Statement of

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Mr. Chairman and Members of the Committee:

I appreciate this opportunity to discuss the impact of increasing health care costs on public programs and private spending and the effects of some recent attempts to control health care costs.

The Growth in Health Expenditures

Over the last twenty-five years health care expenditures have been growing at a much more rapid rate than the overall economy. In 1950, health expenditures amounted to $12.0 billion or 4.6 percent of GNP; by 1975 such spending had reached $118.5 billion or 8.3 percent of GNP.

This increase in spending for health care has been caused by three factors. First, inflation in the health sector, historically, has been more severe than in other segments of the economy (see Table 1). The

past six months have been particularly bad in this respect, for the moderation of overall inflation has not been reflected in the health sector. While the

TABLE 1. Average Annual Increases in Consumer Price Index, Medical Price Index, Semi-private Rooms, and Physician's Fees, Fiscal Years.

	1960-65	1965-71	1972	1973	1974	1975	10/75-3/76
CPI*	1.3	4.2	3.6	4.0	9.0	11.0	4.8
Medical Price Index	2.5	6.3	4.7	3.1	5.7	12.5	10.0
Semi-Private Hospital Room Charge	5.9	14.0	9.4	5.0	6.0	16.4	15.6
Physician Fees	2.9	6.8	5.2	2.6	5.0	12.8	13.6

*Consumer Price Index

CPI increased at an annualized rate of 4.8 percent during the six month period ending with March 1976, the medical index, physician's fees, and semi-private hospital room charges rose at annualized rates of 10.0,

13.6 and 15.6 percent respectively. Second, there have been dramatic improvements in the quality or intensity of medical care. These advances have been characterized by an emphasis on diagnostic and therapeutic techniques which are complex and expensive and often require hospital stays. Third, individuals use more health services today than they did in 1950. For example, per capita use of hospital services has increased by one-third.

All of these developments have been abetted by the growth in insurance coverage which currently pays for 65 percent of personal health expenditures, over twice the fraction paid for in 1950. Because insurance lowers the price of care to the consumer at the time care is sought, it encourages increased utilization. By improving the patient's ability to pay, insurance has enabled providers -- particularly hospitals -- to acquire expensive technology. It has also stimulated inflation because the third-party payers have not resisted price increases by providers and, in turn, the providers have had little incentive to resist demands for wage increases or price hikes on the goods and services they purchase.

Future Health Care Expenditures and the Public Sector

The growth of health care expenditures has become a matter of increasing concern because a larger and larger fraction of both public and private resources are being absorbed by this sector. Largely because of the medicare and medicaid programs the fraction of all health care expenditures flowing through the federal budget has risen from 10.0 percent in 1950 to almost one third today. Over this same period the fraction of the federal budget devoted to health programs has risen from 2.2 percent to 9.2 percent.

This increase in public sector responsibility for health care has not been offset by a decline in private health care spending. Private expenditures for health care accounted for 4.3 percent of personal disposable income in 1950; the comparable figure is estimated to be 6.3 percent for 1976.

CBO projections indicate that under current policies these trends are likely to continue. If price increases in the medical sector return to their historic relationship to overall price increases, and the recent trends in qualitative improvement and utilization are continued, national spending on personal health care

services will rise from an estimated level of $150 billion in fiscal year 1977 to slightly more than $250 billion in fiscal year 1981. Total health care expenditures -- personal health care expenditures plus spending on research, construction and public health services -- would amount to over 10 percent of GNP by 1981, up from 8.3 percent in 1975.

These projections suggest that roughly 8.0 percent of personal disposable income will be devoted to the purchase of private health care in 1981, up from 6.3 in 1976. If existing public sector programs and policy are maintained, the cost of federal health programs can be expected to escalate by about 14 percent annually; by 1981, federal health expenditures would account for 12.3 percent of a current policy budget. Most of the growth would take place in the medicaid and medicare programs which are projected to increase from $31.2 billion in fiscal year 1977 to $51 billion in 1981. The growth in medicare outlays alone from fiscal year 1976 to 1977 will exceed the funding level for all categorical grant programs of the Public Health Service.

