

A RAND NOTE

AUSTERITY IN PUBLIC MEDICAL CARE PROGRAMS:
MISERLINESS OR ECONOMIC RESPONSE?

Joseph P. Newhouse

November 1982

N-1912-HHS

Prepared for

The U.S. Department of Health and Human Services



The research reported herein was performed pursuant to Grant No. 016B-80 from the U.S. Department of Health and Human Services, Washington, D.C.

The Rand Publications Series: The Report is the principal publication documenting and transmitting Rand's major research findings and final research results. The Rand Note reports other outputs of sponsored research for general distribution. Publications of The Rand Corporation do not necessarily reflect the opinions or policies of the sponsors of Rand research.

A RAND NOTE

AUSTERITY IN PUBLIC MEDICAL CARE PROGRAMS:
MISERLINESS OR ECONOMIC RESPONSE?

Joseph P. Newhouse

November 1982

N-1912-HHS

Prepared for

The U.S. Department of Health and Human Services



PREFACE

This Note was written for publication in the "Upon Reflection" column of the Journal of Health Economics. It discusses an interpretation of current health policy which differs somewhat from that widely discussed in the media. Preparation of this Note was supported by the Health Insurance Study grant from the U.S. Department of Health and Human Services.

The author is grateful to Anthony Culyer and Mark Pauly for comments on an earlier draft.

SUMMARY

Recent American cutbacks in public medical care programs are often assumed to reflect the conservative ideology of the Reagan Administration, but may in fact reflect the slowed growth of real income and the continuing rise in medical care prices. Moreover, the reductions in Medicaid may well be greater than in Medicare because of the greater secondary benefits of the latter (benefits to spouses and children). The concept of secondary benefits may also explain why old-age pensions are difficult to reduce, but long-term care is widely perceived as not well supported.

AUSTERITY IN PUBLIC MEDICAL CARE PROGRAMS:
MISERLINESS OR ECONOMIC RESPONSE?

Many have deplored the new era of austerity--some would prefer a more pejorative term--in United States public sector budgets for health programs. Typically, however, critics have suggested that recent reductions only reflect the conservative ideology of the Reagan Administration and that if a more liberal administration came to power, programs to finance and deliver medical care services would be pursued with renewed vigor. But the ideological explanation of the reductions has an economic competitor. The economic explanation is not as dramatic, and not as filled with heroes and villains, but it could well have more predictive power. Distinguishing these explanations may be of general interest, because retrenchment in health programs is also being contemplated or pursued in a number of countries.

According to Mark Pauly's (1971) well-known model of public medical care programs, the taxpaying public desires to transfer an amount of real services that depends upon their income as well as the price of medical services. Thus, over time, assuming stable preferences and other factors constant, we should expect:

- (1) Changes in transfers through
public medical care programs = (Income Elasticity
for Transfers) (Change in Real Income of Voting Public) -
(Price Elasticity for Transfers) (Change in Medical Prices).

Granneman (1980) has estimated the parameters of this equation for the Medicaid program (the American program for certain poor families and individuals). He suggests that the income elasticity of the program is around 1.2, and is over 2 for the Aid to Families with Dependent Children (AFDC) portion. He estimates the price elasticity for real services at -0.9.[1]

Given the difficulties of (a) knowing the appropriate price and income series to use, (b) knowing the appropriate lag structure, and (c) holding all else such as perceived national security constant, I have not tried to use Eq. (1) to determine how well income and price changes predict actual changes in the Medicaid program. But the recent data are qualitatively consistent with the predictions of the economic model. (Orr (1976) finds that a similar model applies to the cash transfers of the AFDC program.)

Growth in real national income has slowed in the United States in recent years. While real national income grew 5.2 percent annually from 1960 to 1970, and 3.5 percent annually from 1970 to 1978, it grew only 1.8 percent from 1978 to 1981.[2] Moreover, given the expansion of other transfer programs, such as old age pensions and disability insurance, the growth in real income among the taxpaying public probably slowed even more, increasing resistance to further transfers. For example,

[1]The numbers in Granneman's paper are expenditure elasticities; the -0.9 figure comes from adding the two price elasticities and subtracting 1.

