

**Remarks by Victor R. Fuchs  
to the Biennial Meeting of the American Society of Health Economists  
June 24, 2008 – Duke University (by video)**

Thank you Ed for that generous introduction. I am tempted to say I don't deserve it. But I have this bad back, and I don't deserve that either – so I guess it evens out.

What a great pleasure and distinct honor it is for me to be able to join you on this wonderful occasion! It is wonderful for me for several reasons.

First, having some familiarity with mortality statistics, I consider myself fortunate to still be around. I am reminded of the old timer who was interviewed by his local newspaper when he turned 100. “How do you feel when you get up in the morning?”, asked the reporter. “Surprised,” was the answer.

Second, it is inspiring to know that health economics is such a vibrant, fruitful field with over a thousand participants in all parts of this country and many more thousands in other countries. Your achievements go far beyond my wildest dreams for the field when I started a health economics program at the National Bureau of Economic Research in the mid 1960s. At that time, we could have held an annual meeting in a small seminar room.

My interest in health grew out of my work on production and productivity in the service industries. I was particularly eager to gain a better understanding of the determinants of health and the determinants of the cost of medical care. The president of the National Bureau, Arthur Burns, tried to discourage me, saying that research on a more conventional topic such as economic growth or business cycles would do more to enhance my professional reputation. I was stubborn, however, and when I succeeded in obtaining a large grant from the

Commonwealth Fund for research in health economics, Burns accepted the verdict of the market and gave me a green light to proceed.

I imagined that three or four years of research would answer most of my questions, and that I would then move on to another subject. Foolish me! Four decades later, despite all that we have learned, the complexity of the subject and especially its application to health policy seems almost as daunting as ever.

Consider the question of reform of U.S. health care. My colleagues and I have just completed the second year of a three year project examining the major issues that are generic to any comprehensive reform. We have held seven workshops with participation by experts from many academic disciplines and leaders from all aspects of medical insurance and medical care. Political questions have been kept to a minimum; nevertheless consensus on critical points has proven elusive. Opinions differ not only because of differences in values and interests but also because the consequences of major policy changes on costs, access and quality are uncertain. Much work remains to be done.

The fact that ASHE has gotten off to such a rousing start is indeed heartening. In recognition of the development and maturity of the field of health economics, ASHE has decided to create a career achievement award for contributions over a lifetime. I am thrilled that this award will carry my name, and I thank you most sincerely for this honor. It is particularly wonderful for me to know that Michael Grossman is the first recipient of this award. Mike joined me at the National Bureau in 1966 and quickly demonstrated the keen intellect, scholarly integrity, and commitment to serious work that has been evident in his research ever since. Under the guidance of Gary Becker, Mike's Columbia dissertation on the demand for health

became a landmark in our literature. When I moved to California in 1974, Mike succeeded me as head of the Bureau's health economics program and also as professor at CUNY Graduate Center.

His work at CUNY has been spectacular. He has continued his own high quality research decade after decade, while training scores of new health economists who continue the Grossman tradition. In my judgement, Mike has created and led the most productive graduate program in health economics in the country. One of the reasons why I admire and feel indebted to Mike is the way he has kept **health** in the forefront of his work and that of his students.

When I entered the field, it was often referred to as **medical** economics. From the start, I tried to change the name to **health** economics. This has happened, and no one has done more than Mike to make sure that health gets its proper share of attention. In that same vein, let me commend the organizers of this year's conference for the title they have chosen, "Equity and Efficiency in Health and Healthcare." Those seven words capture what we are about collectively, bearing in mind that no individual investigator is obliged to cover everything.

Most health economists devote most of their attention to studying *efficiency* in health care. This is readily understandable. From a distance, hospitals and physicians' practices look like firms and patients look like customers. This means that many of the models and theories from general economics can be pulled off the shelf for application to health care. Also, because the U.S. spends so much on health care, even modest gains in efficiency would be very valuable. For example, a one percent improvement in efficiency, holding output constant, would free up enough resources to provide pre-school care for two million children. Or, if you prefer, would pay for a 50% increase in the number of local police officers across the country.

The application of the tools and concepts of efficiency to **health** as distinct from

**healthcare** is more difficult, partly because health is not easily tradeable among individuals. But much useful work has been done, and Mike Grossman has often led the way.

Research on equity has been more problematic than that of efficiency. While many studies have documented disparities in health outcomes between groups classified by ethnicity, income, and education, not many have been successful in elucidating the reasons for these disparities. Moreover, even those relationships that seem robust in cross-section studies of individuals in the United States, often lose their predictive value when trying to explain changes over time or differences across countries.

Similarly, while many studies have documented disparities in access to medical care between groups classified by ethnicity, income, and education, the link between disparities in access and disparities in outcomes has not been so firmly established.

In closing, let me say a word or two about my current research, which focuses on inequality in length of life. This inequality in the U.S. is very large, even when the analysis is limited to the white population. Consider the fate of the members of a white birth cohort born this year. If they experience current age-specific mortality rates, approximately one-fourth of them will die before the age of 70 while almost one-fourth will live to 90 or beyond.

Little is known about the reasons for this large variation in length of life or, more importantly, why the variation in the U.S., and in most individual states, is greater than in other high income countries. I hope that health economists, along with experts from other fields, will shed light on these questions. I am certain that Mike Grossman and those who have trained with him will play a significant role in such an effort.

Thank you again for affording me this opportunity to congratulate Mike and ASHE and to

offer my best wishes for an outstanding meeting.