Health Care in a Free Enterprise System

— Frank Dornfest

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Curriculum vitae

Frank Dornfest is a graduate of the University of Cape Town and was in general practice in Milnerton, Cape Town, from 1966 until 1981. During this time he was actively involved in the Faculty of General Practice of the College of Medicine and is a founder member of the Academy of Family Practice. He was recipient of the Louis Leipoldt and Noristan Awards and he has published numerous articles on family medicine. He is currently living in California where he is Medical Director of the Family Practice Residency Programme of the Community Hospital at Santa Rosa.

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Summary

The free enterprise system has brought tremendous benefits, but great difficulty. The American Health Care is like a gifted child: it has the intellectual capacity without the commensurate emotional development to use wisdom in its application of technology. It has led to a shift in focus from human experience of illness to various technologic facts of disease. What the patient tells has diminished in intensity and necessity. We seem to have a great deal of difficulty taking seriously any human suffering that cannot be directly related to an anatomic or pathophysiologic derangement. There is a fervent belief in the powers of the great god, Science which has led the public to demand from its doctors and their machines what they once asked only of their gods.

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Drawing on my personal five year experience of the United States health care arena, I would like to depict for you, how free enterprise and consumerism amongst other factors, influence daily practice in the US. Clearly this is my own interpretation and it is thrown into sharp relief, by my relatively recent twelve year familiarity with general practice in South Africa. It is also very profoundly coloured by my being a family doctor and equally by being a teacher in part-time practice, and as a medical administrator in a 155 bed community, county hospital.

In any health care arena, overarching national issues influence the day-to-day experience of practice. I would like to articulate for you, how these broad-based issues exercise a particularly intense effect on practice in the US. They do so through the immensely powerful modulating instruments of consumerism, the free enterprise system, as well as other ethical and personality characteristics of the American system. The degree of influence, exerted by national issues, is one of the most striking differences from the South African system.

Although it would seem logical to start with a description of the structure of health care in the US,

to do so would require a mass of data — although a typically American thing to do, but I would find that kind of presentation boring and very likely to miss the point.

I am going to make the daily experience of practice the central focus of our gaze. Our own practice microcosms, rather than the entire health care system, is the home-base ethos which informs our views and even our research.

However, before I describe the effect of the free enterprise system and consumerism on practice, I do need nevertheless to set the context. To do this, using

A country which worships change, and the great god: Science.

relatively few, very broad brush-strokes, I will first review with you what I see as the personality rather than structure of the American system of health care.

The delivery of Health Care in any country is a highly emotionally charged concern of both the individual and the body politic. It is not surprising that a Health Care Delivery system would clearly reflect the personality of its country of origin and the vicissitudes of its history. The national personality in turn, is shaped by at least two groups of factors.

The first group is what I would call, the national ethics — an enduring collection of often dimly perceived or unconscious deeply-rooted ethical feelings — feelings about "what is right and wrong".

The second group of factors is a much more superficial, eminently more pliable and conspicuous set of characteristics of the people.

To look first at the ethic of free enterprise: this is a commitment to limiting governmental control. It stems from the notion that the energies of relatively unbridled competition, will provide an equitable environment for all citizens.

Competition is encouraged not only in private enterprise but within the government and between the government and private enterprise. This does in fact, prevent some of the lockstep of bureaucracy which pervades most government systems. It enables and encourages the American system to respond rapidly to technological progress and new knowledge.

The government is structured so that it is extremely representative and thus also, consumer driven. It is common expectation that local politics can be influenced by a single consumer.

Another regulating force expected to balance out some of the inequities in the free enterprise system, is the civil courts. They are responsible for being exquisitely responsive to the rights of the consumer and consumer groups.

Consumerism is greatly valued and the rights of individuals is partially determined by their buying power. As such there is constant awareness of the power of the dollar.

The US is an enormous country. It comprises 204 000 000 citizens. South Africa has the same population as California and the white population of South Africa is the same size as the population of Los Angeles. Just to personalise this a little, I live in Santa Rosa, in Northern California, which looks and feels much like the Cape because it is on the same latitude. Despite being north of the equator, it has the same climate as Cape Town.

As a result of the large population then, there is great opportunity for the formation of special interest groups — a feature of US politics. They are ubiquitous, and powerful, transcending political parties and economic levels. Elected officials from the federal level down are carefully tuned into their needs.

