Research Department
Federal Reserve
Bank of
San Francisco

January 7, 1983

FRBSF Weekly Letter

All is Not Well

An economy runs on both physical and human capital. In 1960, the cost of maintaining human capital—health care costs—represented about 6 percent of gross national product. This share is projected to double by 1990. While recognizing the importance of high quality medical care, there is a growing consensus that health care costs have "gone out of control" (the cost of a hospital room alone has doubled in the last five years). Such escalation raises problems for both the private and public sectors.

At present, businesses spend nearly $60 billion a year on employee health insurance and the share of the federal budget devoted to health expenditures has reached 10 percent. Because previous regulatory approaches to controlling health care costs (such as the Carter Administration's Hospital Cost Containment Program) were largely ineffective, health insurers and some policymakers are seeking to unleash competitive market forces in the health services industry. To understand the rationale behind these approaches, it is necessary to understand the special economic nature of the health services industry.

Health services industry

Unlike many other industries, the health services industry is largely self-regulated, a legacy of the way in which the field of medicine evolved in the United States. Prior to about 1850, the industry was virtually unregulated, allowing free entry and exit of hospitals and training institutions. In 1847, the American Medical Association (AMA) was formed to ensure that this system did not produce low-quality personnel and services. Over the years since then, the AMA has obtained wide-ranging legislative authority to accredit medical schools, practitioners, and health care facilities. Critics of organized medicine (such as John Goodman of the CATO Institute) argue that this legislative authority has permitted the self-regulators to go beyond concerns over quality control and become a cartel controlling prices and services for the benefit of its members.

Through its accreditation authority, for example, organized medicine has had the power to limit supply and resist the entry of low-cost competition. One often-cited case was the strong reaction of organized medicine in the 1940's to the formation of the Kaiser Foundation Plan of California, which provided health services in a prepaid (rather than fee-for-service) format. The local medical society barred Kaiser's staff from membership and found the Kaiser Plan's director guilty of unethical medical practices. It took a 1943 Supreme Court ruling to overrule the authority of organized medicine in this area and to permit the creation of Kaiser-type services.

In addition, some of the restraints organized medicine puts on its members, such as the ban on advertising, can be interpreted as mechanisms designed to limit price and quality competition. According to a study performed by the Food and Drug Administration, for example, when the ban on advertising contact lens prices was lifted in 1975, average prices dropped 30 percent.

Finally, critics point out that the unusual financial rewards enjoyed in the health services industry are in themselves evidence of a successful restriction of supply. Physicians' reported income has grown much faster than the median income over most of the last fifty years. And, as cited earlier, the income of the medical services industry as a whole has taken an ever increasing share of the national income.

The response of the medical profession to such criticism is that professional control over supply is necessary to ensure quality control. And, indeed, it is widely agreed that the AMA has done much to reduce medical quackery. But regardless of one's view of self-regula-

Research Department
Federal Reserve
Bank of
San Francisco

tion, the effect is still the same—to limit the supply of health services.

Enter insurance

Even in a constrained supply environment, however, the income to the profession is limited by demand—the ability and willingness of the patient to pay. The medical profession learned this lesson during the 1930's when the depressed income of the general population created payment problems for physicians and hospitals. In response, organized medicine entered into a new subindustry—health insurance. It created the predecessors of today's non-profit Blue Cross and Blue Shield. The marketing of these professionally sponsored plans was facilitated both by special tax and regulatory concessions and, inadvertently, by the wage and price control policies of World War II. Unable to provide direct pay increases, employers began offering improved benefit packages, especially in the form of health insurance. As this practice of employment-linked insurance coverage spread, it weakened consumer incentives to economize on medical care and increased substantially the revenue potential for organized medicine. Direct patient payments for medical care today are less than 35 percent of total medical expenditures. In 1950, they were 80 percent.

Medicare

Another major factor in recent health care cost escalation has been the increased involvement of governments in the provision of health care coverage. As health insurance became linked more and more with employment, the poor and the elderly, with weak links to employment, had inferior access to health insurance. The federal Medicare legislation of 1965 was an attempt to provide health care for the poor and elderly. But its reimbursement procedures contained disincentives for cost containment, particularly at the hospital level. The procedures essentially guaranteed reimbursement of costs, and hospitals therefore had little incentive to operate efficiently. As a result, hospital costs have been the leader in increasing Medicare costs that now exceed $80 billion per year.

Proxy demand

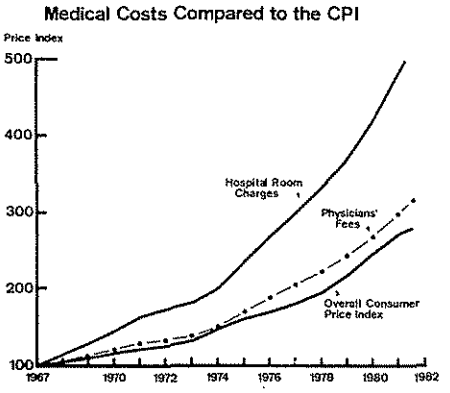
A final feature of the health services industry that may have contributed to the cost spiral is that the consumer of medical services has unusually limited ability to determine his own need for such services. Acting as a "proxy demander" for the patient, the physician can create demand for tests, surgical procedures, and repeat visits, particularly when insurance largely insulates the patient from the resulting costs. The frequency of surgical procedures, for example, appears to be greater in a conventional fee-for-service environment than in a pre-paid environment (where the provider has an incentive to avoid unnecessary procedures).

Unleashing competition ... demand

It is clear from this overview that the problems with the health services industry originate from a multitude of sources, both on the demand and supply sides of the market. Solutions, therefore, must address both sides.

