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HEALTH CARE COSTS AND THE FREE MARKET

INTRODUCTION:

In recent years the American health care system has become the subject of controversy. Though nearly all critics agree that the quality of health care has improved, many find that the improvement in quality has not been commensurate with the increases in costs. In 1975, the United States spent $118.5 billion, or 8.2% of its GNP, on health care; this was an increase from $38.9 billion, or 5.9% of the GNP, in 1965. From 1965 to 1974, the per capita expenditure for medical care increased from $197.75 to $485.36, or by an annual average increase of 9.4%.

These cost increases are growing more and more burdensome both to the consumer and to the taxpayer as the government assumes an increasing share of the burden. They have led to a loss of faith in the American health care system and to proposals which call for vast changes in its present, semi-private status and funding. However, some argue that this loss of faith is misplaced and that, if health care were more responsive to market forces, its costs would not be as exorbitant as they have become. They suggest that in place of government control and funding of the health care sector, a free market approach would be preferable.

HEALTH CARE AND THE FREE MARKET:

In economic theory, prices rise and fall in response to changes in the supply and demand for goods and services. In the real world, and especially in regard to health care, a number of factors serve to insulate the costs of health care from the operation of the free market. It is these insulators that are the primary cause of the cost increases in health care.

Critics of the American health care system (and of the free market) often say that health care cannot be responsive to the market, that demand for it is inelastic because when people are sick, they must purchase health care regardless of the cost. Health providers, it is argued, therefore have a captive market which cannot exercise consumer preferences or simply refuse to buy if they dislike the product. Furthermore, because of the highly technical nature of health care, the average person lacks the knowledge to make intelligent choices as he would in other areas. Because of these peculiarities, say the critics, the government

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should be responsible for seeing that every American receives proper health care at no or very cheap cost and that such health care is a basic right of a citizen in an affluent, industrial society.

There is some truth to the charge that health care cannot be responsive to the market, but it is greatly exaggerated. The demand for health care is no more inelastic than the demand for food, which is also necessary. It is true that people must have health, but there are any number of ways they can improve and protect their own health in easy and inexpensive ways. Furthermore, they are just as capable of exercising a choice among doctors and hospitals, given differences among them of prices and the quality of services offered, as they are of buying a car, a television, or of performing any other economic transaction that involves technical knowledge. It should also be pointed out that technical considerations are not the only criteria involved in deciding which health providers to purchase from. Considerations of cleaniness, courtesy, comfort, convenience, and trust, as well as many other factors often determine our choice of a doctor or hospital. A person who neglects to care for his health or fails to inform himself of available options in buying health care can no more complain of its costs than can a person who fails to eat for a considerable time complain about the high costs of food in the expensive restaurant in which he is finally forced to seek sustenance.

Nor can we be content to let the advocates of National Health Care succeed in persuading us that we have a right to cheap or free health care. Health care consists of economic goods and services; someone had to work to produce and distribute them. If we have a "right" to these goods and services at free or very cheap prices, then their producers/distributors have a corresponding duty to provide them at little or no charge. The recognition of such a duty in law would be nothing less than a form of slavery or forced labor, a concept against which Americans have historically rebelled. Health care, in short, must be paid for, and it must be paid for at a price which offers adequate compensation and incentives to attract efficient providers.

With these principles in mind, let us examine some of the forces which artificially insulate health care from the market and which are responsible for cost increases. Some of these forces are the result of government action which, intended to prevent a health crisis, have actually contributed to the growing problems of health care. Other forces are not the fault of the government (at least not directly) but still reflect social and economic trends which government sometimes encourages.

SOCIAL AND ECONOMIC CAUSES:

Three of these must be examined: the reimbursement system by third parties; the consequences of malpractice litigation, and the rising burden of new and technologically advanced equipment and laboratory tests.

A. Third Party Reimbursement: Payment for most health care costs are borne not directly by the consumer (patient) but are apportioned out among three different sectors: the consumer, the private insurer, and the government. This system of reimbursement increases the cost of health care in several ways. First, it relieves the burden of payment for any one of the three sectors. Thus, none of the three has much incentive in seeing the costs reduced or stabilized. Secondly, coverage by insurance serves to stimulate demand, which in turn forces prices up (assuming no comparable increase in supply). Thirdly, because the patient has already paid his insurance premium, health providers can raise their charges (as well as the quality of their services) without placing the burden on the patient.

As of 1974, about 85% of the American people had some form of private health insurance (87.1% were covered for hospital care and 81.1% were covered for surgical care). The cost of insurance premiums as a ratio to disposable personal income rose from 2.14% in 1960 to 2.57% in 1965 and to 3.59% by 1975, or by little more than 1% for the past ten years.