Change is highly valued, is optimistically viewed as the potential harbinger of improvement. This gives rise to the saying (by, I think Churchill) that Americans tend to come up with the right answers, but often only after they have tried every possible wrong solution.

With the proliferation of technologies has come a suspicion that with science and technology anything is possible. After landing a man on the moon this was proven. This meleorism extends to the expectation that all discomforts and illnesses can be fixed if you can find the right expert. Taken a step further — to some extent there is an expected right to health.

Having overviewed some of the aspects of the national personality, through which broad-based societal issues have their effect, I will explore some of the current national issues in the US which have a bearing on practice.

The pressures of consumerism, the free enterprise system and the value given to change have unwittingly moved health care abruptly away from previous perceptions. These changes are associated with the end of an era, marked by permissiveness, an active social conscience, and government subsidy of small business on a grand scale.

It's no longer a human experience of illness, but various technologic facts of disease.

In the previously untempered free enterprise system of medicine, both patients and doctors were consumers. This led to the unrealistic wide practice of "cadilac medicine". Patients were admitted to hospital at their convenience. The doctor would receive a level of reimbursement, superior to that received for work in the ambulatory care setting. This is part of the reason why American family physicians have spent about 20% of their time in the care of patients in hospitals.

During the 1970's, realising the profitability of health care, the free enterprise system allowed large investment organisations and management entrepreneurs to buy up hospitals, eventually owning large chains. An allied trend was for similar companies to obtain contracts to manage yet other hospitals. This included smaller hospitals owned by local government.

I worked in just such a smaller county hospital owned by local government and managed through a contract with one of these large organisations. This arrangement has introduced a competitive corporate profit orientation into our local government hospital. One result, in our case, is that we — a government hospital, through intense competition are currently locked in internecine war with a competing catholic, privately-owned hospital across town.

. . . the subtle connection between the way physicians think and the way patients experience it.

Partly as a result of this corporatization of hospitals has been the widespread application of marketing techniques and courting of the medical profession, by hospitals which in turn encouraged: inappropriate admissions to hospitals, inappropriate length of admissions, inappropriate use of very expensive emergency rooms ($100 even for a minor illness) — a hotel-like attitude in Emergency Rooms, encouraging the patient to define the emergency.

The corporatisation has also encouraged relatively unfettered availability and application of a staggering array of sophisticated and outrageously expensive medical technologies. Patients are offered or subjected to all that the technology of modern medicine could offer.

Using Santa Rose as an example:

We have established, in my own small hospital, a catheterisation laboratory, and a coronary artery bypass program, in competition with an identical program at the private hospital across town.

Two similar programs, manned by the same surgeons despite being in a city of only 100 000, the size of Kimberley or Krugersdorp sixty miles from a major tertiary care centre in San Francisco.

Free enterprise and consumerism are now amplifying totally opposite national concerns. Government and large employers as well as the consumer, have combined to begin to change the face of medical practice through what I call "the new lies".

The government and large employers who carry the majority of the cost of health care have become increasingly concerned about cost. (General motors recently announced that its bill for health care exceeds its bill from American Steel.)

Consumers have also become very concerned about both costs and the findings of medical malpractice case law. The consumer — although still in love with his own doctor — has developed a great mistrust in the medical profession which has never previously experienced such unpopularity.

Government, consumer and large employer have fostered the growth of large companies, which offer capitated health plans. These Health Maintenance Organisations or HMOs it is said, "will contain health care costs to the consumer", taking the dollars to do so from the rich doctors. I call these "new lies" because the cost of health care continued to increase. The profits, instead of going to the rich doctors, are now going to the rich insurance companies.

Consequence of medicine welling out to the big chains is that Health care is now increasingly seen as an industry. Medicine is now being seen as a saleable item or product, rather than a service provided with noblesse oblige. Doctors are seen as providers of care. The language itself tends to transform the relationships. Increasingly, successful businessmen and lawyers are asserting that medicine has "lost it" and are advising their children not to enter medicine as a career.

On the positive side, some outrageously avaricious physicians who previously drove up the cost of health care, have been partially controlled. It is my personal contention that the face of students applying to medical schools and their earnings-aspirations on entering medicine, will change markedly toward greater service obligation.

