

CONSUMER COSTS FOR MEDICAL CARE

Sylvia Lane
Professor of Agricultural Economics
and Agricultural Economist in the
Experiment Station and on the Giannini Foundation
University of California, Davis

Consumers, employers and governments in the United States spent 71.9 billion on personal health-care in the fiscal year 1972. This was 87 percent of the \$83 billion in national health expenditures. The \$83 billion, comprised 7.6 percent of the Gross National Product. In comparison national health expenditures totaled \$12 billion, 4.6 percent of the Gross National Product for the year in 1950.¹

Of the 71.9 billion spent in fiscal 1972 for personal health-care the direct payments of consumers constituted 34.9 percent. The remaining 65.1 percent was provided indirectly: 26.4 percent from group and individual insurance plans; 24.7 percent from federal government revenues; 12.5 percent from state and local taxes, and about 1.4 percent from philanthropy and industry.² The consumer bore all of the indirect costs through payments for insurance premiums, taxes, contributions to the philanthropic agencies, foregone compensation for employment or higher prices.

Reasons for Increased Costs

Of the total increase in personal health-care expenditures from fiscal years 1965 to 1972 (from \$39 to \$83 billion), the Social Security Administration attributes 10 percent to population growth, 38 percent to increased per-capita utilization of care combined with the rising level and scope of services resulting from innovation (e.g., new techniques, new drugs, and improved procedures for treatment) and 52 percent to price rises.³

In a more detailed study Klarman [3] and others examined three major categories of expenditure -- short-term hospital care physicians' services and dental services -- and found that over the period 1929-1968 the rise in prices contributed one-half of the increase in expenditures; population growth about one-sixth and rising per-capita use (which included quality of services) about one-third.

Population growth and increased utilization partially explain increases in quantity of medical services demanded. Increases in prices, however, are the effect of increases in quantity demanded relative to lesser increases in quantity supplied. Accurate prediction of increases in prices for medical care require identification and analysis of the components of the supply of and demand for medical care, and their respective effects upon prices.

Effects of Factors Underlying Demand

The increase in quantity demanded (or per-capita use) despite increasing prices, i.e., the reasons for the shift of the demand curve up and to the right, has been attributed to higher incomes; a changing demographic composition, such as the relative increase of women in the population, and especially at older ages; higher educational levels and consequent increased awareness of the importance of maintaining health or of the possible benefits from health-care; urbanization; a shift in morbidity patterns from predominance of acute episodic illness to chronic long-term ailments; increased governmental financial support of health-care for the medically indigent, the aged and the disabled which serves to increase real income with the increase constrained to the use of medical care; the astounding advances in medical technology from which consumers wish to benefit; the growth of health insurance and prepayment plans and the increase in the number of physicians.⁴

Parenthetically, rising price levels for components of medical care have been dramatic in recent years. (See Figure 1.) During the period 1950 to 1972, the Bureau of Labor Statistics' Consumer Price Index for all goods and services rose 74 percent. The medical care component of the index, in contrast, rose by 145 percent, almost twice as much. The Bureau of Labor Statistics' subordinate index for hospital room rates showed an increase of over 500 percent.⁵ The "average" family was estimated to pay \$632 for medical care in 1972.⁶