Dr. Martin Feldstein of Harvard University has demonstrated that insurance coverage increases demand for health services. Insured families use hospitals and physicians more, stay in hospitals longer, and have more ancillary services (tests and examinations) than do non-insured families. Thus, the extent of private coverage may be counted as a factor serving to increase demand, reduce the burden of cost, and stimulate price increases.

However, the federal government is responsible for encouraging private coverage as well as for public insurance. The government subsidizes private health insurance by offering a deduction of up to $150 plus all medical expenses that exceed 3% of income. The government also subsidizes employers for their contributions to their employee's health insurance by not taxing these contributions as income. In 1974 the government lost in revenue about $3 billion for employers' contributions and about $2.6 billion for personal income tax deductions.

The government also acts as the largest single contributor to third party payments. In 1974, 64.6% of the health care burden was borne by third parties: 25.6% by private health insurers and 37.6% by government (1.4% was borne by philanthropy and other sources). From 1965 to 1970, the portion of health costs carried by private insurance fell from 24.7% to 24% (though it increased again by 1974) and the government portion increased from 20.8% to 34.2%. This increase was due to the implementation of Medicare and Medicaid programs in 1966.

The government portion of the third party payments was not felt at all by the consumer (though it was certainly felt by the taxpayer) and there was no consumer incentive to hold down costs. Nor do private insurers feel such an incentive. The higher the cost of health care, the more dependent the consumer is on health insurance, and as a ratio of the consumer's disposable income, insurance premiums have increased by only 1% in the past decade.

We may conclude then that the system of third party reimbursement is an inflationary force on the cost of health care; that it acts as an inflationary force because it serves to stimulate demand and is a disincentive to reduce or stabilize costs; and that government is a primary contributor to this system through its fiscal and medical benefits policies.

B. Malpractice Litigation: Between 1970 and 1975, malpractice claims against physicians grew steadily from 1,538 to around 5,000--an increase of 225%. The size of claims increased significantly also; in 1974, in California alone, there were 15 suits with claims of over $1 million. About 30% of claims reaching court are won by the plaintiffs, but legal costs are still incurred by physicians and hospitals and their insurers. By 1975 malpractice insurance had increased in cost by about 600% in the previous 3 or 4 years. In 1975 its cost was estimated at $1 billion: $350 million in premiums paid by doctors and $650 million paid by hospitals. Some doctors have stated that they pay 10-20% of their gross incomes in malpractice premiums.

The result of such increases in malpractice litigation and the cost of insurance has been twofold: first, to increase the fees of both doctors and hospitals to cover the cost of the insurance; and secondly, to contribute to the growth of "defensive medicine"--i.e., doctors taking longer and making more certain of their diagnoses before prescribing therapy or surgery. According to former Secretary of HEW Casper Weinberger, malpractice litigation and insurance cost the country between $3 and $7 billion in 1975.

The causes of this rather sudden upsurge in malpractice litigation are not entirely clear. The most prominent cause is likely to be the increasing estrangement between doctors and hospitals on the one hand and their patients on the other. The family doctor and the general practitioner have become virtually extinct as the medical profession becomes more specialized and "professional." Hence, patients no longer know or trust their doctors as friends or neighbors and are more willing to sue them for what they believe to be negligence or incompetence. Also, as medical care has become more complex, it is probably easier to make mistakes in diagnosis and as surgical techniques have become more sophisticated, the results of surgery have become more serious.

Government probably does little to encourage malpractice litigation, though the size of some of the claims raises questions about the responsibility of the judges involved. However, an important aspect of the propaganda for national health insurance is the gradual discrediting of the medical profession. The leftwing radical group, the Medical Committee for Human Rights, with which Dr. Quentin Young (whom President Carter recently considered for the post of Commissioner of the FDA) has been associated, has referred to the AMA as the "American Murder Association" and indulged in extreme rhetoric about the medical profession. Even more responsible groups have fostered such propaganda which tends to bring disrespect and distrust upon the nation's health providers.

C. Technological Costs: Another factor which increases the cost of health care is the technologically advanced equipment which many hospitals install. It is quite true, as the critics charge, that such equipment is very quickly outdated by even further scientific advances; but their other charge, that such equipment is unnecessary and of only limited usefulness, is more controversial.

Among the more advanced techniques now being used are the Computerized Axial Tomography (CAT) Scanner, used for the diagnosis of cancer; the Intensive Care Unit (ICU) for cardiac problems; renal dialysis techniques for the treatment of kidney failures; and isolation units which duplicate life-support systems for newborn children. There is no doubt that such techniques save lives. Renal dialysis alone is estimated to have saved about 30,000 lives. However, the controversy arises over whether these lifesaving machines are worth the cost. Critics charge that they are not; that the number of lives saved is not enough to justify the extra costs. They also point to the reduced quality of the lives of many patients who have to depend on technology to exist. This argument, however, is a very subjective one; those who face death (often a painful one) without the new technology may not agree that it is useless and should at least have the choice of using it or not--a choice which many critics would deny them by discouraging the purchase of advanced technology by hospitals or doctors.

