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AMERICAN HEALTH POLICY IN THE 1980's

*Kenneth R. Wing**

The author notes that the composition of the "fundamental problem" of rising health care costs is not easily defined. The varying interests of providers, consumers, and the government's budget diverge and overlap in a weblike maze, creating multifarious and fractured perspectives regarding what actually constitutes the problem. Consequently, no underlying ideological thread in American health care policy has emerged to direct a unified response to the "fundamental problem." It is in this political context that American health care policy of the 1980's will be shaped.

Professor Wing has undertaken an exhaustive review of both health care cost data and the trends that these data reveal. He discusses the impact of rising health care costs on the economy, examining expenditures for hospital services, physician services, nursing homes, and other services. He considers the rising costs of health care to state and federal government, particularly the impact of Medicare and Medicaid. Finally, he comments on the growing costs of health care to the consumer, including both rising premium payments for private health insurance and growing out-of-pocket payments. He places these data in the current political context and concludes with some observations regarding American health care policy into the 1990's.

INTRODUCTION

CRITICS NO LONGER punctuate their descriptions of American health care delivery with bold predictions that we face a "health care crisis," as they so often did in the 1960's and 1970's.¹ In fact, by the 1980's, the rhetoric of "health care crisis" has been nearly abandoned, presumably because the politics of "health care crisis" have never really emerged. But while today's health policy critics are much more sanguine in their predictions for the future, most continue to describe our present circumstances in terms suggesting that Americans are currently faced with one fundamental problem. The problem, if not critical, is one that at least requires immediate attention and one that will soon require some difficult social and political choices: the need to contain rising health care

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1. See, e.g., J. Kennedy, Special Message to Congress on Health and Hospital Care, 1961 PUB. PAPERS 77 (Feb. 9, 1961); R. Finch & R. Egeberg, 5 WEEKLY COMP. PRES. DOC. 258-59 (Feb. 18, 1971); White, *Life and Death and Medicine*, 229 SCI. AM., Sept. 1973, at 22.

costs.² Indeed, virtually all contemporary health policy debates, both popular and academic, begin with an all-too-familiar litany of demonstrative cost statistics: Health care costs have been demanding an increasing proportion of the gross national product (GNP); health care cost inflation continues to outpace inflation in general; and the aggregate, annual cost of health care has reached almost unbelievable levels and can be extrapolated beyond the unbelievable in the coming years.³

These cost statistics do highlight a problem of fundamental proportions, even if a full and informed appreciation of the implications of rising health care costs requires a much closer examination and the disaggregation of available data, as will be demonstrated in later sections of this Article.⁴ After critically examining the costs of health care, no one could seriously question two essential observations: that "something must be done"—and done fairly quickly—to contain these costs; and that attempts to contain rising health care costs will soon have substantial impact on the manner and organization by which health care is financed and delivered in this country.

Acknowledgment of the fundamental importance of health care cost containment for contemporary health policy, however, does not mean that health care cost containment is the dominant or focal issue of American health *politics* in the 1980's. Such a suggestion would miscast, at least rhetorically, prevailing circumstances, as well as misjudge, as did those who predicted a "health care crisis" in earlier decades, the realities of American health politics in some important and fundamental ways. Thus, before discussing the costs of health care more fully, several prefatory observations must be made to somewhat refine current notions regarding the need for—as well as the prospects for—health care cost containment.

I. THE CONTEXT

To begin with the most basic, any assessment of our present circumstances should emphasize that Americans face not a single or dominating health care cost-containment problem, but rather a se-

2. See, e.g., Bayer, *Justice and Health Care in an Era of Cost Containment*, 9 SOC. RESP.: JOURNALISM, L., MED. 37 (1983); W. McCLURE & C. WELLER, *COMPETITION AND THE HEALTH CARE PLAN THERAPY FOR MEDICAL MARKETS: AN ANTITRUST POLICY AND HISTORICAL SYNTHESIS* (1983); Scitovsky, "The High Cost of Dying": *What Do the Data Show?*, 62 MILBANK MEMORIAL FUND Q. 591 (1984).

3. See *infra* Table 1 and Figure 1.

4. See *infra* notes 37-71.

ries of related but distinct and, above all, potentially conflicting cost-containment *problems*. At the very least, any description of the rising costs of health care, even the most introductory, should clearly distinguish between the rising costs of health care to the economy and the direct costs to government—the growing costs of Medicare and Medicaid, public employee medical benefits, and other health-related, state and federal governmental expenditures. Both the costs of health care to the economy and the costs to the government should then be distinguished from the cost problems for various consumers—the inflating costs of health insurance premiums, the increasing risk of catastrophic loss from illness or disability, and the rising cost of individual out-of-pocket payments. Politically speaking, the costs to the economy,⁵ the costs to the government,⁶ and the costs to various consumers⁷ are each severable problems, the assessment of which, and more important, the resolution or containment of which, can be achieved independently. Thus, the “fundamental problem” may be defined by referring to any or all of these costs, depending on one’s ideological or political loyalties, and preferences for various reforms or political responses will be skewed accordingly.

Moreover, the distinguishable implications of the rising costs of health care for the various providers, employers, insurers, suppliers, and the many other actors and institutions on the complicated landscape of American health care politics further fractionalize the political reality of the “fundamental problem” and, therefore, the health policy agenda of the 1980’s. Rather than creating a single or focal issue, rising health care costs have created a divisive political struggle among competing interest groups. Defining the nature of the problem is as controversial as fashioning a remedy; and the reform or remedy sought for one problem, as frequently as not, would only exacerbate the other problems.

This refinement of the “fundamental problem” does not refute the notion that these severable cost-containment problems are at least partially convergent in their origins. As reviewed in later sections of this Article, isolating the causal factors responsible for rising health care costs is a complicated and somewhat imprecise task. Nonetheless, at the heart of the problem, as it is defined from virtually any perspective, lie several basic factors, including the most important—continuing inflation of the price of individual medical

5. See *infra* notes 23-146 and accompanying text.

6. See *infra* notes 147-203 and accompanying text.

7. See *infra* notes 204-64 and accompanying text.

services.⁸ But notwithstanding these underlying causal links—and the resulting potential for political alliance among those similarly affected—these various cost problems have been remarkably divergent in terms of how they are defined in the political arenas and in terms of the strategies that are adopted by various interest groups to avoid or mitigate their impact.

Thus, to cite perhaps the most relevant example, the fiscally conservative congressman, whatever his sympathy for those who cry “something must be done” about the rising portion of the GNP spent on health care, primarily perceives the “fundamental problem” as rising federal expenditures. Though he may appreciate that both problems can be traced to such factors as rising medical care prices, he will, nonetheless, prefer to resolve the “fundamental problem” through increases in Medicare cost-sharing, limits on Medicaid eligibility, and the like, rather than through financing or other systemic reforms intended to directly impact on the price of medical services.

Ironically, his equally conservative state counterpart, who may be particularly enamored with the radical reforms espoused by neoconservative theorists, may nonetheless spend most of her political time and energy devising strategies to resolve a cost problem similar in definition to that of the federal legislator but with an opposite result: shifting more of the state’s health budget to Medicaid and other federal programs. To their constituent consumers, even those savvy enough to understand the broader problems caused by rising health care costs or the underlying causes of those costs, the cost-containment problem is almost certain to be defined in terms more immediate and parochial: “do something” about our bills, our potential for bankruptcy, and our inflating premiums. Providers, coalitions of employers, insurance carriers and brokers, and union representatives shift from one political camp to the next, as they follow their own perceptions of the “fundamental problem” and of their short-term self-interest, forming temporary and sometimes rather odd alliances—frequently crossing traditional political lines—on an issue-by-issue basis.

Almost parenthetically, an opposite trend could be easily imagined. In the most obvious scenario, a sufficiently powerful coalition comprised of consumer groups, political liberals, budget-conscious state and federal legislators, employers, and others whose cost problems can be traced to the same underlying causes could

8. See *infra* notes 50-68.

overcome the political resistance to tackling such causal factors as price inflation and pursue a broad and concerted cost-containment strategy. It may well have been such imagination that prompted the rhetoric of crisis in earlier decades or that continues to inspire many of today's health policy critics both to speak in terms that suggest we are faced with a single "fundamental problem" and to advocate systemic reform strategies. But the political battles of the last decades tell us that such imagining is indeed chimerical. The political strategy of preference, or at least of necessity, has been to define health care cost problems narrowly and to focus on efforts to shift or avoid health care costs on an issue-by-issue basis. This strategy has predominated, often in spite of political alliance and, as many would argue, in spite of the long-term consequences of such political expediency for cost containment in the broadest sense of the term.

The reasons for this political state of affairs are not altogether clear, but there are several which are evident. First of all, and worth repeating, health policy issues generally, and health care cost containment in particular, inevitably involve enormous and complicated conflicts, both political and economic. The cost-containment problem of the budget-conscious legislator is clearly different than that of the traditional liberal. The health care costs that concern macroeconomists are not those which concern organized consumer groups, nor are macroeconomic estimates of economic costs the particular costs that concern professionals schooled in public health traditions. In the realm of health policy and politics, one person's cost containment potentially creates another's cost problem. For that matter, one person's cost problem can be another's profit margin. The delivery of health care is, after all, one activity that can be simultaneously described as a system on the brink of crisis and as a strong and growing industry, with equal accuracy.

Other factors shed more direct light on the failure of potential alliances to amalgamate around broader reform strategies and effective cost containment. Health care policy issues, whether defined in terms of cost or otherwise, have rarely commanded the continued attention—or the consistent voting behavior—of the public at large. Thus, there has been no sustained groundswell of public opinion upon which to build political coalitions for major health care reform, at least since the enactment of Medicare and Medicaid in the 1960's.⁹ Nor has there been a particularly good ideological light-

9. See generally T. MARMOR, *THE POLITICS OF MEDICARE* (1973).

ning rod for opinion or around which various interest groups could coalesce.

Americans and American politics *do have* a longstanding and easily aroused egalitarian tradition, traceable through a patchwork of generously funded public programs, and evidenced by an apparent unwillingness to overtly accept the denial of medical care to virtually anyone. Indeed, the strength of that tradition should not be underrated when assessing the political prospects for cost containment, as will be discussed below. But just as clearly, that tradition falls far short of any broad-based or sustained public support for programs that are perceived (or labeled) as socializing health or medical care, or for any "big Government," particularly "big Federal Government," health care reform measure or cost-containment strategy. Thus, whatever the merits of extending the regulatory strategies that were initiated in the late 1960's and early 1970's, strong and sustained public support for hospital cost containment, certificate of need programs, and other "command and control" regulatory programs has been virtually nonexistent.¹⁰ Similarly, while the banner of national health insurance has occasionally garnered the public's attention, it has failed to attract enough sustained support to weather the long-term demands of the political process and has yet to emerge as an important election issue.¹¹

On the other hand, notwithstanding the resurgence of conservative politics in the last decade, market-based strategies for health care reform have also had little success in capturing the public imagination or the political fancy of enough interest groups, particularly as "competition" has been translated into discrete political choices. Thus far, the political track record of the New Federalism, including proposals for reduced tax subsidies for employer-purchased health insurance, vouchers for Medicare, and other dictates of neoconservative ideology for health policy, has been unimpressive.¹² A few privately initiated and arguably competitive

10. See K. WING, *THE LAW AND THE PUBLIC'S HEALTH* 120-29 (2d ed. 1985).

11. For a discussion of the "high water mark" period for political interest in national health insurance and the reasons for its political demise, see Wing & Silton, *Constitutional Authority for Extending Federal Control Over the Delivery of Health Care*, 57 N.C.L. REV. 1423, 1423-28 (1979).

12. See, e.g., C. HAVIGHURST, *DEREGULATING THE HEALTH CARE INDUSTRY: PLANNING FOR COMPETITION* (1982); A. ENTHOVEN, *HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE* (1980); Enthoven, *A New Proposal to Reform the Tax Treatment of Health Insurance*, 3 HEALTH AFF., Spr. 1984, at 21; McClure, *Implementing a Competitive Medical Care System Through Public Policy*, 7 J. HEALTH POL., POL'Y & L. 2 (1982).

characters have clearly emerged in the last years in health care delivery, such as business coalitions, preferred provider organizations, and other alternative financing schemes. But whether these new characters will have a significant impact on health care costs or on the public's attitude towards competition and market-based strategies for health policy has yet to be determined.

What has been impressive, well organized, and politically sustained, however, is the political clout of provider interests, meaning not just individual medical practitioners, but, in particular, representatives of the hospital and nursing home industries, as well as their suppliers, financiers, and the others who share in the distribution of the ever-expanding health care dollar. To the public, providers prefer to posture themselves as the victims and not the perpetrators of rising costs. In the corridors of political power, however, they have unabashedly exhibited an intimidating and powerful political presence, successfully defending their economic self-interest, their professional autonomy, and their predominantly private, but not necessarily competitive, character. Indeed, the course of federal health policy over the last several decades has been affected as much by the political influence of provider interests as it has been by any other political constraint.¹³

Surely this political strength has been losing some ground in the 1980's. In this regard, the political significance of Congress imposing both diagnosis-related group (DRG) reimbursement on hospitals and several years of reimbursement freezes on physicians in the mid-1980's far exceeds the economic significance of either measure.¹⁴ Yet, just as surely, provider influence over health policy has only been bent, not broken, by recent politics. As one measure of their continuing influence, one can look to their success, even in this decade of DRGs and rate freezes, in seeking reimbursement for "indigent care" or for what they characterize as their "uncontrollable expenditures."¹⁵ They have also been successful in influencing deci-

13. See, e.g., P. STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982); T. MARMOR, *supra* note 9; D. HIRSCHFIELD, *THE LOST REFORM* (1970); Wing & Siltan, *supra* note 11, at 1431-38.

14. For a description of DRG-based reimbursement and its impact on hospitals, see Lave, *Hospital Reimbursement Under Medicare*, 62 *MILBANK MEMORIAL FUND Q.* 251 (1984). For a description of the freeze on physician reimbursement imposed under the Medicare program, see Deficit Reduction Act of 1984, Pub. L. No. 98-369, § 2306, 98 Stat. 1061, 1070; H.R. REP. NO. 861, 98th Cong., 2d Sess. 1313-15, *reprinted in* 1984 U.S. CODE CONG. & AD. NEWS 1445, 2001-03.

15. See FLA. STAT. ANN. §§ 395.101, 409.2662 (West Supp. 1985); see also Kinney, *Medicare Payment to Hospitals for a Return on Capital: The Influence of Federal Budget Policy on Judicial Decision-Making*, 11 *J. CONTEMP. L.* 453 (1985).

sions regarding DRG designations, cost-of-living inflators, and other economically crucial, but less publicly visible, decisions, where raw power and sustainable infighting are most advantageous.¹⁶ Providers may no longer be able to resist all efforts to contain costs, but their influence on the manner in which the “fundamental problem” is politically defined and in which that problem may be addressed and contained will continue to be a major political constraint on the health policy agenda of the 1980’s.

The result of these political circumstances is an agenda for health policy issues that is both complex and quixotic. It is ordered as much by the political power of those affected by each issue and by the happenstance of political events as it is by any notion of the relative importance of the variously defined cost problem(s). More important, the net result of this agenda is almost certain to be a frustration of any attempt at major or systemic reform of health care delivery or its financing, as the focus of political attention continually shifts from the heart to the periphery of the problem(s). Under such circumstances, cost containment in its broadest sense, and to the extent that it is achieved at all, is more likely to be a byproduct of concerns for more narrowly drawn and short-term cost problems than it is to be a result of focused attention or of a dominating concern for a “fundamental problem.”

If there is a key to understanding the political reality of the health policy agenda in the 1980’s, it lies in the distinction between, on the one hand, the lack of sustained political interest or ideological commitment of most Americans towards health policy issues and, on the other, the strong and easily aroused egalitarian impulse of that same American public. That same distinction can be stated somewhat differently: while Americans are unlikely to rally around market-based or competitive strategies, liberal-designed regulatory programs, nationalized health financing schemes, or, for that matter, any particular reform strategy for its ideological implications, we are and will continue to be quick to rally around more concrete and immediate issues, as well as programs perceived as necessary to our health care. We are concerned with the outcomes, or, better said, what we perceive as the outcomes of health policy decisions, not the decisions’ ideological roots, or even their underlying rationale. We are not health policy liberals or conservatives because we are not concerned with health policy per se. Nor is our concern,

16. See Morone & Dunham, *Slouching Towards National Health Insurance: The New Health Care Politics*, 2 YALE J. ON REG. 263 (1985); Rosenblum, *Medicare Revisited: A Look Through the Past to the Future*, 9 J. HEALTH POL., POL’Y & L. 669 (1985).

when aroused, necessarily based in either conservative or liberal principles. We are, however, quite concerned with what we perceive we need and, to our credit, what we perceive our fellow Americans need—American medicine.

As critics have long argued, such a political posture is neither logical nor consistent. The price of providing American medicine for virtually everyone is extraordinarily expensive, both in the popular sense and even more so under sophisticated economic analysis. Even in carrying out the apparent dictates of that egalitarian impulse, the current manner in which American medical care is delivered and financed is neither economically efficient nor equitable in its distributional result.¹⁷ For that matter, increasingly persuasive evidence indicates that modern American medicine is not particularly cost effective, especially when compared to the health problems of our aging, postindustrialized society.¹⁸

But neither the graphs and models of the economic theorists nor the health-promotion and disease-prevention strategies of public health reformers have had visible impact on the public perception of the value of medical care services. For that matter, neither have the constant reminders that the nation faces a "fundamental problem" in rising health care costs aroused much public concern or substantially altered either the perception that medical care is valuable or the egalitarian impulse for its distribution. Thus, Medicaid, notwithstanding several rounds of de facto program reductions, survived the onslaught of Reagan-era domestic spending reductions, as Congress found a surprising level of public support for "welfare medicine."¹⁹ Medicare, even as it is depicted as a program on the brink of bankruptcy, still requires gentle handling lest the public perceive a retreat from a fifty-year-old social contract.²⁰

Americans react with equal dismay to increases in the out-of-

17. See P. FELDSTEIN, *HEALTH CARE ECONOMICS* 143-50 (2d ed. 1983) (supply of medical care); *id.* at 91-99 (demand creation, especially regarding the role of physicians); *id.* at 152-57 (the market for health insurance); and *id.* at 198-234 (the market for hospital services). See also Gabel & Rice, *Reducing Public Expenditures for Physician Services: The Price of Paying Less*, 9 J. HEALTH POL., POL'Y & L. 595 (1985); Hurd, *Provision of Health Care to Indigents: Failure at the Local Level in Light of Decreasing Federal Assistance*, 27 WASH. U.J. URB. & CONTEMP. L. 295 (1984); Bayer, *supra* note 2.

18. See, e.g., Waldo & Lazenby, *Demographic Characteristics and Health Care Use and Expenditures by the Aged in the United States: 1977-84*, 6 HEALTH CARE FIN. REV., Fall 1984, at 1; Fuchs, "Though Much is Taken:" Reflections on Aging, Health, and Medical Care, 62 MILBANK MEMORIAL FUND Q. 143 (1984).

19. See Wing, *The Impact of Reagan-Era Politics on the Federal Medicaid Program*, 33 CATH. U.L. REV. 1, 71 (1983).

20. See *infra* text accompanying notes 203-04.

pocket portion of their insurance premiums and to increases in their deductibles or co-insurance intended to mitigate those premium increases. At the same time, they persist in the belief that health insurance coverage is inadequate if anything less than comprehensive; anything less is perceived as a barrier to their medical care. Americans, while generally uncomfortable with big government, have no objection to a large government subsidy for employer-purchased health insurance, even in an era when tax reform is apparently popular. And while they nod knowingly at published accounts of unnecessary surgery—surely we all “know” that the doctors are ripping us off—they react with horror when government-sponsored, utilization-review decisions “throw old people out of the hospitals.”²¹ Perhaps no better illustration of our public temperament can be found than the public’s collective and individual responses to the plight of organ transplant patients who need donations to support their treatment.²²

Whether all this sets the stage for sound public policy, makes for sensible economics, or, for that matter, amounts to rational behavior is somewhat beside the point; it does make for fairly predictable, albeit somewhat fickle, political behavior. It also helps to define the reality of the “fundamental problem,” charting the political future of cost containment as much as do the complexities of the problem, the political power of providers, or any other political observation discussed above.

This Article outlines in more detail the costs of health care for the American economy, for state and federal governments, and for the consumer. From the point of view of assessing either public policy or contemporary politics, these problems can and should be distinguished, even if they are interrelated. In addition, disaggregation of the available data on health care costs, revealing both what is known and what is not known, is an important preliminary step in developing a more sophisticated understanding of the reality of the cost problems of the 1980’s and should serve as an introduction to the other articles in this Symposium.

Obviously, rising health care costs deserve our individual and

21. As one commentator has phrased it, “these serious questions have been engaged in a context marked by passion, pathos, and publicity.” Englehardt, *Shattuck Lecture—Allocating Scarce Medical Resources and the Availability of Organ Transplantation: Some Moral Presuppositions*, 311 NEW ENG. J. MED. 66 (1984).

22. Examples of the role of the media (and critical analysis thereof) are ABC News, June 6, 1983; CBS News, Feb. 16, 1985; “2 AMA Officials Deplore Publicity in Heart Surgery Experiments,” N.Y. Times, Dec. 6, 1984, at A18, col. 2; “Girl Dies in Her 2nd Operation for Heart-Liver Transplant,” N.Y. Times, Mar. 2, 1985, at A28, col. 1.

collective attention, but the nature of the “fundamental problem” and its implications for the various actors and institutions affected by health care costs is neither intuitively obvious nor easily assessed. Inquiry into the various health care cost-containment dilemmas, therefore, should be as informed as possible. Perhaps most important, the various implications of rising health care costs should be viewed against a backdrop of the political environment in which these problems will be defined, their implications assessed, and their resolutions attempted. The reality of the need for—and prospects for—health care cost containment in the 1980’s lies both in an analysis of the technically derived data concerning health care expenditures and in an understanding of the public’s perceptions, of the political power of providers and other interest groups, and of the influence of prevailing social and political circumstances.

II. THE “FUNDAMENTAL PROBLEM:” THE RISING COSTS OF HEALTH CARE TO THE ECONOMY

Viewed in the aggregate, the costs of health care in this country are extraordinarily expensive. According to the most reliable government estimates, national health expenditures (NHEs) exceeded \$425 billion in 1985, 10.7% of the gross national product (GNP).²³ Personal health services, roughly the equivalent of individual medical care, accounted for approximately 90% of this total.²⁴ Several comparisons, as illustrated by Table 1, highlight the growing importance and problematic character of these expenditures for the American economy.

23. These estimates for 1985 are preliminary and unpublished as of September 1986. U.S. Dep’t of Health and Human Services, Press Release (July 29, 1986). For most recent published data, see Levit, Lazenby, Waldo & Davidoff, *National Health Expenditures, 1984*, 7 HEALTH CARE FIN. REV., Fall 1985, at 1 [hereinafter cited as 1984 EXPENDITURES]. The annual summaries of national health expenditures published by the Health Care Financing Administration (HCFA) have become the most reliable and the most often cited estimates of national spending. Note, however, that the data are generally derived from other sources, such as annual surveys of its membership by the American Hospital Association, and rely heavily on the accuracy of various technical assumptions. For an explanation, see Freeland & Schendler, *National Health Expenditure Growth in the 1980’s: An Aging Population, New Technologies, and Increasing Competition*, 4 HEALTH CARE FIN. REV., Spr. 1983, at 1.

