ES. to the NEWS
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CUTTING HOSPITAL COSTS

With its continuing faith in the :p::Mer of goverrnnent to supersede eoonanic forces, the Carter Administration s:ponsored a bill to force hospitals to cut costs by threatening them with federal controls. The House Comnerce Ccmnittee, apparently unconvinced that federal controls on hospital costs would solve the problem any better than price controls on other cormodities, gutted the Carter bill this rronth and passed a watered-dc:wn version.

As approved by the ccmnittee, t...l-ie bill now asks hospitals to cut their inflation by two percent this year and a.."Dt.11er two percent next year. It also provides for federal aid to states to set p their own cost control plans and for a presi-dential ccnmission to monitor cost-cutting efforts.

While the cmmittee deserves kudos for rejecting.federal controls, its alternative misses the boat. Th.e soaring cost of hospital care is a national problem, but it won't be solved by federal controls or rroral suasion. Neither Carter's plan nor t...½e ccmrittee's substitute bill addresses the econanic forces underlying the escalation L hospital costs.

Unlike ccmpetitive business enterprises, rrost hospitals are nonprofit organ izations. The consumer (t.11.e patient) has only in-perfect knowledge of the product (medical care) and little basis for caupa.rative evaluations.

Efficient, canpetitive conditions are also hampered by the financial structure of hospital-care delivery. For one thing, rrost hospital services are covered l::y gover:nrnent or private health insurance or sare other type of prepay:rrent. The patient has little financial incentive to refuse extra medical care, since the bills will go to Medicare, Medicaid, or an insurance company.

Secondly, rrost of t...l-iese third-party payers reimburse hospitals on the basis of their reported costs. This practice, writes noted health econanist Victor Fuchs, "appears to be an open invitation to inefficiency." Not only does the

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patient lack an economic incentive to go hane as soon as possible, but the hospital profits by keeping him in bed and performing tests and services that are not strictly necessary.

Other noncoITp=titive features of the hospital industry include the rigid rredical job categories which prevent assistants from perfonning many simple tasks now limited to physicians.

Sane people try to blarre the high cost of health care on the doctors. Although physicians have a high average incare, they must prepare them.5elves by the longest, most expensi-ve, and most rigorous training period of any profession. Even so, doctors' fees amount to less than 20 percent of total health-care costs. The bulk of the e}..'I:Jeilditures goes to cover hospital expenses exclusive of payments to physicians.

The unique structure of the hospital system demands a solution that offers an econa:nic incentive to at least one of the parties involved in health trans actions -- the hospital, the patient, or the insurance program -- in order to keep costs da.vn and to limit hospital care to what is essential.

One possible alternative to the current cost basis of reimbursement by insurance canpanies or the government is to calculate a rei.'1\bursement schedule based on the average costs of hospitals of similar characteristics throughout a region. Hospitals of belav-average efficiency would be forced to cut costs to survive, while more-efficient hospitals would profit by the extra incare. As tle hospitals introduce cost-cutting measures, the average costs would gradually decline and the reirrburserrent schedules would be adjusted appropriately.

Blan.. et federal controls by an ever-expanding bureaucracy and pleas for self-policing, such as those included in different stages of the bill nav in Congress, have never successfully reduced prices. It is time we try containing costs by incorporating incentives in the financial end of hospital care.

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