These projections make it clear that, even without new or expanded programs, rising health care costs will pose significant problems for both family and government budgets.

Approaches to Controlling Costs

Escalating public and private health care expenditures have been recognized as a serious problem for a long time. Within the last decade, as concern has grown over the budgetary impact of existing federal programs and the potential cost of national health insurance, efforts to find a means of containing these increases have intensified. The most comprehensive attempt to control price increases, the Economic Stabilization Program, is particularly relevant to this committee's present focus. Therefore, I would like to examine the lessons of this experience.

The 32½ month period (August 15, 1971 through April 30, 1974) of Economic Stabilization Program controls represents the only nationwide attempt which has been made to restrain health care costs. Although controls were applied to all health service providers, the most significant impacts were realized in the hospital sector. To understand the intent and success of the Economic Stabilization Program, it is necessary

to briefly review the causes of hospital cost increases.

Hospital care is the single most expensive item in the nation's health bill. In 1977 it is estimated to amount to more than $58 billion or 39 percent of total health spending. In the first quarter of 1976, the cost of hospital services increased at seven times the rate of the CPI and one and one-half times the rate of the medical price index.

An examination of the two basic elements responsible for increases in hospital costs, "inflation" and "changes in services" (the intensity factor), shows some interesting trends (see Table 2). The high rate of inflation of the late 1960s and early 1970s pushed up hospital costs and accounts for over half of the annual increases. But "changes in services" -- both personnel and other factors such as the number of tests, x-rays, level and type of therapeutic treatment -- have also been important.

The increase in this "intensity factor" is partly attributable to our large national investment in biomedical research which has developed new, more complex technologies -- new treatments, drugs and procedures. The effect of making the fruits of this investment in

TABLE 2. Average Annual Percentage Increase in Expenses Per Patient Day

	1950-60	1960-65	1969-71	1971-74	Year Following ESP 1974-1975
Total Expenses	7.5	6.7	14.8	11.5	15.2
Inflation	3.8	3.5	8.2	6.4	10.0
Wages	5.2	4.7	10.0	6.1	9.0
Prices	1.5	1.3	5.1	6.8	11.4
Changes in Service	3.7	3.2	6.6	5.1	5.2
Personnel	3.1	1.7	3.7	2.7	2.5
Other (non-personnel, e.g., x-rays, lab tests, etc.)	4.6	5.6	10.3	8.7	9.3

research available in most hospitals will be a continuation of high rates of growth in new hospital services and thus costs. By way of illustration, in 1960, only 10 percent of community hospitals had intensive care units; today they are present in 59 percent of such hospitals.

During Phase II, which was in effect for 29 of the 32 months of the Economic Stabilization Program, hospitals

were not allowed to increase their annual revenues due to "price increases" by more than 6 percent annually. In order to permit a growth of 2 percent in the quality and quantity of services, total costs per patient day were allowed to rise by 8 percent.

Prices charged by hospitals did conform to Phase II limits. For example, semiprivate room charges increased at the rate of 5.7 percent per year. However, the rate of increase in total costs per patient day, while falling during this period, did not reach the target of 8 percent because improvements in the intensity of services (quality and quantity) rose at 5 percent rather than at the programmed rate of 2 percent. Total costs per patient day increased at an annualized rate of 11.5 percent for the entire period and at 9.6 percent in fiscal year 1974. Phase IV, which was never actually implemented, recognized that the 2 percent factor for improved services was too stringent and that increased flexibility in rate increases would be necessary to permit reasonable expansion and to preserve the economic viability of some institutions.