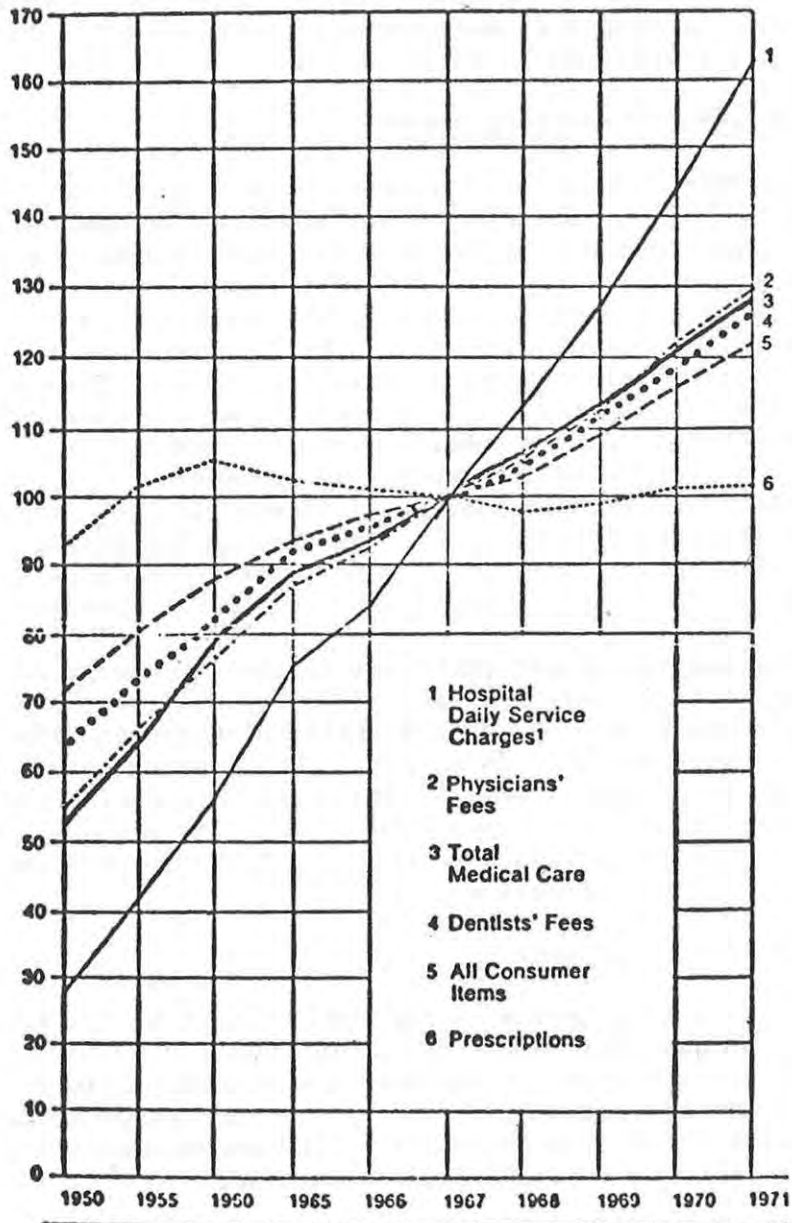
Effects of Health Insurance

Particularly interesting is the influence of health insurance on utilization, or quantity demanded, and prices, and to understand it, it is first necessary to examine the peculiar economic characteristics of the product, medical care. The major difference between medical care and other commodities consumers purchase is the unpredictability of medical care expenditures for the individual household.

The distribution of the annual expenditure on health-care among households is extremely skewed. A study of health-care expenditures by Federal Government employees in 1969 showed slightly more than half the households with two adults and two children spent less than \$260 but 10 percent of the families spent more than \$1,500 and 5 percent spent more than \$2,600. These annual amounts include both the families' direct out-of-pocket expenditures and payments by insurance companies.⁷ Kinney [2, pp. 99-101] found the odds were one in five that medical care expenditures would exceed 10 percent of a household's income in any one

FIGURE 1

Price Indices for Selected Health-Care Items
and All Consumer Items, 1950-1971 (1967=100)



1/ Includes charges to adult inpatients paying full rates for room and board, routine nursing care, and minor medical and surgical supplies.

Source: U.S. Social Security Administration,
Social Security Bulletin, Vol. 35,
No. 1, January 1972, pp. 63 and 64.

year; one in fifty that they would exceed half of its income. The uncertainty concerning the timing and amount of medical care costs induces households to purchase health insurance. By paying a fixed annual premium the household lowers the risk of incurring a much higher unpredictable expense. The insurer can sell insurance at a price that covers his costs of operation, including a competitive profit. His major cost, the cost of claims, can be computed as the actuarial mean of covered medical care costs for insured households. For example, the mean cost of health expenses in the study of Government employees cited was about \$610.⁸ If complete insurance were available, that is insurance with no deductibles, no co-insurance and no limits to benefits, households could avoid all risk connected with outlays for health maintenance by paying \$610 plus the insurer's administrative costs and profit.

The incentive to insure is stronger as the risk of incurring relatively large expenses increases, and as the distribution of expenses becomes more skewed. Therefore, insurance is most complete for hospital care. Federal tax policy encourages the purchase of health insurance with a subsidy that now exceeds \$3 billion a year.⁹ Taxpayers itemizing deductions on federal personal income forms fully deduct the first half of premiums paid for qualifying health insurance to a limit of \$150 and then the remainder of qualifying premiums over and above three percent of adjusted gross income. Employer payments for health insurance are excluded from the taxable income of both employer and the employee, when calculating state as well as federal income taxes. Moreover, health insurance premiums are not subject to the social security payroll tax. Tax incentives have contributed to the over threefold increase in the fraction of consumer health related expense liability paid by insurance in the years 1950 to 1970. (See Table 1.)