On the demand side, generous insurance coverage insulates the consumer from many cost considerations. One obvious remedy is to increase the portion of the health care costs borne by the patient (increasing the so-called "copayment") at least for non-major medical levels of treatment. The Reagan Administration cautiously proposed such a notion for medicare coverage (with the copayment level linked to a means test) but it was greeted by a firestorm of opposition from Medicare proponents. Similarly, private health insurers have found it difficult to market high co-payment plans.

As an alternative, some large health insurance companies and corporations are using their bargaining power to locate "preferred providers"—doctors, dentists and hospitals that agree to discount the cost of their services in return for a secure base of clients. The employer then provides a financial incentive to its employees to utilize these preferred providers. The sketchy evidence of the few such arrangements in place suggests cost savings of 10 to 30 percent. Unfortunately, broad adoption of this approach by insurers usually



requires special changes in state insurance regulations and these changes are often opposed by the medical societies. In the State of California, however, such opposition was unsuccessful and Assembly Bill 3480 recently cleared the way for the use of the preferred provider method by private insurers. An allied measure, Assembly Bill 799, permits the State itself to negotiate fees for services provided to its needy MediCal patients.

At the federal level, analogous proposals are under consideration. The Reagan Administration wants to replace the cost-reimbursement policies of Medicare with a so-called "prospective reimbursement" policy—providers would receive a pre-negotiated fee for the treatment of 450 different illnesses.

...supply

Steps have also been taken to influence supply positively. One major step, taken almost two decades ago was to increase the supply of physicians. Under a federal subsidy plan (the Health Professionals Educational Assistance Act of 1963), the number of physicians per 1,000 population in the United States rose from 1.43 in 1965 to 1.84 in 1979. Yet there is some question whether such an increase in supply will translate into lower physician fees because of the alleged ability of the physician to increase the demand for services until a desired income is achieved. This so-called target-income hypothesis, although shown by economist George Sweeney to be theoretically feasible, is difficult to demonstrate except anecdotally. (The Urban Institute, for example, found that doctors responded to the wage and price controls of the early 1970's simply by increasing the volume of services and procedures performed to restore their target incomes.) But it does seem unlikely that further relative increases in the physician population will lead to substantive reductions in physicians' fees.

zation (HMO) form of medical service. Here, the organization receives a flat fee for providing for the complete health care of the enrolled individual. Incentives are strong in such organizations (such as the Kaiser plan and Blue Cross's "Take Care") to keep costs low because the plans are not reimbursed on a procedure-by-procedure basis. They also have incentives to provide preventative medical services to avoid future costs. Harold Luft of the University of California's Health Policy Research Institute has shown that savings of as much as 40 percent can be achieved by this form of health care delivery system, in comparison to the traditional fee-for-service method, without a sacrifice in quality. Employers and their employees have found HMO's attractive. Indeed, nationally, the number of HMO members increased at an 11.3 percent annual rate from 1976 to 1981 while the total number of persons with private health insurance went up by only a 1 percent annual rate during the same period.

Conclusion

The health care problem appears to be a tangle of inappropriate economic structures and incentives. This suggests that much of the recent growth in expenditures probably represents pure economic waste rather than a major increase in the overall quality of care. Major changes in the health care marketplace will likely be opposed by organized medicine. (Indeed, the AMA has recently sought blanket exemption from Federal Trade Commission authority in an attempt to protect its role as a primary self-regulator of the industry.) But without some major changes, the cost of medical care in the United States will impose a growing burden on the economy.

Randall Pozdena

Research Department
Federal Reserve
Bank of
San Francisco
Alaska • Arizona • California • Hawaii
Idaho • Nevada • Oregon • Utah • Washington

BANKING DATA—TWELFTH FEDERAL RESERVE DISTRICT

(Dollar amounts in millions)

Selected Assets and Liabilities Large Commercial Banks	Amount Outstanding 12/22/82	Change from 12/15/82	Change from year ago Dollar	Change from year ago Percent
Loans (gross, adjusted) and investments*	162,980	402	6,456	4.1
Loans (gross, adjusted) — total#	142,797	224	7,451	5.5
Commercial and industrial	45,453	421	4,120	10.0
Real estate	57,344	− 95	1,534	2.7
Loans to individuals	23,833	44	171	0.7
Securities loans	2,736	− 227	478	21.2
U.S. Treasury securities*	6,986	− 19	1,100	18.7
Other securities*	13,197	197	− 2,095	− 13.7
Demand deposits — total#	42,069	−2,017	− 529	− 1.2
Demand deposits — adjusted	28,798	416	− 139	− 0.5
Savings deposits — total	41,502	4,296	11,480	38.2
Time deposits — total#	90,229	−2,854	528	0.6
Individuals, part. & corp.	80,323	−2,822	− 325	− 0.4
(Large negotiable CD's)	31,321	−1,022	− 4,772	− 13.2

Weekly Averages of Daily Figures	Week ended 12/22/82	Week ended 12/15/82	Comparable year-ago period
Member Bank Reserve Position			
Excess Reserves (+)/Deficiency (−)	135	113	− 93
Borrowings	25	1	1
Net free reserves (+)/Net borrowed(−)	109	112	92

* Excludes trading account securities.

Includes items not shown separately.

Editorial comments may be addressed to the editor (Gregory Tong) or to the author . . . . Free copies of this and other Federal Reserve publications can be obtained by calling or writing the Public Information Section, Federal Reserve Bank of San Francisco, P.O. Box 7702, San Francisco 94120. Phone (415) 974-2246.