plan because it charges, with some complex adjustments, essentially a fixed amount regardless of income (for all employers 80%, all employees 20% of fixed cost of the cheapest plan). A flat percentage of income (e.g. 10%, comparable to the 8.4% employer+2.1% employee contribution proposed by McDermott/Wellstone) can be seen to be a much fairer approach. Going even further the Canadians can look in the mirror (on the wall) and see whose the fairest of them all. The

actual data from the Province of Alberta illustrates the progressive financing there (Himmelstein & Woolhandler, 1994, pp. 176-180).

But the term "fairness" in health insurance takes us beyond simple financing formulas. Many of you are familiar with the concept of "actuarial fairness," which is the basis for our present system of experience-rated private health insurance premiums. Actuarial fairness---the notion that "each person should pay in accordance with the quality of his risk," since it would be unfair were there to be "a forced subsidy from healthy to the less healthy" (Stone, 1993). (As Deborah Stone points out insurers almost always use pejorative words like "forced," "unfair," or "coerced" in front of subsidy to mask the obvious fact that that's what insurance is about---a subsidy from the lucky to the unlucky).

Achieving actuarial fairness requires the practice of medical underwriting, the science of rating, predicting and selecting (and excluding) risk (Bodenheimer, 1990). On the positive side we owe the discovery of high blood pressure as a risk factor for cardiac death to the insurance industry. They performed measurements on tens of thousands of life insurance applicants during the 1930s-60s and calculated the attendant excess risk, thereby laying the basis for what I spend most of my time doing in my outpatient clinic--treating hypertension (Lew, 1973). On the other hand, the underwriting insurance principle strikes at the heart of our current health care crisis. By selectively insuring low risk people and avoiding those with "pre-existing" conditions, it leads to the distribution of insurance and medical care in inverse relation to need (Light, 1994).

Many physicians I know prefer the challenge of caring for sicker and more complex patients. The same cannot be said for any insurance company. You will not see TV or subway ads urging patients with AIDS to join a particular health plan. Seventy percent of AIDS patients lack private health insurance. Put yourself in the shoes of the CEO of a for-profit health plan and ponder the following statistic: the top 2% of

people account for 41% of health expenditures, the top 10% account for 72% (Rice, Brown, & Wyn, 1993). What is the most cost effective way to keep your plan in the black. If you didn't answer, find some way to predict who these 10% of people are, and exclude them...you're fired.

Competition among private insurers is thus focussed on finding ever smaller pools of healthier people to insure. Stone warns us that this "logic of actuarial fairness is so deeply embedded in the structure of competitive markets, and so deeply consonant with social divisions in American society that eradicating it will take more than any current reform proposals contemplate." Actuarial fairness ultimately means fragmenting communities into more and more homogeneous groups, each charged rates to insure profitability based on their own experience. Ultimately this undermines the "mutual aid" function, the original social purpose of health insurance.

To quote Lawrence Brown:

"Insurance as a social institution, invented to spread and pool risk, has degenerated into an industry devoted to shedding and fragmenting risk....Insurers like other occupants of social roles maximize utility with the rules of the game; and if one does not like the way the game is played the answer is not to impugn the sincerity or integrity of the insurance executives or brokers, or urge them to consume heaping bowls of moral fiber, but rather to rewrite the rules of the game" (Brown, 1992).

Consumer Empowerment/Making Politically Feasible

How do we do this? I suggest that we have to begin with a commitment to putting the consumers, not the insurers, back in the drivers seat. Whether you are a strong

single payer advocate, as I obviously am, or believe that the Clinton plan is the best possible solution at this point in time, you must be concerned with the way the special interests have effectively shaped health reform design and debate.

Only an informed and activated consumers movement can get health reform moving through the current gridlock. The Clinton plan (to quote an article from this Sunday's New York Times) "was so misshapen by polling and political considerations, in pursuit of some magical middle group that it became a bureaucratic nightmare" (Toner, 1994). In ruling out "a Canadian-style system of national health insurance, a fairly straightforward means of achieving universal coverage," pollsters' predictions of public antipathy to taxes and government, the NY Times suggested, were permitted to overrule best judgments about the optimal system. Such perspectives underestimate consumers' intelligence. Numerous polls in fact show consumer readiness to support tax financed Canadian style solutions.

In the fall of 1991, Senate candidate Harris Wofford shocked the Washington and Media establishment and changed the political landscape for health reform by overcoming a 40 point deficit in the polls when he called for unspecified "national health insurance." In the fall of 1993 President Clinton also (according to Harris pollsters) "gave his presidency a big lift and altered the political landscape" by appealing directly to the public on the need for health reform (Taylor, 1993). Unfortunately, the Clinton plan once unveiled can clearly be seen to be a compromised and flawed approach, the result of concessions made at the outset to the private insurers (Woolhandler & Himmelstein, 1994; Working Group on Managed Competition, 1994). Ironically, these large insurers have now double-crossed Clinton and are supporting the Cooper/Breaux Managed Competition Act, which does not even include universal coverage.

The erroneous premise was that "political feasibility" lay in quietly hammering out congressional bargains among the major players in

the current system, rather than providing a plan and leadership around which consumers and concerned professionals could best be mobilized. Any plan passed in 1994 is likely to be quickly eviscerated if the public is not actively involved. Theda Skocpol (1993), sounds this warning to the "advocates of inside the beltway bargains:"

"Reformers need to engage the U.S. citizenry as a whole in democratic discussion about the ideas of government-sponsored health care. Advocates of single payer plans can do this more readily than supporters of complex public-private schemes such as pay or play or managed competition, but all those who want inclusive and effective reforms during the 1990's must face the challenge of democratic dialogue."

As Colston Warne used to say "it will be interesting to see how it all turns out." Since sadly he will not be around to see, I hope we can dedicate ourselves to seeing it turn out the way he would have wanted.

References

- AFL-CIO Public Affairs Office (1994, March).
- American College of Surgeons (1994). Position paper: The oversight of medical care: A proposal for reform. Annals of Internal Medicine, 120, 423-431.
- Berwick, D.M. (1989). Continuous improvement as an ideal in health care: A proposal for reform. New England Journal of Medicine, 320(1), 53-56.
- Bodenheimer, T. (1990). Should we abolish the insurance industry? International Journal of Health Services, 20(2), 199-200.
- Brown, L.D. (1992). Policy reform as creative destruction: Political and Administrative challenges in preserving the public-private mix. Inquiry, 29, 188-202.