24. “Personal health care” is defined as the direct provision of care and consists of physicians’ services, hospital and nursing care, drugs, eyeglasses, dentists’ services, and other appliances and professional services. See Gibson, Levit, Lazenby & Waldo, *National Health Expenditures, 1983*, 6 HEALTH CARE FIN. REV., Winter 1984, at 7 [hereinafter cited as 1983 EXPENDITURES].

TABLE 1
AGGREGATE NATIONAL HEALTH EXPENDITURES 1929-1985

YEAR	NHE (in billions)	ANNUAL GROWTH RATE (%) of NHE	% TOTAL GNP
1990	\$ 690	—	12.3%
1985	(425)	(8.9)%	(10.7)
1984	387	9.1	10.6
1983	355	10.6	10.7
1982	321	12.6	10.5
1981	285	15.2	9.6
1980	248	13.3	9.4
1979	215	13.2	8.9
1978	190	11.7	8.8
1977	170	12.9	8.9
1976	151	13.6	8.8
1975	133	12.1	8.6
1974	116	12.5	8.1
1973	103	10.0	7.8
1972	94	12.5	7.9
1971	84	11.4	7.7
1970	75	13.4	7.6
1969	66	12.7	7.0
1968	58	13.1	6.7
1967	52	10.8	6.4
1966	46	10.3	6.1
1965	42	9.3	6.1
1960	27	5.3	5.3
1955	18	7.0	4.4
1950	13	12.2	4.4
1940	4	0.8	4.0
1929	4	—	3.5

SOURCE: Gibson, Levit, Lazenby & Waldo, *National Health Expenditures, 1983*, HEALTH CARE FIN. REV., Winter 1984, Table 1, at 3. Modified by U.S. DEPT. OF HEALTH AND HUMAN SERVICES, HEALTH UNITED STATES 1985 (1985), Table 80, at 128. 1990 projection from Freeland & Schendler, *Health Spending in the 1980's*, HEALTH CARE FIN. REV., Spr. 1984, Table D, at 7. (1985 data are preliminary estimates).

First of all, NHEs have been dramatically and steadily increasing for at least forty years, in both absolute and relative terms.²⁵ In 1950, essentially the eve of the technological revolution in modern

25. See *supra* Table 1.

medicine,²⁶ Americans were spending \$12.7 billion annually for their health care, 4.4% of the nation's GNP.²⁷ What followed was several decades of continually increasing growth. NHEs increased at an average annual rate of over 8% per year through the 1960's, accelerated to an average annual growth rate of 12% after the implementation of Medicaid and Medicare and through the mid-1970's, and grew by an average rate of over 13% from 1975 to 1983.²⁸ More important, as Figure 1 shows, this accelerating growth rate for NHEs, with only a few exceptions,²⁹ continually exceeded the annual growth in the rest of the economy.

Thus, as early as 1972, with NHEs "only" \$94 billion and demanding 7.9% of the GNP, annual health expenditures were described as "staggering" and "unbelievable," and projections into the future were inspiring predictions of "crisis" from a wide range of health policy critics.³⁰ Nonetheless, each year the unbelievable became the believable as the mathematics of compounded percentage increases pushed NHEs over \$200 billion in 1979 and quickly over \$300 billion by 1982 and, each year, to even greater proportions of the GNP.

Between 1982 and 1985, the annual rate of increase in NHEs was somewhat reduced, representing, perhaps, a moderation of the long-term trend of rapid growth.³¹ NHEs increased in 1984 by only 9.1% to \$387 billion, the lowest rate of increase in twenty-five years, reducing the proportion of the GNP spent on health care to 10.6% from 10.7% in 1983.³² Preliminary estimates for 1985 spending indicate that NHEs rose to \$425 billion, 10.7% of the GNP.³³

26. See S. WILLIAMS & P. TORRENS, INTRODUCTION TO HEALTH SERVICES 3-12 (1980).

27. See *supra* Table 1.

28. See 1983 EXPENDITURES, *supra* note 24, at 3, 19.

29. Prior to 1984, the rate of growth of NHEs had exceeded the growth of the GNP in all but two of the prior twenty-five years: 1973 and 1978. See *supra* Table 1; P. FELDSTEIN, *supra* note 17, at 228. The 1973 wage and price control program under the Nixon Administration has been cited as responsible for the reduced growth in 1973. See Wing & Silton, *supra* note 13. The similar trend in 1978 occurred during the Carter Administration and has been traced to the initial (and then disappearing) effect of the so-called "Voluntary Effort." See P. FELDSTEIN, *supra* note 17, at 228, 245. For a discussion of the 1984 growth rate, see *infra* notes 61-64 and accompanying text.

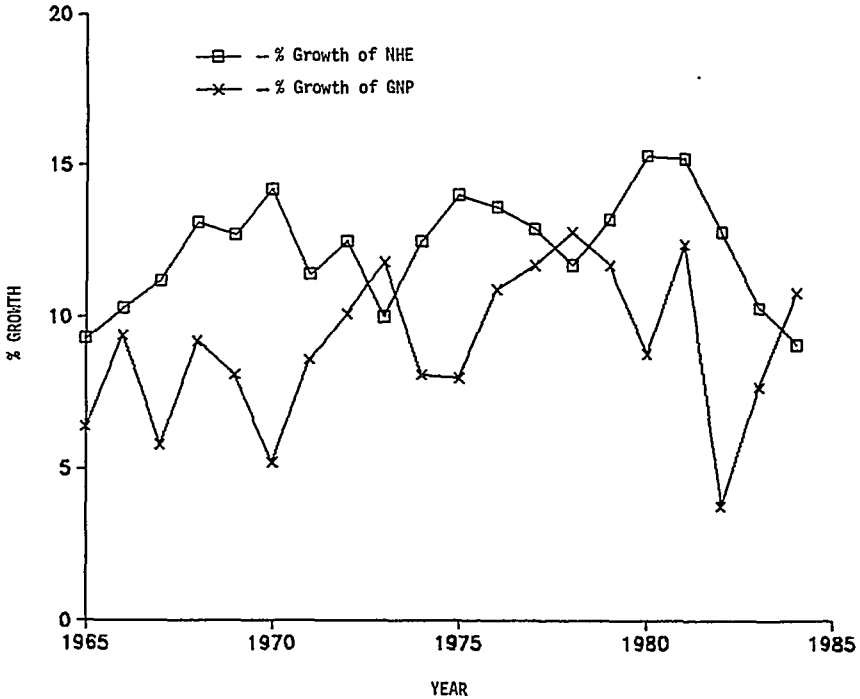
30. See R. Nixon, Special Message to the Congress Proposing a National Health Strategy, 1971 PUB. PAPERS 170 (Feb. 18, 1971). Cf. R. CARLSON, THE END OF MEDICINE (1972). See also sources cited *supra* note 1.

31. See *supra* Table 1; 1984 EXPENDITURES, *supra* note 23, at 1-2, 6-8.

32. See *supra* Table 1; 1984 EXPENDITURES, *supra* note 23, at 3.

33. See *supra* note 23. Projections based on earlier data were made in 1985, estimating

FIGURE 1
GROWTH IN NHE COMPARED TO GROWTH IN GNP, 1965-1984



SOURCE: Adapted from Levit, Lazenby, Waldo & Davidoff, *National Health Expenditures, 1984*, HEALTH CARE FIN. REV., Fall 1985, at 1, and U.S. DEPT. OF HEALTH AND HUMAN SERVICES, HEALTH UNITED STATES 1985 (1985), Table 80, at 128.

These most recent data cast some doubt on the accuracy of future predictions, but some experts have charted the growth of NHEs through the 1990's to well over \$800 billion annually—over 12% of the GNP—and beyond then to even greater demands on the nation's economy.³⁴ But even if these latest spending statistics do signal some slowing in the rate of growth of total spending, it is clear, nonetheless, that NHEs have already grown at a rapid rate for at least four decades, have continually grown faster than the rest of the economy, and have, therefore, represented a sizable and virtually relentless shifting of economic resources from other goods and services to the purchase of health care.³⁵ International compar-

that NHEs would be nearly \$420 billion in 1985, 10.5% of the GNP. See Arnett, Cowell, Davidoff & Freeland, *Health Spending Trends in the 1980s: Adjusting to Financial Incentives*, 6 HEALTH CARE FIN. REV., Spr. 1985, at 8 [hereinafter cited as HEALTH SPENDING TRENDS].

34. See *id.*; see also Freeland & Schendler, *supra* note 23, at 4.

35. See P. FELDSTEIN, *supra* note 17, at 1-4.

isons reveal similar trends in most other industrialized countries, but, at least in the last ten years, in no other economy has the level of spending for health care or the rate of its growth matched that of the United States.³⁶

Whether this represents a problem of fundamental importance, however, is a matter of some debate, particularly since the growth rate of health care costs has slowed somewhat in the last few years. To some extent this rapid growth in NHEs and the consequent shifting of economic resources during the last several decades was predictable. The rapid growth of NHEs virtually coincided with the equally rapid development of modern medical technology, allowing American medicine to treat, and treat more intensively, a variety of ills and conditions in unprecedented ways. To oversimplify, there is much more medical care to purchase in 1987 than there was in 1950. Although not as marked as in earlier years, there has even been some expansion of medical capabilities in the last decade, affecting the available supply of medical services.³⁷

In addition, the American population has grown during this period of NHE growth,³⁸ and, particularly in the last decade, the age composition of that population has changed.³⁹ Elderly Americans now represent a much larger proportion of the population, who, while healthier than their earlier counterparts, still need and use more medical care than their younger contemporaries. Recent data indicate that the average spending on the elderly is as much as three and one-half times that of the rest of the population,⁴⁰ with spending on the growing number of the "very old" even higher.⁴¹ It is also generally accepted in the economic literature that, as an economy "matures," consumers have more resources to spend and tend to spend more of their discretionary resources on medical care and related services.⁴² Indeed, a few critics have attempted to argue that there is nothing inherently wrong with a "mature economy" or a wealthy society spending 12%, 15% or, for that matter, 20% of its economic output on health care, if that is what consumers want

36. See Freeland & Schendler, *supra* note 23, at 6-7; Reinhardt, *Can the United States Learn from Foreign Medical Insurance Systems?*, 59 HOSP. PROGRESS, Nov. 1978, at 60.

37. See 49 Fed. Reg. 252, 338 (1984).

38. See HEALTH SPENDING TRENDS, *supra* note 33, at 1.

39. See Freeland & Schendler, *supra* note 23, at 40.

40. See Waldo & Lazenby, *supra* note 18, at 1.

41. See Soldo & Manton, *Changes in the Health Status and Service Needs of the Oldest Old: Current Patterns and Future Trends*, 63 MILBANK MEMORIAL FUND Q. 286, 291 (1985).

42. See P. FELDSTEIN, *supra* note 17, at 81, 87.

to purchase with their available wealth.⁴³

Thus, in the politically sanitized lingo of economics, both the demand for health services and the supply of those services have increased over the last forty years as a fairly understandable response to changes in technology, in economic and social conditions, and in a variety of other factors.⁴⁴ A consequent increase in total health expenditures and some shifting of economic resources, therefore, may not necessarily represent a social or political problem, or at least one that requires immediate reversal or containment. But while these factors have been and will continue to be influential,⁴⁵ their relative contribution to increases in NHEs—particularly during the 1980's—should not be misunderstood or overstated, nor should they be weighed too heavily in formulating contemporary health policy.

As the estimates in Figure 2 indicate, growth in the population has been responsible for some of the growth in health spending, at a remarkably constant yet relatively small rate: between 6-11% annually during the period from 1968 to 1984.

Of greater importance has been the proportion of spending increases that can be attributed to the "intensity" of services, meaning both the higher rates of utilization of health care services and the greater number of services being rendered to each patient per visit or episode—more diagnostic tests, more complicated (and expensive) procedures, or longer institutional stays for a given illness.⁴⁶ If these estimates are correct, however, the proportion of health spending increases attributable to changes in "intensity" has been declining over time. Changes in "intensity" represented almost 50% of the annual increases in health care spending in the 1960's and early 1970's, but decreased to less than 20% of the annual increases by 1980.⁴⁷ Estimates for the most recent years indicate that the causal role of changes in "intensity" is even smaller.⁴⁸ This is clearly at odds with the popular notions that rising health care costs

43. See, e.g., Ginzberg & Ostow, *Organization and Financing of Medical Care Resources*, 23 MED. CARE 421, 423-24 (1985); E. GINZBERG, *AMERICAN MEDICINE: THE POWER SHIFT* 145-46 (1985).

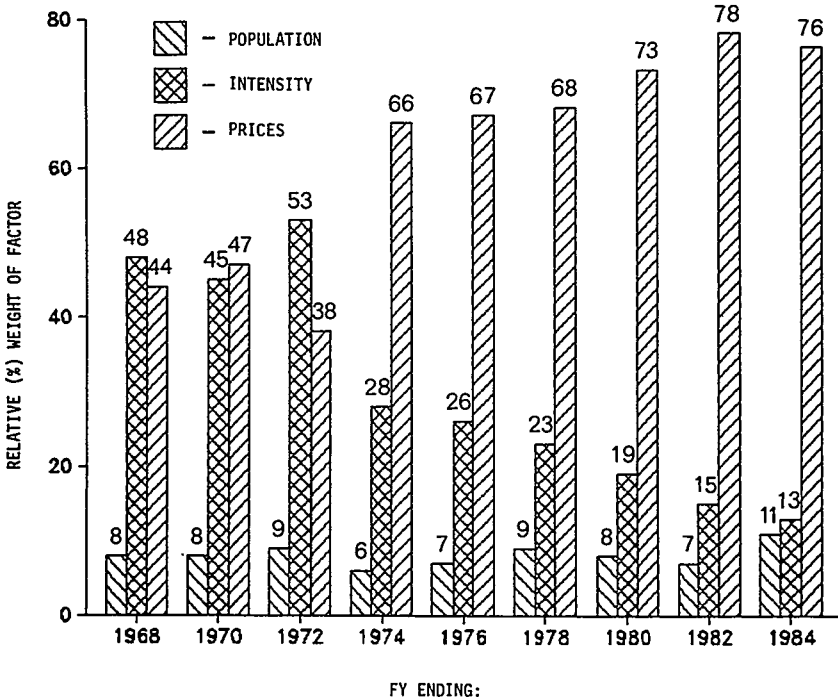
44. See P. FELDSTEIN, *supra* note 17, at 1-4, 49-53, 77-81, 89-93, 99-105.

45. See *infra* notes 116-38 and accompanying text.

46. See HEALTH SPENDING TRENDS, *supra* note 33, at 7-10.

47. See *infra* Figure 2.

48. For 1983, HCFA estimated that changes in "other factors" (including "intensity" and other minor influences) were responsible for 19% of the increase in personal health expenditures. (Note that Figure 2 relates to total NHEs.) See 1983 EXPENDITURES, *supra* note 24, at 9. For 1984, similar estimates show a decline to 13% for "other factors." See 1984 EXPENDITURES, *supra* note 23, at 8.

FIGURE 2**FACTORS RESPONSIBLE FOR NHE INCREASES, 1968-1984**

SOURCE: U.S. DEPT. OF HEALTH AND HUMAN SERVICES, HEALTH UNITED STATES 1985 (1985), Table 81, at 129.

are caused by today's Americans living longer, or demanding unlimited or unnecessary medical care, or by other factors relating to more use of more services. Indeed, these data indicate that historically the relative importance of "intensity" has been declining, even during the period when health spending was increasing at its highest annual rates.⁴⁹

These estimates also indicate that the greatest share of increases in health care spending, particularly in the last ten years, can be attributed to price inflation, meaning inflation in the generally accepted economic sense: increases in what economists call "inputs," or increases in the cost of "inputs," for what are regarded as essentially the same goods or services.⁵⁰ As Figure 2 shows, about two-thirds of the increases in total health spending by 1975 could be traced to price inflation. Since that time, the proportion of spending

49. See *supra* Table 1.

50. See P. FELDSTEIN, *supra* note 17, at 54-64, 224-44. For a full explanation of how price inflation is estimated, see Freeland & Schendler, *supra* note 23, at 7-10.

increases that can be attributed to price inflation has steadily increased, representing nearly 80% of the total annual increase in health spending in the most recent years.⁵¹

Thus, inflation—not intensity or population growth—has been the leading causal factor in the historic growth of NHEs. Inflation is a factor of continuing and *growing* importance, an observation of crucial significance in both defining the exact nature of the “fundamental problem,” and in evaluating the need for and the nature of appropriate remedial responses. Americans are essentially paying more for their medical care in the most literal sense; indeed, the latest estimates indicate that they may be paying more and receiving slightly less.⁵²

This price inflation, of course, has been driven in large part by the inflation in the economy in general, but it also represents a higher level of inflation in health care prices that is specific to health care services. In 1983, 44% of the increase in personal health expenditures was attributable to economy-wide inflation.⁵³ In 1984, despite a slowing of the economy, that figure had increased to 52%.⁵⁴ In both years, approximately one-fourth of the total increase was an *additional* industry-specific price inflation.⁵⁵ As measured by the Medical Care Price Index (MCPI),⁵⁶ price inflation in national health care spending during the last twenty years has continually and significantly exceeded the Consumer Price Index (CPI), the generally accepted measure of inflation in the general economy.⁵⁷ As Figure 3 shows, the annual percent change in the MCPI during the last two decades has—with some notable exceptions⁵⁸—consistently exceeded the increase in the CPI, in some years growing at twice the rate of the CPI. This trend was sus-

51. Estimates for 1984 indicate that inflation was responsible for 76% of the increase in personal health expenditures. (Note that this is personal health expenditures and not total NHEs.) See 1984 EXPENDITURES, *supra* note 23, at 8. In 1982 and 1983, inflation was responsible for 70% of the increase. See 1983 EXPENDITURES, *supra* note 24, at 6, 9. During the prior decade, inflation was responsible for approximately 57% of the increase. See HEALTH SPENDING TRENDS, *supra* note 33, at 10.

52. See *infra* notes 64-68 and accompanying text.

53. See 1983 EXPENDITURES, *supra* note 24, at 9.

54. See 1984 EXPENDITURES, *supra* note 23, at 8.

55. See *id.*; 1983 EXPENDITURES, *supra* note 24, at 9.

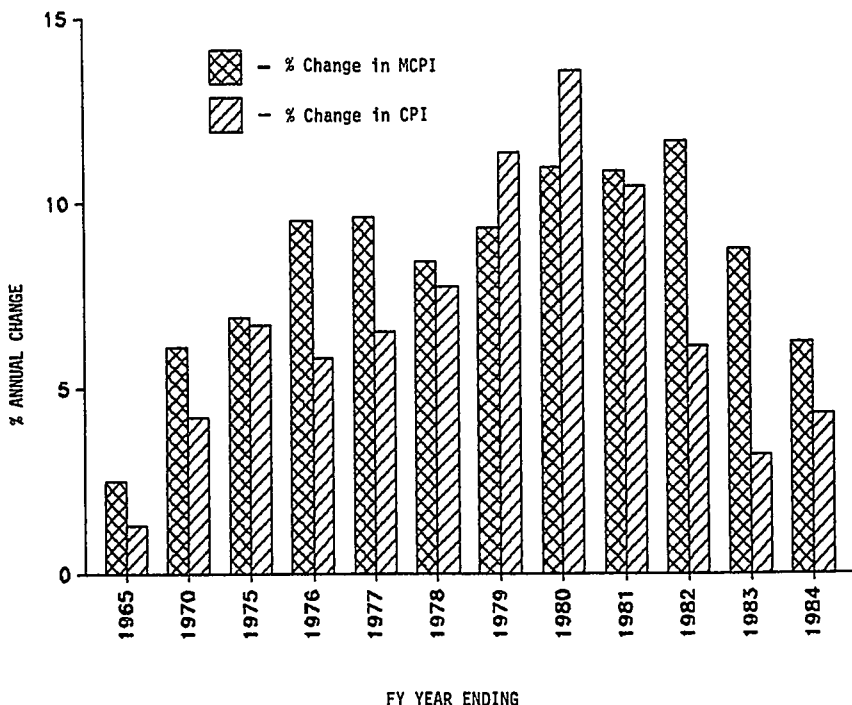
56. See *infra* Figure 3. For a technical definition of MCPI, the medical care component of the Consumer Price Index, see P. FIELDSTEIN, *supra* note 17, at 54.

57. For a technical definition of the consumer price index, the primary barometer of the national inflation rate for the consumer economy maintained by the Bureau of Labor Statistics, see P. FIELDSTEIN, *supra* note 17, at 45-53.

58. Only in 1979 and 1980 was the CPI (slightly) higher than the MCPI. Most experts have attributed this to the peculiar economics of those years and, in part, to the effects of the

tained even during years when the inflation in the general economy itself was regarded as reaching critical levels.⁵⁹

FIGURE 3
CHANGE IN MCPI VS CHANGE IN CPI



SOURCE: U.S. DEPT. OF HEALTH AND HUMAN SERVICES, HEALTH UNITED STATES 1985 (1985), Table 77, at 125.

No other major item in the economy—food, housing, transportation, even energy costs—has matched these levels of specific-price inflation.⁶⁰ Thus, during the last two decades and, most important, during the last ten years (the period of the greatest increases in the costs of health care), Americans have been paying higher prices for their medical care due to a rate of inflation that cannot be explained

so-called "Voluntary Effort" of providers. See P. FIELDSTEIN, *supra* note 17, at 228; Wing & Siltan, *supra* note 11, at 1431, n.41.

59. For further discussion and projections into the next decade, see HEALTH SPENDING TRENDS, *supra* note 33, at 3-9.

60. See P. FIELDSTEIN, *supra* note 17, at 53; HEALTH INSURANCE ASSOCIATION OF AMERICA, SOURCE BOOK OF HEALTH INSURANCE DATA 1984-85 56 (1985) [hereinafter cited as HIAA].

simply by reference to prevailing economic conditions or other mitigating factors.

A relevant economic, as well as political, lesson can be learned from an analysis of the cost data for the last several years, when, ironically, the "fundamental problem" was somewhat obscured by the apparent decline in the rate of increase in NHEs.⁶¹ In 1984, growth of NHEs was slightly less than that of the general economy,⁶² and government reports⁶³ and media accounts were heralding a slowing in the rate of health care "inflation."⁶⁴ But, in fact, the long-term trend of price inflation, driven both by inflation generally and by the inflation specific to health services, was continuing to influence health care spending at a relatively high level. The rate of increase in total NHEs in 1984 was slightly lower than the percentage growth of the GNP only because the rate of productivity of health services declined and was significantly lower than that for the rest of the economy.⁶⁵ The MCPI was still 6.2%—150% of the rate of general price inflation, as measured by the CPI.⁶⁶ Although this was a relative decline compared to 1983, when the MCPI was twice the rate of the CPI,⁶⁷ Americans were still paying more and, perhaps, receiving slightly less, even if health care spending was not publicly perceived as a growing and persistent problem.⁶⁸

This isolation of the dominant and continuing role of price inflation in health care costs is not meant to suggest that other factors that have contributed to the growth of NHEs, or to the shifting of economic resources, should be disregarded in evaluating either his-

61. See *supra* notes 31-32 and accompanying text; Table 1.

62. Growth in NHEs was 9.1% in 1984. Growth of the general economy was 10.8%. The percentage of GNP representing health care spending dipped slightly from 10.7% to 10.6%. See *supra* Table 1; 1984 EXPENDITURES, *supra* note 23, at 3.