Within a capitated system, the physician is faced — at best — with an ethical dilemma of balancing the greater public good (cost containment) against the needs of the individual patient. In fact, he may be balancing his own profit, or worse, corporate profit against the needs of his patient.

. . . more value is fixed on seeing rather than listening.

They insist that he manage his patient with diagnostic elegance — at the same time with parsimony in his laboratory testing and therapy.

To make matters more conflicted, he is asked to do so — partially at his own financial risk. (He is paid a capitation for patient care — and the costs of investigation, specialist consultation and admission to hospital come out of his capitation fee).

The consumer has not yet grasped the dilemma or its effect on him.

In order to contain inpatient costs, the government has developed a new strategy for its elderly patients. It pays a certain amount for each hospital admission based on the diagnosis at the time of admission —

so called Diagnostic Related Groups or DRGs. In the face of this cost-containment strategy, most hospitals have nevertheless done well. The strategies which have allowed them to do so are:

- Rapid discharge from hospital — often at a time which would be considered inhumane in South Africa; and these are all elderly, often frail patients, who frequently have no-one at home to care for them.
- Another strategy has been to move inpatient care to the outpatient setting. Outpatient IV therapy, home blood transfusions for chronic or terminal conditions, chemotherapy, and dialysis. On the other hand the home environment allows much more caring and a family-centered approach.
- Surgical operations which would previously have entailed an admission of at least a few days, are now done as outpatient procedures.
- Therapeutic abortion and herniorraphy are often done under local anesthesia to facilitate outpatient care.

Loss of control by Physicians

With the advent of capitated health schemes, there is an increasing perception by physicians that they have lost control of medical practice. To validate this perception, peer review organisations are employed by non-capitated health insurance companies to look over their shoulders in their practices and to review their notes for appropriateness of charges and procedures or investigations.

The dramatic increase in the amount of time spent on paperwork and the emphasis on inpatient care have markedly lengthened the family physician's day. A move to reverse the serious shortage of physicians in the 1960's and 1970's has resulted in a doctor glut, seriously exacerbated by the influx of foreign medical graduates. This doctor glut is urgently felt by subspecialists and only beginning to be perceived by family physicians.

Do everything and test everything remotely necessary to defend you as a physician.

Despite years of academic family practice, a disproportionately meagre amount of substantive research work has emanated from American family physicians in practice — in marked contrast to this country and Britain. The demands of increasing administration and long hours related to generating income through the care of patients in hospital, have robbed the practicing family physician of time and energy for these activities.

Public infatuation with technology and increased specialisation have set undue value on remuneration for diagnostic tests and procedural skills. The family physician is financially motivated to spend a significant proportion of the day in critical care medicine and procedures.

The relatively rare, over-confident family doctors, of the 50s, 60s and 70s were not much concerned about availability. It was common practice to leave one's practice uncovered during weekends, holidays, and vacations — merely directing one's patients to contact the local emergency room.

Emergency rooms were thus re-framed. Opposing hospitals developed "urgent care centres" in competition with each other and family practice. These urgent care centers are open for extended hours and provide rapid, less expensive care than hospital emergency rooms. From the point of view of the public, this is fortunately beginning to force the family physician to be responsive to the needs for continuity of care.

The practice of medicine has become more the avoiding of malpractice claims than of practicing good patient care.

During the era of social consciousness, government-sponsored programs were established to meet the needs of many special interest groups. This produced a mosaic of services for the elderly, victims of wife abuse, child abuse/neglect, rape, abortion, the indigent requiring sterilisation, and patients in renal failure, etc.

As private and government organisations are competing with one another, there is profusion of these resources. The disproportionate remuneration for in-hospital care, and the romance with technology, has led to an artificially stimulated medical economy. As pointed out by Gayle Stephens, excessive value fixed on seeing, rather than listening, has placed an imperative on the physician to investigate patient complaints. This stimulates multiple investigations which are attractive for their visible results. The defensive response to the malpractice threat has the same effect. It dictates to the physician, — "do everything and test everything remotely necessary" to defend yourself.

Other examples of this artificially stimulated economy are:

The intrinsic right of anyone in renal failure to free ongoing dialysis.

The formation of centers for the care of specific conditions, such as Alzheimers disease, obtaining government grants stimulated by consumer special interest groups. These grants finance diagnostic or treatment procedures of unproven value.

