Medical Prices and Their Control

by ROBERT M. BALL*

During 1968, the Social Security Administration sponsored a series of regional conferences on Health Care Costs, designed to bring together the leaders of the health community and the insurance industry, consumers, and purchasers (both government and private). The conferences aimed at approaching the problem of rising health care costs at the State and local level by stimulating experiments and innovations, with incentives for cost effectiveness, in the organization and delivery of health care services. At the last of the nine conferences, the Commissioner of Social Security delivered the address that follows.

SINCE MOST of the time at this conference will be spent in talking about the problems and difficulties of providing quality medical services and pricing these services—and about the frustrations and the barriers to improved performance—let me begin by reminding you that our difficulties arise from success. It is the fantastic success of modern medical research and the success of modern medical practice at its best that has thrust upon us the problems and difficulties that we will be dealing with at this conference.

A relatively short time ago, hospitals were primarily shelters for the dying. Contact with the physician only slightly increased one's chances of health or life. In those times, issues related to the provision and pricing of medical services were of relatively minor national interest.

Today the great majority of Americans know that medical care can mean the difference between health and disability or life and death. This knowledge has created a demand for health services, which is unprecedented in both size and intensity and which includes both new and expensive procedures and the extension and improvement of care to the impoverished. It is, then, the great professional success of the health field that has made the organization, delivery, and pricing of medical care a matter of great national interest today.

ACCESS TO MEDICAL CARE SERVICES

Because of our conviction of their efficacy, concern for the availability of medical care services now ranks with concern for the availability of other basic needs of life—air, water, food, and shelter. As we talk about the greatly increased cost of medical care, we shouldn't lose sight of the fact that care is also much more valuable.

This belief in the great importance of having access to medical care, which grows out of the success of the health professions, can be illustrated in many ways. For example, when the Medicare program first came into being, we signed up under the voluntary part of the program over 90 percent of all the older people in the country. The percentage was, no doubt, significantly higher as a proportion of the number of people who had actually been reached with an effective story about their opportunity to sign up. It rose to 95 percent of the whole aged population in the first open enrollment period, and this happened even though the people involved are, by and large, a very low income group and they are required to pay currently toward the protection out of their meager income.

Many people felt very strongly about making absolutely sure that they got this protection. Some of you will recall that in the initial enrollment period we mailed out a card to all social security beneficiaries and other older people whose addresses we had. The card was a punchcard with the individual's name and account number prepunched in it. On each card there were two blocks that an individual could check—"yes" if he wanted the insurance, and "no" if he did not. (We included the "no" because we wanted to be sure of an answer of some sort from everyone and know that they had really considered the question.) One man was so anxious to make sure that he got the protection—he wasn't going to take any chance on the Government slipping up—that he not only checked the "yes" block, but he took a pair of scissors and cut the "no" right out of the card. I'm not sure that our computers have recovered from trying to process a card like this even yet!

* Commissioner of Social Security. Address presented at the New York Regional Health Care Cost Conference, January 9, 1969.

PROBLEMS OF MEDICAL CARE COSTS

There is no doubt but that the problems considered here are primarily those that arise from success. This fact doesn't make the problems any easier to deal with and certainly no less real. But keeping this fact in mind may help our perspective. It is not at all true—in the area of health care, at least—that the human condition is deteriorating and that matters are going from bad to worse. The truth is rather that invention and skill, contributing greatly to the quality of life, the capacity for enjoyment, and the reduction and elimination of suffering have for the time being somewhat outpaced old forms of social and economic organization.

It is not the intention here to add to individual and professional frustration through exhortation or to throw down a challenge that I know is already keenly felt. We all know the challenge. We all know that we must find ways to provide access to high-quality medical care for all Americans, to reduce the incidence of illness to the extent possible, and to preserve and enhance the conditions that lead to further gains from medical research and improved practice.

The specific topic of medical costs is important insofar as it is related to these larger goals, and it is importantly related. With the intensity of demand that presses against scarce resources, we have a basic set of conditions that require conscious effort to control costs and resource allocation if we are to move toward our broad goals rather than away from them.