63. In a July 31, 1985, news release, then Secretary of Health and Human Services Margaret M. Heckler announced that "[t]his dramatic decrease in health care inflation is continued good news for Americans . . . Health care providers are increasingly giving more efficient service." (A copy is on file at the School of Law, University of North Carolina). Both assertions by Secretary Heckler—that inflation had decreased and that providers were more efficient—were patently contradicted by the data included in the news release.

64. See, e.g., N.Y. Times, Aug. 8, 1985, at I-15.

65. In 1984, various measures of inputs (e.g., employment, work hours) decelerated markedly from previous years and were estimated at only one-half of the historic rates from the previous decades. See 1984 EXPENDITURES, *supra* note 23, at 7. Output growth slowed as well; in fact, after controlling for inflation, personal health expenditures grew only 2.1% in 1984. The average rate between 1965 and 1983 was nearly 5%. *Id.* at 8. See also *infra* notes 85-89, 105-07, and accompanying text for a discussion of utilization rates for various services.

66. See 1984 EXPENDITURES, *supra* note 23, at 8.

67. See *id.*

68. See *supra* note 64 and accompanying text.

toric trends or the need for cost containment. Changes in demographics, in the patterns of utilization or service, or in our social or economic circumstances will continue to have an influential impact on NHEs. Some experts, for example, have warned that the "graying" of the American population will become one of the dominant factors contributing to future increases in health spending, particularly towards the end of this century.⁶⁹ Conversely, induced or incidental changes in such factors as "intensity" (e.g., a reduction in the rate of hospitalization) can contribute to the containment of rising health care costs, even if they do so only by disguising the influence of price inflation or of other factors, as the data for the most recent years apparently demonstrate.⁷⁰ But such short-term success notwithstanding, the health care cost problem of the 1980's, the one that appears to have the most significant economic consequences and the one that has not been contained in any realistic sense, is price inflation. Price inflation, driven by inflation in the economy but continually exceeding that level of inflation—not "staggering" levels of aggregate spending, a growing or aging population, or significant increases in demand—is the most problematic characteristic of contemporary American health care, at least when viewed in terms of its impact on the economy.

Before further examining either the policy implications of our present circumstances or the political prospects for health care cost containment, whether through modification of price inflation or any other means, it is important to supplement as well as qualify some of the observations made above by examining in more detail the expenditures associated with specific categories of health services.

A. *Expenditures for Hospital Services*

Tracking virtually the same long-term course as total NHEs, aggregate spending for hospital services rapidly increased from \$10.9 billion in 1950 to \$158 billion in 1984,⁷¹ averaging nearly a 14% increase per year from 1965 to 1983.⁷² In the last several years, the growth of hospital expenditures has somewhat slowed, again paralleling the growth of total NHEs. In 1983, total spending was \$147 billion, an increase of 10.5% over the previous year.⁷³ Expenditures

69. See generally S. CRYSTAL, *AMERICA'S OLD AGE CRISIS* (1982); Waldo & Lazenby, *supra* note 18, at 1; Fuchs, *supra* note 18, at 143.

70. See *supra* notes 61-66 and accompanying text.

71. See *infra* Table 2; 1984 EXPENDITURES, *supra* note 23, at 9, 12.

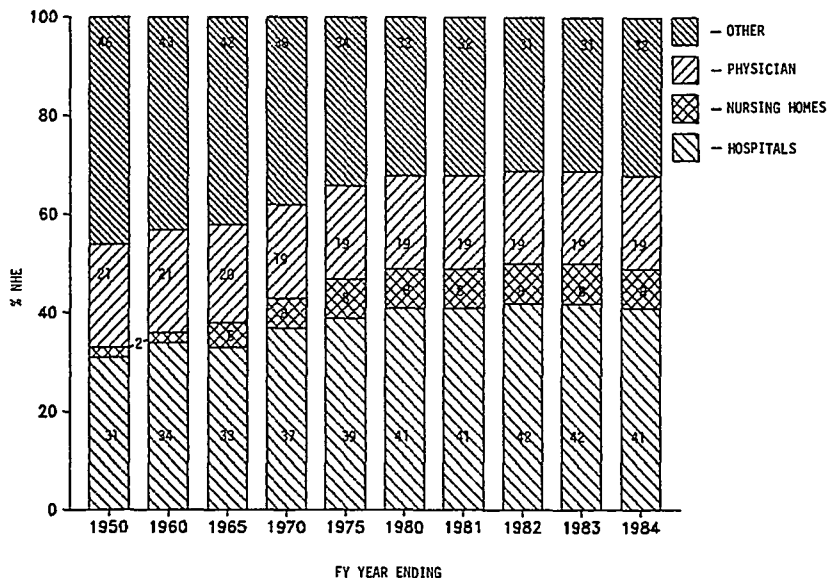
72. See *infra* Table 2.

73. See *infra* Table 2; 1983 EXPENDITURES, *supra* note 24, at 9.

grew by 6.1% in 1984, the slowest increase since 1965⁷⁴ and a rate significantly lower than the growth of total NHEs—clearly one of the most significant developments in recent years.

Notwithstanding the apparent trend of the last several years, Table 2 shows that spending for hospital services during the last forty years has, with a few interesting exceptions, increased rapidly and measurably faster than the rest of the economy, as measured by GNP growth.⁷⁵ Growth of hospital spending has also generally exceeded the growth rate of total health care expenditures,⁷⁶ reaching its highest rate of growth during a decade when utilization of hospital services began to decline, as discussed more fully below.⁷⁷

FIGURE 4
PROPORTION OF NHE BY CATEGORY
OF HEALTH SERVICE



SOURCE: Calculated from Levit, Lazenby, Waldo & Davidoff, *National Health Expenditures, 1984, HEALTH CARE FIN. REV., Fall 1985, Table 2, at 9.*

74. See 1984 EXPENDITURES, *supra* note 23, at 12.

75. The exceptions are 1978 and 1973. See *supra* note 29.

76. See *supra* Table 1. Growth of NHEs exceeded annual growth of hospital expenditures in 1971, 1977, 1983, and 1984. All tolled, however, hospital spending has increased in the last 20 years by 1127%, compared to a 924% increase in NHEs. See 1984 EXPENDITURES, *supra* note 23, at 3, 9.

77. See *infra* notes 83-90 and accompanying text.

TABLE 2
GROWTH RATES PER ANNUM (%)

YEAR	HOSPITALS	DOCTORS	NURSING HOMES	GNP
1985				
1984	6.1%	10.2%	8.9%	10.8%
1983	10.5	10.7	9.3	7.7
1982	14.2	12.8	12.6	3.8
1981	16.4	17.1	17.2	12.4
1980	16.4	16.4	17.2	8.8
1979	14.2	12.3	15.2	11.7
1978	11.9	12.2	16.2	12.8
1977	11.8	15.6	15.0	11.7
1976	16.2	10.8	11.9	10.9
1975	16.4	17.5	18.8	8.0
1974	15.7	11.0	18.1	8.1
1973	10.5	11.0	10.8	11.8
1972	13.5	8.2	16.1	10.0
1971	10.7	11.2	19.1	8.6
1970	15.7	13.5	23.7	5.2
1969	14.7	13.5	11.8	8.1
1968	14.7	9.9	21.4	9.2
1967	16.5	9.8	16.7	5.8
1966	12.9	8.2	14.3	9.4
1965	10.3	8.3	—	6.4
1960	10.3	9.0	—	4.8
1955	10.1	6.5	—	6.9
1950	—	—	—	11.1

SOURCE: Hospital, doctor and nursing home rates for 1966-1984 calculated using data from Gibson, Levit, Lazenby & Waldo, *National Health Expenditures, 1983*, HEALTH CARE FIN. REV., Winter 1984, Table 2, at 7, and Levit, Lazenby, Waldo & Davidoff, *National Health Expenditures, 1984*, HEALTH CARE FIN. REV., Fall 1985, Table 2, at 9. Hospital and doctor rates for 1955-1960 from P. FELDSTEIN, HEALTH CARE ECONOMICS, Table 10-7, at 227, and Table 9-2, at 175 (2d ed. 1983). GNP rates from Gibson, Levit, Lazenby & Waldo, *National Health Expenditures, 1983*, HEALTH CARE FIN. REV., Winter 1984, Table 1, at 3, and Levit, Lazenby, Waldo & Davidoff, *National Health Expenditures, 1984*, HEALTH CARE FIN. REV., Fall 1985, Table 1, at 3.

The importance of this growth in hospital expenditures in defining health policy issues is reflected in Figure 4.⁷⁸ Historically, hospital spending has been the largest portion of the national health budget. That share has steadily grown over the last four decades; in the most recent years, hospital services have commanded over one-half of all spending for personal health services and over 40% of

78. See also P. FELDSTEIN, *supra* note 17, at 224-34.

NHEs.⁷⁹ In 1984, hospital services accounted for 46% of all spending for personal health services, and just over 40% of all spending.⁸⁰ Perhaps more critical from a policy perspective, hospital expenditures have represented even higher proportions of total government expenditures, as discussed more fully in the next section.⁸¹ Moreover, these figures represent only direct hospital charges. If physician charges to hospitalized patients, spending for separately billed procedures, and rehabilitation following hospitalization were included, total spending associated with hospitalization would represent over 80% of all health spending.⁸² Given this dominant role of the hospital in modern American medicine, the analysis of the underlying causes of the growth in hospital expenditures becomes critically important for evaluating both the reality of the need for cost containment and the appropriate responses to that need.

As with increases in total health care spending, price inflation apparently has played a primary and continuing role in the growth of expenditures for hospital services, even as the rate of increase in total spending has begun to moderate in recent years. Indeed, the role of price inflation in rising expenditures for hospital services in the last decade has been particularly dominant, since utilization of hospital services during that time apparently leveled off, and, in the most recent years, even declined according to some measures.⁸³

Data collected from community hospitals,⁸⁴ as shown in Table 3, indicate that the average length of stay historically was increasing until the early 1970's. That rate declined in the next several years and remained fairly constant through 1983. In 1984, the average length of stay in community hospitals dropped to 7.3 days, the lowest rate ever recorded.⁸⁵ Some experts have predicted a continuing

79. See 1983 EXPENDITURES, *supra* note 24, at 7.

80. See 1984 EXPENDITURES, *supra* note 23, at 12; *supra* Figure 4.

81. In 1984, government spending accounted for 53% of all hospital expenditures. See 1984 EXPENDITURES, *supra* note 23, at 12. In the past 10 years, this figure has been fairly stable, although the federal share has gradually increased. See *infra* notes 149, 163, 166, and accompanying text.

82. See P. FELDSTEIN, *supra* note 17, at 3.

83. For a general discussion of the role of price inflation in hospital spending, see *id.* at 62-63. For a discussion of price inflation in most recent years, see 1984 EXPENDITURES, *supra* note 23, at 12. See also HEALTH SPENDING TRENDS, *supra* note 33, at 18-19.

84. Community hospitals represent over 90% of all short-term, acute-care hospitals. While this does not represent all hospitals, the experience of community hospitals is generally regarded as representative of the experience of the entire hospital industry. For a discussion of community hospitals and their characteristics, see Wing & Craig, *Health Care Regulation: Dilemma of a Partially Developed Public Policy*, 57 N.C.L. REV. 1165, 1172 (1979).

85. See 1984 EXPENDITURES, *supra* note 23, at 13; but see *infra* note 182 for data on people over age 65.

decline in the next several years.⁸⁶

TABLE 3

COMMUNITY HOSPITAL: Length of Stay, Admissions, and Costs

YEAR	AVERAGE LENGTH OF HOSPITAL STAY IN DAYS	AVERAGE COST TO HOSPITAL PER PT. STAY	ADMISSIONS PER BED PER YEAR
1985			
1984	7.3	N/A	N/A
1983	7.6	\$2789.18	154.4
1982	7.6	2488.20	156.7
1981	7.6	2160.70	161.9
1980	7.6	1862.80	165.8
1979	7.6	1651.50	162.4
1978	7.6	1476.70	161.1
1977	7.6	1322.40	161.4
1976	7.7	1168.90	160.5
1975	7.7	1030.30	159.2
1974	7.8	886.10	157.8
1973	7.8	798.70	153.2
1972	7.9	831.70	150.0
1971	8.0	738.48	148.2
1970	8.2	664.28	145.6
1969	8.3	581.25	—
1968	8.4	515.59	—
1967	8.3	448.86	—
1966	7.9	380.39	—
1965	7.8	346.94	138.8
1964	7.7	320.17	—
1963	7.7	299.61	—
1962	7.6	279.91	—
1961	7.6	265.85	—
1960	7.6	244.95	129.2
1955	7.8	180.34	117.3
1950	8.1	126.52	111.4

SOURCE: HEALTH INSURANCE ASSOCIATION OF AMERICA, SOURCE BOOK OF HEALTH INSURANCE DATA 1984-1985 (1985), Table 5.15, at 57, and Table 6.8, at 73. 1984 data from AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS xvii (1985).

The rate of admission to hospitals grew moderately through the 1970's but has declined rather markedly in the 1980's,⁸⁷ although

86. Recent predictions estimate that the average length of stay in hospitals will continue to decline into the next decade. See HEALTH SPENDING TRENDS, *supra* note 33, at 19; Free-land & Schendler, *supra* note 23, at 19.

87. A 1984 survey of community hospitals indicated that inpatient admissions declined

the rate of admissions for outpatient services has increased in the most recent years.⁸⁸ During this time, there has been no increase in the number of hospital beds or any other indication that either a change in the supply of hospital services or in the utilization of those services has been primarily responsible for the rapid growth in hospital expenditures during the 1970's, or in the continuing but moderated rate of increase in the 1980's.⁸⁹ One expert estimated that from 1966 to 1980, less than 13% of the increase in hospital expenditures could be attributed to either increased utilization or increases in population.⁹⁰ The remaining 87% was attributable to sizable increases in expenditures per patient day of service, reflecting either inflation in the prices of hospital services or increases in the "intensity" of the services rendered to each patient.

Unfortunately, segregating price inflation from "intensity" in the hospital context is a particularly difficult task,⁹¹ confounded by some peculiar characteristics of American hospital care, not the least of which are the significant variations in utilization rates of hospital services from state to state, and even within the same state—variations for which no satisfactory explanation is available.⁹² But even given this complication, it is fairly clear that price inflation, driven by inflation in the general economy but representing a rate of inflation specific to hospital services that is higher than that of the general economy, has played and continues to play a primary role in rising expenditures for hospital services.

As Figure 5 illustrates, estimates for the decade from 1973 to 1983 indicate that increases in the intensity of service per admission were responsible for less than 25% of the increase in total hospital expenditures. Roughly 65% of the increase during this period can be attributed to inflation, 50% of which was inflation in the general economy, and 15% due to an additional hospital-specific price inflation.⁹³

1.4 million, down 3.7% from 1983. Total inpatient days also declined 22.7 million, a drop of 8.6% from 1983. See 1984 EXPENDITURES, *supra* note 23, at 12-13.

88. See *id.*; HIAA, *supra* note 60, at 66.

89. See P. FELDSTEIN, *supra* note 17, at 230-31 (analyzing the 1970's). If anything, the supply of hospital beds has been shrinking slightly in recent years. See 1984 EXPENDITURES, *supra* note 23, at 13.

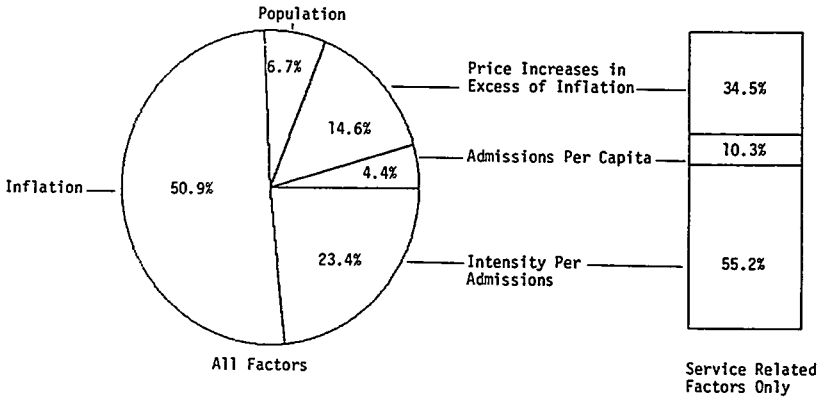
90. See P. FELDSTEIN, *supra* note 17, at 230; Freeland & Schendler, *supra* note 23.

91. See P. FELDSTEIN, *supra* note 17, at 224-233.

92. See *id.* at 224-25; U.S. DEPT. OF HEALTH AND HUMAN SERVICES, HEALTH UNITED STATES 1985, at 142-43 (1985) [hereinafter cited as HEALTH U.S. 1985]. This is apparently true for other services. See P. FELDSTEIN, *supra* note 17, at 82-86, 140-41.

93. See HEALTH SPENDING TRENDS, *supra* note 33, at 18-19.

FIGURE 5
COMMUNITY HOSPITAL INPATIENT CARE
EXPENDITURE GROWTH FACTORS, 1973-1983



SOURCE: Arnett, Cowell, Davidoff & Freeland, *Health Spending Trends In The 1980's: Adjusting To Financial Incentives*, HEALTH CARE FIN. REV., Spr. 1985, Table 7, at 18.

Data for 1983 indicate that the role of intensity per admission in increasing expenditures was less than 16%.⁹⁴ Over 75% of the 1983 increase was due to inflation, 50% from inflation in the general economy and 25% from hospital price inflation over and above general inflation.⁹⁵ The role of inflation moderated somewhat in 1984; 44% of the increase in expenditures was a result of general inflation, an additional 16% from hospital-specific inflation.⁹⁶

The implications of these data are confirmed by other estimates of the rate of increase of hospital price inflation. As measured by average room rate increases, hospital price inflation was 11.4% in 1983, when the MCPI was 8.7% and the CPI was 3.2%.⁹⁷ In 1984, hospital price inflation was only 8.7%, the first time that figure has dropped below double digits in nearly twenty years. Nonetheless, this rate of hospital price inflation still exceeded the MCPI by wide margins and was still nearly twice the rate of the CPI for 1984.⁹⁸

Assuming these data have correctly isolated the causal factors

94. See 1983 EXPENDITURES, *supra* note 24, at 9.

95. See *id.*

96. See 1984 EXPENDITURES, *supra* note 23, at 12.

97. See HEALTH U.S. 1985, *supra* note 92, at 127; *supra* Figure 3.

98. In 1984, the MCPI was estimated at 6.2%. The CPI was estimated at 4.3%. See HEALTH U.S. 1985, *supra* note 92, at 127; *supra* Figure 3.

behind rising hospital expenditures during the last decade and, most critical, during the most recent years, it appears that price inflation, not other factors, has been the driving force behind hospital spending increases. The price inflation problem for hospital spending in the 1980's is somewhat less problematic than it was in the 1970's. The influence of other factors, such as utilization and intensity increases, has been reduced; in fact, hospital utilization has apparently declined. Inflation in the general economy has also moderated. Indeed, the hospital industry in most recent years has frequently attempted to claim the same "success" in controlling "inflation" that some federal policymakers have tried to claim.⁹⁹ But even if the problematic character of inflation is moderated or disguised, hospital prices have been, and continue to be, inflating at a rate higher than general inflation. They will, therefore, continue to have detrimental economic consequences and continue to deserve the public's concern. From a policy point of view, if there is a cost problem associated with hospital expenditures that deserves attention in the 1980's, it appears that both the definition of that problem and the design of remedial solutions should focus on inflation as much as, if not more than, other contributing factors.

B. *Expenditures for Physician Services*

The data on aggregate spending for physician services indicate similar growth trends as those for hospital services; they also confirm the primary influence of price inflation in increasing health care costs.

As with other health care expenditures, spending for physician services has steadily increased during the last forty years, growing from \$2.7 billion in total spending in 1950 to \$14 billion in 1965 to \$75.4 billion in 1984.¹⁰⁰ The rate of this growth has also paralleled that of other health expenditures. As illustrated by Table 2, the rate of growth accelerated through the mid-1970's and peaked at over 17% per year in 1975. Overall, it grew at a much higher rate than the GNP, although the rate of growth was much more variable than that of hospital or other services. In most recent years, however,

99. At the same time that the federal government was announcing that "inflation" in health expenditures for 1984 had been reduced, *see supra* notes 63-64 and accompanying text, the hospital literature was implying that the hospital industry was forging a similar victory. *See, e.g., Hospital Rate of Increase Continues Under 5%*, HEALTH L. VIGIL, May 31, 1985, at 5; *Hospital Expenses Continue Moderate Rise*, HEALTH L. VIGIL, Oct. 18, 1985, at 9-10. Note that both articles discuss the decline in the utilization of services but omit reference to the cost of a unit of service or the continuation of price inflation.

100. *See* 1984 EXPENDITURES, *supra* note 23, at 9.

this rate of growth has somewhat moderated; physician expenditures grew 10.7% in 1983¹⁰¹ and only 10.2% in 1984, somewhat higher than the growth in total NHEs and slightly below the growth in the GNP.¹⁰²

As Figure 4 indicates, these physician expenditures represented a slightly declining proportion of health care spending until the mid-1970's. Since that time, they have demanded a relatively constant and, to some observers, relatively small share of total spending, averaging between 20 and 25% of spending for personal health services.¹⁰³ But in addition to their direct costs, the services of physicians also indirectly affect the total costs of health care. Virtually all other medical care, most notably services in hospitals and other institutions, is ordered or prescribed by a physician, usually incident to the delivery of some direct service.¹⁰⁴ The proprietization of hospital care and the modest growth in recent years of alternative delivery systems may somewhat dilute the traditional autonomy of physicians; their role in determining who gets what kind and what level of service may be thereby reduced. But the physician's role in determining the utilization and "intensity" of all services—and consequently the cost of those services—should be considered as important as the direct costs of physician services in evaluating the need for cost containment and the appropriate remedial responses.

As with hospital expenditures and expenditures for most other health services, the rate of growth of physician expenditures cannot be explained by the rate of growth of the population or, more important, by increases in the utilization of physician services, particularly in the last decade.¹⁰⁵ Available data indicate that physician visits per person have been remarkably constant over the last thirty years, even following the enactment of Medicaid and Medicare.¹⁰⁶ With few exceptions, there has been little change in the rate of physician utilization during the last decade, the period of highest growth of physician expenditures, as illustrated by Table 4.¹⁰⁷

101. See 1983 EXPENDITURES, *supra* note 24, at 6. In the decade prior to 1983, the average increase was 14%. See HEALTH SPENDING TRENDS, *supra* note 33, at 19.

102. See 1984 EXPENDITURES, *supra* note 22, at 8; *supra* Tables 1 and 2. Experts have predicted that the growth of spending for physician services may continue to decline into the next decade. See HEALTH SPENDING TRENDS, *supra* note 33, at 19.

103. See P. FELDSTEIN, *supra* note 17, at 174.

104. Physicians may influence as much as 70% of all personal health spending. See *id*; HEALTH SPENDING TRENDS, *supra* note 33, at 19.

