Health Care Economics: The High Cost of Getting Well

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The cost of medical care in the United States is going up and up and up. In 1950 the health care enterprise cost $12 billion and accounted for 4.6 percent of the gross national product (GNP). Today that enterprise has grown into the third largest industry in the nation (behind agriculture and construction). At a cost of $160 billion last year, the health care industry consumes 8.6 percent of the GNP. Furthermore, health care costs are rising faster than costs in any other sector of the economy. According to Health, Education, and Welfare (HEW) Secretary Joseph A. Califano, Jr., "During the last three years, 1975–1977, costs for medical services rose at a 9.5 percent rate—more than one and a half times the overall rate of increase for all consumer prices." At $1 billion a year, the government's bill for dialysis for Americans with kidney failure equals half of the annual budget for the National Institutes of Health.

Rising health care costs have become a major political issue. Because health costs are one of the most inflationary forces in the present economy, they are a logical and important target for anti-inflationary measures. Thus, President Carter and Secretary Califano are lobbying hard for congressional passage of a hospital cost containment bill that would put a lid on hospital charges. Hospital costs, which account for 40 percent of the health care bill, recently have been going up at an average annual rate of 17.3 percent. The Administration is seeking a 9 percent ceiling, which hospitals oppose; they have made a counteroffer of a voluntary effort to shave current growth rates by two percentage points a year.

Soaring expenditures for health care have become an important consideration in the debate about National Health Insurance (NHI). The President, who made a clear commitment to NHI during his campaign, is under pressure to come through. Furthermore, there is support for national health insurance in some form in Congress and public opinion polls indicate that 80 percent of the American public favors the idea. Certainly, at a time when health care is viewed as a "right," strong arguments can be made for national health insurance in the name of equity. But NHI will cost a lot. Although there is little consensus among health economists about how much more various proposed forms of health insurance will cost, everyone agrees that the nation's health care bill can only go up when some 20 million individuals who now have either no coverage or inadequate coverage are brought into the health care market at government expense.

A national health insurance plan, then, is incompatible with an effective campaign against inflation unless health care costs can be brought back into line with the rest of the economy.

Concern with the high cost of getting well raises a number of other important questions. Why, for instance, is there such apparent distress over the fact that by 1980, expenditures for health care are likely to account for a full 10 percent of the GNP? Some economists believe it is not just a matter of inflation but also of costs versus benefits. The country is spending increasingly more but there is little demonstrable evidence that the population is proportionately healthier. We may simply be spending more for health care than it is worth.

Finding ways to control health care costs requires understanding what it is that drove them out of control. Why does it cost $200 a day for routine hospital care today when it cost only $40 a day a dozen years ago? Why has the federal government's share of the nation's health bill gone from $4.4 billion in 1965 to $50 billion in 1977?

There is no one answer, but there is one applicable generalization. The health care industry is vast—a conglomeration of large systems such as Medicare and Medicaid, major health insurance organizations, and thousands and thousands of individual businesses in the form of physicians in private practice. The industry is uncoordinated and decentralized. All of its many parts are conditioned to "buy" the best that is available without regard to cost, reflecting the American philosophy that nothing is too expensive where one's health is concerned. Nowhere in the system have there been any effective incentives to hold costs down.

Government Programs

"Selling" medical services is not like selling color TV's. There seems to be little or no economy of scale in this field in which volume drives unit costs up. Among the most expensive pieces of social legislation of the 1960's were Medicare (for the elderly) and Medicaid (for the poor), passed in 1965. Not only did M and M bring into the health care system millions of persons who previously had no access to care, they brought them in without any serious cost-control measures. When physicians' "prevailing" fees went up or the price of hospital services rose, the government compliantly paid.

Then, in 1973, with little comprehension of what it was doing, the government accepted an enormous new health care burden: hemodialysis and/or renal transplantation for victims of end-stage kidney disease. Acting out of humanitarian instincts that no American should die of renal failure for lack of money to pay for dialysis, Congress enacted a bill extending federal coverage of dialysis costs to all kidney failure patients, irrespective of need, irrespective of insurance coverage. At the time, Congress was under the impression that this provision would cost in the low millions. Today, the dialysis tab is $1 billion a year and the system is set up in such a way that it favors dialysis in a hospital or clinic rather than less costly home dialysis. The costs of treatment by kidney transplantation have not gotten out of hand only because the supply of donor kidneys is so limited.

Hospital Wages/Physicians' Fees

One frequently heard explanation for the astonishing rise in health costs is that increases in wages paid to hospital workers are responsible. However, as is the

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case in almost every aspect of the cost problem, there is no consensus that wages are more than a partial explanation. In many hospitals wages constitute 60 to 70 percent of total costs. Nevertheless, the President's Council on Wage and Price Stability last year declared: "Although hospital wage rates have risen more rapidly than wages in other parts of the economy, these relatively greater wage increases are responsible for only a small part of the overall increase in the cost of hospital care."