Our discussion here is directed at actions that can be taken by the people and groups represented at this conference—actions that can be taken by physicians and hospital administrators, by businessmen and labor unions and other representatives of consumers, and by insuring organizations and all the other groups connected with decisionmaking in our largely decentralized, largely uncoordinated, and largely voluntary system of health care.

The purpose of the conference is for you to determine what you can do about the problems that confront us. It is as each group with a major stake in the solution accepts its share of responsibility and shows a willingness to work with others that we will move forward. This is not, then, a conference to rehash recommendations about what the Federal Government should do or really what anyone else should do but rather to discuss what those assembled here can do, or recommend and press for.

I intend, therefore, to suggest only the barest outline of the factors that enter into the medical care cost problem, as I see it. If it is a structure that helps your thinking along toward action, good. If not, I'm sure you will adopt what for you is a more practical structure.

Although I think it is quite clear that in the future just about everyone is going to have an intense desire for quality medical services and although I believe that we will not be content in the long run to have access to those services depend upon people's income level—in other words, in economic terms just about everyone in the population will represent an effective demand for services—it does not follow that we are helpless in relation to the demand side of the economic equation. In fact, I would be willing to argue that perhaps our best hope is to reduce the incidence of unnecessary illness, to prevent illness that does occur from getting worse, and to relieve the demand pressure on the most expensive facilities by redirecting that demand, as appropriate, to less expensive ways of treatment.

UTILIZATION OF RESOURCES

For example, in many discussions of the increase in hospital costs that I see, it seems to me that there is an undue concentration on the increase in average daily hospital costs. These increases have, of course, been an important and disturbing phenomenon, but it is even more important and more disturbing if, as I suspect is true, they result partly from the unnecessary use of such expensive health resources. In part the excessive use of acute hospital care indicates a shortage of convenient and workable alternatives. This sort of imbalance among alternative modes of care is not necessarily self-correcting. Excessive use of a hospital may well result in attempts to justify additional beds for the care of acute illness instead of an increase in the supply of alternative modes of care.

The problem of providing economical medical care is community-wide in focus rather than institutional. By analogy, in our inspection of the

problem we need to use both a wide-angle lens and a microscope. Certainly, we should be striving to hold down daily hospital costs. But isn't it even more important to reduce the need for hospital care by emphasis on prevention and early treatment, by the provision of less expensive alternatives to hospital care when they are appropriate, and by discharge from the hospital at the earliest appropriate moment?

As we do a better and better job in providing the appropriate level of care and as we do a better and better job in prevention and early treatment of illness, it is quite possible that the improvement would even contribute toward increasing average hospital daily costs. The patients left in the hospital would tend to be only those needing the most expensive types of care and also with shorter average stays there would be a further tendency to concentrate services. Obviously, however, the cost of illness to the community would be reduced.

Several practical points come immediately to mind in connection with these matters just outlined: what do we do to put more emphasis upon services emphasizing prevention and early treatment, and what do we do to reduce unnecessary hospital admissions and long stays? How much could we improve health and reduce community health costs through such means as more widespread testing for cervical cancer, early treatment of hypertension and diabetes, better spacing of births, the early treatment of handicapping conditions of children, a reduction in the popularity of smoking, and improvements in the nutrition of children and teenagers?

With regard to organization, is it true that group-practice prepayment plans, by removing financial barriers to prevention and early treatment and by their comprehensive coverage of all health services, move effectively in this direction? Are there ideas to be learned from group-practice prepayment plans and perhaps applied elsewhere by those not willing to accept the whole approach, including a closed panel? How effective can we make peer-group utilization review? Would broader scope of coverage under commercial insurance arrangements and Blue Cross-Blue Shield plans also move in this direction?

It is not only coverage of preventive care and the encouragement of early treatment and the insurance coverage of less expensive alternatives to hospital and other institutional care that is needed, but a deliberate effort to make such services more widely distributed.

