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HEALTH CARE OUTLOOK

(By Barbara S. Cooper,* Social Science Research Analyst, Division of Health Insurance Studies, Social Security Administration)

Health care is the third largest industry in this country employing more than 4.4 million people—5.1 percent of the employed population—in over 50 different occupations.[1] It is also one of the costliest commodities. In fiscal year 1975, about $118 billion, or an average of $547 per person, was spent for health, representing about 8.3 percent of GNP.[2]

Who pays

Who pays for this care? Ultimately, of course, we all do, either through taxes, insurance premiums, or directly out of pocket. It is this last method, however, that hits us the hardest. Examining personal health care expenditures—spending for the direct benefit of individuals rather than research, construction, and the like—we find that of the $103 billion total in fiscal 1975, one-third came directly out of our pockets, one-fourth came from private health insurance and except for a small share from philanthropy, the remainder—about two-fifths—came from the Government. In individual terms this means that we paid an average of $155 per person out-of-pocket, private health insurance paid $126, and Government paid $189. However, the distribution of medical care spending by source of payment differs significantly by type of expenditure and age.

For hospital care, the major item of health expenditures, third parties pay 92 percent of the bill. For other items, though, the third party share is not so generous. We directly paid 35 percent of our physician bills, 85 percent of our dental and drug bills, and 42 percent of the remainder.

Third parties play their largest role in the health spending of the elderly, but then the elderly have the largest bills. The average personal health care bill of an aged person reached $1,360 in 1975. However, 71 percent was paid by third parties, primarily the Government through Medicare and Medicaid. Nine years earlier, prior to these 2 programs third parties paid just 47 percent of the aged's health bill. For persons under age 65, private health insurance is the primary third-party payor contributing 35 percent of the bill compared with 29 percent from the Government, 2 percent from philanthropy and industry, and 34 percent directly.[3]

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*The views expressed in this paper are those of the author and not necessarily those of the Social Security Administration.

[1] *Health Resources Statistics, 1974.* National Center for Health Statistics, Department of Health, Education, and Welfare.

[2] Mueller, Marjorie Smith and Gibson, Robert M. "National Health Expenditures, Fiscal Year 1975," *Social Security Bulletin*, February 1976.

[3] Mueller, Marjorie Smith and Gibson, Robert M. "Age Differences in Health Care Spending, Fiscal Year 1975," *Social Security Bulletin*, June 1976.

Despite the assistance from third parties, one way or another we pay and what we have been paying has been going up at tremendous rates.

THE INCREASING HEALTH CARE DOLLAR

Since 1965, health expenditures have been rising at an average of 12 percent a year. During this 10-year period health spending has more than tripled—from $38.9 billion in 1965 to $118.5 billion in 1975—and its share of GNP has risen from 5.9 percent to 8.3 percent. Preliminary estimates indicate that in fiscal 1976, such spending increased 14 percent and reached $135 billion or 8.4 percent of GNP.

Why the rapid growth? Three broad factors can be identified: price inflation, product change and the increase in utilization or the quantity of care demanded and supplied. In order to understand a little about how and why these factors operate, we must first understand something about the medical care market.

Health care in this country is considered a necessity along with food, housing, and clothing. It differs, however, from these other necessities in several respects. First, for these other commodities, a certain basic amount is considered necessary and anything above that is gravy. And, in fact, a lot of spending on these items is gravy. For health, while there is certainly a difference between a visit to the clinic and a visit to a Park Avenue physician, there is no set level of spending per person that is considered adequate. The sicker one gets, the more one has to spend. Further, you never are quite sure about what you are buying in health. The difference between steak and hamburger or silk and muslim is obvious. But when a battery of lab tests is ordered, you are not always sure if it is necessary, why you need it, or what you will get when you are through.

Because there is no clear delineation between "necessary" and "luxury" and because consumers are at the mercy of what the providers tell them, the traditional demand/supply theory does not operate in health. This is significantly different from the economic forces operating with the other necessities of life.

In health, supply essentially creates demand. As one study pointed out, "a hospital bed built is a hospital bed filled." [4] With physicians, the other major health provider, the incentives are also operating to increase services and prices. A surgeon does not get paid unless he operates. The more often a doctor sees you, the more money he makes, the more complicated the procedure, the higher the price. I am not suggesting that doctors rub their hands together saying "Aha, another sucker to bilk." Doctors are not all bad! But the incentives toward increasing their income through more services and/or more complicated procedures may be subconsciously influencing their decisions to some extent.

Thus, an unlimited demand along with incentives for more income contribute toward rising prices and increase in use. Also, contributing is the large role of third parties. Because hospitals know that third parties will pay for nearly all they do and all they charge (they are usually reimbursed on a cost basis), there is no incentive for efficiency or cost-consciousness. Similarly, when physicians know that a patient

[4] Shain, Max and Roemer, Milton I. "Hospital Costs Relate to the Supply of Beds," *Modern Hospital*, Vol. 92, No. 4, pp. 71–73, 168, 1959.

has insurance, they do not worry as much about ordering another battery of tests or additional visits to specialists. Nor does the consumer worry much either. In our minds, if it is covered, it is free which is hardly the case.