105. See 1984 EXPENDITURES, *supra* note 23, at 11-12.

106. See P. FELDSTEIN, *supra* note 17, at 174; HIAA, *supra* note 60, at 66, 75.

107. See *supra* Table 2; *infra* Table 5.

TABLE 4
NUMBER OF PHYSICIAN VISITS PER PERSON PER YEAR
AND NUMBER OF VISITS PER PHYSICIAN PER WEEK

Year	Number of Visits per Person per Year	Number of Visits per MD per Week
1984		
1983	5.0	—
1982	5.1	—
1981	4.6	—
1980	4.8	112.0
1979	4.7	122.7
1978	4.8	130.6
1977	4.8	—
1976	4.9	128.5
1975	5.1	126.5
1974	4.9	125.8
1973	5.0	137.7
1972	5.0	—
1971	4.9	135.8
1970	4.6	132.5
1969	4.3	126.9
1966-1967	4.3	124.1
1963-1964	4.5	—
1958-1959	4.7	—

SOURCE: 1958-1980 data from P. FELDSTEIN, *HEALTH CARE ECONOMICS* (2d ed. 1983) Table 9-3, at 176. 1981 data from U.S. DEPT. OF HEALTH AND HUMAN SERVICES, *HEALTH UNITED STATES 1984* (1984), Table 42, at 97. 1982-1983 data from U.S. DEPT. OF HEALTH AND HUMAN SERVICES, *HEALTH UNITED STATES 1985* (1985), Table 43, at 82.

Estimates of the average number of visits per physician indicate a similar trend: a fairly constant rate during the 1970's and a slight decrease in the most recent years.¹⁰⁸ The leveling off of utilization rates for hospital services in the last decade, obviously correlated with the rate of physician services delivered in the hospital setting, also contradicts the notion that an increase in physician utilization is the driving force behind the continuing increases in total expenditures for physician services.¹⁰⁹

What has been steadily increasing during the last thirty years, including the last decade, a decade characterized by decreasing rates of utilization but steadily increasing physician expenditures, has been the level of physician fees. As Table 5 indicates, the rate of growth of physician fees increased through the 1970's and remained

108. See *HEALTH U.S. 1985*, *supra* note 92, at 82-86.

109. See *supra* notes 84-90 and accompanying text.

TABLE 5
ANNUAL RATE OF CHANGE IN THE CPI AND IN PHYSICIAN FEES, 1955-1984

YEAR	CPI All Items less Medical Care	CPI All Services less Medical Care	CPI Physician Fees
1985	3.4%	5.0%	5.8%
1984	4.1	5.2	7.0
1983	2.9	2.9	7.7
1982	5.9	8.7	9.4
1981	10.3	13.4	11.0
1980	13.6	15.9	11.7
1979	11.4	11.2	9.2
1978	7.6	8.6	8.3
1977	6.2	7.3	9.3
1976	5.5	7.9	11.3
1975	8.9	9.1	12.3
1974	11.1	9.2	9.2
1973	6.4	4.3	3.3
1972	3.3	3.8	3.1
1971	4.1	5.3	6.9
1970	5.8	8.3	7.5
1969	5.4	6.8	6.9
1968	4.1	4.9	5.6
1967	2.4	3.7	7.1
1966	3.0	3.4	5.8
1960-1965	1.2	1.8	2.8
1955-1960	2.0	3.5	3.3

SOURCE: 1955-1981 from P. FELDSTEIN, *HEALTH CARE ECONOMICS*, Table 9-1, at 174 (2d ed. 1983) and 1982-1985 from BUREAU OF LABOR STATISTICS, U.S. DEPARTMENT OF LABOR: CONSUMER PRICE INDEX, "All Urban Consumers" index, various issues.

relatively high until the last several years, exceeding the overall growth of the adjusted CPI for the economy during this period, as well as that of the CPI for all services. In 1983, physician fees rose 7.7%, while the adjusted CPI increased 2.9%.¹¹⁰ In 1984, price inflation was again the significant contributor to the increase in physician expenditures, rising 7% while the adjusted CPI increased only 4.1%.¹¹¹

110. Note that the CPI estimates in Table 5 are adjusted to exclude the influences of medical care increases. For comparison based on estimates of CPI for all items including medical care for these same years, see 1983 EXPENDITURES, *supra* note 24, and Figure 3.

111. See 1984 EXPENDITURES, *supra* note 23, at 11-12. Again paralleling the growth of hospital spending and health expenditures in general, it is clear that inflation has been the dominant and continuing influence on physician spending increases. During the period from 1973 to 1983, it has been estimated that 56% of the total increase was due to general inflation, while 17% was due to an additional price inflation specific to physician services. In-

These data strongly suggest, therefore, that increasing physician expenditures can be traced largely to inflation in the price of physician services. They also indicate that this inflation is due in substantial part to the inflation in the general economy, but also to a higher level of inflation specific to physician services.¹¹² Again, there is some problem divorcing changes in the "intensity" of a physician service from the inflation in its price.¹¹³ The nature of the services delivered by physicians may be changing in various respects; moreover, the costs of providing the same "inputs" for the service would be expected to change roughly at the rate of the CPI or other indicators of general economic inflation. Nonetheless, the inflation of physician fees has generally exceeded these expectations.¹¹⁴ The studies that have attempted to compare actual expenses of maintaining a physician practice also have confirmed that the fees charged by physicians are rising faster than the increases in the expenses associated with those fees.¹¹⁵ Thus, as with rising expenditures for hospital services and for health expenditures in the aggregate, if expenditures for physician services are considered problematic, the major focus of attention should be on the continuing inflation of the prices paid for these services.

C. *Expenditures for Nursing Homes and Other Services*

Notwithstanding the sizable portions of NHEs represented by direct expenditures for hospital services and for physician services, as well as the significant indirect effects of these expenditures on total health spending, some attention should be given to the level of spending for the variety of other health and health-related goods and services that contribute to total health care costs. In 1984, for example, nearly 20% of NHEs, 22% of all personal health services, were spent for drugs, dental and other non-physician professional services, medical supplies, eyeglasses, and other health appliances.¹¹⁶ Another 8% of NHEs were spent for nursing home serv-

creases in "intensity" accounted for another 26%. Population growth accounted for only 7%. The reduction in visits per patient resulted in a *decrease* of 6%. See HEALTH SPENDING TRENDS, *supra* note 33, at 10.

112. See HEALTH SPENDING TRENDS, *supra* note 33, at 10, 18.

113. For estimates of the role of the "intensity" of physician services between 1973 and 1983, see *id.* at 10. For earlier years, see Freeland & Schendler, *supra* note 23, at 103.

114. See P. FELDSTEIN, *supra* note 17, at 173-78.

115. See *id.* In particular, see the analysis of long term trends in physicians' real income, *id.* at 176.

116. See 1984 EXPENDITURES, *supra* note 23, at 9.

ices, as discussed more fully below.¹¹⁷ “Medical sundries” and drugs alone represented 7.5% of all personal health services in 1984.¹¹⁸

As Figure 4 indicates, the proportionate share of total health spending for these other services has been growing slightly over the last several decades, but, overall, the rate of growth of these expenditures has basically traced the same pattern as the growth of total health expenditures: accelerating through the 1970's and growing more slowly in recent years.¹¹⁹ There is, however, considerable variation within this category of spending. The rate of growth of spending for prescription and over-the-counter drugs has been historically slower than the growth of spending for other services and, therefore, the share of total expenditures attributable to drugs has steadily declined in the last three decades, unlike virtually any other item in the health budget.¹²⁰ Expenditures for dental services, on the other hand, have had periods of remarkable growth in the last decade.¹²¹

One major reason for the differing rates of growth for these various items is that unlike hospital services and physician services—for which third-party coverage has been relatively stable in the last twenty years—insurance and other third-party payment for these “other services” historically has been rather limited.¹²² Thus, the occasional extension of such coverage for one or more of these services can prompt rapid increases in the rates of their utilization and, consequently, the growth of their total expenditures. As a result, examination of the causes of rising costs for these items, even in the last decade, requires a separate analysis. Each of the distinct and

117. See *id.*; *infra* notes 123-37 and accompanying text.

118. See 1984 EXPENDITURES, *supra* note 23, at 9. Twenty-six billion dollars were spent for drugs and medical supplies in 1984, a growth of 9.4% over such spending in 1983. See *id.* at 14.

119. The rate of growth of spending for what are categorized in national statistics as “other personal health goods and services” represented \$51 billion in 1984, an increase of 12.9%. See *id.* This is a remarkably high rate compared to the moderated rate of growth in total NHEs and in other major categories of health services for that year. See *supra* Tables 1 and 2. Projections for the rest of the decade indicate that this category of spending will continue to increase at a slightly accelerated rate when compared to other health spending. See HEALTH SPENDING TRENDS, *supra* note 33, at 22.

120. See 1984 EXPENDITURES, *supra* note 23, at 14; 1983 EXPENDITURES, *supra* note 24, at 10. Note that all of the increase in spending for prescription drugs and medical sundries since 1978 can be attributed to price inflation.

121. Price inflation, coupled with a strong increase in demand for dental services—prompted apparently by increased insurance coverage—resulted in an increase in dental expenditures of 15% in 1984. See 1984 EXPENDITURES, *supra* note 23, at 14.

122. See P. FELDSTEIN, *supra* note 17, at 124-25.

varying influences must be isolated, including changes in utilization (prompted by changes in third-party coverage and other factors), changes in "intensity," price inflation, and, perhaps, other influences. While this may qualify and complicate any attempt to summarize health spending trends, such further analyses are nonetheless important in evaluating either the need for cost containment or the impact of possible reform measures. Obviously, any major change in the factors driving expenditures for these items can produce some increase in overall spending or disguise decreases in other items, although any such effects would be on a somewhat lesser scale than those that could be produced by a change in the factors driving expenditures for physician or hospital services. Conversely, factors that produce decreases in spending for drugs, dental services, or other such items may also contribute to the same "apparent success" phenomenon discussed earlier, and, again, complicate the assessment of cost-containment measures. Finally, any cost-containment measure targeted to increases in one category of spending may have an unexpected or undesired impact on other areas of spending.

The potential significance of these other services to cost containment, and the necessity of examining them separately, can best be illustrated by reference to the rising expenditures for nursing home services. Total expenditures related to nursing homes were less than \$500 million in 1960, less than 2% of NHEs.¹²³ That share rose quickly to 5% of NHEs in 1965 and increased to 8% in 1983,¹²⁴ following the enactment of Kerr-Mills, Medicaid and Medicare, and other government programs that provided, virtually for the first time, insurance-type coverage for nursing home services.¹²⁵ As a result, spending for nursing home services has been regarded as the fastest growing portion of the national health budget,¹²⁶ as well as a growing share of state and federal budgets.¹²⁷

In the most recent years, however, spending increases relating to nursing homes, as with other health spending, have apparently

123. See 1983 EXPENDITURES, *supra* note 24, at 7. See generally *supra* Table 2. For projections through 1990, see HEALTH SPENDING TRENDS, *supra* note 33, at 20.

124. See 1983 EXPENDITURES, *supra* note 24, at 7.

125. For a history (through the late 1970's) of nursing homes and government policy, as well as an analysis of the role of third-party reimbursement in spawning the growth of the nursing home industry, see B. VLADECK, UNLOVING CARE 30-70 (1980).

126. See *supra* Table 2; Figure 4. Between 1973 and 1983, nursing home spending increased at an average annual rate of 16%. See HEALTH SPENDING TRENDS, *supra* note 33, at 22.

127. See *infra* notes 149-53, 167-68, and accompanying text.

moderated; total expenditures for nursing homes grew to \$32 billion in 1984, an increase of only 8.9% from 1983. The proportionate share of total health spending has stabilized at roughly 8% of NHEs.¹²⁸

While nursing home spending is relatively small and apparently has slowed from its earlier rates of rapid growth, an examination of the factors responsible for the historic increases suggests, nonetheless, that nursing home spending may become increasingly problematic. In fact, some experts have predicted future nursing home spending—or at least spending for long-term care generically¹²⁹—to be a potential public policy “time bomb.”¹³⁰ As indicated by Figure 6, estimates for the last decade show that increases in the “intensity” of service or in inflation have had a slightly lesser effect on increases in nursing home spending—indeed, service-specific price inflation has been remarkably low—than they have had on spending for other services.¹³¹

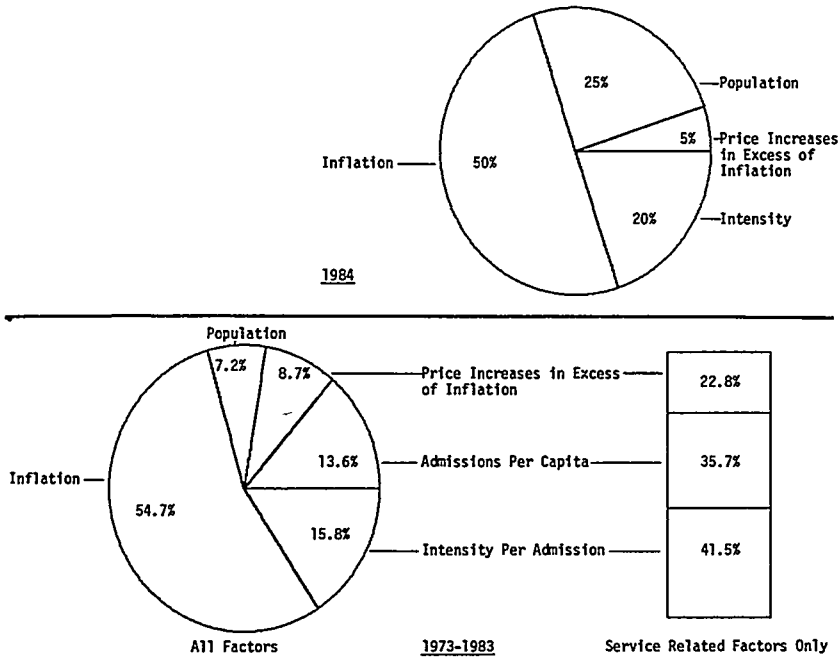
128. See 1984 EXPENDITURES, *supra* note 23, at 13.

129. Nursing homes, of course, are only one type of long-term care. Indeed, the definition of “long-term care” and the appropriateness of providing it through nursing homes is a source of some controversy. See generally Doty, Liu & Wiener, *An Overview of Long-Term Care*, 6 HEALTH CARE FIN. REV., Spr. 1985, at 69.

130. See S. CRYSTAL, *supra* note 69, at 23-26. Extrapolating from the demographic trends of this decade (and assuming no major change in patterns of utilization), the federal government estimated that there will be a 132% increase in the nursing home population by the year 2030. See *id.* at 26.

131. Compare these data with Figure 2 and Figure 5. Note, however, that these estimates exclude spending for intermediate-level nursing home services to the mentally retarded (ICF-MR). ICF-MR spending truly skyrocketed during the 1970's and remains one of the most volatile items in the health budget. See 1984 EXPENDITURES, *supra* note 23, at 13. Indeed, while ICF-MR spending growth has slowed to levels comparable to other nursing home services in the last several years, ICF-MR spending still deserves special attention, especially for Medicaid policymakers. See *infra* note 168; Wing, *supra* note 19, at 1, 9; Wing, *North Carolina's Medicaid Program: The Effects of the Reagan-Era Budget Reductions*, 14 N.C. CENT. L.J. 313, 324-26 (1984).

FIGURE 6
FACTORS ACCOUNTING FOR GROWTH IN
EXPENDITURES FOR NURSING HOME CARE
 (excluding intermediate care facility for the mentally retarded)



SOURCE: Levit, Lazenby, Waldo & Davidoff, *National Health Expenditures, 1984*, HEALTH CARE FIN. REV., Fall 1985, at 13 and Arnett, Cowell, Davidoff & Freeland, *Health Spending Trends in the 1980's: Adjusting to Financial Incentives*, HEALTH CARE FIN. REV., Spr. 1985, at 10.

Increases in utilization, however, played a much larger role than was the case with hospital and physician services. Although traceable to a number of factors,¹³² this increased utilization was due most notably to the shift in American demographics towards the elderly.¹³³ Data for 1984 confirm these observations. The role of population increases continued to grow, while the influence of inflation slightly decreased and differed markedly from the role of inflation in spending for other services.¹³⁴ Pairing the predicted “graying” of the American population with the fairly well-documented, unmet

132. For a discussion of the various factors, see 1984 EXPENDITURES, *supra* note 23, at 13; HEALTH SPENDING TRENDS, *supra* note 33, at 22-23.

133. See *supra* notes 38-41 and accompanying text.

134. See *supra* Figure 6; *cf. supra* Figures 2 and 5.

demand for long-term care even in the existing population,¹³⁵ many experts believe that nursing home spending could well skyrocket in the next decade, even if inflation moderates or spending for other health care services is contained.¹³⁶ Indeed, government policy at both the state and federal levels has already resulted in much more rigorous strategy towards regulating the nursing home industry and containing nursing home costs than it has for any other sector of the health care industry, a posture that will likely continue.¹³⁷

D. *Some Observations*

As all of the discussion in this section should demonstrate, disaggregating the rising costs of health care and assessing their implications for the economy is a complicated and technically difficult task. The available data are too summary and too quickly outdated to provide more than tentative answers even to the most basic questions. The answers to the most critical questions—most particularly, isolating the causal roles of price inflation, changes in service utilization, or changes in “intensity”—can only be addressed in the most qualified and sketchy terms. A review of the literature indicates that critical attempts to submit these questions to sophisticated economic analysis are as much normative models of what might have happened in the past as they are descriptive analyses of either our past or present circumstances.¹³⁸ Indeed, it is fairly clear from the literature—and exceedingly clear in the halls of practical politics—that our ability to understand the economics of health care delivery and to apply that understanding to contemporary policymaking is rather limited.

But while a sophisticated understanding of health care costs may be beyond us, the available data do confirm some basic observations that can and should be applied by health policy decisionmakers in defining the need for cost containment and in charting a course for its resolution. First of all, the “fundamental problem” of health care costs to the economy is not primarily one of Americans demanding ever more medical care; nor is it one of more Americans demanding ever more. Organ transplants or the other offerings of today’s technology for tomorrow’s medicine may

135. See, e.g., Weissert, *Estimating the Long-Term Care Population: Prevalence Rates and Selected Characteristics*, 6 HEALTH CARE FIN. REV., Summer 1985, at 83.

136. HEALTH SPENDING TRENDS, *supra* note 33, at 22-23.

137. See Harrington & Swan, *Medicaid Nursing Home Reimbursement Policies, Rates, and Expenditures*, 6 HEALTH CARE FIN. REV., Fall 1984, at 39.

138. See P. FELDSTEIN, *supra* note 17, at 234-44.

someday create a fundamental cost problem for which, among other things, rationing of one sort or another will be required. Rapid increases in the demand for nursing homes and other services by the elderly, spurred by the predicted shifts in demographics, may also require limits on utilization in the not-too-distant future. The increasing "intensity" of the services delivered will also continue to contribute significantly to future health care costs, as it has in the past, and may become increasingly problematic.

But at least when viewed in the aggregate, these are not the "fundamental" cost problems of the 1980's for the American economy. The cost problems of this decade are woven into the economics of inflation, meaning inflation in prices throughout the economy, as well as inflation over and above general inflation in the prices paid for the goods and services that we regard as health care. NHEs have been increasing for a variety of reasons but primarily because of the rising costs of producing and delivering those services. That inflation continues today, even if it is disguised by the apparent moderation of "health care inflation" in the popular, but technically incorrect, sense of the term.

To blame price inflation for increases in health care costs is, of course, only a symptomatic analysis, not the isolation or the evaluation of underlying causes. And, as with the rise in aggregate national spending, price inflation can in some respects be explained, perhaps even justified, by our social and economic circumstances and the inherent nature of the services which are involved. The slow growth of productivity in health care may not be able to keep pace with the growth of public expectations, leading, economists have argued, to inflation in prices.¹³⁹ Some amount of inflation in the costs of a valuable service, as mentioned earlier, may be part of the price we pay for a maturing economy. For that matter, estimates of price inflation, technically an attempt to measure increases in the cost of the "inputs" used to produce the same product or service or changes in those "inputs," only roughly distinguish between changes in "inputs" and changes in the "intensity" of the service. Surely the same service—a day in the hospital or a visit to the physician—is not being provided today as it was yesterday, even in the most basic sense. But the relative influence of price inflation

139. Economists theorize that industries with slower growing productivity may experience more rapid price inflation; the health care industry generally has slow or even negative growth. When new technology can be applied, however, there is a tendency to oversaturate the market in response to consumer expectations of getting the "best" available. See 1983 EXPENDITURES, *supra* note 24, at 5.

on health care costs, both historically and, in particular, through the last decade, is too significant and too consistent to be dismissed as the product of either these somewhat mitigating circumstances or the difficulty of separating real price inflation from changes in the nature of the services delivered.

Indeed, experts from a variety of disciplines—economists, public policy analysts, health services researchers, and virtually everyone that has studied the “fundamental problem”—have uniformly agreed that inflation in health care prices and the resulting impact on health care costs and, as a result, on the economy, must be traced to other, more retribitional factors, deriving from the manner in which health care is financed and organized. There is little agreement on the relative influence of various systemic characteristics. The literature abounds in debate over the causal relationship between medical care price inflation and a number of factors: cost-based or fee-for-service reimbursement;¹⁴⁰ comprehensive third-party coverage;¹⁴¹ “freedom of choice;”¹⁴² government payment or tax subsidy of health services;¹⁴³ or other structural or financial characteristics of American health care delivery.¹⁴⁴ But the central theme of this criticism is fairly unanimous: the methods by which health services in this country have been traditionally delivered and financed have created the circumstances where both providers and their patients are relatively insulated from the costs of the services that are delivered. At least, the immediate and direct impact of those costs has been greatly reduced. Under such circumstances, providers may be inclined to provide more, for both the best and the worst of motives; and patients may be inclined to request—and accept—more. To some extent, then, the historic increases in utilization of services and the continuing increases in “intensity” of

140. See A. ENTHOVEN, *supra* note 12, at xvii-xxi; Meyer, *Health Care Competition: Are Tax Incentives Enough?*, in A NEW APPROACH TO THE ECONOMICS OF HEALTH CARE 426 (M. Olsen ed. 1981).

141. See Havighurst, *Decentralizing Decision Making: Private Contracts versus Professional Norms*, in MARKET REFORMS IN HEALTH CARE: CURRENT ISSUES, NEW DIRECTIONS, STRATEGIC DECISIONS (J. Meyer ed. 1983); Havighurst & Hackbarth, *Private Cost Containment*, 300 NEW ENG. J. MED. 1298 (1979).

142. See Swoap, *Beyond DRGs: Shifting the Risk to Providers*, 3 HEALTH AFF., Winter 1984, at 117. For a lengthy discussion of the history of “freedom of choice” in American medicine, as well as its economic implications, see Weller, “Free Choice” as a Restraint of Trade in American Health Care Delivery and Insurance, 69 IOWA L. REV. 1351 (1984).

143. See generally McClure, *supra* note 12, at 2; Enthoven, *supra* note 12, at 21.

144. See 1983 EXPENDITURES, *supra* note 24, at 5; 1984 EXPENDITURES, *supra* note 23, at 2-6.

services may also be attributed in part to these systemic characteristics.

But more important, there is little incentive under such circumstances to offset the various pressures on physicians, hospitals, and other health service providers to increase the costs of the various goods and services they provide or, at least, to tolerate such increases.¹⁴⁵ To address the “fundamental problem” of the 1980’s and to contain the rising costs of health care, these systemic characteristics must somehow be modified or reformed. As a matter of sound public policy, such systemic reform should be designed to impact on the inflating prices of medical care services as much as, if not more than, on other factors that influence health care costs.