In other words, part of the solution to the problem is to remove the incentives that now exist when insurance coverage emphasizes hospitalization and does not cover less expensive alternatives. But another part of the solution lies in making sure that communities have well-organized home health services, extended-care facilities, nursing homes, clinics, and good outpatient departments of hospitals. Such facilities do not necessarily spring automatically into being as a result of insurance coverage.

So, on the supply side, the problem in part comes down to planning for the provision of appropriate levels of care—the organization of the services that make it possible for people to stay at home rather than go to a hospital, the organization of services that make it possible to leave a hospital at as early a point as possible, and the organization of institutional services that sort out cases depending upon the intensity of care needed. This is all an important part of fully utilizing scarce resources without reducing the quality of care.

So, too, are the efforts to conserve the services of highly skilled personnel so that technicians and helpers do what they can do adequately and those who are more skilled are allowed to concentrate on the more difficult situation. Obviously, we cannot possibly make up for our present shortages of physicians and nurses and other highly skilled members of the health profession in any near-term period if they continue to work as they now work. The only possible road, while we encourage more people to go into these professions, is at the same time to increase supply by making sure we don't waste scarce skills— that we do use lower skills where lower skills are appropriate and that we use the help of modern technology, as in automated laboratories, for example, wherever that is appropriate.

But the problem on the supply side of the equation is not all a matter of scarcity. There is also in some areas and in connection with some facilities a problem of oversupply and duplication of expensive facilities. Empty beds in some hospitals and expensive equipment that can be used only infrequently result in accumulated

standby costs that are passed on in price. In an area where competition cannot be expected to be very effective there is no practical alternative to community control through areawide planning that prevents overbuilding and encourages a reasonable concentration of expensive equipment and a planned arrangement of facilities.

In attempting to present a broad framework of the cost problem I am obviously not trying to be exhaustive, but there are two other elements in the picture that I would like to mention, at least briefly. One is the question of voluntary restraint in price setting and the other is the matter of incentives to economical and quality performance.

MEDICAL CARE PRICE-SETTING

Where great demand presses against a scarce supply of services, the supplier is clearly in a position to significantly increase his income. This is what has been happening as far as physicians' services are concerned. The result has been brought about in various ways, sometimes as a result of seeing more people but for shorter periods, sometimes by charging separately for procedures that were once covered under a single fee, and also, of course, through the charging of higher fees. Incomes have increased, too, because programs like Medicare now pay customary fees for services that frequently were either rendered for a lower-than-usual fee or rendered free. Ordinarily, in a free market substantial increases would be expected under the conditions I have described.

However, in connection with an essential service that people have come to consider a matter of the greatest importance, the public will resent any appearance of "taking advantage" of the scarce situation to make what is considered unduly high incomes at the expense of the paying public. Thus, we find that many leaders of the medical profession are counseling voluntary restraint on the part of physicians and urging them to limit their increases in fees to what is justified by increases in costs. Listen, for example, to President Dwight Wilbur of the American Medical Association speaking in Miami on December first. "We cannot afford, " he said, "to permit costs to rise any more than absolutely necessary beyond the inflationary increase in our national price structure."

One difficulty in accomplishing this goal, which is a very important one for the public relations of the entire profession, is that there are always some people in any profession who care more for themselves than for the good of the whole. I suspect, therefore, that the medical profession may have to give more attention than it has so far to attempts to control in one way or another the excesses of the minority in order to preserve a posture of reasonable voluntary restraint. The alternatives of widespread public indignation with demands for governmental control and fee fixing are fraught with all sorts of problems and dangers and ought to be avoided if at all possible.

For many years before the passage of the Medicare legislation, physicians had chafed under what they thought were unduly restrictive fee schedules imposed by third-party payers and had long advocated the development of programs that would cover their individual customary fees for professional services, limited only by prevailing fee levels for similar services in their respective communities. The Medicare law basically adopted the position physicians had so long advocated. This entire concept and approach is now undergoing a very real public trial.

