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National Health Care

A Focus on the Economic Fundamentals

For many years, an increasing segment of the vocal public and "liberal" government officials have decried the U.S. "crisis in medical care." Various remedies that would increase the role of government in the provision of health-care services have been proposed. In this article, we describe some distressing aspects of the provision of medical care that are largely the direct result of existing laws. We will also describe, without going into the details of any specific proposals, why any program of so-called national health insurance could not be run on sound insurance principles and could not solve the problems that its most ardent supporters apparently wish to remedy.

Crisis Because of Costs?

The alleged crisis in the provision of medical-care services in the United States is usually thought to have arisen because the costs of medical care have risen far more rapidly than those of most other items. As a result, the allegation frequently is made that "adequate" medical care is beyond the means of a large segment of the population. Before considering this latter assertion, we shall comment on the question of costs.

There are many reasons why the cost of medical care has increased markedly during recent years. In general they can be classified into two broad groups. First, extensive research has resulted in the development of increasingly sophisticated methods of diagnosis and treatment involving high-cost technology and an increased use of resources. Some might argue that these technical advances have not increased the price of medical care but rather have enlarged the scope of medical care available. Regardless of which way the situation is viewed, the availability of new medical products and services has tended to increase the outlays for medical care related to a given illness, accident, or disorder.

Second, and far more pervasive, are the institutional factors that have increased not only the outlays for medical care in general but also the prices of given treatments or procedures. The list of such factors is extensive. The most frequently mentioned factors include:

1. practices by physicians in restricting their number and the range of services that can be provided by less highly trained personnel and in failing to punish unscrupulous or incompetent members of the profession who prescribe unnecessary treatment;
2. lack of coordination among health-care providers, which has resulted in the duplication and underutilization of expensive equipment and facilities;
3. large awards in malpractice litigation, which not only have increased the costs of providing medical care but also have fostered routine use of the consulting physicians and of the latest, most sophisticated methods, even when such may be redundant or of doubtful efficacy;
4. large increases in paperwork required of the providers of health care, which have increased costs without any improvement in service;
5. the increasing proportion of medical-care expenses billed to "third parties" (i.e., private insurers or government agencies), which has diminished the concern about charges by the actual recipients of such care and has provided little incentive for cost-cutting or effective management, inasmuch as unwarranted charges are simply added to premiums or to government budgets;
6. the incidence of nonpayment by patients not covered by "third-party" payment has increased faster than such coverage, and the increased bad-debts expense has been added to the charges billed to all parties.

Many of these institutional factors seem to be a direct result of public policies. For example, the licensing laws of most states have given physicians the monopoly power now of concern to many, and Medicare and Medicaid have added tremendous amounts of paperwork to the burden of health-care providers. President Carter's proposal to limit the payments to hospitals under government programs for patient care seems to be addressed to the fifth consideration above. However, since his proposal attacks the result (increased government outlays) rather than the cause (lack of evaluation of specific services by their users), it probably will create as many problems as it solves.

Who Cannot Afford Medical Care?

Assessments of the quality of medical care in the United States frequently have been based on such data as U.S. infant mortality, life expectancy, or the incidence of specific diseases compared with those data for other countries. We do not believe that such comparisons are valid, because they ignore significant differences among nations such as climate, genetics, culture, living habits, and occupations. There is little reason to believe that such differences are attributable to the inability of a substantial proportion of the U.S. population to purchase medical care.

Some form of free or low-cost care always has been available to the indigent through private charitable institutions, through the doctors or hospitals themselves, or through government hospitals. This has been greatly increased through the Medicare and Medicaid programs. Moreover, the very large "bad-debts" experience of health-care providers suggests that many individuals not so covered have adopted their own "informal programs." However, the appalling conditions often encountered by those least able to care for themselves (such as the

hopelessly retarded, the insane, or the senile) at government-sponsored institutions (such as state hospitals or "Medicaid mills") suggest that these institutions in practice are operated not for the benefit of the patients but for the more potent electorate of relatives whose responsibilities are relieved by such institutions.

As noted above, the alleged crisis in medical care is usually thought to reflect the inability of some portion of the public to obtain "adequate" medical care. However, what is "adequate" can not be determined by any uniform criteria. When an adolescent member of the Kennedy family was afflicted with bone cancer, world-renowned specialists reportedly were flown in from distant points for consultations. Clearly, the level of medical care considered "adequate" by the Kennedy family for its own members could not be provided to every citizen. Some cost criteria must be used by those who ultimately pay for it, whether it is the individual patient, his family, his insurer, a private charity, or a government official.