Third-party payments also contribute to product change, the third major factor in expenditures. Product change results when there is a new way of treating or preventing a condition, be it through new equipment, drugs, procedures, or different skill levels of personnel. This new technology has been responsible for a significant portion of the rise in health expenditures. About half the increase in hospital expenditures is technology-related.[5] Because hospitals are assured of payment, if a new piece of equipment is developed, they go ahead and order it. A recent paper estimates that $46 a day in hospital expenses today is due to changes in the level of service in the last 9 years.[6] This is not necessarily bad, but it is not all good either. The fact is that in many cases we simply do not know the efficacy or cost-effectiveness of new technology when it enters the marketplace. Even after adoption, we still may not know, since adequate testing does not always take place.

Physicians have not been immune to the same trends that have been affecting hospital care. Physicians are traditionally the central providers of care either directly or in the determination of the other services and supplies used by the patient. It is at the direction of a physician that expenditures for hospital care and drugs are made. One study found that supply factors, including technology and number of physicians, appear to be of decisive importance in determining the utilization of, and subsequent expenditures for, physicians' services.[7]

ATTEMPTS TO CONTROL MEDICAL EXPENDITURES

Consumers, policymakers and legislatures have become increasingly concerned about finding ways to curb the explosion of health spending. A number of controls have been tried, including supply limitation through certificate of need for capital construction; financial disincentives to the patient through imposition of deductibles and coinsurance; authorization requirements for hospital equipment purchase and hospital use; review mechanisms and rate regulation. As one report states, "success of these controls in the public and private sectors is spotty." [8]

One of the most successful mechanisms for controlling expenditures has been the development of HMO's or Health Maintenance Organizations. Organized as either a group practice or a foundation of individual practitioners, HMO's generally deliver a comprehensive package of health services to a voluntarily enrolled population on a prepayment rather than a fee-for-service basis. An estimated 6.5 mil-

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[5] *Medical Care Expenditures, Prices and Costs: Background Book.* Social Security Administration, Department of Health, Education, and Welfare.

[6] Gaus, Clifton R. and Cooper, Barbara S. *Medicare and Technology: Alternatives for Change.* Prepared for Conference on Health Care Technology and Quality of Care, November 1976.

[7] Fuchs, Victor and Kramer, Marcia. *Determinants of Expenditures for Physicians' Services in the United States, 1948–1968,* DHEW Publication No. (HSM) 73–3013, December 1972.

[8] Rice, Dorothy P. and Wilson, Douglas. "The American Medical Economy—Problems and Perspectives," in *International Health Costs and Expenditures,* DHEW Publication No. (NIH) 76–1067.

lion persons are enrolled in the 181 HMO's existing in the United States today.

The predominant and traditional HMO structure is organized as a group-practice plan in which physicians are salaried, the HMO is at risk for most care (including hospitalization), and primary care is provided in a multispecialty clinic setting often linked to the HMO's own hospital. It has been found in numerous studies that members of group-practice plans have significantly lower rates of hospitalization and surgery than nonmembers. Since members pay on a capitation basis, the HMO incentive is to keep the costliest care—hospitalization—to a minimum. Since physicians are salaried, they get paid whether they operate or not so that unnecessary surgery is often avoided. In other words, while the incentives in the fee-for-service system are for more and more in the costliest manner, the incentives in the group-practice HMO are for less and less in the least expensive manner. This, however, raises the question of quality of care. Since the HMO makes out better by not hospitalizing or not operating, what about the people who really need such care—do they get it? The evidence seems to indicate that they do. No studies have found death rates or disability days to be any higher in group-practice plans than in fee-for-service. Of course, some plans are better than others just as some doctors are better than others. Nevertheless, a recent study comparing the experience of Medicaid enrollees in 8 HMO group-practice plans with a matched sample of nonenrollees found that the fee-for-service group spent 2½ times more days in the hospital; that both groups had similar outpatient use; both groups had similar accessibility experiences; and both were equally satisfied with care received.[9]

The other major form of HMO is the foundation which resembles the fee-for-service system in organization and method of paying physicians, but includes some additional element of risk for both hospital and physician care by receiving a capitation payment. In the same study referred to above, 2 foundations were compared with the fee-for-service experience and in these cases no statistically significant differences in hospital use was found. It is not clear exactly how much of which factors is responsible for the difference between foundation and group-practice HMO's with respect to hospital use. It could be due to the different financial incentives to the physicians or it could result from the organized nature of group-practice with strong peer pressure and economies of scale allowing for a wide variety of diagnostic and treatment services to be provided without hospitalization.

OUTLOOK FOR THE FUTURE

Although HMO's have proven to be an excellent method of cost control and the Government is supporting their development, they will not become the sole health delivery system in the future. What can we expect in the future? President-elect Carter favors national health insurance and its passage is likely. But he has not decided exactly what form he would support nor do we know what form would pass. There were 5 national health insurance bills introduced in

[9] Gaus, Clifton R., Cooper, Barbara S. and Hirschman, Constance G. "Contrasts in HMO and Fee-for-Service Performance," *Social Security Bulletin,* May 1976.

the 94th Congress and one administration bill (CHIP), the year earlier. The bill that ultimately passes is likely to resemble one of these or a combination of several. The provisions of these bills are described in detail in a Social Security Administration report, *National Health Insurance Proposals.*[10] A summary report of the cost-estimates of these bills has recently been released and is available in the Office of the Assistant Secretary for Planning and Evaluation, Department of Health, Education, and Welfare.[11] I will very briefly summarize their analyses here.