Obviously, any significant improvement in the general economy—a slowing of general inflation, an increase in productivity, or a change in any other “health indicator” of our economic status—can reduce, or at least mask, the economic effects of inflating health care costs. In fact, the health of our economy, rather than the economics of health care itself, may be the best predictor of the day of reckoning for health care cost containment. But just as it is difficult to predict any significant or long-lasting improvements in the American economy, it is equally difficult to foresee the advent of any other mitigating factor to offset the problematic character of health care costs to that economy. In particular, it is difficult to suggest that the historic trend of price inflation, in the technically correct sense of that term, is moderating.

The rising costs of health care may not be a crisis for the economy in the 1980’s; they may not even constitute a problem of fundamental proportions. Nonetheless, strong arguments still can be made that rising health care costs deserve serious attention. Health care continues to demand more and more of our economic output. Health care is purchased at the expense of other economic activities. Every dollar spent on health care cannot be spent elsewhere. When one out of ten dollars is spent on health care, the economic effect of that spending can be said, with only slight exaggeration, to influence virtually everything: interest rates, social and domestic spending, even international competitiveness.¹⁴⁶ All of these economic effects have been muted in recent years by the moderation of the rise in total spending. But health care costs continue to rise and continue to inflate. Given the underlying causes of these trends, it

145. See P. FELDSTEIN, *supra* note 17, at 178-81, 224-25.

146. See, e.g., Thurow, *Letter to the Editor*, 311 NEW ENG. J. MED. 1596 (1984).

is clear that these costs should be of immediate concern, and it is likely that they will become increasingly problematic, particularly if one assumes that the availability and distribution of health care should be maintained at current levels.

From the point of view of the practical politician, however, health care cost inflation has both a different meaning and different implications for the health policy agenda of the 1980's. First of all, the apparent moderation of rising health care costs in recent years, whether truly a resolution of the "fundamental problem" or not, is critically important. Notwithstanding economic analysis, the cost problem in the political arena is precisely what is perceived as the problem, not what is indicated or suggested by empirical data. A reduction in the rate of growth of health care costs is a reduction of the problem, whatever the underlying causes. Any improvement in the economy is a resolution to the problem, not just a postponement of our reckoning with it. The healthier the economy, the greater its ability both economically *and* politically to absorb the effects of rising health care costs.

Moreover, to the practical politician, the difficult task of bringing the implications of rising health care costs for the economy to the attention of various interest groups and, particularly, to the fickle general public during a time of moderating growth of those costs is only one-half of the political problem. Focusing attention on increases in the "intensity" of medical services or on price inflation as being the most problematic aspects of rising health care costs necessarily suggests a range of remedial responses that will gore the providers' oxen in their most sensitive areas. As noted above, there is nearly endless debate among experts over the characteristics or mechanisms of health care delivery most likely responsible for rising health care costs, and little basis in the available data for bringing cloture to that debate. But there is a general consensus that the containment of those costs will require substantial and systemic modification of the manner in which health care is delivered and financed. Yet, such reform will necessarily involve changing the systemic characteristics that provider interests will defend most vigorously. Ultimately, any serious reform strategy designed to affect any of the causal factors in health care spending and, most certainly, intended to contain the increases in the price of a unit of service—whether coerced or mandated, the result of public purchasing, or the result of competitive reforms within the private sector—will directly affront the traditional autonomy of providers, as well as their economic self-interest.

As indicated previously, the ability of providers to defend their interests has been somewhat diluted in recent years, but provider resistance nevertheless remains a powerful political constraint on any cost-containment strategy. Moreover, such resistance can be almost insurmountable under conditions where the public's attention remains unfocused, as it currently is, and the concerns of other affected interest groups have been deflated by the recent trends of moderating costs. Thus, the economic effects of rising health care costs continue to deserve our attention, and remedial strategies can be strongly advised as sound public policy, even though the rate of increase in health care costs is moderating. But it is fairly clear as a matter of practical politics that health care cost containment should not be considered a prominent issue, much less the focal issue, on the health policy agenda of the 1980's. For a variety of reasons—the fickle attention of the American public, the dominant political power of provider interests, the varying definitions of the “fundamental problem,” or simply the fact that the proportions of the problem are within politically acceptable limits—our political institutions do not appear to be focusing on the economic costs of health care or moving towards cost containment, at least in the broadest sense of the term. Rather, as will be discussed in the next section, government policymakers, and particularly federal policymakers, are establishing a health policy agenda for the 1980's that defines the “fundamental problem,” the need for its resolution, and the likely responses to it in much different terms.

III. THE “FUNDAMENTAL PROBLEM:” THE RISING COSTS OF HEALTH CARE FOR THE GOVERNMENT

Even if they have not risen to the level of a “fundamental problem,” the rising costs of health care for the economy should be of some concern to state and federal policymakers. Indeed, as health care costs have grown to demand a greater proportion of the GNP, health care costs may be both a product of prevailing economic conditions and, at the same time, one important determinant of those conditions. But in terms of the real politics of the 1980's, the costs of health care of primary concern to our legislators have not been those to the economy, but rather the direct costs to the state and federal budgets: the rising costs of Medicare and Medicaid, of health insurance benefits for government employees, and of other health-related government programs.

Such concern is understandable, even viewed solely as a matter of public policy and divorced from its political context. Over the

last two decades, government spending for health care has rapidly increased. State, local, and federal governments combined spent only \$11 billion for health care in 1965, 26% of all NHEs.¹⁴⁷ Only two years later, following the implementation of Medicaid and Medicare, total government spending jumped to \$19 billion and grew to represent nearly 37% of all health spending.¹⁴⁸ Between 1968 and 1980, government spending continued to grow rapidly, increasing at an average annual rate of over 14%. It reached \$56 billion by 1975 and nearly \$106 billion by 1980, 42% of all NHEs and over 50% of all hospital care.¹⁴⁹ All tolled, this growth exceeded the rate of growth of NHEs by a significant margin and exceeded the GNP growth rate during this period by nearly 50%, although most of the disproportionate growth of government spending occurred between 1965 and 1975, as indicated by Table 6.¹⁵⁰

147. See 1984 EXPENDITURES, *supra* note 23, at 3.

148. See *id.*

149. See 1983 EXPENDITURES, *supra* note 24, at 3-4, 16.

150. See *supra* note 1 and accompanying text. Note, however, that these figures reflect total government spending. The growth rates for federal health spending and for Medicare spending during this period differ significantly. See *infra* Table 7. Similarly, government health spending as a proportion of all government spending has also followed a different trend. See *infra* notes 155-57 and accompanying text.

TABLE 6
GOVERNMENT SPENDING (in billions): PERCENTAGE of NHE

YEAR	FEDERAL EXPENDITURES	% OF NHE	STATE AND LOCAL EXPENDITURES	% OF NHE
1985	\$127.6	(30.4)%	\$51.9	(12.4)%
1984	111.9	28.9	48.3	12.5
1983	102.7	28.9	45.4	12.8
1982	93.2	29.0	41.9	13.0
1981	83.5	29.3	38.1	13.3
1980	71.0	28.7	34.3	13.9
1979	61.0	28.4	29.8	13.9
1978	53.8	28.4	26.1	13.7
1977	47.4	27.9	22.7	13.3
1976	42.6	28.2	20.3	13.5
1975	37.0	27.9	19.3	14.5
1974	31.0	26.6	16.6	14.3
1973	25.2	24.4	14.2	13.7
1972	22.9	24.4	12.5	13.3
1971	20.3	24.3	11.4	13.6
1970	17.7	23.6	10.1	13.5
1969	16.1	24.5	8.9	13.5
1968	14.1	24.3	8.0	13.7
1967	11.9	23.2	7.0	13.7
1966	7.4	16.1	6.1	13.2
1965	5.5	13.2	5.5	13.0
1960	3.0	11.2	3.6	13.5
1955	2.0	11.3	2.6	14.4
1950	1.6	12.8	1.8	14.4

SOURCE: Gibson, Levit, Lazenby & Waldo, *National Health Expenditures, 1983*, HEALTH CARE FIN. REV., Winter 1984, Table 1, at 3, and Levit, Lazenby, Waldo & Davidoff, *National Health Expenditures, 1984*, HEALTH CARE FIN. REV., Fall 1985, Table 1, at 3.

In fact, the government's proportionate share of all health spending essentially stabilized between 1975 and 1983, and in the most recent years the rate of growth of both state and federal government spending has been slightly slower than that of NHEs, as Table 7 indicates. In 1983, total government spending for health care was \$148.8 billion, an increase of 9.6% from 1982.¹⁵¹ In 1984, government spent \$160 billion on health care, an increase of 8.2% from 1983, representing 41% of all NHEs.¹⁵² In both years, the

151. See 1983 EXPENDITURES, *supra* note 24, at 3.

152. See 1984 EXPENDITURES, *supra* note 23, at 3, 31-32. See generally HEALTH SPENDING TRENDS, *supra* note 33, at 9-10 (discussing probable future public spending trends).

NHE growth rate was slightly higher.¹⁵³

TABLE 7
GOVERNMENT HEALTH BUDGET GROWTH: % Change in Expenditures

YEAR	STATE and LOCAL	FEDERAL	TOTAL NHE
1985			
1984	6.5%	9.0%	9.1%
1983	8.4	10.2	10.6
1982	10.4	14.6	13.9
1981	9.7	17.5	15.2
1980	12.2	13.9	13.3
1979	14.3	13.3	13.2
1978	15.1	13.5	11.7
1977	11.8	11.4	12.9
1976	5.2	14.8	13.6
1975	13.8	16.0	12.1
1974	17.0	22.9	12.5
1973	13.3	10.0	10.0
1972	10.3	12.6	12.5
1971	12.5	15.0	11.4
1970	12.8	14.0	13.4
1969	10.8	14.0	12.7
1968	13.6	18.4	13.1
1967	13.6	46.7	10.8
1966	12.1	34.5	10.3
1965	8.5	12.9	9.3
1960	7.2	6.5	7.8
1955	7.0	4.3	7.0
1950	8.4	—	12.2

SOURCE: Gibson, Levit, Lazenby, & Waldo, *National Health Expenditures, 1983*, HEALTH CARE FIN. REV., Winter 1984, Table 1, at 3, and Levit, Lazenby, Waldo, & Davidoff, *National Health Expenditures, 1984*, HEALTH CARE FIN. REV., Fall 1985, Table 1, at 3.

Obviously, much of the growth in government spending during the last two decades has been a result of Medicaid and Medicare. In fact, virtually all of the increase in government's share of total health spending since 1965 has been a result of the increase in *federal* spending prompted by these programs.¹⁵⁴ The state and local share of personal health services has actually declined from 13% in 1967 to 10% in 1983, despite the portion of Medicaid costs paid by

153. See *supra* Table 1.

154. See *supra* Table 6.

each state.¹⁵⁵ It may be equally critical to note that the percentage of all government spending that has been required for health care rose markedly from 1965 to 1983, reaching a peak of 13.2% of all state and local budgets and 12.5% of the federal budget in 1983, as Figure 7 indicates.¹⁵⁶ In 1984, however, the share of local and state spending required for health care dropped to 12.8%, while the share of the federal budget required for health spending rose slightly to 12.7%.¹⁵⁷

As Medicare and Medicaid have grown to finance care for one out of five Americans, and three quarters of all public spending for health care, they have become the primary vehicles for government influence over health policy.¹⁵⁸ But at the same time, the growing costs of these programs—most specifically, the growing costs for the federal budget—not their impact or adequacy, have become the more dominant focus of political concern.

A review of the available data summarizing the historic costs associated with these programs clearly indicates that these costs deserve political attention. But it also indicates that the emergence of government spending as the focal issue on the health policy agenda derives not from the costs of these programs per se, but from the

155. See 1983 EXPENDITURES, *supra* note 24, at 17-19. Note that this estimate is for personal health services, not NHEs. The state and local share of total NHEs has remained fairly constant, but it has clearly not increased. See *infra* Table 8. These figures deserve some emphasis, since they are frequently obscured in public debates. Almost all of the increase in the proportionate share of government spending for health care in the last 20 years has been due to a sizable increase in the federal share of health spending. And most of that increase has been a result of Medicaid and, in particular, Medicare spending. Expressing the state and local share in terms of personal health spending has particular relevance: the state and local share has declined, notwithstanding Medicaid spending for nursing homes and other personal health services financed in part by state and local government. Obviously these figures are all relative; the state and local spending has been increasing—and in the eyes of state and local legislators, it has been “inflating”—but health spending generally, and federal health spending in particular, has been growing at a much faster rate. See *infra* Figure 7.

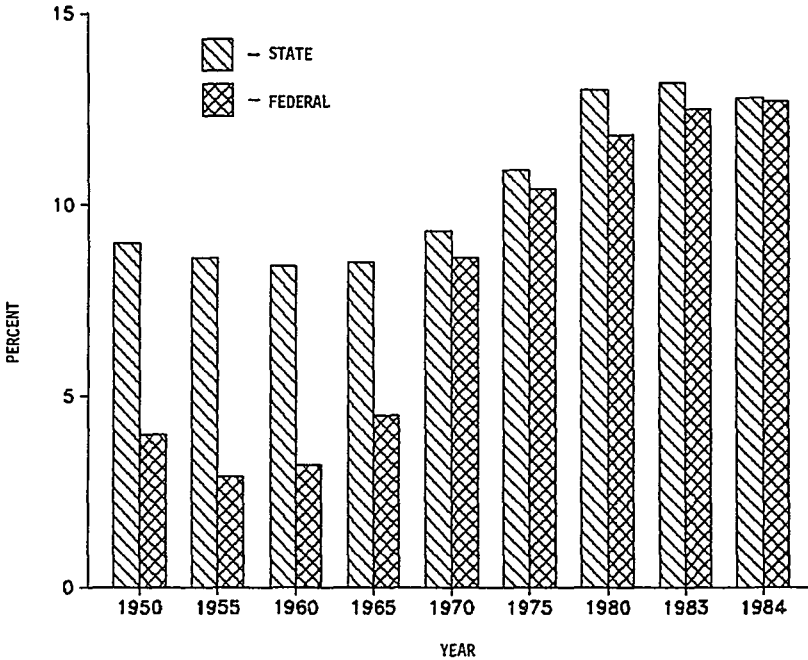
156. See also HEALTH SPENDING TRENDS, *supra* note 33, at 11.

157. Preliminary data for 1985 indicate that state and local spending will drop again to 12.6%, while federal spending will increase to 12.9% of the federal budget. Telephone interview with Sally Sonnefeld, Division of National Cost Estimates, Office of the Actuary, Health Care Financing Administration (March 26, 1986).

158. See 1984 EXPENDITURES, *supra* note 23, at 23; Gornick, Greenberg, Eggers & Dobson, *Twenty Years of Medicare and Medicaid: Covered Populations, Use of Benefits, and Program Expenditures*, 6 HEALTH CARE FIN. REV., Supp. 1985, at 13, 20 [hereinafter cited as Gornick & Greenberg].

Government influence has been heaviest in institutionally based medical care. Medicare and Medicaid combined spent \$48.6 billion, 38% of all hospital care in 1984. See 1984 EXPENDITURES, *supra* note 23, at 9, 22. All tolled, including state and local funding, government financed 53% of all hospital services and 49% of all nursing home services in 1984. See *id.* at 17.

FIGURE 7
GOVERNMENT EXPENDITURES FOR HEALTH AS A
PERCENT OF TOTAL GOVERNMENT EXPENDITURES,
 Selected Years 1950-1984



SOURCE: Arnett, Cowell, Davidoff & Freeland, *Health Spending Trends in the 1980's: Adjusting to Financial Incentives*, HEALTH CARE FIN. REV., Spring 1985, at 18.

larger political and economic determinants that have isolated and magnified the immediate importance of these costs.

A. Medicaid

There is no doubt that Medicaid, since its inception, has been an expensive undertaking for both the states and the federal government, as Table 8 indicates.

TABLE 8
MEDICAID EXPENDITURES (in billions) AND ANNUAL PERCENT CHANGE

YEAR	STATE AND LOCAL EXPENDITURES	% CHANGE	FEDERAL EXPENDITURES	% CHANGE
1987				
1986				
1985	\$18.6	11.0%	\$22.7	9.6%
1984	16.7	8.2	20.7	6.8
1983	15.5	9.1	19.4	10.0
1982	14.2	6.7	17.6	6.6
1981	13.3	18.3	16.5	18.1
1980	11.2	15.8	14.0	15.5
1979	9.7	13.4	12.1	14.4
1978	8.6	12.0	10.6	10.5
1977	7.6	—	9.6	—
1976	8.3	—	10.3	—
1975	5.6	23.7	7.0	24.7
1974	4.6	11.2	5.6	12.6
1973	4.1	18.2	5.0	19.5
1972	3.5	24.1	4.2	23.5
1971	2.8	28.6	3.4	32.2
1970	2.2	—	2.6	—

SOURCE: Telephone interview with Myles McDermott, Budget Branch, Division of State Operations and Financial Management, Health Care Financing Administration, U.S. Dept. of Health and Human Services (April 4, 1986) (% change for 1976, 1977 omitted because of redefinition of fiscal year in 1976).

Particularly in the first few years of implementation, as more states established their programs and as coverage and eligibility were expanding, Medicaid's costs truly skyrocketed.¹⁵⁹ As the programs were stabilized in the 1970's and, more important, as Congress and the states turned to various cost-cutting measures in attempts to contain these costs,¹⁶⁰ the growth rate of Medicaid expenditures roughly paralleled that for NHEs.¹⁶¹ Between 1972 and 1982, the average annual increase for the states' share of Medicaid spending was 16.9%; the annual growth of the federal share was slightly lower, although obviously there was a great deal of variability from state to state.¹⁶²

159. See Wing, *supra* note 19, at 15-16.

160. See *id.* at 16-28.

161. See *supra* Table 8 for state and federal expenditures and annual percentage increases. Note that these are recent estimates and differ slightly from estimates cited in other sources. See *infra* notes 162-65 and accompanying text. For increases in NHEs, see *supra* Table 1.

162. See Gornick & Greenberg, *supra* note 158, at 50. From 1973 to 1983, the average

In contrast, however, the growth of Medicaid spending in the 1980's has slowed considerably, even when compared to the moderating growth of NHEs. In 1982, total Medicaid spending grew only 6.7%, following the first round of Reagan-era budget reductions, when NHEs grew 12.6%.¹⁶³ In 1983, the Medicaid growth rate was 9.7%, again considerably lower than the growth of NHEs.¹⁶⁴ In 1984, total Medicaid costs had grown to over \$37 billion, but the aggregate growth rate was still only 7.1% over the previous year, and again lower than that for NHEs.¹⁶⁵

There is little reason to believe that these recent trends of slowing growth will be reversed. Indeed, it would appear that, in relative terms, Medicaid costs have already been contained—at least when viewed in the aggregate. Again, Medicaid spending differs significantly from state to state. The political decision to constrain the growth of the Medicaid population has apparently already been made and has been successful.¹⁶⁶ Nor is it likely that the use of Medicaid service coverage will grow; to the contrary, the pattern for at least a decade has been to reduce coverage and limit utilization growth.¹⁶⁷ Presumably, Medicaid is still subject to various other factors, such as price inflation and intensity increases, that can increase Medicaid spending, as they influence other health care expenditures. But there is no factor specific to the growth of Medicaid costs, or anything unique to the services financed through Medicaid—with the notable exception of ICF-MR services¹⁶⁸—that should necessarily draw political attention to the costs of Medicaid

annual increase in the federal share was just over 13%. See HEALTH SPENDING TRENDS, *supra* note 33, at 11.

163. Using the estimates in Table 8, state and federal spending increased only \$2 billion in 1982. For a discussion of the Reagan budget cuts, see Wing, *supra* note 19, at 42-59.

164. In 1983, total Medicaid spending increased to \$34.9 billion. See *supra* Table 8; 1983 EXPENDITURES, *supra* note 24, at 23.

165. See *supra* Table 8; 1984 EXPENDITURES, *supra* note 23, at 24. Projections into the future have predicted a Medicaid growth rate into the next decade of 9% per year. HEALTH SPENDING TRENDS, *supra* note 33, at 11.

166. While Medicaid data on the number of people eligible for the program are difficult to analyze, it is clear that the number of recipients (and probably the number of eligibles) has not increased in at least a decade, and may even have declined. See Gornick & Greenberg, *supra* note 158, at 27-28. This should be compared to the *increase* in the number of poor people during the same period of time. See *id.* at 34.

167. For an analysis of the use of services by the Medicaid population and the complexities of the available data, see *id.* at 41-42; Wing, *supra* note 19, at 17-28, 49-59, 66-69.

168. As noted earlier, long-term care generally and, in particular, ICF-MR services funded by Medicaid, present problems deserving separate and special attention and that have already required considerable government cost containment. See *supra* note 131.

or require that Medicaid spending be viewed as a problem of growing importance.

What is not clear, and what could well be the more critical measure of the problematic character of Medicaid expenditures, even as they have been contained, is whether Medicaid spending is continuing to outgrow other state expenditures and, in particular, the growth of state revenues. As discussed more fully below, the most crucial question for Congress as it defines the need for and the design of Medicaid cost containment may be the size of the gap between federal expenditures and federal revenues, a gap that has widened even as Medicaid expenditures have slowed.¹⁶⁹ Similarly, Medicaid was, until the 1980's, the fastest growing portion of the states' budgets,¹⁷⁰ growing, at least in the aggregate, faster than the growth of state revenues.¹⁷¹ If this trend has continued, or continues in some states, there will certainly be substantial political pressure for cost containment at the state level, regardless of recent trends of slowed growth in Medicaid expenditures. Unfortunately, recent data for revenue growth of individual states is not available.¹⁷²

B. *Medicare*

Since the first full year of its implementation, total Medicare expenditures have risen from \$3.4 billion to nearly \$62 billion in 1984 and have grown to represent nearly 50% of all government expenditures for personal health care.¹⁷³ As reflected in Table 9, the rate of this increase has been dramatic, nearly doubling the aggregate growth of NHEs during the last two decades and growing 20% in some years.¹⁷⁴

169. See *supra* notes 163-65 and accompanying text.

170. State Medicaid expenditures increased from 2% of total state spending to 7.7% between 1965 and 1981, and from 23.8% of state welfare budgets to 60% of all welfare budgets during this period (although this is partially explained by the slow increase in spending for the cash grant programs). See Gornick & Greenberg, *supra* note 158, at 48.

171. State revenues grew at an average annual rate of only 11.4% between 1972 and 1982, while Medicaid spending grew at an annual average rate of 16.9%. See *id.* at 50. Note, however, that these are aggregate figures. There was great variation from state to state.

172. For aggregated data on state expenditure and revenue trends, see NAT'L GOVERNOR'S ASS'N AND NAT'L ASS'N OF STATE BUDGET OFFICERS, FISCAL SURVEY OF THE STATES (1985).

173. See *infra* Table 9; 1984 EXPENDITURES, *supra* note 23, at 23-24.

174. See also *supra* Table 1; HIAA, *supra* note 60, at 28.

TABLE 9
MEDICARE: Enrollment, Disbursement, % Growth.