[2]Unless otherwise cited, the figures are calculated from data in the Economic Report of the President. Here and elsewhere I have used the GNP deflator as a price index for all goods and services and the Consumer Price Index for Medical Care Services as a price index for medical services.

between 1978 and 1981 transfer payments to persons grew 5 percent per year in real terms. At the same time, the relative price of medical care services was growing about 2 percent per year faster than the GNP deflator.[3]

Granneman (1980) has elaborated Pauly's model somewhat. He points out that changes in income and price, in addition to their direct effects on the size of the aggregate transfer, exert indirect effects on desired transfers per beneficiary by affecting the number of beneficiaries. A cyclical downturn expands the number of beneficiaries, and the desired transfer per beneficiary falls.[4] This enhances the general perception of cutbacks in the transfer programs. An increase in the price of medical services can have a similar effect by reducing consumption among not fully insured consumers; if, as a result, some individuals fall below the level of consumption deemed socially optimal, the number of beneficiaries would increase and the desired transfer per beneficiary would decrease.

Perhaps as a result of reduced income growth and increased prices, the Reagan Administration's budget for FY83 includes proposals to reduce Medicare (the transfer program for the aged) by 3 percent and the federal share of Medicaid by 10 percent over what they otherwise would have been (Budget of the United States, 1982). The rate of growth of

[3]Had I used the overall Consumer Price Index instead of the GNP deflator as a numeraire, the increase in the relative price of medical care services in the 1970s would have been smaller and the relative price would have fallen in the 1978-81 period. I believe the weight of home mortgage interest rates in the CPI probably makes the CPI a less desirable measure of the price of all goods and services for Pauly's model than the GNP deflator.

[4]In effect, the increased number of beneficiaries increases the price to the taxpayer of any statutorily defined benefits; hence, there is an inverse relationship between benefits per beneficiary and the number of beneficiaries.

the programs would be slowed considerably by these proposals; indeed, if the proposals were enacted, federal expenditures on the Medicaid program would only rise at a 4 percent annual nominal rate for the next three years. The prospect of negative real growth under these conditions seems highly probable.

Although the Reagan Administration's proposals are not yet law, few would doubt that the rate of growth in both Medicare and Medicaid will slow. Indeed, even prior to the Reagan Administration, the Medicaid program was declining in real terms. From 1978 to 1980 the real annual growth rate of the Medicaid program was -3 percent, although from 1970-78 it had grown at a 9 percent real rate (Gibson and Waldo, 1981). The Medicare program fared better, continuing to grow at a 9 percent real rate in both periods, but the Administration proposals would restrict Medicare to a 6 percent annual growth rate in nominal terms from 1982-1985; this too seems likely to result in negative real growth.

Of course, the proposed reductions in the medical transfer programs could reflect ideology. It is probably impossible to show that the tastes of the median voter have or have not changed in favor of less redistribution. But economists usually prefer predictions that come from the assumption of stable preferences, while the press seems to focus nearly exclusively on presumed changes in ideology among the electorate.

The distinction between the economic and ideological explanations is not just a matter of taste, because the two explanations can lead to quite different predictions. The ideological explanation implies that the cuts will be reversed if an administration with a different ideology comes to power (i.e., the tastes of the median voter could change

again), even if real income continues to grow slowly or fall and prices continue to rise, while the economic explanation suggests that the transfer programs could continue to fare badly unless the relative price of medical care ceases to increase as rapidly or unless the growth of real income picks up. The economic explanation also suggests that reductions could occur in many countries, because the combination of rising medical prices and lower real income growth is certainly not limited to the United States.

The argument thus far applies in principle to all public sector transfer programs and, although often overlooked in the din of daily debate, is well known among economists. Of somewhat greater novelty is the question of whether economic or political-economic factors can explain the seemingly more favorable treatment of Medicare than of Medicaid. One's first response may be that the Medicare population contains many more primary beneficiaries who vote: The aged outnumber Medicaid-eligible voters by at least a factor of five. But this is too simple. The greater number of beneficiaries makes any given increase in dollars per primary beneficiary of the Medicare program correspondingly more expensive to the taxpaying public.

A rather neglected factor in the discussion of public transfer programs is the benefit accruing to individuals whom I will call secondary beneficiaries of the program. Secondary beneficiaries are those who receive a welfare gain from a public transfer through a federal program but are not direct recipients. Although all may benefit from all transfers (general altruism), it is reasonable that a transfer to an immediate relative will generate greater benefit than a transfer to an unknown beneficiary. Indeed, in the case in which private

transfers already take place, such as an adult child partially supporting an aged parent, the private transfer may be reduced as the public transfer increases.