- Burack, R.C., et al. (1993). Patterns of use of mammography among inner city Detroit women. Medical Care, 31, 322-334.
- Chassin, M.R., et al. (1987). Does inappropriate use explain variations in the use of health care services? Journal of the American Medical Association, 258, 2533-2537.
- Enthoven, A.C. (1993). Why managed care has failed to contain health costs. Health Affairs, (Fall), 27-43.
- Evans, R. (1989). Presentation to Society for General Internal Medicine Meeting.
- Hayes, G.J., Hayes, S.C., & Dykstra, T. (1993). Physicians who have practiced both in the U.S. and Canada compare the systems. American Journal of Public Health, 83, 1544-1548.
- Health-care hucksters: What their ads say--and don't say. (1994, February). Consumer Reports, pp. 116-117.
- Hill, R.B., & Anderson, R.B. (1988). The autopsy--medical practice and public policy. Stoneham, MA: Butterworths.
- Himmelstein, D.U., & Woolhandler, S. (1994). National health program book: A source guide for advocates. Monroe, ME: Common Courage Press.
- Inglehart, J.K. (1994). Health reform--the role of physicians. New England Journal of Medicine, 330(10), 728-731.
- Karpatkin, R. (1994, February). Memo to readers. Consumer Reports, p. 71.
- Lew, E.A. (1973). High blood pressure, other risk factors and longevity: The insurance viewpoint. American Journal of Medicine, 55, 281-294.
- Light, D.W. (1994). Life, death and the insurance companies. New England Journal of Medicine, 320, 488-489.
- McDermott, J. (1994). Evaluating health system reform: The case for a single payer approach. Journal of the American Medical Association, 271, 782-784.
- Priest, D. (1993, March 12). Health care theorists of Jackson Hole: Policy heroes or special interests? Washington Post, p. A15.
- Rice, T., Brown, R., & Wyn, R. (1993). Holes in the Jackson Hole approach to health care reform. Journal of the American Medical Association, 270, 1357-1361.
- Schiff, G. (in press). Diagnosis tracking and health reform. American Journal of Medical Quality.
- Schiff, G. (1992). Can patient education really make a difference: Introductory remarks. USP Open Conference (pp. 13-18). Bethesda, Maryland.
- Schiff, G.D., Bindman, A.B., Brennan, T.A., & the Physicians for a National Health Program Quality of Care Working Group (1994). A better quality alternative: Single payer health reform. (Draft position paper available from PNHP Suite 500, 332 S. Michigan, Chicago IL 60604).
- Shapiro, M.F., Ware, J.E., & Sherbourne, C.D. (1986). Effects of cost sharing on seeking care for serious and minor symptoms. Annals of Internal Medicine, 104(2), 246-251.
- Skocpol, T. (1993). Health insurance reforms in the 1990s. Journal of Health Politics Policy and Law, 18(3), 532-549.
- Stone, D.A. (1993). The struggle for the soul of health insurance. Journal of Health Politics Policy and Law, 18(2), 287-317/ Summary report Chicago and Cook County health care summit (1990, April).
- Symonds, W.C. (1994, March 21). Whither a health care solution? Oh, Canada. Business Week, p. 82.
- Taylor, H. (1993, October 11). President Clinton's health care proposal has given his presidency a big lift and altered the political landscape. The Harris Poll, # 50.
- Toner, R. (1994, March 20). Following the crowd on health care, and getting lost. New York Times, Sec.4, p.1.
- Torchia, M. (1994, March). Using data to improve quality. Business and Health, pp. 23-27.
- U.S. Congress, Office of Technology

- Assessment (1993). Benefit design: Patient cost sharing (OTA-BP-H-112). Washington, DC: U.S. Government Printing Office.
- Waitzkin, H. (in press). The strange career of managed competition: From military failure to medical success. American Journal of Public Health.
- Warne, C.E. (1993). The consumer movement: Lectures by Colston E. Warne. R.L.D. Morse (Ed). Manhattan, KS: Family Economics Trust Press.
- Weiler, et al. (1993). A measure of malpractice: Medical injury, malpractice litigation and patient compensation. Cambridge: Harvard University Press.
- Wennberg, J.E. (1987). Editorial: The paradox of appropriate care. Journal of the American Medical Association, 258, 2568-2569.
- Williamson, J.W., Walters, K., & Cordes, D.L. (1993). Primary care, quality improvement and health systems change. American Journal of Medical Quality, 8(2), 37-44.
- Woolhandler, S., & Himmelstein, D.U. (1991). Deteriorating administrative efficiency in U.S. health system. New England Journal of Medicine, 324, 1253-1257.
- Woolhandler, S., & Himmelstein, D.U. (1994, March 11). Universal care? Not from Clinton. New York Times, (Op Ed).
- Working Group on Managed Competition (1994). Managed competition: An analysis of consumer consumers. International Journal of Health Services, 24, 11-24.

Endnotes

1. The title is taken from a book entitled *Vietnam: The Logic of Withdrawal* by Howard Zinn published by Beacon Press in 1967. Had the logic of his arguments been heeded then by President Johnson, many thousands of lives would have been saved.
2. Director General Medical Clinic.

International Trade: What Is the Consumer Interest?

The following is a manuscript of the address made by Mark Silbergeld at the Esther Peterson Consumer Policy Forum. The forum provides an opportunity whereby the consumer interest with respect to a contemporary consumer policy issue is identified and clarified.

Mark Silbergeld, Consumers Union of U.S., Inc.¹

Good morning! I am very pleased to have the opportunity to address this august gathering. The American Council on Consumer Interests is comprised of the most distinguished academics in America in the various disciplines related to consumer welfare and consumer behavior. The knowledge you generate is immeasurable and invaluable. The experts you train are the lifeblood for the perpetuation of knowledge about how consumers behave and how markets perform. And your participation in the many and varied activities of consumer-interest organizations throughout the country helps to make the consumer movement not merely one that is active, but also one that is informed and, therefore, more persuasive on behalf of consumers.

When your President, Barbara Slusher, on behalf of the program committee, invited me to participate in this session, I accepted immediately. This is, after all, the "Esther Peterson Forum". Who can say "NO" to Esther Peterson? Esther is not here with us today -- she has substantially but not fully recovered from a recent injury and feels that she should not yet travel great distances in a season of uncertain weather. She asks me, however, to bring to you her greetings and warm personal wishes. I am pleased to report that, although Esther has cut back the level of her activities, she remains vigorously involved in the consumer movement. Those among you who heard her rousing address to the Consumer Assembly in Washington earlier this month can attest to this.

I would like to preface my remarks by stating that while they are based on Consumers Union's position on trade and on the Uruguay

Round Final Draft Act, some observations reflect my own opinions. Therefore, you should not attribute any given statement to CU.

The issue of international trade traditionally has had a far reaching effect on consumers. On the most basic level, of course, trade benefits consumers by moderating the costs of goods and services through the mechanism of competition. By this same means, it increases the choice and quality of products available to us as consumers. It is not my purpose here today to address the theories, relate the empirical observations or describe in detail all the transactions through which this happens -- some of you in the audience are able address that issue far more elegantly than am I. Suffice it to say that there is general agreement (Smoot, Hawley and Perot to the contrary not withstanding) that this does happen and that it is usually to the consumer's benefit.

On a more complex level, however, international trade and formal trade policies interact in complex ways with economic and social policies, including such basic ones as environmental policy, income distribution policy, consumer and worker health and safety policy -- and with even more fundamental policies that underlie the conditions of personal and political freedom.

International trade is an activity which has roots almost as old as mankind itself, kept alive by the mutual ability of various geographies and peoples to extract, produce and fashion goods and services that some others cannot, or at least cannot as efficiently. Trade can bring goods to consumers who would normally not have access to comparable items, thus increasing the

choice that consumers have in the marketplace. This increased choice creates competition, serving the dual purpose of increasing quality of goods and lowering costs in an attempt to woo the savvy consumer. This is a result of trade which translates into tangible benefits that the consumer can experience when standing in the market place -- or, as it is referred to in Minneapolis, the shopping mall.