FISCAL YEAR	NUMBER OF ENROLLED PERSONS	TOTAL DISBURSEMENTS (A and B)	% GROWTH
1986	—	\$76,070	6.9%
1985	—	71,183	13.9
1984	—	62,480	9.7
1983	30.0	56,935	12.9
1982	29.5	50,424	18.7
1981	29.0	42,488	21.3
1980	28.5	35,025	20.1
1979	27.9	29,157	15.6
1978	27.2	25,218	17.0
1977	26.5	21,549	21.2
1976	25.7	17,779	20.3
1975	25.0	14,782	30.3
1974	24.2	11,348	19.7
1973	23.5	9,479	7.5
1972	21.3	8,820	12.0
1971	20.9	7,875	10.2
1970	20.5	7,149	8.4
1969	20.1	6,598	23.4
1968	19.8	5,347	57.4
1967	19.5	3,396	—

SOURCE: Enrollment from HEALTH INSURANCE ASSOCIATION OF AMERICA, SOURCE BOOK OF HEALTH INSURANCE DATA 1984-85 (1985), Table 4.3, at 34. Disbursement from Board of Trustees, Federal Hospital Insurance Trust Fund, 1985 Annual Report, H.R. Doc. No. 99-47, 99th Cong., 1st Sess., at 30 and Board of Trustees, Federal Supplementary Medical Insurance Trust Fund, 1985 Annual Report, H.R. Doc. No. 99-48, 99th Cong., 1st Sess., at 21. 1985 and 1986 are estimated disbursements.

As with spending for NHEs and for most health services, the rate of growth of Medicare appears to be moderating in the most recent years; yet that rate has continued to exceed that for NHEs. In 1983, Medicare grew 12.9%, as compared to 10.6% growth in NHEs.¹⁷⁵ In 1984, when NHE growth slowed to 9.1% and the increase in government spending for health care fell to 9.0%, Medicare spending growth was 9.7%.¹⁷⁶ As noted above, the rate of growth of total federal health spending has essentially stabilized in this decade, but only because expenditures for Medicaid and other

175. See *supra* Table 9. See *supra* Table 1 for growth of NHEs and growth of GNP during this same period.

176. See *supra* Table 9; 1984 EXPENDITURES, *supra* note 23, at 24. See also *infra* note 179.

federal health programs have been contained or, in some cases, markedly reduced.¹⁷⁷ Medicare spending has continued to grow in both relative and absolute terms; thus, Medicare has continued to demand a large and growing proportion of the federal budget.¹⁷⁸

A review of the factors responsible for the growth of Medicare spending indicates why these rising costs may be both particularly problematic and expected to continue. Obviously, a good portion of the increases over the last two decades is attributable to the inflation in the prices of medical services and the increases in the "intensity" of services, as described previously.¹⁷⁹ But Medicare costs have been compounded by several additional factors. The eligibility for the program has been expanded several times in the last two decades.¹⁸⁰ More important, the population over age 65, as noted pre-

177. See HEALTH SPENDING TRENDS, *supra* note 33, at 11. For a discussion of the programs that have been contained or "streamlined," see HOUSE COMM. ON THE BUDGET, 99TH CONG., 2D SESS., PRESIDENT REAGAN'S FISCAL YEAR 1987 BUDGET 1-17 (Comm. Print 1986) [hereinafter cited as 1987 BUDGET].

178. See *infra* Figure 8. Medicare represented approximately 6.8% of the federal budget in FY 1983 and grew to nearly 7% in 1984. See HOUSE COMM. ON THE BUDGET, 99TH CONG., 1ST SESS., PRESIDENT REAGAN'S FISCAL YEAR 1986 BUDGET (Comm. Print 1985); 1987 BUDGET, *supra* note 177, at 16, 217. (Note that these figures are based on congressional estimates of budget outlays, not actual expenditures, and differ slightly from the figures cited in Table 9.)

179. Roughly 70% of Medicare spending is for hospital services; another 20-25% is spent for physician services. See 1984 EXPENDITURES, *supra* note 23, at 23. Hence, Medicare spending would be expected to at least parallel growth rates in spending for these services in the general population. But the growth of Medicare spending for these services has generally exceeded that for the rest of the population. From 1977 to 1983, Medicare hospital expenditures grew at an average annual rate of 16%, compared to a 13.9% increase in overall hospital expenditures. In 1984, the Medicare rate slowed to 9.6%, compared to 6.1% overall hospital spending. See 1984 EXPENDITURES, *supra* note 23, at 24.

Medicare spending for physician services has also been growing at a higher rate than overall spending for physician services. In 1983, it was \$13.4 billion, an increase of 17.6%, despite the relative decline in the growth rate for spending on physician services in the general population. In 1984, the first year of the Medicare physician rate freeze, however, Medicare spent \$14.6 billion, an increase of only 8.9%. See *id.* at 20-22.

180. There have been several major (and various minor) expansions of Medicare eligibility since the inception of the program in 1965. In 1972, Medicare eligibility was significantly expanded by including disabled Social Security recipients and people with end stage renal disease (ESRD). See Social Security Amendments of 1972, Pub. L. No. 92-603, §§ 201, 299I, 86 Stat. 1329, 1370, 1463. In 1983, federal employees and employees of non-profit organizations were required to participate in the Social Security payroll tax and, therefore, became potentially eligible to receive Medicare benefits. See Social Security Amendments of 1983, Pub. L. No. 98-21, §§ 101, 102, 97 Stat. 65, 67, 70. For a discussion of eligibility, see Gornick & Greenberg, *supra* note 158, at 20-25.

With regard to the services covered, the essential package of services included in the original legislation has remained virtually intact, with occasional minor additions (e.g., hospice care was added in 1983) and, less frequently, the withdrawal of coverage. See 1984 EXPENDITURES, *supra* note 23, at 24; Gornick & Greenberg, *supra* note 158, at 35-41.

viously, has been growing at a rate at least double that of the general population, a growth rate that will continue and may well explode as the "baby boom" generation ages.¹⁸¹ Medicare growth rates also have been fueled by increases in the rates of utilization of services by the Medicare population, again somewhat in contrast to indications for the rest of the population, although the most recent data shows a reversal of this trend.¹⁸² But even if the higher rates of service utilization by Medicare recipients have leveled off, the disproportionate growth of the Medicare population over age 65 will continue in future years, contradicting any likelihood that the growth of Medicare spending will continue to moderate. To the contrary, unless there are drastic reductions in Medicare utilization, Medicare expenditures will continue to grow at rates as high as, and more likely higher than, those for NHEs.

The growing political importance of the Medicare, Medicaid, and other government health spending programs is only partially explained by reference to the sizable and growing level of expenditures required to maintain these programs—even in light of the possible rapid expansion of Medicare expenditures in the not-too-distant future. At both the state and federal levels, it is clear that the major forces that have essentially translated these cost problems of serious proportions into problems of critical proportions—costs for which a political response is virtually inevitable—come from the opposite side of the budgetary ledger.

Contemporary federal politics provide the best illustration. Prompted by economic stagnation, Reagan-generated tax reduc-

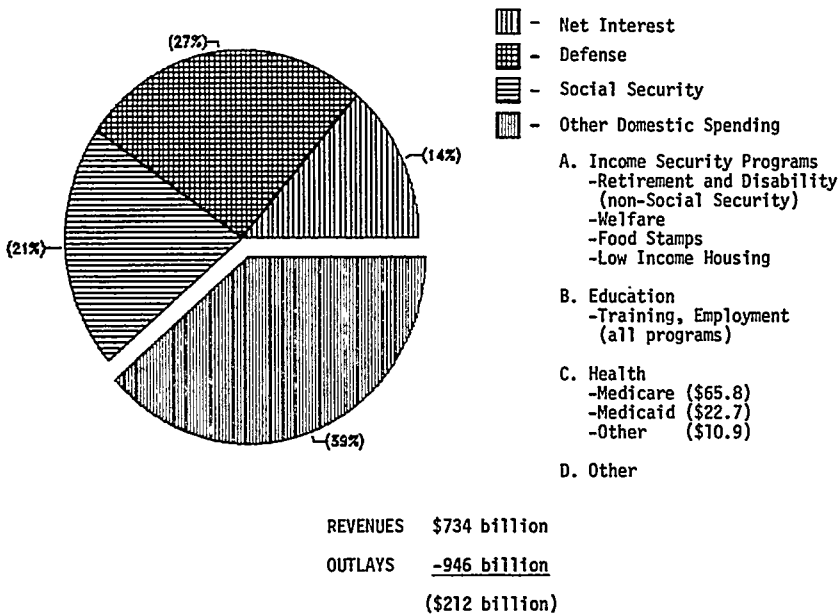
181. People over age 65 constituted only 9.4% of the general population in 1966; but by 1984, this had grown to 11.6% of the population. See Gornick & Greenberg, *supra* note 158, at 20-22. See generally Waldo & Lazenby, *supra* note 18.

182. The data supporting Medicare utilization increases is somewhat mixed and difficult to interpret. Since the beginning of the program, there has been a steady increase in the utilization of hospitals by Medicare recipients (as measured by the discharge rate), even when other factors, such as eligibility increases, are controlled. See Gornick & Greenberg, *supra* note 158, at 35. This is somewhat at odds with the data reflecting hospital utilization by the general population during the same period. See *supra* notes 83-90 and accompanying text. However, preliminary data for 1984 indicate that for the first time in a decade, the admission rate for Medicare recipients dropped by roughly 4%. See Beebe, Lawrence & Lintzeris, *Medicare Admissions and Length of Stay for Short Stay Hospitals*, 7 HEALTH CARE FIN. REV., Supp. 1985, at 117. And, during the last 10 years, the average length of stay for the elderly has been declining, paralleling the trend in the general population. See Gornick & Greenberg, *supra* note 158, at 35; 1983 EXPENDITURES, *supra* note 24, at 22.

During this same period of time, there is also evidence that the Medicare utilization rates for physician services has been increasing, although this may be caused in part by the use of physician services incident to hospitalization. See Gornick & Greenberg, *supra* note 158, at 37-39.

tions, and the continually widening gap between federal expenditures and federal revenues, the federal budget has driven the national debt over \$2 trillion and has created annual losses of over \$200 billion, as demonstrated in Figure 8.¹⁸³

FIGURE 8
FEDERAL BUDGET (in billions) FY 1985



SOURCE: House Comm. on the Budget, 99th Cong., 2d Sess., President Reagan's Fiscal Year 1987 Budget (Comm. Print 1986) at 1, 141, 193, 206, 211, 217, 229, 249, 265-66.

The political implications of these debts can be easily sketched: service on the debt now requires nearly 14% of federal spending,¹⁸⁴ while military spending has grown to 28% of the budget during this decade.¹⁸⁵ Social Security alone requires 21%, and other income transfer programs (federally financed retirement and welfare programs) annually demand between 13 and 14% of federal spending.¹⁸⁶ The remaining 25% of the budget must support the long list

183. See also 1987 BUDGET, *supra* note 177, at 9, 35.

184. See *id.* at 249-51.

185. See *id.* at 73, 141. This represents an increase of 24% from the pre-1980 levels of expenditures, although it is somewhat less of an increase than the present administration originally intended. See Wing, *supra* note 19, at 32-33.

186. See 1987 BUDGET, *supra* note 177, at 218-31.

of other federal domestic programs, of which Medicare is far and away the largest and among the most rapidly increasing. And Medicaid, even as its costs grow more slowly, is still among the largest items.¹⁸⁷ Even if total federal revenues are increased by economic growth or by tax rate changes, or total spending is affected by military spending cuts or Social Security reform (unlikely possibilities at best), annual budgetary gaps of \$200 billion cannot be easily closed without targeting the more politically vulnerable domestic spending programs.

The emergence of Medicare costs as a problem of fundamental importance and as the focal issue on the health policy agenda in the 1980's has also been prompted by its peculiar revenue structure. Revenues for Part A of Medicare, covering essentially hospital and related services, are funded exclusively by a portion of the Social Security payroll tax,¹⁸⁸ and are maintained and disbursed through the Federal Hospital Insurance Trust Fund.¹⁸⁹ This financing structure was more than adequate through the first fifteen years of the program.¹⁹⁰ The accumulated surplus was maintained at well over 50% of annual Part A expenditures from the inception of the program through 1980.¹⁹¹ But as program expenditures have continued to rise rapidly in the 1980's, revenues have grown more

187. See *supra* Figure 8; 1987 BUDGET, *supra* note 177, at 265.

188. In 1985, employers and employees each contributed 1.35% of payroll to a maximum of \$39,600. Increases in both the percentage paid and the maximum ceiling on payroll subject to the tax are scheduled for periodic increases through 1990. See 26 U.S.C. § 3101 (1982). There is no contribution to the trust fund from general revenue or any other tax basis. *But see infra* note 189. Any shortfall in Part A payments is paid out of accumulated surplus in the trust fund, a financial backstop that has been invoked on only two occasions thus far. See *infra* note 190.

189. For a technical description of the trust fund and its management, see BOARD OF TRUSTEES, FEDERAL HOSPITAL INSURANCE TRUST FUND, 1985 ANNUAL REPORT, H.R. DOC. NO. 47, 99th Cong., 1st Sess. 8-17 (1985) [hereinafter cited as 1985 TRUST FUND REPORT].

To be technically correct, there is a small amount of general revenue funding of the hospital trust fund to cover various recipients of Medicare that are not covered through their participation in Social Security. See *id.* at 8-13.

More important, Medicare services are also financed by the payments of recipients at the time they receive the services through the various cost-sharing requirements imposed on Part A recipients. In 1985, recipients paid the first \$400 of Part A costs, \$100 per day for the 61st through 90th day; \$200 per day for "lifetime reserve" days; and \$50 per day for the 21st through 100th day of SNF care. See 49 Fed. Reg. 38,514 (1985). These cost-sharing requirements are periodically revised. See 42 U.S.C. § 1395e (b)(2) (1982); 1985 TRUST FUND REPORT, *supra*, at 66-67.

190. Prior to 1985, trust-fund shortfalls occurred only in 1972 and 1983, the latter as a result of interfund borrowing by the Social Security trust fund. 1985 TRUST FUND REPORT, *supra* note 189, at 30.

191. See *id.*

slowly. Annual revenue shortfalls are now predicted to recur regularly. The eventual depletion of the trust fund appears inevitable,¹⁹² although the timing of this “trust fund crisis” is still a subject of some debate, as illustrated by Figure 9.¹⁹³

In any event, the widening gap between Medicare Part A expenditures and Part A revenues from payroll taxes will eventually require either new expenditure reductions or new revenue increases of approximately \$20 billion each year, at least by the middle of the next decade.¹⁹⁴

Concurrent with the emergence of the Part A “trust fund crisis,” Medicare Part B expenditures¹⁹⁵ have been growing at a rate

192. See *infra* Figure 9. Only under the most optimistic (generally regarded as unrealistic) economic and political assumptions could such a crisis be averted; on the other hand, the trust fund could be depleted as early as the mid-1990's. Even under the most realistic assumptions, sizable annual shortfalls are predicted by the early 1990's, and the depletion of the fund is predicted by the end of the decade.

Moreover, from an actuarial perspective, the trust fund may already be viewed as a financial crisis. Historically, the Board of Trustees has managed the trust fund like an insurance scheme and recommended that a 50% cushion—a surplus of 50% of the annual expenditures—be maintained by the fund, presumably to offset any sudden shifts in program costs. While this is standard practice for insurance schemes, there is no compelling reason to maintain such a surplus. The risk of such a sudden increase by a program of this size is very small, and, speaking politically, the trust fund only parallels private insurance; in reality it is a government program for which such actuarial conservatism may not be required.

It is also important to note that all of these assumptions already consider the influence of prospective reimbursement and DRG-based reimbursement for hospitals. Thus, any modification of the program to forestall or avert a crisis in the trust fund would necessarily be in addition to these cost-containment measures. For a detailed discussion, see 1985 TRUST FUND REPORT, *supra* note 189, at 33-48, 56.

193. It should not go unnoticed that, during the 1990's, the Social Security Trust Fund will build up an incredibly large surplus—over \$480 billion by 1994—in anticipation of the equally incredible payouts that will be required when the “baby boom” generation retires. For a discussion, see Munnell, *Social Security and the Budget*, NEW ENG. ECON. REV., July-Aug. 1985, at 5, 12. It is very conceivable that the Medicare Part A trust fund “crisis” will be temporarily averted in the 1990's by borrowing from the Social Security fund.

It should also be noted that this “trust fund crisis” is not the similar “crisis” that will be generated in the early part of the 21st century as the “baby boom generation” ages. See 1985 TRUST FUND REPORT, *supra* note 189, at 38-39.

194. See 1985 TRUST FUND REPORT, *supra* note 189, at 46; Ginsburg & Moon, *An Introduction to the Medicare Financing Problem*, 62 MILBANK MEMORIAL FUND Q. 167, 169-72 (1984).

Expressing this financial problem somewhat differently, in order for the trust fund to be supported entirely by payroll deductions through the end of the century, the payroll tax rate will have to be raised at least .52% (for both employer and employee) *over and above* the scheduled increase to 2.9% of payroll by 1990. See 1985 TRUST FUND REPORT, *supra* note 189, at 47.

195. For a general discussion of Part B financing, see Hadley, *How Should Medicare Pay Physicians*, 62 MILBANK MEMORIAL FUND Q. 279 (1984); see also BOARD OF TRUSTEES, FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, 1985 ANNUAL REPORT [hereinafter cited as 1985 MEDICAL INSURANCE REPORT].

even greater than those of Part A, a trend also predicted to continue.¹⁹⁶ Ironically, since revenues derived from monthly premiums are supplemented by general revenues, this presents no "trust fund crisis" comparable to that for Part A funding.¹⁹⁷ Nonetheless, these rapidly increasing Part B expenditures will present a growing political problem as the demand on general revenues must necessarily grow at an even faster rate than the rate of growth of Part B expenditures.¹⁹⁸ Annual general revenue contributions have already risen from 50% of total Part B spending in 1967 to 82% in 1984; and each year the program demands an even greater portion of the already precarious federal budget.¹⁹⁹

C. *Some Observations*

Obviously, government spending for health care deserves serious attention, given the growth rates over the last two decades and the sizable portion of annual state and federal budgets such spending now represents. On the other hand, government health spending has apparently stabilized, at least when taken in the aggregate, and, in the last several years, state and local spending has even decreased relative to total health spending. Most notably, Medicaid spending has also grown significantly more slowly than total health expenditures and the rest of the economy. Only the federal share continues

196. From 1967 to 1984, Part B expenditures increased at an average annual rate of 17.9%, somewhat higher than the Part A growth rate, and much higher than the NHE growth rate for the same period. See Gornick & Greenberg, *supra* note 158, at 42-43. That rate of increase dropped to 9.4% in 1984, a rate obviously influenced by the physician rate freeze during that year. Predictions for Part B growth indicate that the program will continue to grow faster than Part A and much faster than NHE growth. See 1985 MEDICAL INSURANCE REPORT, *supra* note 195, at 49.

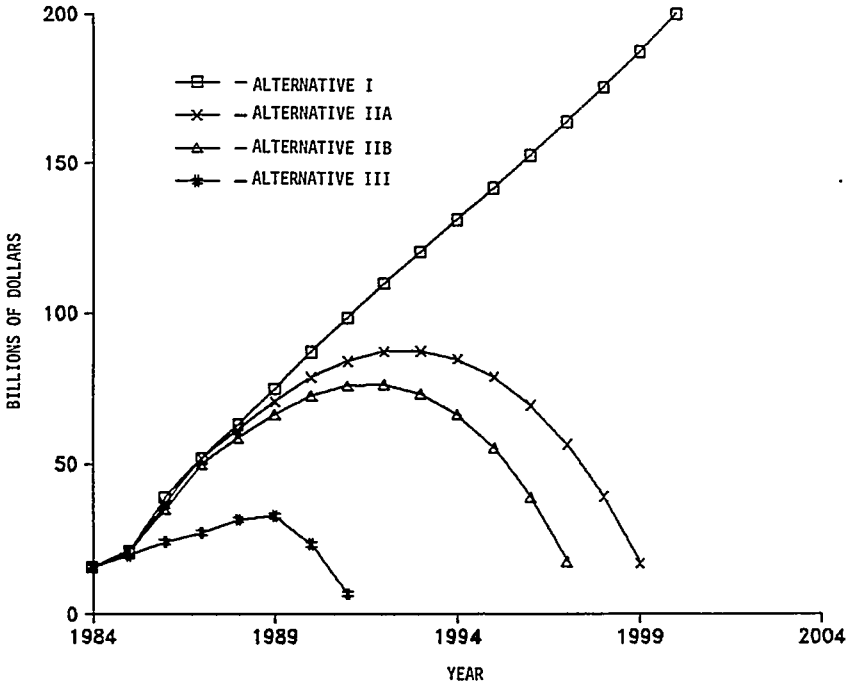
197. Part B of Medicare is funded by the monthly premiums paid by each enrollee (\$15.50 a month in 1985), supplemented by general revenues to cover the remaining portion of program expenditures. See 42 U.S.C. § 1359 (1982); 1985 MEDICAL INSURANCE REPORT, *supra* note 195, at 51.

198. Through 1983, the annual increase in the monthly premium could not increase more than the cost of living increase for Social Security (and Medicare) recipients. Beginning in 1984, however, Congress established premium rates at 25% of the cost incurred by aged program beneficiaries. This represents a smaller percentage of total program costs, since the same premium is paid by disabled beneficiaries while the average incurred cost by the disabled is much higher. For an explanation, see 1985 MEDICAL INSURANCE REPORT, *supra* note 195, at 8, 51-59.

This formula means that the rate of premium increases will be much lower than the rate of increase of program expenditures. The net result is that the general revenue contribution must be increased at an even higher rate than the increase in Part B expenditures.

199. Total disbursements in 1984 were \$20.3 million. General revenue contributions were \$16.8 million. See *id.* at 12.

FIGURE 9
YEAR END FUND ESTIMATIONS FOR THE HOSPITAL
INSURANCE TRUST FUND UNDER ALTERNATIVE SETS OF
ASSUMPTIONS



SOURCE: BOARD OF TRUSTEES, FEDERAL HOSPITAL INSURANCE TRUST FUND, 1985 ANNUAL REPORT, H.R. Doc. No. 99-47, 99th Cong., 1st Sess., at 42.

to grow at levels that could be described as increasingly problematic, and most of that can be attributed to Medicare growth rates.

Clearly, the rising costs of the Medicare program present an immediate problem of serious proportions and will someday present problems of critical proportions. It would be timely, therefore, to consider major reforms of the increasingly inadequate Medicare revenue structure. It would be equally timely to address the underlying causes of rapidly increasing Medicare expenditures and to attempt to maintain Medicare expenditures within more acceptable limits, particularly as the Medicare population continues to grow. Indeed, given the magnitude of the problem, at least as it is projected into the future, both substantial revenue reform and substantial cost-containment measures will eventually be necessary if the program is to survive.

But Medicare has not become a cost problem of fundamental proportions and the focal issue on the health policy agenda of the

1980's simply because it is an increasingly expensive program, just as Medicaid and other government health spending programs have not been exempted from that political attention even as their costs have moderated. The driving force in Congress with respect to cost containment—meaning in this context containing the costs to the federal budget—derives in large part from two political facts: 1) the gap between federal revenues and federal expenditures has reached unprecedented levels, and 2) the de facto result of other federal priorities has isolated Medicare and other domestic spending programs as prime targets for remedying this structural deficit. The reliance on payroll taxes and, to a lesser extent, monthly premiums to fund Medicare has further isolated Medicare as a budgetary scapegoat. At the state level, similar revenue shortfalls have created, and will continue to create, parallel political pressures for the containment of the costs of Medicaid and other state health programs, again meaning cost containment in the more limited sense of the term. Until these budgetary pressures are relieved—by major changes in the economic climate or by the radical reordering of contemporary government priorities—containment of the costs of government health programs will remain as the primary objective of the health policy agenda of the 1980's.