Over 80 percent of the population were insured, at least in part, against bearing the full cost of hospitalization in 1970. Over 77 percent were insured against some of the costs associated with surgical care; and 71.7 percent were covered by insurance at least in part for in-hospital visits. The percentages were lower for non-hospital associated health-care. Forty-five percent were covered for office and home visits, 16 percent were covered in the case of nursing care at home, and only 6 percent in the case of dental care. (See Table 2.)

Table 3 illustrates the fact that in addition to children and the poor those most likely to be without hospital insurance are men 17 to 24 years of age; those with less than eight years of education; non-whites; the farm population (although non-metropolitan area residents in general, have less hospital insurance coverage than metropolitan area residents); private household workers; and, of the farm population, farm-workers.

Among persons in the labor force (age 17-64), white-collar workers had higher coverage rates than blue-collar workers. Persons who were "usually working" were more often covered by health insurance than the retired or those who were keeping house or engaged in some other non-employment activity such as attending school. Also, persons with a

TABLE 1

Proportion of Consumer Expense for Medical
Care Met by Health Insurance

Year	Total	Hospital care	Physicians' services	Other types of care
Consumer expense (in millions)				
1950	\$ 8,125	\$ 1,832	\$ 2,597	\$ 3,696
1955	11,668	2,997	3,433	5,258
1960	17,997	5,119	5,309	7,569
1965	27,479	8,135	8,181	11,163
1970	39,044	13,673	10,201	15,170
Insurance benefits (in millions)				
1950	\$ 992	\$ 680	\$ 312	<u>1/</u>
1955	2,536	1,679	857	<u>1/</u>
1960	4,996	3,304	1,593	\$ 99
1965	8,729	5,790	2,680	259
1970	15,744	10,008	4,908	828
Percent insurance of consumer expense				
1950	12.2	37.1	12.0	---
1955	21.7	56.0	25.0	---
1960	27.8	64.5	30.0	1.3
1965	31.8	71.2	32.8	2.3
1970	40.3	73.2	48.1	5.5

1/ Included in physicians' services.

Source: U.S. Department of Health, Education and Welfare, Social Security Administration, Medical Care Costs and Prices: Background Book, GPO, Washington, D.C., January 1972, p. 101.

TABLE 2

Coverage Under Private Health-Insurance Plans
(Net Enrollment by Age and Type of Care, 1970)

	All ages		Under age 65		Age 65 and over	
	Number in thousands	Percent of civilian population	Number in thousands	Percent of civilian population	Number in thousands	Percent of civilian population
<u>Hospital care</u>	162,989	80.3	152,567	83.5	10,422	51.3
<u>Physicians' services</u>						
Surgical services	157,670	77.7	147,618	80.8	10,052	49.4
In-hospital visits	145,589	71.7	137,229	75.1	8,360	41.1
X-ray and laboratory examinations	142,441	70.2	134,839	73.8	7,602	37.4
Office and home visits	91,581	45.1	87,625	48.0	3,956	19.5
<u>Dental care</u>	12,210	6.0	12,079	6.6	131	.6
<u>Prescribed drugs</u>						
Out of hospital	100,966	49.7	97,736	53.5	3,230	15.9
<u>Nursing</u>						
Private duty	100,235	49.4	97,017	53.1	3,218	15.8
Visiting nurse service	106,882	52.6	103,064	56.4	3,818	18.8
Home care	32,392	16.0	27,371	15.0	5,021	24.7
<u>HIAA estimates</u>						
Hospital care	181,624	89.4	170,214	93.2	11,410	56.1
Surgical services	167,850	82.7	158,406	86.7	9,444	46.4

Note: Enrollment, as of December 31, 1970.

Source: U.S. Social Security Administration, Social Security Bulletin, Vol. 35, No. 2, February 1972, p. 4.