One year ago it was necessary for the Secretary of Health, Education, and Welfare to initiate a substantial increase in the premium for the supplementary medical insurance part of Medicare, about a third of which was attributable to the continually rising cost of physicians' services. Last week in Washington, the Secretary was again faced with actuarial recommendations that the premium be increased for the fiscal period beginning next July 1. In the face of those recommendations, he made a decision to retain the existing premium rate and coupled that decision with an urgent plea to the doctors of the Nation to exercise a maximum of restraint in their charging practices during the next 18 months. He also directed the Social Security Administration to take all possible steps to maintain program payments within the income limitations provided by the existing premium rate. Consumer groups, the Congress, and the Nation will be carefully watching cost trends during

the next 18 months to see whether a program based largely on customary and prevailing charges can be kept within reasonable cost limits.

FINANCIAL INCENTIVES FOR ECONOMICAL AND QUALITY PERFORMANCE

The final area that I wish to briefly explore is the idea that we may be able to design ways of setting up financial incentives for the improved management of health care organization, financial incentives for the better utilization of services, and financial incentives that in a variety of ways could lead to the more economical operation of health care institutions without lowering quality.

It is quite true in the area of hospital services, for example, that today a very high proportion of care is paid for on the basis of reimbursing for the cost of that care as long as the cost is "reasonable." This is an approach used widely by Blue Cross and, of course, used in Medicare and Medicaid. It is an approach with certain advantages. It guarantees continued payment for an improved level of care that quite frequently costs more than the old level of care. It underwrites innovation and improvement. At the same time, it is quite true that the method does not provide in itself any incentive for an institution to economize in the delivery of services. It does not follow that there are no other incentives—but it is quite true that the method of cost reimbursement does not in itself supply additional incentives. It certainly would be well to do so if we can develop practical plans.

Basically, the hospital is the work place of the physician and he correctly is interested in its being of the highest quality. For the benefit of his own patient he tends to want everything to be available and to be of the best. Yet, individually, he has no real stake in the economical operation of the hospital. He tends to be a policymaker without the cost restraints that are imposed on most policymakers. If the administration of the hospital, as distinct from the medical staff, has a guarantee of being reimbursed on a cost basis, there is not very much in the way of economic restraint to balance against the push for increased expenditures—even when those expenditures involve large standby costs or are to an extent largely convenience or prestige items.

Much of the very sizable increases in hospital costs can be at least superficially explained by reference to the specifics of more expensive procedures and the need for hospital wages to catch up competitively with wages elsewhere in the economy. But the gnawing doubt that remains is whether, on the average, the productivity of hospital labor could be increased and whether the management of hospital resources could be improved if there were specific incentives leading in those directions.

We are, therefore, now engaged in a nationwide attempt to develop sound incentive reimbursement experiments as authorized by the Congress in the 1967 social security amendments. Four experiments have been approved and are getting underway, and many others are nearing the approval stage. To date there have been over 500 expressions of interest in the program, and many of these will likely result in practical proposals. Here is an opportunity to move from theory into experimentation.

SUMMARY

In summary, I think it can be said that the knowledge—and the means of using it—are accumulating in the many areas affecting health care costs. There are a variety of choices—choices that may help restrain increases in health care costs and provide more effective health services to the people you serve.

You are the deciders—the choicemakers—the "doers" on home grounds. And it is with you that the ultimate solutions to present problems in the delivery of health care will find expression.

There is special significance to these conferences that the health field and consumer interest may not have fully realized. Although they were called by the Secretary of Health, Education, and Welfare, the conferences constitute a recognition of the key role of the private sector in drawing the blueprints for tomorrow's health care system. For those who have long expressed apprehension that the Federal Government would ultimately have to "take over"—and there are many who do entertain these fears—

these conferences offer not just evidence of our faith in the voluntary approach but an opportunity to demonstrate the vitality and capability of the field to design and implement the changes necessitated by a rapidly changing technology and the increasing needs of the American people for an improved delivery system of health services.