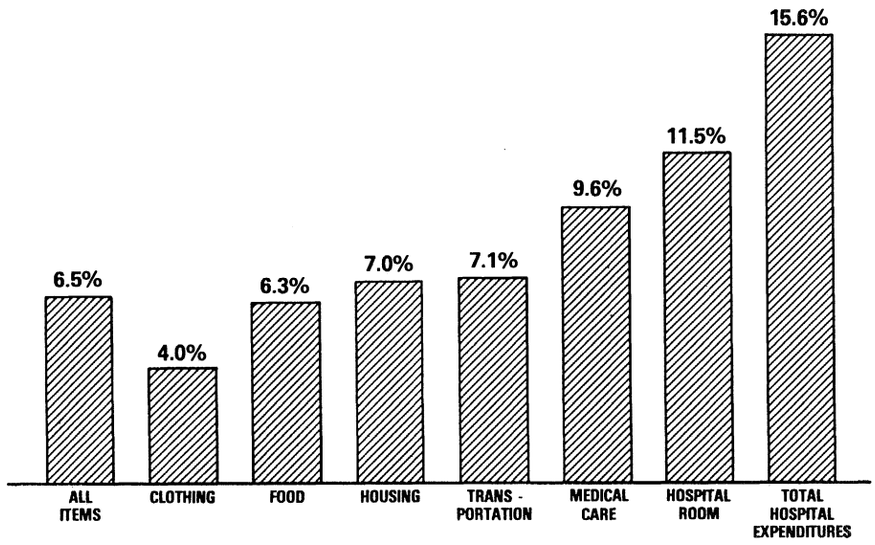
Physicians' fees also contribute to the health cost spiral. This spring the Council on Wage and Price Stability reported that physicians' incomes are rising faster than those of any other occupation and called average fees "unjustifiably high" by established economic standards. Last year doctors' fees rose by 9.3 percent, 50 percent more than other consumer prices.

Excess Beds/Too Many Specialists

An oversupply of hospital beds and too many specialists as compared with primary care or family doctors are other factors that contribute to skyrocketing health costs, according to authorities. In October 1976 the Institute of Medicine–National Academy of Sciences issued a report that says evidence indicates that "significant surpluses of short-term general hospital beds exist or are developing in many areas of the United States and that these are contributing significantly to rising hospital care costs." The Institute called for an overall reduction of at least 10 percent in the ratio of short-term beds to the population within the next 5 years, a recommendation that HEW officials charged with implementing the National Health Planning and Resources Development Act of 1974 are taking seriously. They are, however, meeting with opposition. Even though there is broad agreement that the country has a surplus of beds, no individual hospital wants to be the one to cut down by closing an obstetrics unit or giving up prestigious cardiac surgery.

Another Institute of Medicine report, issued this month, challenges the health care industry (in this case through the medical schools) to create incentives for primary care physicians. The Institute asks for a moratorium on increasing the number of medical students on the grounds that expanding enrollments during the past 10 years have eliminated any concern about a doctor shortage. Furthermore, the Institute noted other reports that every new doctor adds about $250,000 a year to the nation's health bill for office visits, tests, and so on. Then, in a series of recommendations that are bound to stir controversy, the Institute suggests among other things (i) that health insurance plans and government agencies refuse to pay for specialized care unless it has been called for by a primary care doctor; (ii) that primary care physicians and specialists be paid the same fee for the same work (now, for instance, a family doctor might charge $20 to take stitches in a cut on your leg but a plastic surgeon would get $100; and (iii) that physicians in all parts of a state receive equal fees, bringing an end to the practice of paying city doctors more than rural practitioners for the same service.

1977 ANNUAL INFLATION IN MEDICAL CARE COMPARED TO OTHER MAJOR ITEMS



"High" Technology

Virtually all health policy-makers agree that widespread dissemination of new, usually expensive, types of medical technology accounts for one big portion of the upward surge of health care costs. During the past decade, intensive care units and coronary care units (CCU's), which require not only expensive equipment but also large numbers of trained personnel, have become common. A day in a coronary care unit costs several hundred dollars and most hospitalized coronary victims can expect to spend at least a couple of days being monitored in a CCU. However, their lifesaving value is being questioned. Some studies suggest that victims of certain types of heart attacks actually do as well at home as in a stressful CCU.

Coronary bypass surgery is another recent development in cardiology that is coming under scrutiny. The popular operation has yet to be shown to prolong life, yet it is being performed thousands of times a year at a cost of $10,000 to $25,000 per operation.

Computed tomographic (CT) scanning is another example of a new innovative technology whose widespread use is being vigorously debated because of the high costs involved. CT scanners, which employ radiographic and computer technology, can produce high-quality images of soft tissues, in contrast to conventional x-rays, which are best suited to hard structures such as bone. At first, in the early 1970's, CT scanners were used diagnostically for examination of the head, but now scanners are available that can make transverse section images anywhere in the body. At a cost of $300,000 to $700,000 per machine, CT scanners are the Cuisinart of the medical business. As a prestige item, every hospital and many individual physicians or physicians' groups want one. But to find a CT scanner cost-effective, the hospital or doctor must try to put it to maximum use. What many health planners and insurers (who pay the bill) are concerned about is the efficacy and expense of widespread use of this new technology before the full spectrum of its diagnostic value and possible side effects is known.