TABLE 3

Hospital Insurance Coverage of Persons Under 65, 1968

Characteristic	All persons covered (percent)	Age			
		Under 17 years (percent)	17 to 24 years (percent)	25 to 44 years (percent)	45 to 64 years (percent)
<u>All</u>	78.2	75.0	74.0	82.6	81.1
<u>Sex</u>					
Male	78.7	74.7	74.5	84.4	81.6
Female	77.8	75.3	73.6	80.9	80.7
<u>Family income</u>					
Under \$3,000	36.3	23.3	52.2	31.8	44.1
\$3,000 to \$4,999	56.8	49.0	58.2	58.1	67.7
5,000 to 6,999	78.5	74.6	75.4	81.5	84.0
7,000 to 9,999	89.3	88.4	84.2	91.2	91.3
10,000 and over	92.3	91.8	87.9	94.0	93.3
<u>Education of head</u>					
Less than 8 years	56.7	48.3	49.6	61.6	66.1
8 years	71.4	65.1	65.5	73.0	78.5
9 to 11 years	74.3	69.3	69.2	78.3	82.5
12 years	84.2	82.2	80.0	86.7	87.7
13 years or more	89.5	89.1	85.6	91.6	89.8
<u>Race</u>					
White	81.4	79.6	76.9	84.7	83.2
All other	56.0	49.4	54.5	65.8	61.1
<u>Urbanization</u>					
Metropolitan	81.3	78.2	77.0	84.8	84.6
Nonmetropolitan					
Nonfarm	74.4	71.0	70.3	79.8	76.9
Farm	61.9	59.7	56.3	65.7	64.7
<u>Occupation</u>					
White-collar workers	88.7	a/	82.8	90.5	89.8
Blue-collar workers	83.0	a/	73.8	84.0	86.8
Service workers	72.5	a/	68.1	73.7	74.2
Private household workers	55.7	a/	59.9	50.1	57.5
Farmworkers	54.5	a/	50.2	51.0	58.5
Farmers and farm managers	65.9	a/	65.6	64.8	66.5
Farm laborers and foremen	37.0	a/	46.1	29.4	35.0

a/ Not available.

Source: U.S. Department of Health, Education and Welfare, Public Health Service, Hospital and Surgical Insurance Coverage; United States - 1968, Vital and Health Statistics, Ser. 10, No. 66, January 1972, and U. S. Department of Agriculture, Family Economics Review, September 1972, p. 15.

disability that prevented them from doing productive work in or out of the home often lacked coverage. Only 48 percent of the 2.6 million persons with such a disability had hospital insurance coverage. And, only 64 percent of the unemployed members of the labor force had hospital insurance compared with 84 percent of those who were currently employed.¹⁰

About 17 percent of the civilian population under age 65 (representing some 31 million persons) was still wholly uninsured in 1970. The percent of persons aged 65 and over who had private health insurance was generally much lower than that for other age groups, largely because of their coverage under the Medicare program.¹¹ Income is probably the most important factor in determining whether a family has hospital or surgical insurance. (See Table 4.) But medicaid protection applied to about 9- $\frac{1}{2}$ million poor families with children, at the end of 1970, and an additional 1- $\frac{1}{4}$ million poor, disabled and blind.

The post-World War II development of fringe benefits through collective bargaining and the growth of union-management health and welfare funds have been major forces in the tremendous growth of voluntary health insurance in the United States.¹² It is estimated that over three-quarters of health insurance is purchased on a group basis under employee benefit plans.¹³

In 1972 private health insurance paid about 80 percent of consumers' expenditures for hospital care. About 20 percent was paid out-of-pocket.¹⁴ Insurance pays about half of consumers' expenditures for physicians' services but this is a reflection of coverage for surgical fees being more complete than for ambulatory care by specialists and general practitioners.¹⁵ Over-all about 40 percent of consumer expenditures for medical care are met by private insurance. Public programs (Medicare, Medicaid, Defense Department) paid about half of the national expenditures for hospital care in fiscal 1971; about 60 percent of the expenditures for nursing-home care; about a quarter of the expenditures for physicians' services; and much lower percentages for other medical services.¹⁶

Effects of Factors Other Than Health Insurance

Fuchs and Kramer [1] examined the argument that both public and private insurance lower the net price of physicians' services to consumers inducing an increase in the demand for medical care and consequent higher total expenditures (i.e., both public and private). The hypothesis fitted the data in 1966-1968, when with the introduction of Medicare, the growth in expenditures coincided with a major increase in third-party payments. Indeed they found an absolute as well as a relative decrease in direct spending by patients after 1966. However, the upsurge in utilization of physicians' services before 1966 was not explained by increased insurance coverage,¹⁷ but by the increase in the number of physicians. Physicians recommend appropriate treatment and are responsible for increased utilization and costs when treatment is continually more expensive. There is little argument that the pattern

TABLE 4

Health Insurance Coverage Related
to Income Level

Income level	Percent of under age 65 population	
	Hospital insurance	Surgical insurance
Under \$3,000	36.3	34.8
3,000- 4,999	56.8	54.6
5,000- 5,999	78.5	76.7
7,000- 9,999	89.3	87.8
10,000 or more	92.3	90.7

Source: Medical Care: Costs and Prices,
op. cit., p. 97.