But the issues of international trade often run much deeper and are less cut and dried than simple cost and quality benefits. Even within the narrower context of commercial activity, consumers have competing interests in trade policy. And this especially is a dilemma for lower-income consumers, whether at home or abroad. Consumers want more affordable food but they also want it to be safe -- however, accepting slight risks can in some instances be a way to keep down the price of foods. Consumers want affordable pharmaceuticals, which may be more affordable if they are available from sources other than a patent-holder, but they may also want the most modern medicines, which may not be available in places where the patent-holder perceives the patent laws not to afford it adequate protection. Consumers may enjoy more and lower-prices services such as banking and insurance if trade in services across borders increases competition, but opening borders to such foreign competitors may raise questions about the effectiveness of local regulatory bodies on behalf of consumers.

Trade also affects issues broader than these commercial ones, issues so essential that we view them very emotionally -- employment, working conditions, public health and safety, the environment and national sovereignty. To note that, however, does not necessarily mean that trade agreements are the only or the best instruments by which to address these broader social issues. As the International Organization of Consumers Unions has stated, "The environment is too important to leave to trade officials." Trade agreements should be environmentally friendly, but they are no substitutes for separate international agreements that deal with the environment --or

human rights or labor conditions or other social issues-- more directly. Therefore, it is important to step back and view the juncture between trade and these broader issues analytically and in context.

Further, it is easier to bring trade and social issues closer together in smaller agreements involving a limited number of contiguous nations -- such as the NAFTA agreement -- than in global agreements such as the GATT. Much has been achieved, at least on paper, in the NAFTA environmental agreement, which lead several of our largest environmental organizations to support NAFTA ratification. That made sense because we share borders with Mexico and Canada and have direct trans-border environmental problems.

Negotiating the same kinds of specific "do list" environmental improvement programs in single negotiation with many dozens of developing nations in Asia, Africa and South and Central America seems a far less feasible undertaking. Every added trade partner in such a negotiation far more than doubles the trade-offs, to the point where the geometric progression of difficulty would prove enormous. GATT, the global agreement, is about to consider undertaking a "green" program when its ministers meet in April. It is at the same time essential to insist that GATT become green and otherwise more socially aware and, at the same time, to have realistic expectations about the time needed both to work out a plan and as to the level at which problems can be effectively addressed.

What have we learned from the involvement of citizen organizations in the debates about GATT and NAFTA? One lesson, I conclude, is that is necessary to keep in mind two things in evaluating trade agreements. The first is the larger picture -- the broad directions in which international trade public policy must move in order to keep up with the realities of an increasingly global economy and changing ways in which business is done. The other is the fine print -- the nuances of the voluminous, often arcane texts that make up trade agreements.

As to the first, much of the

advocacy against these agreements assumes that governments through trade agreements can control the fine details of investment and business decisions throughout the world. This is not so. Governments do a fair job when they set rules of honesty and fair play, rules to promote health and safety. They do less well when they try to direct technology and investment rather than to set the rules by which technology may be applied and investments may be made.

As to the second, the "big picture" of trade is like a TV screen. It is made up of the little pixels of light and color that constitute the fine print of trade agreement texts. If the fine print is flawed, we will not perceive the big picture may not be what it seems. Nor will we see the big picture accurately if we misperceive the fine print, or if we view some little corner of the picture as the whole. This is part of what has taken place in the debates on NAFTA and GATT.

The latter is, I think, a fair description of what has happened during the GATT and NAFTA debates. There has been a perception in some quarters that these agreements will result in the demise of our safety and environmental standards as well as our national sovereignty. In my view, this resulted in part from citizen advocates of good intention testing the "worst case" interpretations of the fine print by insisting, and apparently believing, that these interpretations were necessarily the meaning of the Draft Agreement of the GATT Uruguay Round that surfaced in December, 1991, the so-called "Dunkel Draft".

As it turned out, these were not the meanings. The Office of the U.S. Trade Representative and other officials involved in the negotiations insisted from the outset that the "doomsday" readings of, for example, the food safety text did not reflect the intent of the negotiators. In the end, changes were made in the text to clarify that the text meant no threat to U.S. food safety laws or regulations. I will illustrate that for you momentarily. To conclude my point, these many doomsday readings of the food safety text, which eventually proved incorrect, began for some to make up

the big picture of an agreement that would comprise food safety and our national sovereignty.

It may be fair to say that these efforts also constituted much of the pressure that brought about the clarifications in the texts of both the GATT and the NAFTA food safety agreements. If so, it seems also fair to say that, at the same time, they contributed to a misperception of the big picture that may have misled many less-skeptical citizens into believing that the sky was indeed falling and that what we have to look forward to in the future is a continuing national epidemic of food poisoning and food-borne disease. One would hope for a less misleading way of bringing about improvements through the negotiations process.

I would like to illustrate this point with one example. First, however, it may prove helpful to explain the context. The purpose of the Uruguay Round of the GATT is to address non-tariff barriers to trade. The kinds of barriers included in the category "non-tariff" is broad and varied. It includes agricultural subsidies and non-tariff import restrictions as well as other means of managing farm economies; national intellectual property laws (and the lack thereof); the lack of market access for foreign providers of many kinds of services -- including consumer banking and insurance services; and standards, including both private and governmental product technical standards and food safety standards.

Some of these barriers are in fact barriers simply because of a lack of uniformity among nations. Others are barriers by design. Nations that want to protect national industries from foreign competition found myriad ways to do so. For example, by writing a standard so that a domestic product but not a foreign product would meet the standard. Or so that nation's unique method of testing to meet the standard was the only governmental test or inspection method acceptable, even though there is nothing inherently inappropriate from a health or safety endpoint about an imported good's use in the domestic market.

These barriers injure consumers as well as exporting producers, for they deprive consumers of the competitive benefits of trade. Thus, there is nothing conceptually "anti-consumer" about the Uruguay Round or its food safety proposal. (Since the NAFTA food standards negotiations started with the GATT Dunkel Draft, these remarks at this point apply equally to the NAFTA.)

What is important to consumers of food is to assure that, in both concept and drafting detail, the food safety agreement --or "Sanitary and Phytosanitary Agreement", as it is formally known-- does not threaten the right of the U.S., or any country, to maintain strict food safety measures, provided that they are for the valid purpose of protecting human, plant and animal life and health, rather than for the invalid purpose of excluding foreign products as a national economic objective.

As I have already suggested, consumers have dual interests in an affordable, varied diet and in a safe food supply. While these interests are can be made consonant, they are not automatically so. And where a health concern is genuine and not theoretical, at least in economies of plenty, health is generally given a higher priority over price. However, there is a greater potential tension between these competing considerations where the health concern is real but the degree of risk is slight and the cost effect is substantial. There also may be income-distributive effects, with some consumers on very limited food budgets willing to take greater risks than those on ordinary or generous food budgets.

The Dunkel Draft reflected a scheme that was to require that there be a scientific basis for each national food safety measure. A country whose products were excluded through application of such a measure could successfully challenge the measure through the GATT dispute settlement process if it could demonstrate that such was not the case. This would allow nations to have scientifically-based food safety standards but at least curtail the ability to use unscientific standards primarily for the purpose of trade

discrimination.

