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No Free Aspirin?

The House Ways and Means Committee quietly began hearings last week on a major unfinished piece of New Deal legislation—national health insurance. Actually, a national insurance plan was first proposed a half-century ago by the American Medical Association, but the proposal became mired in controversy for decades thereafter, and failed to make any headway until the advent of the Medicare program in the mid-1960's. But now, in the mid-1970's, the proposal to extend insurance from the aged to all segments of the population has gained wide support across the political spectrum, so that a history-making piece of legislation may soon emerge from Congress.

Yet, to paraphrase a favored economic cliche—there's no such thing as free aspirin. Medical-care costs have soared in recent decades, especially after the introduction of Medicare, a piece of legislation which supported a strong upsurge in demand but weakened the role of the market mechanism in allocating medical resources. Meanwhile, despite its sharply rising costs, and despite its highly advanced technology, the health-care industry has failed to produce a completely satisfactory product for its consumers.

Poor health, high cost

Although Americans spend much more per person for medical care than the citizens of any other country, the blunt truth is that they don't enjoy commensurately higher health levels. Fourteen nations have lower rates of infant mortality than the U.S., with its death rate of 19.8 per thousand live births. (In some Boston slums, one out of nine babies dies.) The U.S. ranking in male life expectancy continually declines, so that it now stands in 27th place, just between Poland and Romania. (The atmosphere apparently is more conducive to female health, since the U.S. ranks 12th in female life expectancy.)

Health personnel are badly distributed and in short supply. About a third of the 50 states have less than one physician per 1,000 population, with the number per thousand ranging between 2.2 in New York and 2.0 in Massachusetts to 0.7 in Mississippi and Alaska. Consequently, the nation has been forced to turn to foreign-trained doctors to fill shortages; they now make up roughly 14 percent of available medical manpower, and fill almost 30 percent of hospital internships and residencies.

At the same time, the cost of providing health services has gone up steeply, from $3.6 billion in 1929 to $94.1 billion in 1973 (fiscal years), while medical claim on GNP has more than doubled over that period, from 3.6 percent to 7.7 percent. The fastest growth of spending occurred in the post-World War II period, particularly in the recent Medicare era. Medical-care expenditures rose at an 8.2-percent annual rate over the 1950-66 period, but then surged at a 12.2-percent annual rate between 1966 and 1973. Most of the recent

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increase was in publicly financed programs, which jumped 19.4 percent annually in the 1966-73 period.

Why so costly?

The growth of population and real income helped account for rising spending in each of those periods, but the most important factor was the rise in prices of health care. Over the 1950-66 period, population increased at a 1.6-percent annual rate, as against 1.0 percent annually during the 1966-73 period; in contrast real per capita income grew at a 2.2-percent rate in the earlier period but at a 3.1-percent rate between 1966 and 1973. More importantly, medical-care prices rose at a 3.5-percent rate between 1950 and 1966 but at a 5.7-percent rate since 1966—considerably more in each case than the overall rise in consumer prices.

In searching for the reason for this price upsurge, we should recognize that a large part of consumer demand is determined by physicians themselves. It is they who suggest hospitalization, who prescribe drugs, and who order tests and X-rays, so that they are not only the suppliers of medical care but also the patients' advisers on how much to buy.

The problem is accentuated by the fact that physicians' approach to medical care is dominated by technological rather than cost considerations. Medical tradition in essence emphasizes giving the best care that money can buy—and most patients wouldn't have it otherwise. Still, this approach goes against the basic economic proposition that decisions involving the allocation of scarce resources to competing goals require the weighing of costs against benefits.

Weakened market mechanism

The rapid acceleration of costs of the past half-decade or so reflected all of the above factors, plus the advent of Medicare and Medicaid—the extension of health services among the aged and the poor. These segments of the population constituted an enormous pool of previously unfinanced health-care needs, and once their needs began to be financed, the demand for health care jumped further ahead of available supply. By 1973, public funds spent on these two programs alone reached $13.4 billion.

In addition, Medicare and Medicaid accentuated an already evident shift in the character of the nation's health-delivery system, measured by source of expenditure. Between 1929 and 1966, the public share of the health bill rose from 13 to 26 percent, but by 1973, public funds provided 40 percent of a rapidly rising total. Another 26 percent of the total represented insurance payments rather than direct consumer payments.

These changes worked to reduce further the market character of the health-delivery system. To emphasize again, the medical system has always been characterized by the fact that, within certain limits, the seller-physician tells the buyer-patient the amount and prices of

the services he has to buy. But even these restraints are now being eliminated by the third-party payment of medical bills. Increasingly, one party obtains the services, another party provides them, and yet another pays for them. Under these circumstances, very little is left of the market mechanism, to limit the number and price of physician and hospital charges. Thus the highest rate of inflation has occurred in hospital services, where direct payments by patients account for only 8 percent of the total bill.

Congressional task

Congress is now working on an exceedingly difficult problem: how to bring adequate health care to all segments of the population, but at a bearable cost to the Federal budget and to the national economy. Some 15 bills have been introduced in an attempt to reconcile these conflicting objectives, but most interest is centered in the Administration proposal and the Mills-Kennedy bill.

The two bills are rather similar in concept, with the Mills-Kennedy plan involving about $8.5 billion a year of new Federal funds, as opposed to the Administration's $6.4 billion pricetag. But there are also several important differences. The legislative plan would make participation compulsory under the social-security system, while the Administration plan would make membership voluntary. The Mills-Kennedy bill envisions a straight 4-percent payroll tax to finance the program, with the employer paying 3 percent and the employee 1 percent; the Administration bill would have the employer pay (at least initially) 65 percent of the $415 annual insurance premium.

The Mills-Kennedy bill would require the individual to pay $150 a year in medical-care costs ($300 maximum per family) before he could receive any benefits. The Administration bill has the same $150 deductible feature, but calls for a $450 family maximum. Both plans then would require beneficiaries to pay 25 percent of additional medical-care costs, up to $1,000 a year under Mills-Kennedy and up to a $1,500 maximum under the Administration plan.

Whatever happens, the American consumer is almost certain to be paying considerably more for good health in future years. (John Dunlop, as head of the Cost of Living Council, recently supported his plea for continued controls in this area by predicting that hospital costs otherwise would soar 16 to18 percent a year.) Of course, much of the inflation in demand has already occurred, with the development of the Medicare and Medicaid programs, not to mention the continued spread of private-insurance plans, which now reach 80 percent of the population in one form or another. But these demand pressures will increase further, in an atmosphere of weakened cost controls, as the nation accepts the concept that an affluent society should provide all of its members with a minimum standard of health care.

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