of private insurance coverage, and public programs (Medicare, Medicaid) have been responsible for patients' use of hospitals when less expensive ambulatory care would have been equally efficient.¹⁸ The demand for hospital care has also been a function of technological advance. Open heart surgery and kidney transplants, prime examples of advanced techniques, are performed in hospitals. Hospital costs have increased as supply factor cost increases have kept pace with increases in demand.¹⁹ Increased hospital costs could and have been passed on to consumers either directly or through continually increasing insurance premiums or increased taxes²⁰ and hospitals have been encouraged to produce a continually more technologically advanced and expensive product. Demand permitting, and competition not being extant in this industry, physicians and other suppliers of medical services have also been able to pass on increased costs through administered prices.²¹

Effects of Factors Underlying Supply

Supply curves for the components of medical care have shifted to the right as quantities of all of the components and the productivity of many have increased but, apparently not sufficiently, in any case, to make for any reduction in prices.

Problems related to supply include (1) a shortage of primary care since physicians to fulfill this function are in short supply; (2) an uneven distribution of medical services with an excess of some types of medical services and facilities in some areas and a shortage in others; (3) less than optimum utilization and shortages of health manpower in some categories; and (4) continually increasing costs of providing services not being offset by increases in productivity.²²

The shortage of physicians to provide primary care has been blamed on the higher earnings and prestige of specialists.²³ The ratio of physicians providing primary care (general practitioners, pediatricians, internists, obstetricians, and gynecologists) continues to decrease. They were 65 per 100,000 population in 1966; 59 per 100,000 in 1970.²⁴ The total number of physicians has actually increased somewhat in relation to the population. The ratio was 141 per 100,000 in 1950; 149 per 100,000 in 1966 and 159 per 100,000 in 1970.²⁵

Physicians and other providers of medical services are not evenly distributed. The six states with the highest per-capita incomes (California, Connecticut, Illinois, New Jersey, New York and Massachusetts) averaged 160 practicing physicians per 100,000 people in 1970. This was almost double the 87 physicians per 100,000 people in six less affluent states.²⁶

The difference in the ratios of general practitioners is small -- 22 to 27 physicians per 100,000 people. The difference in the availability of specialists is highly significant -- 29 per 100,000 in the six more affluent states; 14 per 100,000 in the less affluent. Within most states there are also differences with relatively fewer physicians in both rural and inner-city areas.²⁷ Similar disparities exist among

other categories of medical manpower.²⁸ Hospital beds and beds in nursing homes are not in short supply for the United States as a whole, but some remain empty because of their location and some are in old and low-quality facilities.²⁹ Medical manpower may or may not be in short supply.³⁰ The question of how they are utilized is relevant and there are wide differences in the numbers of personnel believed necessary because of variations in treatment methods, and regional practice. Evidence suggests many categories are not distributed in accordance with demand -- shortages exist in some areas and overages in others -- and some categories are in short supply throughout the United States.³¹ (Registered nurses, in part because large numbers of licensed nurses are not actively engaged in nursing; dental assistants; hygienists, et al.) Increases in productivity have occurred but have not resulted in lowering costs of medical care because demand has increased for more expensive procedures which are largely the result of technical progress.³²

Inferences

Since medical care, and concomitantly health insurance, are superior goods (demand is income elastic) implying that the demand will increase as income continues to increase, as consumers wish to reap the benefits from the increasing capabilities of medicine; and since the health-care industry is characterized by administered prices, supply shortages which will not be resolved in the short run, and continually increasing costs, in part due to continually more expensive technology, prices for medical care must be expected to continue to increase. Quantity demanded will also increase and the medical-care or health-care industry will continue to increase its share of the Gross National Product.

Policy Implications

Currently suggested "solutions" to the problems of the increases in consumer prices and consumers' consequent loss in welfare or lack of financial accessibility to medical care generally center around changes in the health-care delivery system or rather some of its institutions, and increasing insurance coverage, either under private sector insurance with government subsidies paying some premiums or under a governmental system such as social security.