A second reason why the use of advanced technology is spreading among health providers is the fear of malpractice litigation that they have. Advanced techniques of diagnosis and treatment (and laboratory tests also) serve to reduce the errors that health providers make and many of them feel insecure unless they can take advantage of them.

Finally, it should be pointed out that such new technology and medical care tends to reduce the length of stay in a hospital. According to Blue Cross, in 1947 hospitalization for pneumonia lasted for an average duration of 16 days at $10 a day; by 1966 hospital charges had increased to about $40 a day, but the duration of a stay for pneumonia had dropped to 5 days. Thus, though the cost of a day in the hospital had increased by 4, the cost per stay had increased by only 1.25, plus the time saved by the patient in returning to work sooner. The reduction in time was due to the improvement in techniques of treating pneumonia.

These are the principal forces which serve to increase the costs of health care in the United States. As we have seen, some, such as the reimbursement system, are directly related to government intervention and serve to insulate the costs from the exercise of consumer preference in the market. Others are more directly related to social and economic developments in American society. However, there are a broad range of still other forces which are directly or indirectly related to government intervention which increase the costs even more.

D. Government:

I. Direct Causes of Health Care Increases

(a) Government Regulation: The Methodist Hospital of Memphis, Tennessee, recently estimated that it spends over $500,000 a year in complying with government regulation. A recent estimate by Patricia S. Coyne, writing in Private Practice magazine, of the total cost of government regulation to the hospital sector of health care places it at $4 billion or about 8% of the total hospital cost. This estimate includes not only the cost of compliance with the regulations themselves, but also of the salaries of the additional employees necessary to administer compliance.

(b) Medicare and Medicaid: In 1974, Medicare programs spent $11.3 billion and Medicaid spent $11.2 billion, together composing 55% of all public medical care spending and nearly 22% of the total cost of health care in that year ($104.2 billion). This expense in itself amounted to about 2% of the GNP for that year, but the cost increases which this kind of expenditure causes are also expensive. The provision of health care by the federal government under these two programs at greatly reduced costs to the utilizers serves to increase the demand on health care, and this pushes up the price of the remaining supply for other consumers. A second aspect of the programs which increases costs to other consumers is that the federal government compensates participating hospitals for Medicare expenses only for actual care, and not for overload expenses (therapeutic facilities, equipment costs, etc.). The result is a gap between the value of the services expended and the value of the reimbursements received from the government, and hospitals must pass this discrepancy on to paying patients by increased costs. In FY 1966-7, health spending increased by 13.7% as opposed to only an 8.3% increase in 1965-6. The per capita amount also increased from 7% in 1965-6 to 12.5% in 1966-7. Nor did these rates of increase drop significantly until the imposition of wage and price controls in the early 1970's. Furthermore, between 1965 and 1970, the government portion of payment for personal health care expenditures increased by 13.4% (as opposed to an increase of only 1.1% in the previous five years). In the years from 1965 to 1970, the cost of hospital care increased by $13.8 billion (as opposed to $4.5 billion in the previous five years). Physicians' services also increased steeply in price in the same years. From 1960 to 1965, they increased by $3 billion. From 1965 to 1970, physicians' services increased by $5.6 billion.

The Medicare program served to increase doctors' fees in three different ways. First, the program caused an increase in the overhead by requiring additional paperwork, office help, and administrative equipment. Secondly, the statistical average of doctors' fees increased due to Medicare because under the program some former charity patients began to pay for services received. The figuring in of these new patients thus increased the final statistical average of doctors' fees. The third and probably most important increase in doctors' fees due to Medicare has derived from the reimbursement procedures for doctors under the program.

This procedure stipulates that doctors be paid on the basis of their "usual, customary, and reasonable" (UCR) fees. Physicians now began to

pay much closer attention to their fees than they had before, to calculate carefully what their "usual" fees were, what those of their colleagues were, and what they had been in the past. Anticipating inflation or tighter government control of their incomes in the future, some doctors inflated their reportings in order to cover future cost increases. Others increased their fees in the belief that only by doing so for the more affluent patients could they afford to treat poorer patients under the Medicare or Medicaid programs. Finally, as with hospital costs, Medicare and Medicaid increased doctor's fees by stimulating the demand for doctors' services without increasing the supply of doctors. The average annual increase in doctors' fees between 1960 and 1965 was 2.8%, before implementation of the programs, but afterwards, between 1965 and 1970, it was 6.6%.