Under this proposal, a national food standard that was the same as an international standard would be presumed not to violate the Agreement. Nothing in the Draft stated or directly implied, however, that national standards more strict than international ones would be presumed to violate the Agreement.

The expressed concerns followed this script. The science basis and an asserted preference for international standards would be used to weaken U.S. food standards (including some stricter-than-federal state standards) bringing them down to (supposedly unacceptably low) international standards. A trade complaint could be filed under this proposed new GATT dispute process in which the "dueling science" arguments of the complaining and defending parties would be tried before a three-member panel. The panel could then choose among the arguments of the parties as to which "science" it agreed with, relying if it chose on the opinion of experts identified by the supposedly weak Codex, and throw out a strict U.S. standard because it agreed with the arguments of the challenger and the opinions of the Codex-supplied experts that science did not require so strict a standard.

If this characterization were accurate, there would indeed be a valid U.S. consumer concern with the food safety agreement. We are accustomed to and fully expect to be adequately protected by food safety standards that are among the strictest in the world. We would not want to see these standards pulled down to some lower common denominator as the result of a trade agreement. And certainly, we would not tolerate this result as the product of a process in which a trade dispute panel choose to side with the arguments of foreign government against, for example our own Food and Drug Administration, in a re-evaluation of the science on which the FDA relied in setting the standard.

But this scenario is indeed "doomsday". The expressed concerns ignored certain other highly-relevant considerations of the text that put the question of safety back into context. The Draft very specifically

recognized the right of member nations to set their own level of acceptable risk and to maintain higher than international food safety measures in order to achieve these risk levels. The international standards referred to are, for the most part, those of the Codex Alimentarius Commission, a sub-agency of the United Nations and hardly the "secretive group of scientists" that it was characterized by some. The Codex's standards, while sometimes less strict than those of the U.S., are often more strict. And the Draft did not suggest that a higher-than-Codex food standard was presumptively violative of the agreement, merely that one which was equivalent was presumptively not. After all, over one hundred countries work together to adopt Codex food standards, although none is obliged to adopt them; it seems quite reasonable to assume that a standard to which many countries subscribe is not one that has been adopted primarily for the purpose of trade discrimination.

The meaning of "science basis" question was resolved, first in the final version of the NAFTA final agreement," then in the GATT Final Act that was adopted on December 14, 1993. The NAFTA food safety agreement defined "scientific basis" to mean "a reason based on data or information derived using scientific methods". The GATT Final Act provides that there is scientific justification for a stricter-than-Codex standard if it is adopted "on the basis of an examination and evaluation of available scientific information..." and the nation adopting the standard "determines that the relevant international standards, guidelines or recommendations are not sufficient to achieve its appropriate level of protection."

The United States should have little difficulty sustaining its food safety standards under these criteria. The NAFTA standard is simple. The judgment of validity is simply whether a standard has a reason based on scientifically-based reasons or data. The GATT criterion is more complex, in that it requires the standard to have taken into account the adequacy of the Codex standard. However, as the NAFTA

provision does, it takes into account only whether the required determination has taken place, not a challenging country's arguments about the validity of or the determination. No dueling science appears to be contemplated by either definition.

Thus, the "pixel" of the science-basis requirement as it turns out in the final agreements turns out to give the big picture a very different appearance than did the characterizations of this issue during the debate. I could cite numerous additional points which turned out the same way. When all of these pixels are adjusted to reality, the picture is quite different. No longer is the big picture on the screen one of "Frankenstein", but instead something quite ordinary.

Finally, we come to what may be the root of much of the controversy surrounding our participation in international trade -- a narrow view which assumes that the appropriate culture in an international setting is always an American culture. The fear of losing our rights to protect our own standards and national sovereignty is predicated on the belief that most Americans have that our standards and our politics are the only right ones in the world. In many ways we want to insert into the international context our own exact ways of doing things, based on the idea that we need to bring other nations around to our way of thinking. While our goals for health and safety are valid, we must realize two things. First, that there may be other ways than our own of reaching them. Second, consumers in other countries, especially those in differing economic and cultural situations, may have other preferences in balancing such potentially competing considerations as risk and income. And they may have higher priorities than the adoption of our own current ones, such as basic sanitation before clean air.

In a world of so many cultures and customs, we need to learn to take the needs and views of others into account. Trade, and especially the rules set out in trade agreements, should be used sparingly as a tool for forcing change in other countries. Used to address every

concern, it loses its effectiveness. And the victims may be the very people we mean to help. I was impressed recently by a radio interview with a China expert regarding the attitude of the Chinese dissident movement toward the extension of Most Favored Nation status by the U.S. to China. Apparently, the dissidents reduce their level of activity whenever the MFN consideration is pending with our government because they do not want China to lose this status. While they want the political freedom that we too seek in threatening to change China's MFN status, they realize that if the status is withdrawn, many people will not work, many Chinese consumers will have lowered standards of living.

This is not to say that trade agreements should be accepted without question. Certainly there are many issues in international trade which require close scrutiny to ensure that the wants and needs of consumers are adequately represented. As consumers we all have an interest in making sure that trade agreements become more modern and equitable in serving everyone's social concerns and needs -- not just our own. Today's economy is too global for any one nation to force every last jot of its own domestic agenda and process on all others. While remaining vigilant, we still must encourage the positive side of international trade so that consumers all over the world may reap the benefits trade can bring.

Endnotes

1. Director Washington Office.

International Trade: What is the Consumer Interest? Comments

An invited presentation at the Annual Conference of The American Council on Consumer Interests. Comments are a reaction to the presentation of Dr. Mark Silbergeld's address in the Esther Peterson Consumer Policy Forum.

Jean Kinsey, University of Minnesota¹

In today's global economy, trying to identify consumers' interest in international trade is a little like trying to explain how consumers benefit from living and working in a market economy where goods are rationed by price and that price is determined largely by forces of supply and demand. Mark Silbergeld, in his initial statement has it right. Consumers benefit from international trade through lower prices, greater choice of products and services, and generally increased product quality. These may sound like platitudes, but they are profound and treasured results and should not be taken lightly or taken for granted.

Another benefit that is often overlooked, and sometimes considered to be in competition with domestic labor interests, is the second round benefits derived from increased demand for our goods and service by other countries. Our ability to sell our products to others depends upon the spending power of consumers in other countries. This is increased when foreign countries develop their own industries, provide safe and stable political environments and good paying jobs for their workers.

This was the NAFTA story. We needed NAFTA because we need Mexico to be a strong nation both economically and politically. This is also the China story. In spite of many concerns about "human rights" violations, we offer "most favored nations" status to China because allowing them to export goods to us at the same low tariffs our other trading partners enjoy helps their economy become stronger, their wages grow, and their middle class develop. As they accumulate the household capital to purchase more consumer goods, they become the consumers of

things we produce, they adopt new technologies and a market economy develops. Not incidentally, this is also believed by many to be the surest path to long run political freedom and less central control over markets.

The bottom line in all trade negotiations is the ability to keep the market place open for goods and service that consumers want, on both sides of the border. Why then, do we confront the numerous competing interests that Mr. Silbergeld speaks about? I suggest it is precisely because international trade is so beneficial to consumers on both sides of the border that it has become "the carrot" in international relations. Threatening to remove that carrot is a most powerful bargaining tool short of threatening to use "the stick" that is, a military intervention.