The sum of benefits to secondary beneficiaries I will term secondary benefits. The amount of secondary benefits to those who vote is important because, per dollar of transfer payment, the program with more secondary benefits to voters is likely to fare better in the political arena. In particular, the income (and perhaps also price) elasticities for programs with large secondary benefits may be closer to zero; transfers to unidentified needy individuals may well be seen as more discretionary than transfers to relatives.

Almost certainly the Medicare program bestows more secondary benefits on voters than does the Medicaid program. In the Medicare program, which covers virtually all the aged, the aged person's spouse and (adult) children are secondary beneficiaries. By contrast, most Medicaid-eligibles old enough to vote are mothers in single-parent homes. Indeed, the AFDC portion of Medicaid, which Granneman estimates has a very large income elasticity, would seem to generate relatively few secondary benefits to voters.

Over 40 percent of the Medicaid budget, however, goes for nursing home care. Because the aged are primary beneficiaries of these services, it may seem as if the political economy of Medicare and Medicaid should be more similar. But unlike the aged as a whole, the aged in nursing homes who are on Medicaid will generate relatively small amounts of secondary benefits. (Moreover, they themselves are probably less likely to vote than the aged outside nursing homes.) Only 12 percent of all the elderly in nursing homes are married, compared with

53 percent of the non-institutionalized elderly (National Center for Health Statistics 1981), and 46 percent of the institutionalized elderly are childless, compared with only 20 percent of the aged in general. These percentages refer to the entire institutionalized population but, if anything, the Medicaid-eligible elderly in nursing homes probably have fewer spouses and children than the average nursing home resident. In sum, Medicaid probably generates relatively few secondary benefits and as a result may exhibit greater sensitivity to income and perhaps price changes. The amount of secondary benefits could also explain why public long-term-care programs are not more generously supported, while at the same time it is difficult to find votes to reduce public old age pensions (the Social Security program).

The reductions in the transfer programs have an obvious implication for private health insurance. If the Medicare program is reduced through additional cost-sharing and increased limitations on reimbursement, as is now being discussed, the market for supplementary insurance for Medicare-eligibles is very likely to expand.

Both the numbers of purchasers and the scope of covered services could increase. The Medicaid reductions seem much less likely to create a supplementary insurance market. The reductions are likely to cause reduced access (because of lower fee schedules, which by law cannot be supplemented), less coverage of certain services (e.g., dental), and perhaps a reduction in the quality of care rendered to nursing home patients (if reimbursement to homes is curtailed). The reduced value of Medicaid could induce some primary beneficiaries to increase their participation in the labor force, but many recipients, including the aged in nursing homes, cannot do so. For these individuals especially--

if the economic explanation is important in explaining the budgets of public sector transfer programs--the ever-rising relative price of medical care services and the lackluster overall performance of the economy are bad news.

REFERENCES

- The Budget of the United States, Fiscal Year 1983; Washington, D.C.: Government Printing Office, 1982.
- Gibson, Robert M., and Daniel R. Waldo, "National Health Expenditures, 1980," Health Care Financing Review, 3:1, September 1981, pp. 1-54.
- Granneman, Thomas W., "Reforming National Health Programs for the Poor," in National Health Insurance: What Now, What Later, What Never? Ed. Mark V. Pauly; Washington, D.C.: American Enterprise Institute, 1980.
- Health Care Financing Administration, "Long Term Care: Background and Future Directions," Washington, D.C.: Government Printing Office, 1981 (Publ. No. HCFA 81-20047), p. 10.
- National Center for Health Statistics, Characteristics of Nursing Home Residents: Health Status and Care Received: National Nursing Home Survey, United States, May-December 1977; Washington, D.C., 1981. National Health Survey (PHS) 81-1712, Series 13, No. 51, Table D).
- Orr, Larry L., "Income Transfers as a Public Good: An Application to AFDC," American Economic Review, 66:3, June 1976, pp. 359-371.
- Pauly, Mark V., Medical Care at Public Expense; A Study in Applied Welfare Economics, New York: Praeger, 1971.