The resultant confusing proliferation of services, has little or no integration. It has fueled the fires of fierce

competition in an arena with a minimum of government regulation, causing health care delivery to become more and more fractured. In the midst of this embarrassment of riches, there now is no discernible health care system, resulting in serious breaches in some areas, while multiple redundant providers compete in others.

With the Reagan administration has come delegation of the cost of indigent care to the states and counties. At the same time, health care dollars are frozen at previous levels. This has reduced the remuneration to physicians and they in turn have simply refused to take care of these indigent patients.

So at a federal level, the ethic of fiscal solvency has supplanted social conscience. In any case, the previous illusion of exemplary medical care for all — was possible only because it was available to a mere two thirds of the population — a form of medical apartheid.

Consumer education

The complexities of the American health care system, with its subspecialisation, has made education about health care mandatory for the would-be informed consumer. This has heightened consumer interest in health, already at the level of an obsession.

The knowledge and communication explosions have markedly reduced the time for the spread of knowledge and facts. New concepts about health and disease need to be absorbed by medicine at an incredible rate.

This places physicians under enormous pressure to remain up to the minute. The media have access to medical information at the time of publication.

Continuing medical education has become an immense industry as a combined consequence of the knowledge explosion and tax deduction. Entire journals are devoted towards informing the medical community about the availability of continuing medical education.

Conferences draw large crowds of hundreds to even thousands. I have spoken at conferences where the last row of participants were not visible. There is simultaneous recording of these conferences with immediate availability to thousands of subscribing doctors obtaining new information within one month.

Hospitals, marketing to physicians, in an attempt to attract patients, commonly provide free meals and free continuing medical education. At my own hospital, there are eight to ten major educational opportunities every week. This has made continuing medical education far less prestigious. Because free meals are

often available to physicians caring for patients in hospitals, even food is not a draw card for attendance at continuing medical education courses.

Medical information systems are available by modem for almost anyone who has a computer. Even full text articles from a wide selection of medical journals is available through this kind of system.

All of this, combined with the romance and infatuation with medical technology, has diminished the value placed on clinical experience. Seeking out help, from someone with experience of a particular condition, is almost frowned upon. A majority of physicians would undertake the treatment of a relatively rare condition,

Obstetrics is practiced with a maximum pathology scenario constantly in mind.

based on information derived from the reading of a few journal articles.

Conditions such as tuberculosis are treated by any physician in private practice, even lacking frequent contact with that disease. Encouraging this, large federal government organisations, like the centers for Disease Control, provide monthly and sometimes weekly protocols for the treatment of a broad range of infectious diseases, further reinforcing this trend.

The representative form of government as an ethic, leads to great sensitivity of government to consumer issues. It is likewise very sensitive and able to react to pressures from the large corporations and special interest groups.

The power of the family physician in the US can be ascribed to the same ethic. His opinion, as a leader in his community is highly sought after by local elected officials. This might encourage optimism about really being able to provide health care appropriate to local needs. This is often the case. However, besides being consumer-driven, the government is driven by the most effective lobby. This is often the large corporations who can afford to employ commercial lobbying groups. These groups can more effectively propagandize the government and the public by clever use of the media.

The elected officials at both a state and federal level are equally responsive to the consumer and not surprised at being lobbied even by someone like me. They frequently are, as part of a strategy by Family Practice Residency Directors as a group. Examples are, concerns about family practice residency funding, or the new "Humane death and dying legislation" which addresses the issues of physician assistance of euthanasia. They need to take note of us as an influential group with family practice-related voters and myself, in the case of my residency, as I have an annual budget of $5,5M.

The judicial system, which is exquisitely sensitive to consumer rights, is able to pursue conflicting and irresolvable principles and theories simultaneously. It is possible to be in two court cases at the same time regarding the same situation, (or patient) for opposing and irresolvable legal principles. If you add to this the glut of underemployed lawyers in the US, these two factors have been mostly responsible for the malpractice crisis in that country. Similar factors that I've mentioned, work to encourage unrealistic expectations in consumers. I would like to give you a local example of how wide open the civil court system is. On behalf of our hospital, I recently took the public health officer to court. I work for the same local government as he does. I was claiming that a decision to route neurosurgical emergencies to another hospital was arbitrary, capricious and in restraint of trade. An extreme example of consumer ethics motivating departments of local government to sue each other. However it is also an example of a system which has the freedom to protect the consumer.