Because trade is so important, it invites those with a multitude of agendas to suggest that we construct barriers to trade in order to force the behavior of other nations to conform to our sense of morals or ecological standards, or treatment of human beings. It also allows those domestic industries that seek protection from foreign competition to solicit government rules that reduce that competition. The latter is as old as trade itself. It has resulted in taxes on imports, known as tariffs, which make imported goods more expensive than they would otherwise be. It has resulted in government subsidies to exporters, making our goods cheaper in foreign countries than the would otherwise be. Examples are export subsidies on wheat and other feed grains that ensure that U.S. farmers have places to sell their commodities. The General Agreement on Trade and Tariffs (GATT), organized in the

1940s to promote free trade among countries with market economies, had as its central objective, the reduction of tariffs. Over the years they successfully decreased tariffs from 40% to 8% through a series of multilateral trade agreements. (Kinsey, 1993). In fact, they have been so successful at this mission that there is now a question about whether they can continue to perform a useful function unless their powers and roles evolve. Their viability is threatened not only by their own success, but by 1.) The proliferation of bilateral trade agreements which tend to develop their own governing bodies and 2.) The increase in nontariff measures over which they have had little authority and poor regulatory mechanisms.

I think I agree with Mr. Silbergeld that the Uruguay Round of GATT negotiations was about nontariff trade measures. Not that they started out to be so, but that the issues that held it up for nearly 7 years, were not centered around tariffs. Neither were they technically nontariff trade barriers (NTB), but they were issues and trade measures that became a series of barriers to negotiating a settlement. Issues like agricultural subsidies that make agricultural products cheaper in foreign countries and therefore competitive with local farmers, occupied an inordinate amount of time and press. Issues like ownership of patents and property rights in the entertainment industry and numerous side issues like environmental custodianship presented very troublesome debates. Also, nontariff measures are growing as a substitute for tariffs and they are more difficult to detect, identify and arbitrate.

Food safety was highlighted during these times because health and safety regulations can be used, deliberately or inadvertently, as NTB. In the GATT Article XX(b) there is a long standing agreement that "sanitary and phytosanitary" measures imposed by a country to protect the health and safety of its own domestic consumers are acceptable and are not to be considered official trade barriers (Bredahl and Forsythe, 1988). In other words, any country

has the right to protect its own consumers from food products that are believed to be harmful to their health. There are some caveats on this allowance, however. Mr. Silbergeld referred to the "scientific evidence" standard. Now, these measures must be based on "scientific principles and cannot be maintained against available scientific evidence." In addition, and most importantly for trade, they must not be discriminatory. That is, we cannot hold imports to a higher safety standard than we hold our domestically produced (and sold) goods. If we do, then we have constructed a technical NTB that can be appealed to the GATT (Multilateral Trade negotiations, 1990). This authority to discern whether a standard is discriminatory is relatively straight forward compared to an appeal that claims that a safety measure has no scientific basis. The "dueling scientists" approach referred to by Mr. Silbergeld, is feared by many as the path to lower standards and less safe food. In addition, the European Court has set a precedent by imposing a "fourth hurdle" and that is a criterion of "need". It was used in the case banning the use of growth hormones in the production of meat (in the EC) on the basis that there was no compelling "need" for this technology (Kramer, 1991). It seems that competing scientific evidence can be overridden when it appears to submit consumers to unknown risks.

The attraction of substituting nontariff measures for tariffs is that they are not nearly as transparent. It is harder to tell whether they are in place to protect consumers' health or to protect the profits of domestic industries. Two examples are the 1990 ban on U.S. meats by the European Community on the basis of unsanitary processing and the subsequent ban on meats produced with growth hormones. In the first case, the EC claimed that our processing plants were not sanitary enough to meet their standards. Our meat industry cried "foul" but eventually those who had the most to gain by exporting meat to the EC cleaned up their act, and resumed exports. Was this a case of the EC imposing a health standard

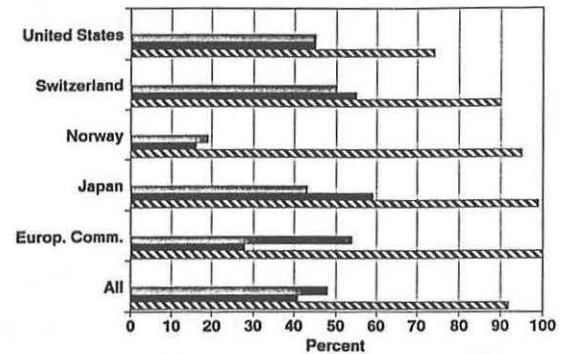
that was designed mostly to protect their own meat industry? Did our meat firms sanitary practices fall below EC standards for their own producers? In any case it was a short lived ban and one from which the U.S. industry recovered quickly. Why? Because they had an economic incentive to do so and we, the U.S. consumers are probably better off for it. I suspect that this was a case of a legitimate nontariff measure invoked to protect consumers' health. In contrast, however, the EC ban on importing meat from animals that have been treated with growth hormones is probably a nontariff barrier. Yes, it is nondiscriminatory; EC farmers are also not suppose to be using growth hormones. However, there is no scientific basis since there is no known health problem to humans from the presence of these hormones; some argue they are undetectable in the end product. But again, those producers who really want to sell in the EC market, adopt to these regulations and produce without the use of growth hormones. The U.S. even established a certification program for hogs and horses produced without hormones (Kramer, 1991).

A graduate student and I have looked into the proliferation of NTM and have found that in developed countries a very large percent of food products are traded under some type of NTM. Figure 1 (Kinsey, 1993; Laird and Yeats, 1990) shows that 100% of the value of food traded in the EC was subject to some type of NTM in 1986. These measures could be any one of a number of trade measures not specifically designed to restrict quantity, but to control quality such as health or safety standards, customs clearing requirements, package or labeling criteria or advertising restrictions. Figure 2 shows the distribution of these trade measures (called Type II measures, Laird and Yeats, 1990). Almost 35% of them are imposed on foodstuffs and 16% on raw agricultural products in the OECD countries. Among all of the various types of NTMs that countries use including quantity controls like quotas and anti dumping regulations, technical regulations and standards comprise one third (Figure 3, Ndayisenga and Kinsey, in press). Most of these technical regulations

are the health and safety standards so important to food products.

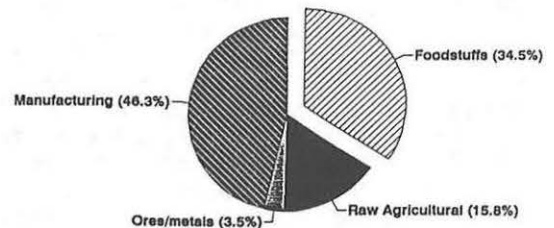
Should we worry about our food safety standards eroding under trade agreements where GATT or some other international arbitrator might force us to import less safe food? Is the so called "harmonization" process dangerous to improving health and safety for consumers in high income

Figure 1 Percent of Trade Value Affected By Nontariff Trade Barriers - 1986



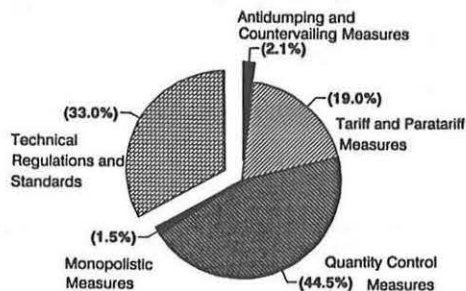
Source: Laird and Yeats, 1990

Figure 2 Percent of U.S. Type II NTB's Applied to Various Products, 1986



Source: Laird and Yeats, 1990

Figure 3
Distribution of Nontariff Measures
in Developed Countries



Source: Ndayisenga and Kinsey, 1994

countries? In general I'd say no; The reasons are:

1. Individual countries' standards for health and safety are encouraged and are protected by international agreements. In short, nations have the right to protect their own domestic consumers.