The measures employed by hospitals to restrain cost increases during the Economic Stabilization Program

are not altogether clear. The very rapid post-control price rebound would suggest, however, that temporary economies such as not hiring new personnel or restraining wage increases were employed rather than changes which might have a long-term effect. This response could, in part, be due to the short time-frame of the ESP program and the uncertainty about how long the controls could be expected to last.

An examination of hospital operating expenses during this period suggests the following common pattern of response to the controls.

Wage Increases: In 1974, payroll expenses accounted for 54 percent of overall hospital costs. Wage increases were severely curtailed during the period of the Economic Stabilization Program. This curtailment followed a period of rapid "catch-up" wage increases in the late 1960s as the traditionally low-paid hospital workers were unionized and attempted to gain wage comparability with workers in other sectors of the economy (see Table 3). In the post-ESP period wage increases have recovered.

TABLE 3. Annual Percentage Increase in Earnings Per Employee in Community Hospitals and All Services.

Year	Hospital Employees	Service Workers
1969	9.4	8.9
1970	10.1	8.4
1971	10.3	6.5
1972 (ESP)	8.0	5.5
1973 (ESP)	4.5	6.7
1974	5.7	8.8
1975	9.8*	NA

*estimated

Source: American Hospital Association and Department of Commerce, Bureau of Economic Analysis.

Staffing Patterns: An additional means of holding down payroll costs is to reduce staffing ratios -- personnel per patient. While actual cut-backs do not seem to have occurred during the Economic Stabilization Program, the steady growth in employees per daily patient census was slowed in 1973 (see Table 4). After the removal of controls, hospitals began to increase their staffs at close to the pre-ESP rate.

TABLE 4. Employees Per Daily Inpatient Census

Year	Employees Per Patient Per Day	Percent Increases from Previous Year
1969	2.80	--
1970	2.92	4.3
1971	3.01	3.1
1972 (ESP)	3.10	3.0
1973 (ESP)	3.15	1.6
1974	3.26	3.5
1975	3.37*	3.4*

*estimated

Source: American Hospital Association

Nonpayroll Costs: Nonpayroll costs also increased at a slower rate during the Economic Stabilization Program years. Nonpersonnel inputs consist of items that can be purchased easily such as drugs, and x-ray machines, and large scale capital equipment or facilities which require much more

advanced planning. Because of the long lead-time required, it was not until 1974 that major capital acquistition projects were affected. Even then the impact was slight. In 1974, the total assets of all hospitals increased by 9.2 percent, a rate somewhat slower than the 10.4 percent for the 1971-73 period. In the post ESP period the rate of increase in the acquisition of nonpersonnel inputs seems to have returned to the post-medicare rate of about 10 percent.

Operating Margins: During the controls period, hospitals lowered their operating margins. That is, they absorbed cost increases without raising prices by lowering their operating margins and, for short period, some went into debt. Prior to the Economic Stabilization Program, community hospitals had maintained operating margins which averaged 1.5 to 2 percent of revenues. In the first year of controls, margins were reduced to 0.7 percent; in the second year they dropped to -0.1 percent. Following the lifting of controls in 1974, operating margins were increased to 1.7 percent.

In summary, during the Economic Stabilization Program hospitals seemed to have employed temporary measures rather than attempting to effect basic institutional change. Specifically, they:

-- held down wages,

-- attempted to freeze staff/patient ratios, and

-- reduced operating margins.

As soon as controls were lifted, these restraints were dropped. Hospital expenditures increased by 15.2 percent in the year following the Economic Stabilization Program.

As a further illustration of post-ESP catch-up, the daily cost under medicare hospital insurance increased 16.2 percent from FY 1975-76 and is projected by the Social Security Administration to increase another 14.6 percent in fiscal year 1977.