This analysis, of course, only outlines the current agenda and the concerns that are likely to be addressed. Whether the federal or state governments can resolve the “fundamental problem” of government health costs remains very much an open question. Thus far in this decade, we have witnessed only the initiation of political movement. The growing concern for the impact of health program expenditures on government budgeting has combined with other political interests to produce noticeable shifts—but only shifts, not political breakthroughs—in the political logjam that has so often thwarted health care reform measures in the past.

The congressional approval of prospective reimbursement of hospitals on a DRG-basis²⁰⁰ and of physician rate freezes in 1984 and again in 1985²⁰¹ are surely symbols of an unprecedented willingness to reform Medicare and to tolerate direct confrontation with provider interests. Likewise, Congress' willingness to pare federal expenditures for Medicaid and to cut deeply into other federal health programs during the first two terms of the Reagan adminis-

200. See Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 248, § 101, 96 Stat. 324, 331.

201. See Deficit Reduction Act of 1984, Pub. L. No. 369, § 2306, 98 Stat. 1061, 1070; Pub. L. No. 201, § 2, 99 Stat. 1665 (1985).

tration is also unprecedented.²⁰² Only a decade ago, such reimbursement reforms and such an aggressive federal posture on budget reduction would have been politically unthinkable. But the political posturing of this decade should be considered aggressive only in relative terms. And these initial steps towards cost containment should not be mistaken for the initiation of a successful, or even a sustainable, political strategy.

It is harder to characterize the pattern of political activity in the states, primarily because the states' agendas have been in large part reactive to the recent federal measures. But, clearly, the growing concern for their revenue bases and for the containment of health program costs have spawned a wide variety of initiatives and reforms to directly contain the costs of state programs and, in some cases, to affect these costs by moderating health spending generally.²⁰³ But both contemporary politics and political history warn us that neither the direction of states' strategies nor their ultimate success can be determined by extrapolation from these recent initiatives.

As discussed in the introduction to this Article, health policy issues generally, and health cost issues in particular, invariably translate into frustrating and quixotic political struggles where the definition of the problem to be resolved is as much in controversy as is the design of remedial reforms. Nowhere can the fundamentally conflicting nature of the underlying interests be better demonstrated than when various levels of government attempt to contain or avoid the growing costs of health care to their budgets by shifting part of that budgetary burden to other levels of government and to other payors.

A successful cost-containment strategy—successful in the sense that it could achieve the type of cost savings inherent in the budgetary demands driving current politics and in the sense that it could be sustained long enough to achieve lasting results—would require one of two unlikely scenarios to develop in the next several years. A fiscally conservative political movement would have to emerge which would be strong enough to dominate the health politics of the 1980's, allowing both the states and the federal government to move beyond the relatively modest cost-saving measures of the

202. See Wing, *supra* note 19, at 42-89.

203. A detailed review of these activities is beyond the scope of this Article. For a survey of recent state legislative reforms (conducted by the national association of proprietary hospitals), see *Special Report: State Legislative Roundup—Indigent Care*, FED. AM. HOSP. REV., Sept.-Oct. 1985, at 12.

early 1980's and to make "big dollar" reductions in the budgets of Medicare, Medicaid, and other government spending programs. In essence, the political resolve would have to emerge to overtly sacrifice the public programs to the needs of fiscal policy. Alternatively, a powerful political consensus could develop around a broader cost-containment strategy, one that would serve both the budget-conscious interests of government and the interests of other payors and affected groups by attempting to reform the financing or delivery of health care generally. As noted earlier in this Article, advocates from both the left and the right have been plotting such radical reforms for some time, although historically none have developed a sustainable political following.

In fact, neither scenario, or any comparable political circumstances, appears to be developing in the 1980's. Notwithstanding the new initiatives and the growing concern for the costs of government health programs, cost containment, even in its narrowest definition, has achieved relatively modest results if measured in dollar value. As yet, there is little real political effort, only continuing political rhetoric, directed towards "big dollar" budget reductions for health care spending or towards systemic reform. Even in enacting measures that have successfully pared Medicaid spending, both the states and the federal government have been extremely careful to avoid the appearance of containing costs through program reductions, even when they have arguably done so. Most significant, at no level of government is there any serious movement to overtly retreat from the historic governmental commitment to maintaining a Medicaid program for the poor or a Medicare program for the elderly and disabled—even while so many bemoan the costs of that commitment.

There is considerable debate in Congress concerning the next generation of cost-containment measures, such as prospective reimbursement of physicians and modifications of the DRG-based hospital reimbursement. But, at least relative to the size of the budget deficit and the funds that will be needed to avoid a trust fund depletion, the debate tends towards "small dollar" cost containment. This is a reflection of the tentative nature of the political movement that has initiated some cost-containment measures but that faces substantial political barriers if it is to continue in the direction of a "big dollar" solution.

Ironically, neither the modest successes of the cost-containment measures that have been enacted nor the likely failure of any attempts to achieve deeper budget savings through program reduc-

tions are visibly driving government policy towards the adoption of a broader health care reform strategy. The reasons for this, as discussed earlier, lie in the complex and somewhat peculiar nature of American health politics. Interest groups, even those who might ultimately benefit under a broader strategy, are compelled by their divergent and parochial perceptions of the "fundamental problem" to prefer short-term and temporary alliances on an issue-by-issue basis. Providers and others who would be adversely affected by such strategies use their political clout effectively to frustrate reform—frequently without conceding that they are trying to do so. The influence of the general public, as consumers or even as taxpayers, is seldom felt; and when the public call is heard, it is more often a quicksilver reaction to an anecdotal problem and rarely a firm demand for systemic reform. Until one or more of these primary variables is significantly altered, the growing concern for the costs of health care to the government budgets is certain to remain focused at the periphery and not the heart of the problem.

The resulting politics are likely to be lively and frenetic, but frustrating and unsuccessful. Successes will be achieved only at the margins. Bits and pieces of competition theory will be jerry-built into existing programs. Regulatory mechanisms will be abandoned and reworked. Success will be measured not by progress towards an ideological goal, but rather by short-term budget consequences, and limited to modest results by the political barriers that have shifted but not tumbled down.

IV. THE "FUNDAMENTAL PROBLEM:" THE GROWING COSTS OF HEALTH CARE TO THE CONSUMER

Beyond the costs of health care in terms of aggregate expenditures or in terms of how they affect state and federal budgets lie the costs of health care in the most literal sense: the direct costs to individual consumers.

Private payments from all sources contributed \$227 billion to health care expenditures in 1984, representing 58.6% of all NHEs.²⁰⁴ This proportionate share has been gradually increasing in the 1980's,²⁰⁵ by way of contrast, this share had declined from 75% in 1960 to 63% in 1970 and had dropped to a low of 57.4% in

204. See 1984 EXPENDITURES, *supra* note 23, at 3. Note that private payments are disproportionately higher for personal health care (individual medical services) than for other health needs. See *id.* at 10.

205. See *id.* at 3.

1980.²⁰⁶ In absolute terms, private payments for health care grew at an average annual rate of 12.4% between 1973 and 1983 and grew 9.7% in 1984.²⁰⁷

A. *Private Health Insurance*

A large portion of these payments are made by consumers through the purchase of private health insurance. According to insurance industry estimates, 192 million people carried some form of private health insurance at the beginning of 1984, representing roughly 86% of the population under age 65, but also nearly 16 million people over age 65.²⁰⁸ This figure, however, is somewhat misleading and exaggerates both the number of people covered and the extent of their insurance coverage. Not all of these people have insurance coverage throughout the year.²⁰⁹ Further, while most private insurance includes some form of hospital coverage, coverage for physician services and, particularly, other services is not as extensive.²¹⁰ Even when a policy covers these categories of services, coverage is often limited by fixed dollar ceilings, durational limits, specific exclusions, or by other cost-sharing provisions.²¹¹ In addition, a number of these policies are supplemental, as in the case of Medi-gap policies for Medicare beneficiaries, and many people purchase two or more such policies—in some cases, providing du-

206. *See id.* *See also* HEALTH SPENDING TRENDS, *supra* note 33, at 8. Note that government projections estimate that this figure will (again) decline into the next decade.

207. *See* 1984 EXPENDITURES, *supra* note 23, at 3; HEALTH SPENDING TRENDS, *supra* note 33, at 8. Note, however, that the growth rate for subsequent years is predicted to moderate through 1990. *See id.*

208. *See* HIAA, *supra* note 60, at 4-5. Note that these estimates assume a definition of health insurance that includes a (relatively small) number of policies providing disability income insurance. For this and other reasons, other authorities have estimated the proportion of the American population with health insurance coverage to be somewhat smaller. *See infra* notes 248-51 and accompanying text. The definition also includes all forms of medical expense reimbursement: indemnity, services benefit plans, and health maintenance organizations. *See* HIAA, *supra* note 60, at 4-5.

The number of people with some form of insurance increased rapidly from 1950 to the early 1960's, but, not unexpectedly, that number has grown only gradually since then, reflecting little more than the increase in the size of the population. *See id.* at 10. *See* HEALTH SPENDING TRENDS, *supra* note 33, at 4. On the other hand, coverage of some kinds of services, including dental care and services other than physicians and hospitals, has grown more rapidly, apparently indicating real growth in the extent of coverage. *See* 1984 EXPENDITURES, *supra* note 23, at 19.

209. *See infra* note 250.

210. *See* HIAA, *supra* note 60, at 9-14.

211. *See* S. WILLIAMS & P. TORRENS, *supra* note 26, at 309-10. For further discussion of the distribution of cost sharing in private health insurance policies, see Farley, Ginsburg, Curtis & Wilensky, *Private Health Insurance: What Benefits Do Employees And Their Families Have?*, 2 HEALTH AFF., Spr. 1983, at 92.

plicative and unnecessary coverage.²¹²

Perhaps the most critical observation after reviewing the publicly available literature is that surprisingly little is known about the distribution of these insurance policies or the details of their coverage or financing.²¹³ What is known indicates that private health insurance pays only about one half of the private share of personal health care expenditures. Private health insurance policies paid \$107 billion, 31% of all personal health care in 1984.²¹⁴ While this represented an increase of only 6.9% from 1983, slightly decreasing the private health insurance share of spending for personal health care, the growth of insurance spending for individual benefits has roughly tracked the growth of NHEs, at least since 1980.²¹⁵ Because of more extensive coverage, private health insurance pays for

212. Medi-gap policies are particularly illustrative. Essentially, they are designed to cover the cost-sharing requirements of the Medicare program, reflecting both the apparent preference of many Americans to have comprehensive insurance coverage and the substantial magnitude of the cost sharing that can be required of Medicare recipients. Two thirds of the Medicare population have Medi-gap or other supplemental policies. See Cafferata, *Private Health Insurance: Premium Expenditures and Sources of Payment*, DEPT. OF HEALTH & HUMAN SERVICES (DHHS) Pub. No. (PHS) 3364, at 3 (1984). For further description of Medi-gap policies, see Garfinkel & Corder, *Supplemental Insurance Coverage Among Aged Medicare Beneficiaries*, DHHS Pub. No. (PHS) 20205, at 10-12 (1985). For a review of duplicative or unnecessary insurance, see STAFF OF HOUSE SELECT COMM. ON AGING, 95TH CONG., 2D SESS., *ABUSES IN THE SALE OF HEALTH INSURANCE TO THE ELDERLY IN SUPPLEMENTATION OF MEDICARE: A NATIONAL SCANDAL* (Comm. Print. 1978).

213. Virtually the only source of public information regarding the extent of private insurance coverage and the sources of private payments are periodic national surveys by the federal government. The National Medical Care Expenditure Survey was conducted in 1977; that data was supplemented by the National Medical Care Utilization and Expenditure Survey in 1980. The latter included a sample survey of employers of people who participated in the 1977 survey. The 1980 supplemental survey was updated in 1983, but those data have not yet been publicly analyzed. The 1977 general survey should be repeated in 1987. For a general discussion, see Monheit, Hagan, Berk & Farley, *The Employed Uninsured and the Role of Public Policy*, 22 INQUIRY 348 (1985) [hereinafter cited as *The Employed Uninsured*]. See also Arnett & Trapnell, *Private Health Insurance: New Measures of a Complex and Changing Industry*, 6 HEALTH CARE FIN. REV., Winter 1984, at 31, 32.

214. See 1984 EXPENDITURES, *supra* note 23, at 15-16. Note that total private health insurance expenditures—including administrative costs—were higher, a total of \$120.5 billion in 1984. See *id.* at 10.

215. See *id.* at 15. Private health insurance doubled its proportionate share between 1950 and 1965. From 24% in 1965, it grew to a high of 32% in 1983. In the last 10 years, however, the growth of personal health care purchased by private health insurance has roughly tracked the growth of all health spending, although the growth rate in the early 1980's was higher than the comparable rate for NHEs. See 1983 EXPENDITURES, *supra* note 24, at 12; for growth of NHEs, see *supra* Table 1. The growth rate in 1984, nonetheless, was the lowest in at least a decade. See 1984 EXPENDITURES, *supra* note 23, at 15-16.

It should be noted, however, that *total* expenditures in 1984 through private insurance jumped over 10% (due to the huge increase in administrative expenses), from \$9.4 billion to \$13.4 billion. See *id.* at 10-11.

a higher proportion of hospital and physician services.²¹⁶

The cost of these insurance-financed services, as perceived by the consumer, may be at least partially measured by the rate of increase in the aggregate premiums paid. Over the long term, total premiums for private health insurance have increased dramatically, growing at an annual rate of 14% since 1950 and increasing four-fold between 1973 and 1983.²¹⁷ In 1983, aggregate premiums increased 11.2%—a rate noticeably higher than both the growth of the benefits purchased with these premiums and the growth of NHEs during that year.²¹⁸ In 1984, the growth rate slowed to 9%, slightly below the growth of NHEs, but still higher than the growth of total insurance benefits for that year.²¹⁹

Thus, consumers, either individually or collectively, could perceive the growth of insurance premiums as problematic, even in the last few years when health costs have generally moderated.²²⁰ As a practical matter, however, most consumers are at least partially insulated from the direct impact of these premium costs. A majority of Americans receive their health insurance as part of their employment benefits.²²¹ It has been estimated that employers pay all, or almost all, of the premiums for nearly one half of their employees and as much as 75% of all health insurance premiums,²²² a benefit to the employee that is not subject to income or social security taxation.²²³ Obviously, the number of people who purchase their insurance directly, either independently or through their employment,

216. Prior to Medicare and Medicaid, private insurance paid for 41% of all hospital services. That share dropped to less than 34% in 1967, increased gradually to 38% in 1983, and dropped slightly to 37% in 1984. See 1984 EXPENDITURES, *supra* note 23, at 15-17. The share of physician expenditures has been steadily climbing from 31% in 1965 to 44% in 1984. *Id.* at 17-18.

217. See 1983 EXPENDITURES, *supra* note 24, at 12; HEALTH SPENDING TRENDS, *supra* note 33, at 12.

218. Total premiums were \$110.5 billion. See 1983 EXPENDITURES, *supra* note 24, at 12; *supra* Table 1.

219. Total premiums were \$121 billion. See 1984 EXPENDITURES, *supra* note 23, at 15; *supra* Table 1.

220. For example, at least through 1983, health insurance premiums represented an increasing percentage of disposable income. See HIAA, *supra* note 60, at 24.

221. See Taylor & Lawson, *Employer and Employee Expenditures for Private Health Insurance*, DHHS Pub. No. (PHS) 3297, at 5 (1981) (estimates from 1977 data).

222. According to government sources, employers paid \$82 billion of a total \$111 billion in premiums in 1983. See HEALTH SPENDING TRENDS, *supra* note 33, at 12. The 1977 data indicate that employers paid only two thirds of all premiums. See Cafferata, *supra* note 212, at 3. In contrast, as many as 13% of employees paid 100% of their health insurance directly in 1977, including those who purchased group policies through their workplace. See *id.* at 13.

223. For discussion and background, see CONGRESSIONAL BUDGET OFFICE, TAX SUBSIDIES FOR MEDICAL CARE: CURRENT POLICIES AND POSSIBLE ALTERNATIVES (1980).

should not be overlooked. And, obviously, these aggregated data disguise some variations in premium costs; a small percentage of the population pays insurance premiums over twice the national average.²²⁴ Finally, episodic “jumps” in premium costs for both individually purchased and employer-purchased policies are not uncommon.²²⁵ Nonetheless, there is no indication that the growing cost of private insurance premiums per se is either perceived as a political issue of fundamental importance by the consumer public in the 1980's or that it will become so, unless premium cost trends shift more noticeably.

On the other hand, viewed from the employers' perspective, the data describing the growth of health insurance premiums may well outline a cost problem of fundamental importance, and the resulting activities of employers attempting to avoid these costs may eventually draw the attention of the consumer public to the costs of insurance premiums. Employers contributed \$82 billion towards the private insurance premiums of their employees in 1983, an increase of 17.6% from 1982.²²⁶ As Table 10 indicates, this followed an average annual growth rate for employer-paid health insurance premiums of 16.4% between 1973 and 1983. Even higher growth rates are predicted for the 1980's.²²⁷

224. See Cafferata, *supra* note 212, at 11.

225. See *infra* note 228 and accompanying text. It should be noted that employer-purchased health insurance benefits benefit some employees more than others. The extent of coverage and amount of employer payment is directly related to income, occupational status, degree of unionization, and other factors. See Taylor & Lawson, *supra* note 221, at 5-10. In addition, there are a number of interesting variations in the level of premiums paid across geographic regions and demographic groups, as well as the percentage of the premium paid directly by the employee. See generally Cafferata, *supra* note 212.

226. See HEALTH SPENDING TRENDS, *supra* note 33, at 12, 16.

227. See *infra* note 234.

TABLE 10
EMPLOYER CONTRIBUTION FOR EMPLOYEE HEALTH
INSURANCE

Year	Private health insurance premium total contribution (billions)	Medicare Part A (billions)	Total employee compensation (billions)	Contributions for health benefits as % of compensation
1983	\$82.0	\$18.5	\$1,984.9	5.1%
1982	69.7	16.6	1,864.2	4.6
1981	58.9	15.9	1,765.4	4.2
1980	49.8	11.6	1,599.6	3.8
1979	44.2	\$10.6	1,458.1	3.8
1975	24.0	5.6	931.4	3.2
1973	18.0	5.3	801.3	2.9
1970	12.1	2.3	612.0	2.4
1965	5.9	—	396.5	1.5
1960	3.4	—	294.9	1.2
1955	1.7	—	224.9	0.8
1950	.7	—	154.8	0.5

SOURCE: Arnett, Cowell, Davidoff & Freeland, *Health Spending Trends in The 1980's: Adjusting to Financial Incentives*, HEALTH CARE FIN. REV., Spr. 1985, Table 10, at 16.

Some employers have reported "leaps" in premium costs in the 1980's as high as 100% per year.²²⁸ If their share of the contributions to the Medicare trust fund is included, an expenditure which has also been rising rapidly in recent years, employers can make a strong case for describing their total contribution for employee's health-related benefits as skyrocketing in the 1980's.²²⁹ Even in relative terms, the employers' burden appears increasingly problematic; employers' total contribution for health benefits has been growing faster than total employee compensation for at least a decade.²³⁰ Thus, the same mechanisms that have tended historically to insulate many consumers from the impact of the rising costs of privately financed health expenditures—employer purchased and tax-subsidized health insurance premiums—may be having the opposite effect on employers. Those that have committed themselves to providing broad health insurance coverage as part of their employee compensation package now find that this is an increasingly

228. BUREAU OF NATIONAL AFFAIRS, CONTROLLING HEALTH CARE COSTS: CRISIS IN EMPLOYEE BENEFITS 1 (1983) [hereinafter cited as CONTROLLING HEALTH CARE COSTS].

229. See HEALTH SPENDING TRENDS, *supra* note 33, at 16.

230. See *id.*

expensive employee benefit, the cost of which is largely controlled by outside factors.

Not unexpectedly, various employers, as well as the business community collectively, have been actively seeking in recent years ways to contain their "fundamental problem" of rising health care costs. They have formed business coalitions,²³¹ promoted preferred provider organizations and other alternative schemes,²³² and attempted in various ways to modify employee health benefits or insurance coverage.²³³ Indeed, initial data for 1984 indicate that the rate of increase in the employers' share of total health insurance premiums has noticeably moderated, suggesting that these efforts may be having a measurable effect.²³⁴

It would be, of course, speculative to assume that this moderating rate of increase is a direct result of any or all of these employer-initiated measures or, for that matter, that this trend will continue.²³⁵ It is clear, nonetheless, that employers have become increasingly sensitive to the rising costs of employees' health benefits in the 1980's and that their efforts to contain or, more important, to avoid those costs will become increasingly relevant to consumers and to their evolving perception of the cost of privately financed health insurance.

B. *Out-of-Pocket Payments*

Beyond private insurance premiums, whether purchased

231. See CONTROLLING HEALTH CARE COSTS, *supra* note 228, at 21-30.

232. See *id.* at 57-81.

233. See 1984 EXPENDITURES, *supra* note 23, at 6; *Health Benefits: Employers in the Driver's Seat*, WASH. REP. ON MED. & HEALTH—PERSPECTIVES (K. Glenn ed. July 8, 1985).

234. According to a private research firm's analysis of Department of Commerce unpublished data, the employers' share of health insurance premiums rose only 8.7% in 1984. This estimate is based on data somewhat revising earlier published reports on the amount and rate of increase of the employers' share of premiums. According to this source, employers paid \$97.2 billion in 1984, \$89.4 billion in 1983 (an increase of 11.2%), \$80.3 billion in 1982 (an increase of 16.7%), \$68.8 billion in 1981 (an increase of 15.4%), and \$59.6 billion in 1980. Telephone conversation with Deborah Chollet, Employee Benefit Research Institute, Washington, D.C. (May 8, 1986). Note that these data are slightly different from those contained in Table 11 *infra*. Part of this difference can be explained by the fact that the Department of Commerce includes both disability and health insurance premiums under their definition of "health insurance," see *supra* note 208, and this may increase the total amount and somewhat modify the rate of increase. In any event, the decline in the rate of increase in 1984 under either data set is too significant to be discounted. For a somewhat anecdotal analysis of recent developments, see BUREAU OF NATIONAL AFFAIRS, HEALTH CARE COSTS: WHERE'S THE BOTTOM LINE? (1986).

235. See discussion of various factors that can contribute to increases in aggregated health expenditures, *supra* notes 37-70.

through employment or not, lie the costs of direct or out-of-pocket payments. Taken in the aggregate, the relative share of personal health care expenditures paid directly by consumers had been steadily and dramatically *decreasing* until the most recent decade, as illustrated by Table 11. Consumers paid over 50% of the costs of personal health care services in 1965; that share dropped to 32.5% in 1975 and to 28.5% in 1980.²³⁶ In the early 1980's, that trend slowed but continued; but in 1984, total direct payments by consumers increased from 27.4% to 27.9% of personal health care, a total of \$95 billion.²³⁷

TABLE 11
DIRECT CONSUMER PAYMENTS

Year	Total Payments (billions)	Per capita	% of all expenditures
1984	\$95.4	\$389	27.9%
1983	86.4	355	27.4
1982	77.2	321	27.1
1981	70.8	297	27.9
1980	62.5	265	28.5
1975	38.1	170	32.5
1970	26.5	124	40.5
1967	19.0	91	42.6
1965	18.5	91	51.6
1960	13.0	71	54.9
1955	9.1	54	58.1
1950	7.1	46	65.5
1940	2.9	21	81.3
1935	2.2	17	82.4
1929	2.8	23	88.4

SOURCE: Levit, Lazenby, Waldo & Davidoff, *National Health Expenditures, 1984*, HEALTH CARE FIN. REV., Fall 1985, Table 4, at 16.