2. The International Standards developed by the United Nations Codex Alimentarius Commission with the cooperation of over 100 nations, has set high standards, many of which exceed those of the United States. For example, when looking at pesticide residues on food products, the Codex standard was stricter than the U.S. standard in 16 percent of the cases when looking at the average daily intakes criteria and in 34 percent of the cases when looking at minimum residual levels for specific commodities (GAO/PEMD-91-22). If we can produce scientific evidence that others' standards are too low, arbitrators will likely rule in favor of the higher standards. After all, we are all consumers of food, the international community is interested in these benefits too.

3. Producers in any country, to the extent that they have an organized marketing channel, respond to the demands for high quality and safe food. For example, the U.S. meat producers mentioned above and Chilean grape producers meet our

standards because it is in their economic interest to do so. The power of consumer demand for safe food in the market place works as long as the information feedback works.

4. Harmonization does not mean identical standards for everyone. It means the "use of international standards, guidelines or recommendations by all the contracting parties ... to increase coordination and integration between international and national systems and approaches for approving the use of food additives and for establishing tolerances for contaminants in foods, beverages, and feedstuffs." (Multilateral Trade Negotiations, 1991; Kinsey, 1993) It does not mean that all foods will have the same identity or recipe in all trading countries. It does mean that all traders will agree to follow some minimum international guideline for food safety such as that set out by the UN's Codex Alimentarius Commission. Agreeing about what to agree on is not a trivial matter, however. Agreeing to accept each others standards for processing food is quite different than agreeing to submit to the importers standards of quality in an end product. The latter requires infinitely more inspections and costly monitoring. The former leaves more room for variation in sanitation and safety, but is cheaper to regulate.

The debates about how to ensure safety occupy more time and effort than the setting of the standards themselves. They have important implications for the end result. What is encouraging in all this is that the combination of two important forces seems to be working to ensure consumers safe food at a very reasonable price. 1.) Consumers demand for high quality and safe food is being listened to by domestic and foreign producers. If they want to sell in this affluent, informed market, their products must meet the standards consumers demand. 2.) The necessary complement of a "credible threat" of government enforcement of the health and safety standards that are not transparent to the buyer is in place, even though it is not without fault and laxity. Without this government backup in the form of

the Food and Drug Administration, Commerce Department, and Environmental Protection Agency, to name a few, consumer demand for high quality and safety would not prevail, especially when the safety characteristics cannot be seen or known to consumers at the time of purchase.

Therefore, in international trade, just as in domestic markets, consumers' preferences drive the market. But when those preferences are over unknown or unknowable characteristics, only the presence of a knowledgeable inspector who can inform consumers or enforce standards will ensure that consumer products are safe in the short and the long run.

Consumers' ultimate interest in international trade is having lower priced, higher quality and bigger variety of goods to choose from. Ensuring their safety involves not only information readily available to the buyer and the seller, but the government inspector who can exercise the heavy hand of a ban when it is necessary to protect consumers' health.

The interesting questions are, I suggest, not about whether consumers benefit from trade, but about how they can be better served by various trade policies. Free trade is not free. It requires incredible public infrastructures for transportation, information, finance and oversight. How their infrastructures are built, monitored and financed affects the distribution of benefits that consumers and producers will realize from the inevitable growth in international trade.

References

- Bredahl, M.E., & Forsythe, K.W., Jr. (1988). Harmonizing phytosanitary and sanitary regulations through GATT negotiations (Staff Paper 11). University of Missouri-Columbia: Department of Agricultural Economics.
- Government Accounting Office (1991). International food safety: Comparison of U.S. and codex pesticide standards (Report to Congress, GAO/PEMD-91-92, August).
- Kinsey, J. (1993). GATT and the economics of food safety. Food Policy, 163-176.
- Kramer, C. (1991). Implications of the hormone controversy for international food safety standards. Resources, 105, 12-14.
- Laird, S., & Yeats, A. (1990). Quantitative methods for trade barrier analysis. London: MacMillan.
- Multilateral trade negotiations, The Uruguay round agreement - text on agriculture, part C: Decisions by contracting parties on the application of sanitary and phytosanitary measures. (MTN.TNC/W/FA 21 December, 1991).
- Ndayisenga, F. & Kinsey, J. (in press). The structure of nontariff trade measures on agricultural products in high income countries. Agribusiness: An International Journal.

Endnotes

1. Professor, Dept. of Agricultural and Applied Economics.

International Trade: What Is the Consumer Interest? Comments

An invited presentation at the Annual Conference of the American Council on Consumer Interests. Comments are a reaction to the presentation of Dr. Mark Silbergeld's address at the Esther Peterson Consumer Policy forum.

Rachel Dardis, University of Maryland¹

Dr. Silbergeld has indicated that a reduction in trade barriers need not necessarily result in a reduction in consumer protection or environmental protection. Thus, I am going to focus on some common beliefs or misconceptions about international trade which may hinder the growing momentum toward open import markets and increased consumer choice.

The first belief is that exports are good while imports are bad. This is a mercantilist belief in which trade is viewed as a zero sum game (GATT riddance, 1993). In a mercantilist government there are two risks, which are not equal. There is the risk of losing real jobs in import competing industries versus the risk of losing hypothetical jobs in export related industries. Thus, there is an incentive to maintain trade barriers while negotiating for market access. This approach ignores the fact that international trade can increase the wealth of all trading nations. There has been a reduction of trade barriers in countries such as Australia, New Zealand, Mexico, Chile and India as these countries realized that they were the losers from continued isolation from the world economy (GATT riddance, 1993).

The second belief is that free trade only benefits consumers. However, a review of U.S. trade laws noted that "protectionism imposes some of its greatest costs on American producers" (Bovard, 1994, p.47). Anti-dumping laws are an example of protectionist trade laws. They are justified on the basis of fair trade which has been called "free trade's reasonable-sounding evil cousin" (Richman, 1994, p.68). The United States has found dumping in well over 90 percent of the cases it investigates due to a 1974 law designed to enable U.S. pleaders win

(Richman, 1994). Dumping disputes are still outside GATT's control but there are indications that the United States has become concerned about the spread of anti-dumping laws in other countries. Once again, the United States may be the eventual loser from trade policies which it initiated and which it fought to exclude from GATT.

Import quotas on steel are another example of trade barriers which hurt producers. They have increased steel prices and produced shortages of certain types of steel in many instances. This, in turn, has eroded the competitive position of many American industries such as automobiles, ship-building and tool-making. Import quotas also cost U.S. consumers approximately \$7 billion a year according to the Institute for International Economics (Bovard, 1994, p.51).