This type of decision and who makes it also affects the allocation of resources to and among preventive, routine, intensive and prolonged care. Some analysts have asserted that the knowledge that large medical bills would be paid by "third parties" may cause some individuals to neglect their health. Whether or not this is the case, the allocation of resources to medical care clearly will vary according to the degree to which decisions are made by individuals using their own resources or by bureaucrats using the public's funds.

Abandoning The Insurance Principle

The purpose of insurance is to spread the risk of specific, unpredictable losses or expenses among a group of persons. Each individual member of the insured group thus trades the certainty of a small expense (usually called a premium) for the knowledge that he will be spared the possibility of a large loss. Losses must be not only unpredictable for the insured as individuals (i.e., not under their control) but also quantifiable in money terms for the insured group as a whole.

Private insurers long have sold health-insurance policies, and such policies differ widely in the amount and degree of coverage provided. In recent years, much private health-insurance coverage has become increasingly comprehensive, paying an increasing proportion of all medical expenses of policyholders. This has involved significant deviations from sound insurance principles insofar as coverage has been provided for expenses that are controllable in some degree by the policyholder (such as whether to seek medical advice for a head cold) and that are predictable to some extent for the insured individual.

The premiums for such policies usually are paid by employers for the benefit of their employees, and the reason for this practice is that such purchases are not subject to payroll or income taxes, although they represent payments by the employer to the employee. Reportedly, this provision of the tax law enables employers to purchase health insurance for their employees for about one-third less than employees could purchase it for themselves with after-tax income. The differential in premium cost covers not only the cost of paperwork but also the cost of additional medical care used by employees because "it's free." According to the Office of Management and Budget, the "tax expenditure" involved in the exclusion of employer-purchased health insurance from taxable incomes will be about $5.8 billion in fiscal year 1978. Thus, much of the private medical insurance sold in the United States reflects the availability of this "tax loophole" rather than genuine insurance coverage of unforeseeable expenses.

That the provision of the tax law mentioned above has caused increased utilization of health-care services by its beneficiaries is presumably a source of satisfaction to its sponsors, inasmuch as the use of medical services by covered employees is apparently greater and more "adequate" than it would be otherwise. However, to the extent that advocates of a system of "national health insurance" succeed in increasing the use of medical-care services to "adequate levels," the costs of such increased service and related paperwork will not be disguised as "tax expenditures." Those costs will be in the budget, presumably partly as a replacement for and partly as an addition to existing Federal spending for health care. Such spending is estimated at $56 billion in fiscal year 1978.

Catastrophe Insurance

Advocates of increased government payment for health care frequently have acknowledged some of the problems associated with existing government health-care programs. Nevertheless, they have asserted that some form of guaranteed protection against financial ruin should be made available to all citizens, since the costs associated with treatment of grave accidents or illnesses can be larger than the net worth of most families. That this is the situation is a reflection of major technological advances enabling the saving and prolongation of life. Presumably, universal coverage for such expenses would foster further discoveries and the possibility of further expenses. Practical measures of limiting such expenses again require some determination of what is "adequate." As a recent Congressional Budget Issue Paper noted, "For the patient, his doctors, and his family, even a marginal extension of life – whatever the financial cost – is generally considered worthwhile but society may be forced to view the question differently."

Private "major medical" insurance long has been available in almost any amount at a reasonable cost. We believe that it would be preferable for individuals or families to determine for themselves the extent of the coverage they feel worthwhile (perhaps with some regulation of insurers to accept "poor" risks) rather than to allow "society" (read: bureaucrats) to "view the question differently," i.e., make decisions that will determine for nearly all Americans the level of health-care services available to them.

Those Americans unwilling to make the financial sacrifice of purchasing such insurance coverage must bear the risk of financial ruin for their actions. The small percentage of Americans financially unable to purchase such coverage has little wealth to lose anyway.

Conclusion

Most probably some Americans receive less medical care than they need to maintain good health, but most probably this is the situation everywhere in the world. The opposite probably also occurs: some medical care received is of no value in promoting good health. Although the law of diminishing returns is just as valid for medical care as for other things (i.e., each increment in the resources devoted to medical care will provide, on average, smaller benefit than that provided by the preceding increment), the

medical problems of every individual are unique, and there is no way to predict the efficacy of a given procedure or treatment in an individual case. In short, there can be no substitute for judgments based on what medical care is available and at what cost. The most important judgment is that of the individual patient to seek or not to seek medical attention and from whom to seek it in the former instance.