While this represented an average of approximately \$389 in direct payments per person and an increase of 10.4% from 1983,²³⁸ these expenses were unevenly distributed across the population. Many people pay a relatively modest amount through cost sharing

236. See 1984 EXPENDITURES, *supra* note 23, at 16.

237. See *id.* The portion of the bill paid by consumers varies greatly according to the category of service. Direct payments accounted for only 9% of hospital care and 28% of all physician payments in 1984. On the other hand, almost half of all nursing home care and as much as three fourths of other services, such as eyeglasses and drugs, were funded out of pocket during that year. See *id.* at 27-28; Rossiter & Wilensky, *Out-of-Pocket Expenses for Personal Health Care Services*, DHHS Pub. No. (PHS) 82-3332, at 1-3 (1982).

238. See *supra* Table 11.

for insurance-covered services or for ambulatory or other services frequently not covered by health insurance policies;²³⁹ on the other hand, some people incur extraordinary or catastrophic health care bills. One study estimated that over two thirds of all families spend less than 3% of their income out-of-pocket for personal health services, with at least one half spending less than 2%.²⁴⁰ By way of contrast, that same study estimated that 10% of all families had out-of-pocket payments in excess of 10% of their incomes, and 4.2% had direct payments in excess of 20%.²⁴¹

Who are these people and how much do they pay? The fact that so little is known about these consumers is itself a political commentary. Neither government sources nor private insurers apparently collect or publish useful data identifying out-of-pocket payors in other than general terms.²⁴² Provider sources tend to describe such expenditures only in aggregate terms and in terms that primarily reflect the fiscal impact on provider budgets.²⁴³ Nonetheless, the sketchy data that are available suggest that even for those who have some amount of coverage, insurance does not insulate consumers from the risk of high, or even catastrophic, health expenses. They also suggest that this risk is increasing in the 1980's.

Statistics concerning the Medicare population are at least illus-

239. For estimates of the amount of out-of-pocket expenses by the insured, see study discussed in CONGRESSIONAL BUDGET OFFICE, CATASTROPHIC MEDICAL EXPENSES: PATTERNS IN THE NON-ELDERLY, NON-POOR POPULATION 79-81 (1982) [hereinafter cited as CONGRESSIONAL BUDGET OFFICE].

240. See Rossiter & Wilensky, *supra* note 237, at 8.

241. See *id.* Analysis of that same data has resulted in an estimate that in 1977 only .4% of the population, or slightly less than one million people, had out-of-pocket expenses for hospital services in excess of \$1,000; coincidentally, a surprisingly high number of people had no out-of-pocket payments and were hospitalized. See Taylor, *Inpatient Hospital Services: Use, Expenditures, and Sources of Payment*, DHHS Pub. No. (PHS) 83-3360, at 5 (1983). Estimates from another source indicate that 1.5% of the population (individuals, not families) in 1980 under age 65 and 5% of the population over age 65 incurred out-of-pocket expenditures for medical care in excess of \$1,000; and 2.8% of the population under age 65 and 16% over age 65 had out-of-pocket expenditures in excess of 5% of income. See Garfinkel, Riley & Iannacchione, *The High Cost of Health Care* 53-55 (July 26, 1985) (in press, Research Triangle Inst. (1986); unpublished paper in possession of the author).

A more recent analysis of the 1977 data, attempting to extrapolate trends for the out-of-pocket liability of those with insurance, has concluded that a surprisingly large number of people with private insurance still run a substantial risk of high out-of-pocket expenses, while a small number run a slight chance of extraordinary out-of-pocket expenses. See Farley, *Who Are the Underinsured?*, 63 MILBANK MEMORIAL FUND Q. 476, 496-501 (1985). For further discussion of the incidence of catastrophic expenses, see CONGRESSIONAL BUDGET OFFICE, *supra* note 239, at 38-45.

242. See *supra* note 213.

243. See, e.g., UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES (F. Sloan, J. Blumstein & J. Perrin eds. 1986).

trative. Even with virtually 100% Medicare coverage of the population over age 65, that population has to rely on private resources for roughly 50% of their health expenditures, 25% of which are paid out-of-pocket—a share that is likely to increase in the 1980's.²⁴⁴ Two and one-half million elderly paid more than \$1000 in copayments alone in 1984.²⁴⁵ Long-term care in a nursing home can cost over \$30,000 per year; yet long-term care is only partially covered by Medicare, Medicaid, or supplemental policies, such as Medi-gap policies.²⁴⁶

Similar data on the cost sharing or out-of-pocket liability experience of those who are privately insured are virtually nonexistent, but it has been estimated that a significantly high proportion of the privately insured, representing perhaps as many as 26% of the nonelderly population, are among those who risk high out-of-pocket payments despite their insurance coverage.²⁴⁷

While the distribution of out-of-pocket payments across the population, as well as recent trends in those payments, can only be suggested from available data, some measure of the implications and importance of these direct payments by consumers can be determined by reference to the characteristics of those who are likely incurring the largest share of these expenditures. Obviously, most of the high out-of-pocket payors are those who are uninsured or "underinsured."²⁴⁸ Estimates of the number of uninsured in this country have varied considerably, although experts have generally agreed that the percentage of uninsured has increased in recent years and may have been as high as 17% of the nonelderly population by the end of 1984.²⁴⁹ As many as 20 million Americans were

244. See Waldo & Lazenby, *supra* note 18, at 25; *Catastrophic Insurance*, WASH. REP. ON MED. & HEALTH—PERSPECTIVES (K. Fackelman ed. Apr. 21, 1986). This is roughly the same percentage of their total health bill as they paid in 1977. But the proportion paid out of pocket by the aged is projected to increase in the next decade as government cost-containment measures limit the amount paid by Medicare. Among other things, Medicare cost sharing limits will increase by 23% in 1986. See *Medicare Hospital Cost-Sharing to Increase 23% . . .*, HEALTH ADVOC., Nov. 1985, at 1; 1984 EXPENDITURES, *supra* note 23, at 27.

245. It should be noted that Medicare paid 75% of hospital expenses and 58% of physician services for Medicare recipients in 1984. A very large proportion of the direct payments by the elderly are for nursing home and other health-related services. See *Catastrophic Insurance*, *supra* note 244. Medicare paid for only 2% of nursing home care in 1984. Even with Medicaid coverage for those who exhaust their financial resources, the beneficiary frequently pays for one half of the cost of nursing home services with private resources. See *id.*

246. See *id.*

247. See Farley, *supra* note 241, at 477.

248. See *id.* at 481-87.

249. For 1977 data and analysis, see Davis & Rowland, *Uninsured and Underserved: In-*

without health insurance during all of 1984, and somewhere between 30 and 40 million people were without insurance at some time during that year.²⁵⁰ Another expert has estimated that the number of inadequately covered—the uninsured all of the year, the uninsured part of the year, and the uninsured for a significant portion of their potential medical bills—could be as high as 56 million people.²⁵¹

Ironically, the major descriptive characteristic of the uninsured population is their lack of financial resources. At least one half, and possibly two thirds, are poor or low-income people.²⁵² A significant number of these potential out-of-pocket payors represent unemployed workers and their dependents, although the proportion of the uninsured that are unemployed is also a number that is subject to considerable debate.²⁵³ As noted earlier, perhaps as many as one half of the uninsured are employed at some point during the year, although predominantly in low-wage, seasonal, and part-time em-

equities in Health Care in the United States, 61 MILBANK MEMORIAL FUND Q. 149 (1983). Recent estimates based on (unpublished) data collected by the Department of Commerce indicate that 15.5% of the population were uninsured in 1982 and that that figure increased to 16.5% in 1983. See *Financing Indigent Health Care*, 44 EMPLOYEE BENEFIT RESEARCH INST.—ISSUE BRIEF 4 (1985). Similar estimates were made in A. Monheit, *What Have We Learned From Survey Data on the Uninsured?*, speech to the Am. Pub. Health Ass'n 3, 21 (Nov. 19, 1985) (unpublished paper in possession of the author). Another recent estimate concluded that nearly 17% of the nonelderly were uninsured in 1984. See K. Swartz, *Changes in the Uninsured Population Over Time: Implications for Public Policy*, speech to the AMERICAN PUBLIC HEALTH ASSOCIATION (Nov. 19, 1985) (unpublished paper in possession of the author). All these figures should be compared to the more conservative estimates of the private insurance industry. See *supra* note 208.

By way of comparison, as many as 30% of the nonelderly had no insurance prior to 1965. Following the enactment of Medicaid and Medicare, that proportion has declined until the upward trend of the last few years. See K. Swartz, *supra*, at 1.

250. The number of people uninsured throughout the whole year, of course, is much smaller than those uninsured at any one time. Estimates based on the 1977 survey, see *supra* note 213, and similar studies in 1980 and 1982 have shown that the population uninsured throughout the year is between 7 and 9% of the nonelderly, roughly 20 million people. See A. MONHEIT, *supra* note 249, at 3.

251. See Farley, *supra* note 241, at 499.

252. Defining "poor" or "low income" as income less than twice the poverty level, one expert estimated that one half of the uninsured—despite Medicaid and other programs—were poor or low income people in 1977, but that percentage may be higher in later years. See A. MONHEIT, *supra* note 249, at 15, 24. Swartz estimated that two thirds of the uninsured in 1984 had incomes less than twice the poverty level—and one third were below the poverty line. See K. Swartz, *supra* note 249, at 2. See also Farley, *supra* note 241, at 477.

253. See Monheit, Hagan, Berk & Wilensky, *Health Insurance for the Unemployed: Is Federal Legislation Needed?*, 3 HEALTH AFF., Spr. 1984; Berki, Wyszewianski, Lichtenstein, Gimotty, Bowlyow, Papke, Smith, Crane & Bromberg, *Health Insurance Coverage of the Unemployed*, 23 MED. CARE 847 (1985).

ployment.²⁵⁴ Nonetheless, periodic increases in the rate of unemployment in recent years have clearly led to increases in the number of uninsured.²⁵⁵

Notwithstanding the inadequacy of available data to describe more specifically the level and distribution of direct payments by consumers or the characteristics of those consumers, it is clear that many Americans face a risk of high out-of-pocket payments and that the burden of these payments falls most heavily on those with the least ability to "afford" the resulting financial hardship. Some indeterminate number of consumers face direct or out-of-pocket payments that will strain or exhaust their income or other resources. Others, in anticipation of those costs, will choose to delay or forego medical care.²⁵⁶ Still others will seek treatment and be denied access because of their inability to pay and their ineligibility for public programs.²⁵⁷ Indeed, the highest irony may lie in the tendency to define the rising costs of medical care for consumers in terms of the amount or portion of health care expenditures that are direct or out-of-pocket payments. The "price" of direct payments by consumers should be measured both in terms of dollars spent and dollars *not* spent, the latter reflected by the death, disability, or discomfort of those who find medical care financially inaccessible.

Such human costs are difficult to tabulate in other than anecdotal terms:

—In February, 1985, a thirty-four year old man with a knife

254. See *The Employed Uninsured*, *supra* note 213, at 348-57; A. MONHEIT, *supra* note 249, at 6-14.

255. In 1983, Congress predicted that 9.6 million jobless Americans and an equal number of their dependents were without any form of health insurance as a result of their loss of employment. See H.R. REP. NO. 236, 98th Cong., 1st Sess. 18 (Part 2 1983).

In 1983, following a year of economic recession and high unemployment, the number of people with employer purchased health insurance declined by one million. See *Financing Indigent Care*, *supra* note 249, at 3-4. The dynamics of this relationship should be noted: When employment levels increase there may not be a comparable increase in the number of people with employer-purchased health insurance if rehired workers receive reduced benefits or if they accept employment without any insurance benefit program.

256. For a review of the differential utilization rates between the uninsured and the insured, and the resulting impact on health status, see Davis & Rowland, *supra* note 249, at 62-75. As summarized by these authorities:

[L]ack of insurance coverage has three major consequences: It contributes to unnecessary pain, suffering, disability, and even death among the uninsured; it places a financial burden on those uninsured who struggle to pay burdensome medical bills; and it places a financial strain on hospitals, physicians, and other health care providers who attempt to provide care to the uninsured.

Id. at 73. See also Aday & Andersen, *The National Profile of Access to Medical Care: Where Do We Stand?*, 74 AM. J. PUB. HEALTH, Dec. 1984, at 1331.

257. See *infra* notes 258-60 and accompanying text.

wound penetrating his skull was denied emergency neurosurgery at a private hospital in San Francisco. Though he received first aid in the emergency room, the hospital was unable to find a neurosurgeon to accept the patient, possibly because he was uninsured. Two other hospitals refused to accept the victim. He died following transfer to another hospital.²⁵⁸

—In June, 1985, a fifty-six year old man with third-degree burns on his side and back was refused emergency treatment at two Texas hospitals because he was uninsured. He was briefly examined but refused admission at a third because he did not have a cash deposit to cover additional care. After seven hours and seventy miles of driving, he was finally admitted to a public hospital in Dallas.²⁵⁹

—A resident at Cook County Hospital in Chicago reported in October of 1985 that a patient arrived in the emergency room with a note from a private physician that read: "Please assume medical care of Mrs. Smith. She is no longer eligible for medical assistance and cannot afford to see me."²⁶⁰

Other reports of refusals to provide initial first aid in emergency rooms or to continue treatment following first aid indicate that such "horror stories" are not aberrational and, indeed, may be becoming more frequent.²⁶¹ "Dumping" uninsured patients or those without preadmission cash deposits, even when the practice presents substantial risk to the transferred patient, has apparently become the preferred cost-containment strategy of many providers.²⁶²

There are also preliminary statistical indications that the rising

258. See *Uninsured Patient: Why East Bay Man Didn't Get Treated*, San Francisco Chron., Feb. 6, 1985, at 6, col. 5.

259. See Taylor, *Ailing, Uninsured and Turned Away*, Wash. Post, June 30, 1985, at 1, col. 3.

260. See Bernard, *Patient Dumping: A Resident's Firsthand View*, 34 NEW PHYSICIAN 23 (1985). Perhaps a more serious illustration of the result of termination of public benefits is provided by the account of a surgical supply company that demanded the return of a breathing monitor from a former Medicaid patient because the reimbursement order was (incorrectly) not renewed, leading to the brain death of a one year old child. See Bonnyman, *A Tragedy in Tennessee*, HEALTH ADVOC., Fall 1985, at 5.

261. See Dowell, *Indigent Access to Hospital Emergency Room Services*, 18 CLEARINGHOUSE REV. 483, 483-84 (1984); Fine, *Opening the Closed Doors: The Duty of Hospitals to Treat Emergency Patients*, 24 WASH. J. URB. & CONTEMP. L. 123, 124-25 (1983).

262. See Annas, *Your Money or Your Life: "Dumping" Uninsured Patients from Hospital Emergency Wards*, 76 AM. J. PUB. HEALTH, Jan. 1986, at 74, 75; Himmelstein, Woolhandler, Harnly, Bader, Silber, Backer & Jones, *Patient Transfers: Medical Practice as Social Triage*, 74 AM. J. PUB. HEALTH, May 1984, at 494 [hereinafter cited as *Patient Transfers*]; Friedman, *The "Dumping" Dilemma: The Poor Are Always With Some of Us*, 56 HOSP., Sept. 1982, at 51. Himmelstein studied 458 consecutive transfers from 14 private hospitals to a public hospital in Alameda, California. The study found 103 patients at high risk and 33 patients jeopardized as a result of the transfer. See *Patient Transfers, supra*, at 495.

costs of health care for some consumers are translating into increases in human costs. Maternal and child health experts are now documenting a slowdown in the historic decline in overall infant mortality, a nationwide *rise* in the postneonatal mortality rate (deaths in the first year of life), and increases in both the percentages of low-birthweight babies and the number of women who have had late or no prenatal care.²⁶³ These same experts have alleged that these trends are due, at least in part, to the inability of indigent women to find affordable medical care.²⁶⁴

C. Conclusion

Does any of the above support the thesis that the costs of health care to the individual consumer have become a public policy problem of fundamental proportions? Surely the data suggesting that there has been a measurable decline in the health status of some Americans must be seriously regarded. Tracing the causal connection between rising individual costs and declining health status, however, is a difficult and easily confounded task. Firm evidence of this connection, unfortunately, can only be gathered and evaluated historically. And, given the predilection of most public and private sources to focus on the financial rather than the human costs of health care, more convincing evidence may take a long time to amass, if it is ever to be available at all. Consequently, the public policy assessment of these troubling statistics may be as much a value judgment as a scientific inquiry. For those for whom preliminary signals of declining health status are sufficient to justify action, then "something should be done" to avoid the possibility that the apparent trend in these statistics will eventually be validated. For

263. For a discussion of the recent trends in infant mortality, see D. HUGHES, K. JOHNSON, J. SIMONS & S. ROSENBAUM, *MATERNAL AND CHILD HEALTH DATA BOOK: THE HEALTH OF AMERICA'S CHILDREN 3-4* (Children's Defense Fund 1986). Perhaps the most disturbing statistics are those that document the increase in the postneonatal mortality rate. In 1983, postneonatal mortality rose 3%, a reversal of a twenty-year trend of declining annual rates; preliminary data for 1984 indicate that the rate increased another 6%. See *id.* at 3.

Increases in the percentage of babies with low birthweight and in the percentage of women with late or no prenatal care were also documented. In fact, 5.6% of the women delivering in this country in 1983 had late or no prenatal care—the third year in a row that this figure had increased. Statistically, babies born to women with inadequate prenatal care are three times more likely to die within their first year of life. See *id.* at 5, 38.

264. A recent study illustrates the connection between indigency and access. Reviewing care received in a charity hospital in Florida, the Children's Defense Fund found that 30% of the women delivering in 1982 received no prenatal care at all, that a majority had tried, but were unable to find, affordable prenatal care. S. ROSENBAUM, *POLICY PAPERS ON MEDICAL INDIGENCY IN AMERICA 23* (Children's Defense Fund 1986).

those predisposed to tolerate some risk of declining health status or, more critically, for those whose self-interest may be adversely affected by likely remedial responses, the public policy implications of these preliminary statistics can always be questioned.

The causal connection between rising individual costs and the specific accounts of health care denied or foregone is more difficult to overlook or deny; nevertheless, the policy implications may still be questioned. Incidents of malfeasance or nonfeasance, for financial and other reasons, have always plagued American health care delivery. Are these "horror stories" really becoming more frequent, or are they merely becoming more frequently publicized? More importantly, what sort of limit on individual financial liability would be required to avoid their recurrence?

As a matter of public policy, the stronger evidence that rising individual costs should be viewed as a fundamental problem in the 1980's lies in the aggregated expenditure data. The private share of NHEs has been rising rapidly in this decade—in sharp contrast to historic trends. The costs of private health insurance premiums also have been rising rapidly and disproportionately. Many consumers may be insulated from the direct impact of these rising premium costs, but others are not. Moreover, for those who have employer-purchased health insurance, the reactions of their employers to rising costs may soon serve to dissolve that insulation and to prompt an awakening of consumer sensitivity.

Available data also indicate that the level of out-of-pocket payments by consumers, whether insured or not, is also increasing. Indeed, the increase in the number of underinsured people in this decade may be the most starkly problematic statistic in this Article—if not as a matter of public policy, then surely as a matter of popular politics. While little is known about the distribution of out-of-pocket payments actually paid or incurred, or the social or demographic characteristics of those payors, the sheer size of the underinsured population may warrant the conclusion that, as a matter of public policy, "something should be done."

It is fairly predictable that the burden of health care costs on consumers generally, and on some individual consumers in particular, will continue to grow in the next decade. State and federal governments may have trouble overcoming the political barriers to their various cost-containment efforts, but, to the extent that they are successful, it is apparent that their primary objective will be to limit the costs of health care to government budgets and not necessarily the costs to the consumer pocketbook. If anything, the

course of government policy in the next decade will increase the cost burden on individual consumers. Similarly, employers, eager to limit their share of the increasing costs of health insurance premiums, may experiment with a variety of cost-containment strategies. Ultimately, however, their strategy of preference is likely to be cost containment in the narrow and parochial sense, translating into higher costs for individual consumers.

As noted previously, health care cost containment inherently involves conflicts between competing interests where, as frequently as not, one group's cost containment complicates another's cost problem. The interests of consumers, employers, and government policymakers could conceivably converge on a broad and mutually beneficial cost-containment strategy; but such a scenario appears unlikely under current political circumstances. Both private and public third-party payors are more likely to attempt to shift or avoid costs than to attempt to contain health care costs in the broader sense of the term. As a result, the costs of health care to consumers are almost certain to increase and, consequently, to represent an increasingly important public policy problem.

The political importance of increasing individual costs may be even greater; indeed, it may be the key element in understanding the health policy agenda of the 1980's. Americans, as discussed previously, display a strong egalitarian tradition with respect to medical care. Whether funded through private or public mechanisms, medical care is an extraordinarily valued service. The notion that some people must pay high medical bills, for whatever reason, is essentially unacceptable. The perception that some people cannot afford adequate medical care is even more repugnant, even in a decade where costs may be perceived as rapidly rising. Suggestions that rising costs have caused women to forego prenatal care during pregnancy or infants to die unnecessarily—if ever proven conclusively to be true—are politically explosive. Only the most ideologically committed market theorist—and the most politically naive—could discount the importance of any perception that medical care is foregone or denied for reasons of cost in American health care politics.

This political lesson has been learned and relearned many times. Both "small dollar" and "big dollar" Medicare reform strategies must somehow be achieved without the perception that the federal government is abandoning its commitment to the nation's elderly. Medicaid budgets may be pared, whether justifiably or not, but program cuts must be made in the name of eliminating fraud and abuse

or improving program efficiency—rarely in the name of service reduction. And while many states are attempting to limit their spending on health programs, just as many are undertaking new programs to finance “indigent care.”

Even the Reagan administration, which has presided over the largest health program reductions in history, has recently endorsed the study of a new federal program to finance “catastrophic health insurance.” A variety of schemes have been advanced by neoconservative theorists for limiting the multibillion-dollar federal tax subsidy of employer-purchased health insurance, but few legislators have been willing to actively pursue them. Such an overt reduction in government support for health insurance would surely face substantial political backlash, even in an era when major federal tax reform is apparently feasible. In fact, while “privatization,” “competition,” and the other tenets of traditional economic analysis have obviously become part of the contemporary health policy dialogue, government implementation of the dictates of neoconservative theorists remains, at best, tentative and experimental. However conservative Americans have become in principle, they are still egalitarian in preference when it comes to accessible medical care.

Surely the health policy agenda of the 1980's will focus on the fundamental problem of cost containment. But the issues on that agenda, and the likelihood that they will be addressed, will reflect both the divergent definitions of that fundamental problem and the peculiar political constraints within which private and public decisions must be made.