(c) Hospital Construction: Between the passage of the Hill-Burton Act of 1946 and 1974, the federal government provided more than $2.8 billion for the construction of about 370,000 hospital beds. About one-third of these were in new hospitals and the other in older ones. This program has also served to increase the cost of hospital care. The poor and indiscriminate planning of these new hospitals has resulted in an excess capacity. HEW estimates that of the nation's 947,000 hospital beds, 200,000 are empty at any given time and 100,000 of them are unnecessary. According to Secretary of Health, Education, and Welfare, Joseph Califano, each excess bed costs $20,000 a year to maintain (a total of $2 billion for the unnecessary beds). Hospitals, of course, are very popular with politicians, since they create the illusion of concern with public health and give employment both to construction workers and to the hospital staffs themselves. In 1974, the Hill-Burton Act was modified to require certification of need by a state before new construction is allowed. However, these restrictions have not been implemented fully.

In addition to poor or politically inspired planning, another factor in increasing the costs of hospital care due to hospital construction has been the improvement in hospital care itself. The average length of stay in American hospitals has decreased from 8.3 days in 1969 to 7.8 days in 1973 (this is the same length of stay as in 1965). As the length of stay has declined, two effects on prices have occurred. First, the same number of services is provided in a shorter time, and thus the cost per day has increased (though the total cost of the stay may remain the same). Secondly, decline in length of stay reduces the growth of patient days; as this declines at the same time that bed supply increases, occupancy rate also declines. The cost per empty bed must thus be spread among the remaining patients, and their costs increase.

It may seem that it is contradictory to blame rising costs on both increased demand (as we have emphasized up til now) and at the same time on increased supply of hospital beds. This apparent discrepancy is resolved when we reflect that the increased supply of beds would meet the demand only for increased demand of <u>inpatient</u> services. From 1969 to 1973, outpatient visits to community hospitals increased by an

annual average of 9.13%, while the occupancy rates in the same period declined by an average of 1.1%. There has thus been a decreasing demand for beds at the same time that there has been an increased demand for outpatient services. (Outpatient visits have increased from 328.9 per 1,000 civilian resident population in 1955 to 859.9 per 1,000 in 1973.)

II. Indirect Causes: Among these might be included the reimbursement system discussed above, but also the costs of labor and inflation, for which government bears direct responsibility.

(a) Labor: Hospitals are labor intensive institutions. A hospital, according to Blue Cross statistics, requires 14 times the labor used by a hotel of comparable size. Moreover, unlike private industry, hospitals cannot increase production and thereby avoid the cost problems associated with labor cost inflation. Also, as a hospital improves its services, this is likely to mean an increased employment of labor, and not the replacement of labor by technology, as in other sectors of the economy. As hospital services have become more sophisticated, the labor employed in them has had to be more and more skilled; this too has pushed up its costs, as has minimum wage legislation. The number of employees necessary to care for the average patient has increased from 1.8 in 1950 to 3.2 in 1973. According to HEW,

> "Demand for hospital services, especially after the introduction of Medicare and Medicaid, forced hospitals to compete for skilled labor in increasingly tight labor markets. Collective bargaining agreements, while still not pervasive, have been increasing in the hospital industry, adding to pressures for higher wages. Finally, the application of the minimum wage law to hospital employees has helped to close the earnings gap between traditionally low-paid hospital workers and workers in other service industries." (Medical Care Expenditures, Prices, and Costs: Background Book, 1975, p. 40)

(b) Inflation: Hospitals are particularly exposed to inflation, which is caused by excessive government spending, because they use intensively many goods and services especially affected by inflation: energy for heating and illumination above the normal usage of an institution of comparable size, food, and construction costs. Dr. Alexander MacMahon, President of the American Hospital Association, has recently stated that 10% of the annual 15% increase in hospital costs is due to inflation alone.

CONCLUSION:

As we have seen, there are a number of factors that serve to increase the cost of health care in the United States. Several important causes are due to the efforts of the government to make health care available to more people at less cost, to stimulate demand but not necessarily to

increase supply or at least not in the right sectors. While from a humanitarian point of view, such policies may seem commendable, a strong case can be made that in reality they are cruelest of all, since they raise costs for others who could previously afford health care and also for those who now have the expectation of receiving health care more regularly. For the past several years, many different national health care plans have been devised and submitted to Congress, and President Carter has promised to support and submit such a plan of his own by March, 1978. Most of these plans have not dealt with the problems of health costs as they have been outlined here; they have not tried to reduce demand for health care or to insure that an adequate supply of health care is maintained under their proposals.

Most national health care plans seem to approach health problems with the traditional ideas of government regulation and control of the health services. However, this approach in the past has only resulted in increasing the costs of health care, and it would not be surprising if a more comprehensive program such as is apparently contemplated by the planners would have similar effects. Perhaps a more viable and more timely alternative to more of the same kind of government intervention in health care would be a truly radical approach: to rely on the voluntary pricing system of the free market and the adjustment of costs to supply and demand that would ensue.

By Samuel T. Francis
Policy Analyst