The third belief is that high-wage countries cannot compete with low-wage countries. However, this belief ignores the fact that labor costs are based on labor productivity as well as wages. High-wage countries can afford to make their manufacturing operations more capital intensive than low wage countries so that their workers are more productive. High-wage countries also have better transportation and communication facilities. The success of U.S. capital goods on world markets is an example (Warner, 1993).

The Uruguay Round was completed in December, 1994 after seven years. It was designed to reverse a thirty year trend toward protectionism and has achieved some notable successes including a reduction in farm subsidies, the phasing out of the Multi-Fiber Arrangement over a ten year period and the inclusion of trade in services under GATT's trading rules (Richman, 1994). It is

estimated that liberalization of the U.S. textile and apparel industries will save consumers \$17 billion a year in 1990 dollars (Spiers, 1994). However, The Uruguay Round also has some failures and there is little doubt that non-tariff barriers will continue to remain a problem. The key question is the degree of support for multilateral free trade in most trading countries. Fortunately, the consumer is not alone in this battle. Business and industry also has a stake in free trade. This includes import using industries, distributors and retailers of imports, U.S. firms with foreign production operations and foreign firms with U.S. production operations (GATT riddance, 1993). All these parties could be a powerful political force in creating more open import markets.

Finally, the U.S. automobile industry is an interesting example of the gains from trade. This industry has focused on improvements in productivity, quality and customer service in order to compete with Japanese cars (Taylor, 1994). These changes have benefitted consumers and might not have occurred without the stimulus of global competition. This is why consumers and their representatives must continue to argue for multilateral free trade.

References

- Bovard, J. (1994). U. S. trade laws harm U.S. industries. Regulation, 16(4), 47-58.
- GATT riddance? (1993). Regulation, 16(3), 6-9.
- Richman, L.S. (1994). What's next after GATT's victory? Fortune, 129(1), 66-70.
- Spiers, J. (1994). GATT's payoff. Fortune, 129(3), 28.
- Taylor, A. (1994). The new golden age of autos. Fortune, 129(7), 50-66.
- Warner, A. (1993). The secret behind American export success. Regulation, 16(3), 52-60.

Endnotes

1. Professor, Department of Economics.

**International Trade in Theory and Practice:
What Is the Consumer Interest?**

Producers have obtained a wide range of restrictions to trade, and the removal of such barriers provides clear benefits. But trade theory offers more to consumers than is actually delivered by trade policy. The "New International Trade Theory" (NITT) permits us to see that consumers are excluded from any role in formulating trade policy. It also allows us to see why there is so much trade in dangerous or useless products. Thus the NITT explains the need for international rules - like the UN measures Esther Peterson fought so hard to achieve.

Robert R. Kerton, University of Waterloo¹

Our Esther Peterson presentation is comprehensive, sensitive, and precisely directed at a policy of immense importance to consumers worldwide. It is therefore a fitting tribute to Esther herself. The paper advances the discussion, making a common position on trade among IOCU countries a more likely prospect.

Dr. Silbergeld rightly points out that international trade usually offers consumers more choice and better quality, both of which improve consumer welfare. (Key reviews on the consumer interest in trade are Blackhurst, 1986, and Dardis 1986). And there is little doubt that the December 14, 1993 success of multilateral trade negotiations is an important achievement for most of the world's consumers. Good news too, is the March, 1994 signing of the Basel Accord on the waste trade. Even so, we should recognize that independent studies by the OECD, and by the World Bank, agree that virtually all of the African countries south of the Sahara are losers under the General Agreement on Tariffs and Trade (GATT). Indeed, trade policy is in the fine print, as Mark Silbergeld notes. And the fine print in regional pacts like NAFTA calls for a more sceptical view than is evident in early, rosy, assessments (US Department of Commerce, 1993; Canada, Ministry of External Affairs, 1992; Kantor, 1993).

Three points merit special scrutiny: First, a major shift in the fundamental theory of international trade offers both benefits and

threats to consumers throughout the world. Second, there is a small but growing portion of trade which is wreaking unconscionable harm on consumers. And third, the non-tariff barriers (NTBs) deserve far more attention from consumer researchers and from policy-makers.

Major Shift In Trade Theory

Two major developments in trade theory have taken place over the last few years: one is the "new" international trade theory, and the other is its policy result, "strategic trade policy" (STP). Consider each from the point of view of consumer welfare: is either of the new policies a substitute for other policies for consumer protection? Does either indicate new or different roles for consumer action? Are the new approaches, on balance, likely to be a threat to consumers? An opportunity?

Classical Trade Theory: Comparative Advantage (CA)

If a country is prevented from trading, it is restricted to using only its own resources to produce the goods desired. If two countries are allowed to trade, each can specialize by using more of its resources to make extra units of the good in which it has a "comparative advantage". CA is defined in terms of the opportunity cost of final output. Comparative Advantage: If each country specializes in the production of the what it does best (the output it can produce at a lower opportunity

cost), total output will increase. If the two countries are allowed to trade, they could either continue producing as before, which leaves them as well off as before, or they can take advantage of the principle of comparative advantage.

From the consumer's point of view, CA is one form of consumer protection policy. It protects against inefficient production, though by itself, it does not guarantee that the efficiency gains are passed on from producers or owners to consumers. True competition is what ensures that the gains from trade are passed on to consumers. But in the world of trade theory there is a new kid on the block, one we have to recognize. The new theory is explained in the work of Krugman (1986).

The "New International Trade Theory" (NITT)

What is "new" about the NITT? The modern theory still makes use of the principle of comparative advantage, but most interpretations of the NITT also recognize that an up to date theory of international trade must include:

- (a) effects on third parties,
- (b) the presence or absence of monopoly power, and
- (c) incomplete information.

(a) Downstream benefits on third parties (externalities). It is possible that firms and consumers who are not part of the original exchange will gain some benefit from freer trade. For example, if trade expands, economies of scale might allow prices to decline in the domestic market. Similarly, trade may increase productivity of firms making use of traded inputs, or augment satisfaction of consumers of downstream products.

The trick is to be sure that these positive effects really are likely to exist, rather than being a ruse by some industry seeking favoured status under "strategic trade policy". NITT opens the door to "strategic" protectionism for firms (who get themselves denoted as strategic) while not allowing for consumer input. This is a glaring

deficiency in the NAFTA agreement - especially in its dispute resolution panels. The error is extended in the supplemental environmental agreements which use the same panels (Kantor, 1993).

Overall, the NITT provides a sharper view of the externalities. This matters because it has become increasingly evident from research on innovation that downstream benefits are frequent.

(b) Market Structure. One primary characteristic of the NITT is the willingness to recognize that many exchanges take place under conditions of less than perfect competition. Market structure becomes an explicit part of the analysis. For researchers steeped in consumer economics, this recognition comes rather late, but is clearly a welcome improvement. One can recognize for example, pricing and other duopoly behaviour by Airbus and Boeing in the selling of passenger airliners. NITT makes sense of the effort of Sri Lanka to try to deal with oligopolistic power in the international pharmaceutical industry. The new theory can sharpen - significantly - our understanding of these issues.