In the past there has been a tendency for the various segments of the health field to deal separately with the development of new ideas and solutions to problems. Hospitals have met with hospitals at national, State, and local levels. Physicians have tackled problems within the circles of their own professional organizations. This is the pattern that has pervaded the deliberation of other providers of health services and extended itself into paramedical groups. And almost completely beyond the pale has been the consumer whose dollars are being spent and for whom the total system operates. Now, within the framework of these conferences, we have a broad mix of interests, where people can talk across the table—providers, health insurers, and consumers—each contributing his specialized knowledge and perspective. Perhaps one of the long-range benefits we may derive from these meetings is that the individuals and organizations represented here will seek to meet from time to time in other forums and under other auspices to continue the exchanges we have here and to translate agreements into continued action.

Recent Publications*

SOCIAL SECURITY ADMINISTRATION

BUREAU OF FEDERAL CREDIT UNIONS. *State-Chartered Credit Unions, 1967.* Washington: The Bureau, 1968. 21 pp.

Operating statistics based on summary data from State supervisory authorities and credit union officials.

OFFICE OF RESEARCH AND STATISTICS. *Reimbursement Incentives for Hospital and Medical Care: Objectives and Alternatives.* (Research Report No. 26.) Washington: U.S. Govt. Print. Off., 1968. 80 pp. 45 cents.

Presents legislative history of reimbursement formulas and analysis of various types of reimbursement plans.

OFFICE OF RESEARCH AND STATISTICS. *Social Security Household Worker Statistics, 1964 (With Selected Preliminary Estimates for 1965).* Washington: The Office, Sept. 1968. 31 pp.

OFFICE OF RESEARCH AND STATISTICS. *Social Security Programs in the United States.* (rev. ed.) Washington: U.S. Govt. Print. Off., 1968. 120 pp. 55 cents.

Information on the development and status of all major public income-maintenance programs, health insurance and medical assistance under the Social Security Act, and private employee-benefit plans.

OFFICE OF RESEARCH AND STATISTICS. *Social Welfare Expenditures Under Public Programs in the United States, 1929–66,* by Ida C. Merriam and Alfred M. Skolnik. (Research Report No. 25.) Washington: U.S. Govt. Print. Off., 1968. 254 pp. $2.

Presents historical and trend data that measure the growing involvement of government in social welfare programs and activities; data relate to public programs directly concerned with income security and the health, education, and welfare of individuals and families.

SOCIAL AND REHABILITATION SERVICE

COHEN, WILBUR J. "Rehabilitation in the Seventies." *Rehabilitation Record,* vol. 9, Nov.–Dec. 1968, pp. 1–3. 30 cents.

Effects of recent legislation on the rehabilitation program in the next decade.

GENERAL

BERLIOZ, CHARLES. "Inventory of Measures and Services Designed to Promote Rehabilitation in Social Security Institutions." *International Social Security Review,* vol. 21, 1968, pp. 3–131. $1.80.

Detailed analysis of the replies to a questionnaire.

CULBERTSON, JOHN M. *Marcroeconomic Theory and Stabilization Policy.* New York: McGraw-Hill Book Co., 1968. 549 pp. $12.50.

HALL, PERRY B. *Family Credit Counseling: An Emerging Community Service.* New York: Family Service Association of America, 1968. 127 pp. $8.75.

Report on a study of family credit counseling provided through nonprofit, community-based programs.

HOGSETT, STAN. "The Complexities of Federal and State Relationships in Workmen's Compensation." *Rehabilitation Literature,* vol. 29, July 1968, pp. 194–197. 50 cents.

KITTNER, DOROTHY R. "Negotiated Health and Retirement Plan Coverage." *Monthly Labor Review,* vol. 91, Dec. 1968, pp. 24–28. 75 cents.

Emphasis on estimated coverage in 1960–66.

LOREN, EUGENE L., and BARKER, THOMAS C. *Survivor*

(Continued on page 23)

* Prepared in the Library, Department of Health, Education, and Welfare. Orders for items listed should be directed to publishers and booksellers; Federal publications for which prices are listed should be ordered from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.