The list of expensive new technology available to medicine goes on: a plethora of laboratory tests, burn centers, fetal monitoring. . . . But the point is simple. At today's costs, we may have to rethink the prevailing attitude that if something can be used in a medical setting it *should* be used. It may be necessary to recognize that there are times when we cannot afford high-technology

medicine and perhaps do not need it.

One of the forces that operate to drive costs up (and to encourage overuse of new technology) is the sense that somebody else is paying for it. If a hospital's costs go up, the hospital just passes them on to the patient, but they are passed on indirectly through insurance, with much of the cost of increased premiums absorbed by employers, so the individual seldom feels the pinch. Nor does the physician. As Secretary Califano said in an interview recently, "He's [the doctor] ordering a service he's not paying for. In the hospital, the patient's probably not paying for it. The third-party carrier—Medicare, Medicaid, the Blues, or some insurance company—pays for 90 percent of those hospital costs. So there is no incentive at any point except for him to give every conceivable test he thinks might in one way or another be relevant. Even a few that aren't relevant." And the 1965 $40-a-day hospital room rises to $200 a day.

Solutions

Any number of approaches to slowing the inflationary health care spiral have been proposed; none wins universal support. The diversity that makes the health care industry uncoordinated and expensive also makes it hard to find common ground.

The majority of the remedies now before the Administration and Congress involve regulation. One model, for instance, would treat the health care industry like a public utility in which some agency of government—be it federal, state, or local—would set rates for hospital costs in much the same way rates are now set for electric power. In general, the President's hospital cost containment bill follows this line. The government would tell hospitals that unless they can get an exemption because of special circumstances, rates can rise by only 9 percent (or whatever figure is chosen) in a given year. The individual hospital then is responsible for making its own cost-cutting choices. At present, at least nine states have rate-setting regulatory agencies—each operating in a slightly different manner from the other—that seem to have somewhat successful in holding costs down within state boundaries.

In addition, the federal government has, during the past 3 or 4 years, created a number of new agencies whose ultimate purpose is to control costs and whose successes have been varied. Professional Standards Review Organizations (PSRO's) were created in 1972 ostensibly to ensure quality care for all patients by having local physician-run PSRO groups review hospital admissions to ascertain whether the admission itself, length of stay, and services received were medically necessary. In fact, PSRO's, were they effective, would exert pressures that would lower costs. (The principal objection to an unnecessarily long hospital stay is cost, after all, not the patient's inconvenience.) But the PSRO's track record to date has been indifferent. The Office of Management and Budget would like to cancel the program for being itself more costly than it is worth. Califano has won them a 1-year reprieve to show that they can be effective.

The 1974 health planning act, which established a national network of Health Systems Agencies (HSA's), marks another federal attempt at controlling costs through regulatory procedures. Under that law, construction of new hospitals and expansion of existing ones are allowed only after the local HSA is satisfied that a real need exists. In effect, those wishing to build or expand must file the medical equivalent of an environmental impact statement, showing that they will not be adding excess beds or services to an already well-supplied area.

In March, HEW issued a new regulation under health planning guidelines setting strict standards for the acquisition of CT scanners. As is the case with nearly all such regulatory actions, it has provoked strong opposition. According to EMI Medical, Inc., a company that sells CT scanners, of the approximately 1000 scanners currently in use in this country, only 20 percent meet the standards for use (set in terms of numbers of patients who actually need CT scans) that HEW has established. EMI charges that the scanner "has become the scapegoat in the war against rising health care costs" and argues that what constitutes a de facto moratorium on future purchases will adversely affect the quality of health care in this country for a long time to come. HEW, on the other hand, thinks it has done something right. In any event, the case is illustrative of the kinds of issues that regulations raise.

It is important to note, with respect to CT scanners, coronary care units, bypass surgery, and all the other forms of costly new technology now available, that no one is saying that they have *no* place in medicine. Indeed, each represents an invaluable advance *when used appropriately*—and there's the rub. Who's to decide?

Although Califano and others in government—both in the Administration and on Capitol Hill—stoutly insist that they do not want to "take over the practice of medicine," a commonsense look at the list of existing and proposed regulatory actions reveals a gradual move in that direction. In this brief summary, it is impossible to cover the territory staked out by the array of federal agencies, particularly but not exclusively within the Department of Health, Education, and Welfare, that have responsibility for health care. In the absence of effective action by the private sector, and in an area in which usual marketplace forces appear not to apply, government regulation seems to be a natural—indeed, inevitable—approach to slowing the cost spiral, even though there is absolutely no guarantee that regulation will work.