The Health Maintenance Organization as a Solution to Consumer Medical Care Cost Problems

The Administration proposes to improve the health-care delivery system by encouraging the establishment of Health Maintenance Organizations. A Health Maintenance Organization has been defined by the Department of Health, Education and Welfare as "an organized system of health-care which accepts the responsibility to provide or otherwise assure the delivery of an agreed upon set of comprehensive health maintenance and treatment services for a voluntarily enrolled group of persons in a

geographic area and is reimbursed through a prenegotiated and fixed periodic payment made by or on behalf of each person or family unit enrolled in the plan."³³ Apparently there are many variations that fit this definition. Examples of prototypes are as various as the Kaiser Foundation Medical Program with a prepaid membership of 2,247,000 to the Family Health-Plan of Southern California which serves a few thousand families in the Long Beach, California, area.³⁴ In general, according to the Department of Health, Education and Welfare, an HMO should have the capacity to provide or arrange for any health services which a population might need to reasonably maintain its health. This, in some instances, may constitute simply a referral of the patient to needed care from some other source. As a minimum, there must be formal arrangements either to provide directly or to secure from some other source: ambulatory physician services, preventive services, in-patient hospital care, and emergency care. For Medicare populations, they are required to go further and provide or arrange for Part A and B benefits, including Extended Care Facility care, home care, and psychiatric care.³⁵

For the consumer, the Health Maintenance Organization while oftentimes more convenient (one-stop medicine) is not necessarily a less expensive solution or even a financially accessible solution.³⁶ Typical membership charges for a subscriber family with two or more dependents in the Kaiser Foundation Medical Program in Northern California in 1972 were \$50.57 a month, and typically an employer paid \$12 (although many employers paid more) and the subscriber \$38.57. In addition there were additional charges for pregnancies (\$60); visits to the doctor's office (\$1.00); house calls (\$3.50 or \$5.00 depending on the time); interrupted pregnancies (\$40) and drugs and prescriptions. There was no provision for dental care and limited provision for several other types of health-care.³⁷ Granted this is a far more inclusive package of services than that provided for under the Bureau of Labor Statistics' higher budget, it would still cost the consumer \$462.84 a year, before additional charges, in the typical case.

Obviously not everyone could be enrolled or could afford to be enrolled in a Health Maintenance Organization under present methods of financing health-care.³⁸ Moreover, while Health Maintenance Organizations keep prices for medical services from rising as rapidly as they might in other settings often because of the higher productivity of their physicians and other categories of medical manpower; lower hospital utilization rates by their subscribers; their emphasis, in their own interest, on preventive medicine; and their capability, when centralized, of greater administrative efficiencies,³⁹ they will probably not decrease the net quantity demanded of medical services. Any reductions they may effect would tend to be off-set by their offering more complete care and, especially if governmentally subsidized health insurance becomes more widespread, their increasing their number of subscribers.⁴⁰ Furthermore, subscribers, having prepaid, would find net out-of-pocket costs of services, despite deductibles, generally lower than under fee-for-service arrangements and might tend to increase their use of the

services.⁴¹

National Health Insurance as a Solution to Consumer Medical Care Cost Problems

Various national health insurance plans have been proposed in the last decade. (See Table 5.) For the most part the more recent ones, including the latest Administration proposal, have four features in common.⁴² They all provide for (1) Employee Health Insurance, in several cases to be paid for by employer and employee like the payroll tax; (2) deductibles; (3) government subsidies to underwrite premiums, in most cases for the unemployed, disabled, self-employed, low-income and high insurance risk groups; and (4) limits to the out-of-pocket payments that a household or a person would pay for covered services (medical expenses and included prescription drugs).

Although they contain deductibles, (in the case of the current Administration plan employers would pay 65 percent of the premiums for a minimum level of insurance coverage the first three years; and 75 percent thereafter; employees and their dependents would pay the remainder of the insurance premium cost -- 35 percent of the premium for the first three years directly and 25 percent thereafter -- plus a deductible of the first \$150 in annual medical expenses and the first \$50 for prescription drugs outside a hospital) it does not seem likely, in view of past experience, that increasing insurance coverage or government subsidies as the proposed bills would do, will decrease demand. And since increasing prices are due in large part to continually increasing demand, and national health insurance or the government's paying for medical care do nothing to increase the supply of medical manpower or facilities or encourage any increases in factor productivity or use of cost-saving technologies, prices can only be expected to increase further. Consumer costs for medical care paid directly and indirectly will thus continue to increase into the foreseeable future.

The problem can only be mitigated, not solved. All of the proposals for governmentally subsidized health insurance involve a reduction in, or tax deduction or credit for, individual direct payments and most would make it easier for low-income persons and others not covered by insurance or present government programs to meet medical bills, but what low-income persons, and others not paying fully, directly or through insurance, will not be paying will be paid through taxes. This then should be recognized as a complex form of income redistribution and the equity considerations embodied in all pending governmentally subsidized health insurance proposals, as well as the efficiency of their methods, should be argued in light of this premise.