Any system of health insurance that deviates from sound insurance principles by paying expenses that largely are in the insured's control or that could be expected to be incurred by all individuals will serve to increase the demand for medical services presumably in proportion to the extent that costs are not borne by the medical-care recipient.

Although an increase in the use of medical-care services may be desired by some, any plan of government-sponsored health insurance that achieves the goal of providing all medical services anyone might want will be a virtually open-ended claim on public funds. This has been the experience with the Medicare and Medicaid programs, and it has been the experience in other countries with national health-care plans. Attempts to curtail such government outlays or to retard their growth can only be effected by imposing government controls on the supply of medical-care services. Once such controls become effective, consumers may find that increased waiting time for medical attention or the absence of medical facilities will have rendered "adequate" medical care unavailable at any price. That hardly is a way to ensure adequate medical services.

STATISTICAL INDICATORS

Among the primary leading indicators, the index of housing permits increased and continued to expand during May. No other new data were received for the primary leaders, 67 percent of which are appraised as expanding cyclically.

No new data were received for any of the primary roughly coincident or lagging series. One-hundred percent of the series in both of these groups are expanding cyclically.

That 67 percent of the primary leading series are appraised as expanding cyclically suggests that general business activity will continue to expand during the next few months.

BUSINESS

MANUFACTURERS' ORDERS, SALES, AND INVENTORIES

Note: All data are adjusted for seasonal variations.

According to the Department of Commerce, the average amount (in current dollars) of new orders received by manufacturers increased 5.6 percent during the 3 months ended in April to a record $110.1 billion. This average amount was 13.4 percent more than that during the comparable year-earlier 3-month period. New orders for both durable and nondurable goods increased to record average amounts during the 3 months ended in April.

New orders received by manufacturers, which had decreased at a compound annual rate of 2.6 percent during the 3 months ended in September, increased at a compound annual rate of nearly 25 percent during the subsequent 7 months. That rate of increase in new orders was greater than the 20-percent compound annual rate of increase during the 15 months following the March 1975 cyclical trough in this series. Because the recent rate of increase in new orders received by manufacturers clearly is unsustainable, an abatement in that rate would not be surprising.

The average amount of shipments (sales) of manufacturers during the 3 months ended in April was a record $109.2 billion. This average amount was 6.3 percent more than that during the preceding 3 months and 12.6 percent more than that during the 3 months ended in April 1976. Total shipments by manufacturers increased substantially to record amounts during February and March but decreased slightly during April. Shipments of durable goods also increased to record amounts during February and March before decreasing during April, but shipments of nondurable goods increased to record amounts during all 3 months. After having decreased slightly during the 3 months ended in October 1976, total shipments increased at a compound annual rate of nearly 28 percent during the following 6 months. That rate of increase also is unsustainable, and an abatement of it can be expected.

The trends of constant-dollar new orders and of such sales of durable-goods manufacturers also have been upward, but at lesser rates than the current-dollar series. The constant-dollar series clearly are expanding cyclically even though they have not exceeded the record amounts of late 1973, which the current-dollar series have done.

That both current-dollar new orders received by and sales of manufacturers increased to record amounts during the 3 months ended in April has favorable implications for the production of such goods during the next few months. The percent changes in the average amounts of manufacturers' new orders and shipments during the 3 months ended in July 1976, October 1976, January 1977, and April 1977 from those during the preceding 3-month periods were as follows:

	Compound Annual Rates of Change During 3 Months Ended:			
	July 1976	*Oct. 1976*	*Jan. 1977*	*Apr. 1977*
New Orders				
All manufacturers	+7.8	–2.3	+26.1	+24.3
Durable-goods mfrs.	+12.6	–5.9	+39.7	+22.5
Nondurable-goods mfrs.	+3.0	+1.8	+13.0	+25.9
Shipments				
All manufacturers	+11.3	–1.3	+19.6	+27.5
Durable-goods mfrs.	+9.1	–3.3	+26.8	+23.8
Nondurable-goods mfrs.	+4.2	+0.9	+12.3	+26.2

Manufacturers' unfilled orders at the end of April were 1.6 percent more than those at the end of January and 5.5 percent more than those at the end of April 1976. Although this series has been in an upward trend since reaching a cyclical trough in February 1976, the amount of unfilled orders at the end of April was about 8 percent less than the record amount of unfilled orders at the end of September 1974. Unfilled orders of durable-goods manufacturers, which account for about 95 percent of total unfilled orders, were 5.6 percent more at the end of April than those a year earlier.