If the hospital industry had expected ESP controls to be long-term rather than temporary, institutional responses would probably have been quite different. Hospitals perhaps would have closed underutilized services, reduced staffing ratios, and curtailed the acquisition of new capital assets. If changes of this nature had been introduced during ESP, the rate of increase in hospital costs would have been slowed even after controls were lifted. Instead, hospital operations were left largely unchanged, even when maintaining the status quo necessitated deficit financing. This ensured that in the post-controls period costs would rebound sharply.

One conclusion which might be drawn from this experience is that if a new program of industry-wide controls is contemplated, it must be flexible and carefully constructed, suitable for long-term or permanent application. Otherwise, it may be counterproductive. Hospitals anticipating periodic controls may increase charges when they are able to ensure an adequate operating margin during periods of controls. Simi-

larly, hospital workers may demand high wage settlements in anticipation of future restraints.

During the past year other measures have been suggested to limit the increase in federal health program costs. One approach is to place a cap on increases in hospital reimbursement under medicare and medicaid. Alternatively, an attempt could be made to moderate the rate of increase in hospital expenditures by imposing limits on reimbursable costs under medicare and medicaid. Those hospitals whose costs are relatively high would not be fully reimbursed.

Both of these approaches, and others which deal exclusively with the federal programs, pose certain problems. The Economic Stabilization Program controlled overall wages and prices in the health sector, and, therefore, affected all providers and users of services equally. There was no incentive to discriminate against any class of patients or to shift costs between public and private sector patients. This would not be true if controls are in place only for public programs. In that instance, costs not reimbursed by by medicare and medicaid might be shifted to private patients. Also, there is some danger that if controls on the public programs are maintained for a long period of time medicare and medicaid beneficiaries might be given a lower standard of care than private patients.

Other Cost Control Measures

My comments today have focused primarily on our experience under the Economic Stabilization Program and on other approaches that would alter hospital reimbursements. However, I would emphasize that the question of controlling costs is complex and solutions to the problem must be pluralistic in nature.

Although the increases in expenditures for medicare and medicaid have been due, in large part, to inflation and improvements in services, increased utilization has also played a major role. In recent years Congress has acknowledged the need to deal with the question of utilization of services through the passage of several important pieces of legislation. Most of these programs are still in their initial stages of development and it is therefore impossible to predict their ultimate impact. The Comprehensive Health Planning Act of 1966, the Social Security Amendments of 1972 (including the establishment of the Professional Standards Review Organization program), the Health Maintenance Organization Act of 1974, and the more recent National Health Planning and Resources Development Act represent efforts to change patterns of health service delivery and to utilize resources more effectively. These efforts merit continuing examination as to both their individual effectiveness in controlling utilization, and the actual impact of utilization controls as a means of reducing costs.

Conclusion

The use of financing mechanisms to limit costs and direct the development of services would represent a fundamental change in the federal health role. Historically, public financing has been modeled on private insurance. Payments have reinforced the prevailing patterns of delivery. The first stages of the Economic Stabilization Program continued this precedent by imposing uniform reimbursement limits on all providers. The Social Security Amendments of 1972, the HMO Act of 1973, and the Phase IV Economic Stabilization Program regulations signalled a shift in federal policy towards using the financing system to direct change in the organization and delivery of services.

Thus the era of money without controls may be drawing to an end. Not only has the financing and planning legislation of the last four years committed the federal government to deeper intervention in directing the health care system, but most discussion of national health insurance focuses on how the extension of financing can be used to improve the delivery system and control costs.

In designing such controls, the Congress will confront problems of achieving equity between types of services, providers and beneficiary groups; of redistributing care to areas of greatest need; and of guiding the development of

cost-efficient new delivery systems which are acceptable to providers and consumers. But even if the direction was clear in each of these areas--and at the moment there seems to be little consensus about any of them--we must also consider the feasibility of administering a complex system of incentives and controls.

It is clear that the development of financial incentives and disincentives which can restrain inflation and wasteful expenditures without at the same time curtailing desirable improvements in the quality of health services, and imposing undesirable rigidities on the delivery system will be a sensitive and difficult task.