TABLE 5

National Personal Health Care Expenditures Under Selected Proposals
by Source of Funds, Fiscal Year 1975
(in billions)

Proposal	Total	Private sector				Governmental sector			
		Total	Individual direct payments	Health insurance	Other	Total	Federal	State and local	Private premium payments ^{a/}
No bill	\$103.0	\$63.8	\$30.1	\$32.5	\$1.2	\$ 39.2	\$26.3	\$11.2	\$1.7
Mills-Schneebeil-Packwood	109.5	60.8	22.7	37.3	.8	48.7	32.2	10.2	6.3
Mills-Kennedy	112.3	32.7	20.3	11.7	.7	79.6	68.8	7.5	3.3
Ullman	114.0	64.2	16.1	47.4	.7	49.8	44.5	4.1	1.2
Burleson-McIntyre	111.0	62.6	21.9	40.0	.7	48.4	35.8	8.2	4.4
Fannin	107.0	63.6	26.6	36.0	1.0	43.4	31.7	10.0	1.7
Griffiths-Kennedy	116.0	13.3	9.9	3.0	.4	102.7	99.4	3.3	--
Fulton-Broyhill-Hartke	112.8	70.2	21.1	48.3	.8	42.6	34.4	6.5	1.7
Long-Ribicoff	107.4	59.9	28.1	30.9	.9	47.5	34.6	11.2	1.7

^{a/} Private premium payments under public programs.

Source: U.S. Department of Health, Education and Welfare, Estimated Health Expenditures Under Selected National Health Insurance Bills, 1974.

FOOTNOTES

¹Committee for Economic Development, Building a National Health-Care System, New York, April 1973, pp. 28 and 29. Data from U.S. Social Security Administration, Office of Research and Statistics. The difference between the amount spent for personal health-care and total national health expenditures in the United States mainly includes administrative costs for public health activities, medical facilities construction and research costs.

²Ibid., p. 40.

³U.S. Social Security Administration, Social Security Bulletin, Vol. 35, No. 1, January 1972, pp. 5 and 9, and idem, "Research and Statistics Note," No. 19, November 29, 1972, p.2.

⁴See Somers, Herman M., "Economic Issues in Health Services," in Contemporary Economic Issues, edited by Neil W. Chamberlain, revised edition, Richard D. Irwin, Inc., Homewood, Ill., 1973, p. 119; Victor R. Fuchs and Marcia J. Kramer, Determinants of Expenditures of Physicians' Services in the United States 1948-1968, DHEW Publication No. (HSM) 73-3013, December 1972, pp. 1-19; and Report of the Commission on the Cost of Medical Care, Volume 1, General Report, American Medical Association, 1964, pp. 57-76.

⁵U.S. Department of Labor, Bureau of Labor Statistics, Handbook of Labor Statistics, 1972, GPO, Washington, D.C., 1972, p. 291. The consumer price index for medical care and particularly its hospital care component has been accused of overstating the true price increases because of it not reflecting the improved effectiveness of a physician visit or a day in the hospital. Changes in costs of treating specified episodes of illness have been advanced as a more valid measure but Anne Scitovsky found, by measuring medical cost changes in terms of the average cost of treatment of five common conditions over a fourteen-year period (1951-1965) that the cost of treatment, with one minor exception, had increased significantly more than the medical care price index. See Anne A. Scitovsky, "Changes in Cost of Treatment of Selected Illnesses, 1961-1965," American Economic Review, December 1967, pp. 1182-1195.

⁶This is the Bureau of Labor Statistics' intermediate budget estimate for a family of four. The U.S. Department of Labor, Office of Information, Autumn 1972 Urban Family Budgets, Washington, D.C., June 15, 1973, p.2.

⁷Feldstein, Martin S., "The Medical Economy," Scientific American, Vol. 229, No. 3, September 1973, p. 151.

⁸Loc. cit.

⁹Loc. cit.

¹⁰U.S. Department of Agriculture, Family Economic Review, September 1972, p. 16.

¹¹U.S. Department of Health, Education and Welfare, Social Security Administration, Medical Care Costs and Prices: Background Book, GPO, Washington, D.C., January 1972, p. 96.

¹²Somers, Herman M., op. cit., pp. 131-132 and W. W. Kolodrubetz, "Employee-Benefit Plans in 1966," Social Security Bulletin, April 1968, p. 29.

¹³Source Book of Health Insurance Data, 1971-1972, Health Insurance Institute, New York, N.Y., 1972, p.16.

¹⁴Feldstein, loc.cit.

¹⁵Medical Care Costs and Prices: Background Book, op. cit., p. 101.

¹⁶Ibid., p. 88.

¹⁷Fuchs and Kramer, op. cit., p. 88.