Catastrophic protection: The Long-Ribicoff bill

This bill provides a program for the general population whose benefits would be limited to persons who incur unusually long hospital stays or large health expenses. The program would be administered by the Federal Government and financed by social security taxes. As an alternative to the Government plan, employers and self-employed persons could purchase equivalent private health insurance. In addition, the proposal includes a Federal medical assistance plan which would replace and improve the present Medicaid program.

Mixed private-public plans: The proposals of the Health Insurance Association, the American Medical Association and the American Hospital Association, and CHIP

These proposals which have a broadly similar approach would all establish (a) an employer plan requiring or encouraging employers to offer specified private health insurance to their employees; (b) a plan for low-income persons administered and financed by Federal or State Government, or a combination of both; and (c) continuation of the Medicare program or provision of other special coverage for the aged. Special arrangements or plans would also be provided under these proposals to assure coverage for self-employed and other persons. While coverage under a plan of the NHI programs would be available to the entire population, some persons would still find it advantageous to obtain private health coverage outside of the program.

Federal program: Health Security

This bill would establish a program covering the entire population to be financed through a combination of social security taxes and general revenues, and to be administered by the Federal Government.

National Health Insurance costs

In order to determine the economic impact of the proposed bills, it was first necessary to project costs without any bills. It was estimated that with no national health insurance program in fiscal 1980, personal health care expenditures would reach $223.5 billion, 31 percent coming out of pocket, nearly 31 percent through private insurance, and 38 percent from public funds, largely Federal.

Total personal health expenditures by source of funds for each bill are shown on the attached table.

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[10] Waldman, Saul, *National Health Insurance Proposals, Provisions of Bills Introduced in the 94th Congress as of February 1976,* HEW Publication No. (SSA) 76–11920.

[11] Waldman, Saul. *Executive Summary: A Comparison of the Costs of Major National Health Insurance Proposals by Gordon R. Trapnell Associates,* Department of Health, Education, and Welfare.

SUMMARY

There are advantages and disadvantages to each of the proposals. For example, catastrophic coverage is highly inflationary, encouraging use of expensive equipment and services; private insurance may perpetuate the current cost crisis; and Federal insurance may create a massive, inefficient bureaucracy. Cost-sharing may be hard on low-income families; income-related cost-sharing may be difficult to administer; and no cost-sharing may encourage overutilization. The list of problems goes on, but so does the need for some national program of insurance. Undoubtedly, some program will be enacted in the next few years, but we must wait to find out which one.

TOTAL U.S. HEALTH CARE EXPENDITURES, AND EXPENDITURES COVERED BY ALTERNATIVE NATIONAL HEALTH INSURANCE PROGRAM, BY CHANNEL OF ADMINISTRATION, FISCAL YEAR 1980

[In billions]

Channel of payment	No NHI program	Long-Ribicoff	Administration (CHIP)	Health Insurance Association of America	American Medical Association	American Hospital Association	Health Security
Total Health Care Expenditures							
Total U.S. expenditures	$223.5	$233.3	$234.8	$234.5	$243.8	$248.5	$248.3
Private sector	139.0	135.6	133.6	131.6	143.6	133.8	47.4
Out-of-pocket	70.1	66.0	60.5	67.9	59.5	50.1	38.2
Private insurance	66.3	67.1	70.6	71.2	81.7	81.7	7.6
Other private	2.6	2.5	2.4	2.5	2.4	2.0	1.6
Public sector	84.5	97.7	101.3	102.9	100.2	114.7	200.9
Federal Government	59.3	74.9	68.7	57.0	82.0	95.7	189.4
State and local government	21.5	19.1	21.0	21.0	14.5	12.4	10.4
Government insurance premiums	3.7	3.7	11.0	14.9	3.7	6.6	1.1
Expenditures Covered by National Health Insurance Program [1]							
Total expenditures		80.4	121.6	125.9	140.0	159.0	181.7
Private sector: Private insurance		6.8	44.0	47.8	64.7	67.7	0
Public sector		73.6	77.6	78.1	75.3	91.3	181.7
Federal Government		58.9	56.6	51.7	66.6	80.5	176.7
State and local government		12.1	11.4	12.6	6.1	5.3	5.0
Government insurance premiums		2.6	10.6	13.8	2.6	5.5	0

[1] The national health insurance program is defined to include the newly established plan or plans, and the medicare and residual medicaid program if these programs are retained under the proposal.

Source: Gordon R. Trapnell Associates, "A Comparison of the Costs of Major National Health Insurance Proposals," prepared for the Office of the Assistant Secretary for Planning and Evaluation, Department of Health, Education, and Welfare, September 1976.