Civil case law has had a profound effect on quality control of medical care. An important series of cases, including the famed "Elam" case, has established the obligation on hospitals, to control the standards of care offered by the physicians who work in them. This has changed the entire relationship between the hospital and the doctor.

It has caused the medical staff of a hospital to become an organised legal entity. The medical staff is responsible to the medical care in that hospital. As a result, any physician who wishes to work in a hospital, is required to apply for privileges. He is then required to demonstrate his right to those privileges, and participate in peer review of his and other's patients care in hospital.

A significant part of the family physician's day is spent in hospital and committee meetings and in dictating long descriptions of his initial evaluation, daily care, and discharge diagnosis and plans. All this to meet

Videotape their discussions with patients about informed consent to cover themselves.

the standards of care acceptable in his hospital — in order to maintain his privileges.

Case law, such as the famous Bouvier decision, has placed legal pressure on the medical profession to consider very seriously ethical considerations in their care of patients. This has seen the advent of laws like the California Durable Power of Attorney for Health Care law, in which a directive may be left to physicians

that decisions about medical care are seconded to someone who is named, should the person/patient become mentally incompetent. Although these have arisen in an atmosphere of lack of trust by patients, they've had a profoundly salutary effect on patient care and the standard of ethics in American hospital care.

The physician now works constantly under the pressures of observation by those who insure the costs of his patients' health care. This, too, is fueled by lack of trust and consumer pressure.

American Society thoroughly enjoys and believes in the power of consumerism.

The malpractice crisis in the United States of course is common knowledge throughout the world. And, having discussed some of the forces and its genesis, let me point out one or two examples of its effect in daily practice.

Some of the highest risk areas are the Emergency Room and Obstetrics. The practice of medicine in Emergency Room has become very much more directed to avoiding malpractice claims than to good patient care. This has produced an inevitable clash between emergency medicine and family practice, which are almost diametrically opposed in terms of their orientation toward the need to keep patients in or out of hospital.

The same applies to Obstetrics. Remembering that Obstetrics in the United States is often a primary care discipline, family practice and obstetrics compete very heavily for the care of pregnant patients. Any new trend in obstetrics tends immediately to be embraced by family practice. This is because any departure from the local standard of obstetrician-type care is almost indefensible in court.

So, in common with the emergency room, because of the malpractice crisis, obstetrics is practiced with a maximum pathology scenario constantly in mind. All possibilities of pathology — however remote — having to be excluded as far as technology will allow.

Physicians therefore are under great pressure from the consumer, mediated through a sensitive judicial system. Informed consent has recently been taken to new and increased lengths, so that some physicians are now beginning to videotape their discussion with patients about informed consent, to demonstrate that they have covered remote complication as part of their process.

One of the characteristics of American society is its enjoyment of, and belief in, the power of consumerism. This makes the dollar the subject of almost every conversation.

With the colossal size of the U.S. and the opportunity to special interest groups to form, (with the graying of America) one of the most powerful groups is the American Association of Retired Persons. Another is the National Rifle Association.

Special interest groups like these also arise around pathologies as well as social classes. There is a plethora of these groups which support and supply information to their members. A recent example in our area is a group formed around previous polio victims. The members of this group are very well-informed. So are those suffering from chronic Epstein-Barre virus or mononucleosis.

These groups apply pressure for special facilities and are a great challenge, especially to the family physician who, in many cases might know less about the disease than the patient. The special patient is not unknown elsewhere, but the degree of sophistication evinced by members of these special groups magnifies the pressure considerably.

With the general level of education in the area of cardiology, it becomes very difficult for the family physician to treat patients with chest pain.

There is huge pressure placed on the shoulders of the treating physician confronted by a patient with chest pain in a hospital, particularly if it has an open catheterization laboratory.

Much of the pressure of course, also comes from the hospital, in an era when hospitals are half empty, battling to maintain a census of inpatients which will at least cover their costs. The special interest groups have also been responsible for pressure on the government to produce a surfeit of community resources. It is common to hear doctors bemoaning their inability to keep track of this enormous array of community resources.

The press participates in gross inequities in the use of resources. It is often the media which determines which patient will get a liver transplant from which donor. The pressures from the media, and consumers of course, has made staggering advances available to the general public, at a cost they cannot afford.