¹⁸Feldstein, loc. cit.

¹⁹Feldstein, op. cit., p. 154, and The Rising Costs of Hospital Care, U.S. Department of Health, Education and Welfare, Washington, D.C., 1971, pp. 74-77.

²⁰Feldstein argues that since net out-of-pocket costs for hospital stays have remained much the same in constant dollars since 1950, consumers are willing to buy more expensive care than if they were not insured, loc. cit.

²¹Medical Care Costs and Prices, op. cit., pp. 111-112 and 115-116.

²²Committee on Economic Development, Building a National Health-Care System, pp. 32-34.

²³Ibid., p. 32.

²⁴American Medical Association, Distribution of Physicians in the United States, 1970, Chicago, 1971. The figures do not include physicians employed by the Federal Government.

²⁵American Medical Association, Reference Data on Socioeconomic Issues of Health, Chicago, 1971, p. 24.

²⁶Committee on Economic Development, op. cit., p. 32.

²⁷See Haug, J. N. and G. A. Roback, Distribution of Physicians, Hospitals and Hospital Beds in the U.S., 1969, Vol. 1, American Medical Association, Chicago, 1970, p. 11 and idem, 1970, American Medical Association, Chicago, 1971, pp. 111-~~113~~.

²⁸McNerney, Walter J., "Why Does Medical Care Cost So Much?", The New England Journal of Medicine, Vol. 282, No. 26, June 25, 1970, p. 1459.

²⁹Committee on Economic Development, op. cit., p. 33.

³⁰The problem of a stratified professional hierarchy and the reluctant acceptance of physicians' assistants and similar groups, in many cases because of fear of malpractice suits, which obviates against the most efficient use of medical manpower, deserves mention.

³¹Committee on Economic Development, op. cit., p. 34, and McNerney, op. cit.

³²Feldstein, The Rising Cost of Hospital Care, op. cit., pp. 36-51, and Report of the Commission on the Cost of Medical Care, op. cit., p. 135-137.

³³U.S. Senate, Subcommittee on Health of the Committee on Labor and Public Welfare, Health Maintenance Organizations: Questions and Answers Relating to Subcommittee Questionnaire, GPO, Washington, D.C., 1972, pp. 9 and 10.

³⁴Ibid., p. 45 and Milton I. Roemer, et al., Health Insurance Plans, Studies in Organizational Diversity, University of California, School of Public Health, Los Angeles, 1970, passim.

³⁵Health Maintenance Organizations: Questions and Answers. . ., op. cit., p. 49.

³⁶However, when full costs are considered it may be the lowest cost alternative for providing health services under our present arrangements in the United States. See Herman M. Somers, "Economic Issues in Health Services," op. cit., pp. 140-142. Ultimately whether or not the Health Maintenance Organization will become the predominant institution for the delivery of medical care depends, in large part, on whether or not it is supported by physicians. Physicians support, in turn, depends upon whether the institution furnishes sufficient incentives, still a problematic area. Quality of care in HMO's appears to be no better and no worse than in private practice at least judging by malpractice insurance premiums. See Richard C. Auger and Victor P. Goldberg, Prepaid Health Plans and Moral Hazard, unpublished manuscript, University of California at Davis, 1973, passim, and particularly p. 46, and Proceedings of the Health Maintenance Organization Conference, Golden Empire Comprehensive Health Council, April 15, 1972, Sierra College, Rocklin, California, 1972.

³⁷Information from Kaiser Foundation Medical Program.

³⁸Health Maintenance Organizations: Questions and Answers. . ., op. cit., p. 82.

³⁹Committee for Economic Development, op. cit., pp. 56 and 57; Auger and Goldberg, op. cit., pp. 36-46; and Golden Empire Comprehensive Health Council, op. cit., pp. 29-46.

⁴⁰Marketing activities of prepaid health plans in California are now notorious. See Victor P. Goldberg, "Some Emerging Problems of Prepaid Health Plans in the Medi-Cal System," unpublished manuscript, University of California, Davis, 1973.

⁴¹Auger and Goldberg, loc. cit.

⁴²See U.S. Department of Health, Education and Welfare, National Health Insurance Proposals, Provisions of Bills Introduced in the 93rd Congress as of February 1974, Washington, D.C., Government Printing Office, 1974; and Estimated Health Expenditures Under Selected National Health Insurance Bills, A Report to Congress, Government Printing Office, July 1974, and the digest of the Nixon Administration's Statement on the New Comprehensive Health Insurance Plan, reprinted in the Sacramento Bee, February 16, 1974, p.1.

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