Current-dollar inventories of all manufacturers at the end of April were 2.1 percent more than those at the end of January and 8.1 percent more than those at the end of April 1976. Such inventories of durable-goods manufacturers, which account for nearly two-thirds of all inventories, were 1.8 percent more than those at the end of January and 7.3 percent more than those a year earlier. Although current-dollar inventories of durable-goods manufacturers during April were 8.5 percent more than those at the cyclical trough of such inventories in

February 1976, these inventories in *constant* dollars increased only 0.3 percent during this same 14-month period. That the physical volume of durable-goods inventories has changed little since reaching a cyclical trough indicates that manufacturers have increased their production largely to fill orders only. Apparently, they do not wish to be "caught" with large inventories if sales unexpectedly begin to decrease, as happened in early 1974. Such caution should help sustain the current business expansion, inasmuch as any slight "pause" in manufacturers' sales need not trigger a massive inventory correction.

Ratios of inventories to sales (shipments) for manufacturers of all goods, durable goods, and nondurable goods for January and April 1977 as well as for July and October 1976 were as follows:

	1976		*1977*	
	July	*Oct.*	*Jan.*	*Apr.*
All goods	1.64	1.71	1.62	1.56
Durable goods	2.01	2.14	2.00	1.91
Nondurable goods	1.24	1.27	1.21	1.18

p Preliminary.

The trends of these 3 ratios have been similar. From a cyclical peak early in 1975, they trended downward through mid-1976. They subsequently increased somewhat for several months and then resumed their downward trend in late 1976. During April these ratios were at or near cyclical lows. The ratio of inventories to sales of durable-goods manufacturers has been a useful indicator of future production of such goods. During the postwar period, production of durable goods has not begun to contract cyclically until several months after the inventories-sales ratio of such manufacturers reached a cyclical trough. This series reached a cyclical low during March and increased slightly during April. However, this series apparently still is in a decreasing trend, which suggests that production of durable goods will continue to increase.

Preliminary data reveal that new orders received by, shipments of, and unfilled orders of durable-goods manufacturers increased during May. These preliminary estimates indicate that the favorable trends for such series during recent months have continued.

Manufacturers' orders, sales, and inventories data through April suggest that industrial production will continue to expand cyclically during the next few months, although perhaps at a smaller rate of increase.

SUPPLY

INDUSTRIAL PRODUCTION

Production of steel, automobiles, and electric power (1) in the 1- and 4-week periods ended on the indicated dates in the current year and (2) in the corresponding periods of earlier years was as follows:

Steel	*1972*	*1973*	*1974*	*1975*	*1976*	*1977*
Ingots (million tons)						
1 week: June 18	2.59	2.93	2.81	2.05	2.66	2.61
4 weeks: June 18	10.53	11.81	11.41	8.35	10.79	10.80
Automobiles						
Vehicles (thousands)						
1 week: June 18	190	217	174	150	194	212p
4 weeks: June 18	723	832	650	571	746	802p
Electric Power						
Kilowatt-hours (billions)						
1 week: June 18	34.1	38.7	37.2	39.1	41.5	42.2
4 weeks: June 18	132.0	144.0	144.2	146.3	153.6	162.5

Percent change from 4 weeks a year earlier: +5.8

p Preliminary.

DEMAND

RETAIL SALES

Estimates of retail sales during the most recent week and 4 weeks compare with such sales during the corresponding periods a year earlier as follows:

Period	*Percent change*
Week ended June 18	+11
Four weeks ended June 18	+12

PRICES

COMMODITIES PRICES

	1976	*1977*	
Index	*June 14*	*June 6*	*June 13*
Spot-market, 22 commodities*	534	562	555
Commodity-futures	739	820	792
Steel-scrap	$84.17	$62.50	$62.17
	June 24	*June 16*	*June 23*
Gold	$124.70	$139.85	$140.15

*For the preceding Tuesday.

Note: The indexes are, respectively, those of the U.S. Bureau of Labor Statistics, Dow-Jones, and *Iron Age*. The spot-market and futures indexes are converted so that their August 1939 daily averages equal 100. The steel-scrap index is a composite price for No. 1 heavy melting scrap. The gold price is the final fixing in London.

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