Pressure from the media and consumers made staggering advances available to the public, at a cost they cannot afford.

With change seen as a harbinger of improvement, with the consumer sensitive court systems, the sensitivity of federal, state and local government to consumers, rhythmic variations have become a characteristic of the style of health care delivery. These changes occur as four year election tides, which rhythmically impact upon the basic ocean of health care. An additional system of changes substantively affecting the delivery

of health care, comprises highly distinctive, more prolonged currents. These currents are usually motivated by the special interest groups I have mentioned. They often occur as frequently as once a decade, lasting as long as that. They are palpable and remarkably powerful.

The push to change repeatedly and the value placed on change as a social instrument are enabled and encouraged by the framework of the American political system. The frenetic media respond to the pressures of their own free enterprise competitive system. These produce such extreme transformations in values that even while a new current of value flows, it emerges clearly enough to be labelled as an era eg the era of social consciousness, the current conservative "Yuppie" era. Each era brings profound changes in the style of health care, such as the current worsening of access to health care by the socially disadvantaged.

With the first hint of a change in tide and current in the ocean of health care, like tide-pool animals, vast numbers of researchers, administrators of health care and social agencies, prepare themselves to change their feeding habits.

Two years ago the federal emphasis was on the elderly and it is now swinging to AIDS and the homeless.

Medical research workers in universities are offered only accommodation and must earn their keep by garnering funds from grant money in the area of research. Research emphasis is placed mostly on whatever subject is best funded. The entire research community almost visibly stands on its toes to pick up and bend toward the slightest hint, whiff or rumour of changing trends in Washington. At the same time, this pressure tends to hold research, to some extent, to the relevance of society.

Change brings about a profusion of new experiments and models, only to yield in turn to new models reactive to the rapid spread of any new values. Because of consumer pressure, islands of previous experiments remain, coexisting with a profusion of new services.

Consumerism makes it difficult to withdraw previous failed social models. An example of this is the overabundance of medical school slots, which were built up in response to the doctor shortage of the 1950s and 60s. Because state funding of universities is driven by enrollment of students, the medical education industry which arose to take care of the doctor shortage, cannot easily be adjusted to deal with the doctor glut.

The interaction of these vectors has encouraged standards of medical care amongst the highest in the world, and the abuse of medical technologies. These coexist apparently unselfconsciously, with difficult or no access to care for a vast indigent, under-insured and uninsured population. The patient brought into the emergency room after being partially resuscitated by the ambulance company paramedics (who are under the malpractice gun to resuscitate everyone who collapses) and who is successfully resuscitated but brain damaged. The system seems to try its best to throw the patient away if it is only partially successful.

The infatuation with technology that started after the Second World War has brought the mixed blessings of the most sophisticated medical technology known to man. A consequence is the consumer-oriented drive to produce specialists to implement the technology and reinforce the belief that anything and any disease can be fixed.

These irresolvable imperatives of consumerism, free enterprise and reality have produced a need to reduce the practice of medicine to protocols or algorithms. This practice of defensive medicine, to some extent safeguards the physician from malpractice claims. Protocols and algorithms clearly assist physicians with a falling income to be able to treat anything that comes their way. This plays into the lack of respect for experience as a factor for seeking out the counsel of a wise physician.

From the Journals

Making access to health care more equal: the role of general medical services

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Abstract The Resource Allocation Working Party (RAWP) recognised the need to consider both health authority and primary care services in achieving its objective. RAWP and the subsequent Advisory Group on Resource Allocation (AGRA) found (but did not publish) considerable variation in resources used by both services but could not find a clear relation between them. Statistics provided by the DHSS were used to compare spending by 80 area health authorities in 1980-1 with expenditure per head on general medical services by their corresponding family practitioner committees. There was considerable variation in the provision of resources for both services and no clear relation between the variations in spending on each service. Only 40 of the 80 areas had both health authority and family practitioner committee spending levels within 10% of "target".

Subregional inequalities in resources tend to be related to variations in admission rates, which in turn are related to general practitioners' referral behaviour. These results emphasise the importance of finding out more about inequalities in the provision of general medical services and their relation to the use of hospital services. They also suggest that RAWP's aim of equality of opportunity of access to health care resources may be achieved only if general medical services are brought into the equation as well.