If the NITT is to be extended as a major improvement for consumer policy, it will be necessary to recognize that the theory provides a solid basis for establishing an effective international framework for competition, perhaps as a body of law in an EC tradition, perhaps as an international anti-monopoly commission along the lines of U.S. practice. The OECD prepared an excellent survey in the consumer interest (1986). However the published material dates from a 1984 conference, just before the NITT became prominent. There is an urgent need for a current consumer-oriented analysis.

(c) Information costs. The NITT also incorporates the fact that information problems are significant. While this is hardly news to consumer researchers, it is a clear and important gain in the trade area. We cannot simply assume that consumers in developing countries have accurate scientific information on products

which are useless or dangerous. Informational problems must be expected to be even more omnipresent for international consumers than in smoothly performing national markets.

Strategic Trade Policy (STP)

The effort a country makes to favour its oligopolies or to get a head start which allows it to gain downstream benefits is known as "Strategic Trade Policy". (STP). The NITT legitimizes this strategy. Under STP, a country calculates what is best for it, taking account of responses of trading partners and competitors. This can be done by allowing for information shortages, market imperfections and expected downstream benefits. A country is tempted to try to "pick its winners" and provide trade protection to firms which have special potential. Inevitably the focus is parochial.

The NITT, which seemed to promise so much to consumers leads to STP which is just the opposite. The reason is that consumers are rarely included in the planning process. In effect, STP is based on information provided by producers, so it comes as no surprise that the ultimate policy is closely related to the producer interest. At another level, this threat is even more insidious: The aggressive use of STP leads countries to seek provisions in GATT and NAFTA for the benefit of its national firms. Intellectual property and plant breeder's rights "privatize" some public goods to the disadvantage of international consumers. We need to explore if this is a social gain.

Trade In Dangerous Products

The Silbergeld paper does not address the waste trade, nor double standards, nor other unconscionable international transactions. But if we do not deal with it here, it is hard to see where it will get serious treatment. Most of trade theory presumes that necessary information will be available even when this is unlikely. It further presumes that legal remedies which are available in some countries are regularly available in the international arena. The fastest growing sector of International exchange is the trade in pirate products, fakes, and

service sector scams. On some conservative assumptions, trade in unapproved pesticides was in the order of \$ 1.5 billion as early as 1978 (U.S. General Accounting Office, 1979).

Over 8000 pharmaceutical and chemical products have been banned in industrial countries, or have had their use restricted, yet these same products circulate in trade to poorly informed consumers in developing countries (Kerton, 1990, p.6). Why? The clue is in the cost of finding information. (as allowed in the NITT). The full answer is that poor countries do not have the capacity to understand direct scientific messages. In an examination of health "capability" in 111 developing countries, the World Health Organization found that only nine had fully functioning drug assessment systems.

On balance, it is undoubtedly true that most transactions in international trade make both parties better off. But there are far too many exceptions which cause serious physical and economic harm to unsuspecting consumers.

Tariffs and NTBs

Historically, the chief policy used for protection was the tariff, whose popularity was aided by the fact that it brought revenues to the government. More recently there has been an explosion in non-tariff barriers (NTBs), a shift which may be partly explained by efforts to reduce tariff protection. One attempt to track the huge range of NTBs, made by the European Commission, uncovered more than 100,000 different technical regulations in the Community (EC, 1988, 55, p. 49). These cover a wide range of barriers from customs forms, to tax rules to specifications for electrical sockets.

The harm done to the consumer is readily apparent, and especially so for those NTBs introduced (often with the claim "to protect consumers") by strong lobby groups. My favourite example was a regulation to protect the defenceless Canadian consumer from the clear and imminent threat posed by short carrots. But most are not humorous at all. The U.S. imposes content requirements

impeding efficient low cost subway cars and busses from entering the market.

The use of non-tariff barriers (including "voluntary" and other quotas) has been driven to the point where they are far more significant than tariffs, as measured by harm to consumers (Corbet, 1986). Further, NTBs harm low income consumers most of all, and that includes consumers in wealthy countries (Jenkins, 1980). There are numerous special provisions protecting agriculture in developed countries, and these, plus the multi-fibre agreement, harm poorer countries specifically. Yet if one counts the number of new NTBs, UNCTAD research shows that: "... most of the new trade interventions by developed market economy countries, consisting mainly of restrictions and retaliatory actions were directed primarily against other [developed] countries. This was due particularly to the complex system of trade measures built up against Japanese exports, especially in the EEC and to a lesser extent in the United States" (UNCTAD, 1987, p. 194).

General equilibrium estimates of the impact of NTBs on the world's consumers also lead to the conclusion that they do far more harm than tariff barriers. Whalley computed the possible world gains from the multilateral abolition of all protection, finding that NTBs had up to four times the impact of tariffs (1985, p. 181)

Three conclusions can be drawn: first, NTBs do much more harm than tariffs do. Second, consumers have been losing ground with the rapid growth of these barriers (even within the NAFTA treaty). Third, the recent GATT Agreement converts many of these NTBs into tariffs which are to be reduced over the next few years - a real achievement. The consumer cannot receive full benefit under trade agreements because, when it comes to creating the fine print, the consumer is not a central participant in trade policy.

Conclusion

The Silbergeld paper covers considerable ground with conciseness which commends it to potential users. The lecture - and all three reactions

to it - show that tariffs are not nearly as important as NTBs. The paper also suggests that consumer welfare depends very much on the lines written in a treaty. International trade theory promises a great deal to consumers. Trade policy delivers much, but not so much as the theory predicted. The Esther Peterson Lecture makes an important contribution to indicating why this is so. We still have some explaining to do, but Esther can be proud of the progress.

References

- Blackhurst, R. (1986). The effects of trade restrictions on consumers. In OECD, International Trade and the Consumer. Paris
- Canada, Department of External Affairs. (1992). The NAFTA Manual, North American Free Trade Agreement. Ottawa.
- Corbet, H. (1986). Public scrutiny and protection: Trade policy and the investigative branch of government. In OECD, International Trade and the Consumer (pp. 224-237). Paris.
- Dardis, R. (1986). Government intervention and consumer welfare, the impact of international trade restrictions. Journal of Consumer Policy, 20, 243-260.
- European Commission. (1988). European Economy. Directorate General for Economic and Financial Affairs, No. 35; March.
- Jenkins, G. (1980). Cost and consequences of the new protectionism, the case of Canada's clothing sector. The North-South Institute, Ottawa.
- Kantor, M. (1993). NAFTA supplemental agreements on labor and the environment. Office of the United States Trade Representative, Washington, August 13.
- Kerton, R. (1990). Double standards: Consumer and worker protection in an unequal world. The North-South Institute, Ottawa.
- Krugman, Paul R. (1986). Strategic trade policy and the new international economics. Cambridge and London: MIT

- Press.
- Organization for Economic Co-operation and Development. (1986). International trade and the consumer. Report on the 1984 OECD Symposium, Paris.
- United States Department of Commerce. (1993). International trade agreements: GATT and NAFTA: Why they are important, Consumer Bulletin, Office of Consumer Affairs, Oct.8.
- United Nations Conference on Trade and Development. (1987). Trade and Development Report, 1987. United Nations, Geneva and New York.
- Whally, J. (1985). Trade liberalization among major world trading areas. Cambridge and London: MIT Press.

Endnotes

1. Professor of Economics, Waterloo, ON Canada, N2L 3G1.