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Increases in health care costs reflect both inflation and improved technology. Average annual medical care cost increases outpaced the general rate of inflation and the rate of growth of personal income for the period 1969-1981. This increased the proportion of public and private resources expended on health care and contributed appreciably to the cost of employer-paid health insurance plans. Slower economic growth, squeezed profit margins, and shrinking tax revenues have magnified the impact and heightened awareness of health care cost increases. In the public arena, this has generated a plethora of rules and regulations which focus on symptoms rather than on the underlying causes of cost increases and has contributed little toward understanding of the industry or resolution of the dilemma inherent in public provision of health care services.

The Health Care Industry: An Overview

The health care industry accounts for a large portion of public and private activity in Michigan. During 1981, Michigan's health care industry employed over 210,000 health care professionals and accounted for 7.4% of statewide employment. The health care field ranks as the state's fourth largest employer following manufacturing, retail sales, and state and local government. Of the 210,000 employed in health care, a little over 15,300 (7.3%) were practicing physicians, and 45,200 (21.5%) were active registered nurses. Roughly one-third of the practicing physicians were educated in Michigan's four medical schools.

Gross health-related revenues exceeded $7.8 billion in 1981; direct wage and salary employment absorbed approximately $3.38 billion of this total. Michigan has 110,892 licensed inpatient beds distributed among 845 separate facilities. These facilities include not only general, psychiatric, and VA hospitals, but also nursing homes, chronic care medical facilities, retardation centers, and homes for the aged.

Across the nation, the largest share of health care expenditures (45.7%) is for inpatient hospital care; physician[1] services follow (21.4%); and nursing home care ranks third (9.5%). These categories of services also account for the majority of health outlays in Michigan.

In 1980, the average length of stay in a Michigan hospital was 7.8 days compared with 7.9 for the nation. Michigan has a lower number of beds per 1,000 population (4.3) than either the U.S. (4.4) or the East North Central Census region (4.7) of which it is a part. This is balanced by a higher occupancy rate. Michigan's occupancy rate is 78.0% compared to 75.8% for the U.S. and 76.9% for the region. The higher occupancy rate should reduce the average cost of a patient day in a Michigan hospital since the overhead costs are spread over a larger pool of patients.

Yet even with a lower utilization rate (154.7 per 1,000 population compared to 160.7 for the nation) and higher occupancy rate, hospital costs in Michigan exceed those of the region and the nation. The 1980 average cost of a patient day in a Michigan hospital was $267.38, 6.7% higher than the regional average of $250.56 and 9.1% higher than the $245.15 national average. Michigan's higher average cost largely reflects the state's higher wage level. This difference is significant because

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[1]Includes M.D.'s and D.O.'s and others such as podiatrists and chiropractors.

hospital charges comprise a major portion of total health care expenditures. Medicare (33.9%), Blue Cross-Blue Shield (31.7%), and Medicaid (11.3%) provide 76.9% of the health care coverage in Michigan compared with 64.4% nationwide. Per capita health care outlays in Michigan were $851 in 1981, 12.9% above the $754 level of 1980. This rate of increase outstripped the 9.3% inflation rate of 1981, as well as the 2.6% increase in Michigan personal income.

Health Care Cost Increases

Spiraling health care costs are attributable to both supply and demand factors. Sophisticated and expensive medical technologies such as CAT scanners, transplant surgeries, and chemotherapeutics are increasingly acquired and deployed by small facilities seeking to attract more highly qualified personnel. Greater acceptance of these technologies, along with expanded accessibility and an increased need to practice defensive medicine, have generated increased demand while minimal deductibles on health insurance policies have reduced consumer resistance to the associated higher costs.

While health care expenditures by state government increased more slowly than expenditures per capita, health care continued to account for a larger proportion of the total state budget (Table 1). State appropriations for health care increased 11.7% between 1980 and 1981 and grew from 20.4% to 22.4% of the total state budget. This change has been attributable to two distinct factors: recession-induced erosion of budget revenues and increased human service requirements. The number of people receiving state-financed medical assistance increased 11.9% while total state outlays increased a mere 1.6% from 1980 to 1981. This necessitated reductions in other state program areas such as education and local revenue sharing and focuses attention on the divergence between the growth trend of the economy and health care outlays and its impact on government and private expenditures.

Increased availability and usage of health maintenance organizations have generally resulted in lower hospital use rates and lower health care costs for plan subscribers with no attendant decreases in health care status. Ambulatory care facilities have provided less costly alternatives to emergency room visits. Both services appear to exert some price restraint pressure in the private provision of health care via increased competition.

Government initiatives have taken a somewhat more aggressive approach to price restraint and cost containment. Most of the cost containment methods used to date have sought to curtail access, delay payment, impose ceilings on provider reimbursement, or discourage utilization through patient co-payments and increased paperwork. Examples of these techniques include certificate of need review; implementation of a three-year rebasing formula for Medicaid; imposition of ceilings on reimbursement of per diem, total, and routine services; elimination of payment for nonemergency use of hospital emergency rooms; reimbursement on a fee-for-service basis; and elimination of adjustments for unanticipated inflation growth.

Learning from Experience

Recession-induced unemployment and subsequent loss of employer-paid health insurance has increased the individual cost of health care services for unemployed workers. This shift of financial responsibility for medical care from third-party payers to individuals has reduced their use of health care services, creating a situation of excess supply and exerting substantial price restraint pressure. As a

result, the recession has more effectively constrained increases in health care costs than either government regulation or emerging competitive forces. However, medical care costs have continued to increase at a rate well above that of inflation and have commanded an increasing share of public and private resources. Current reimbursement policies for health care expenditures reduce patient and provider incentives to assess the relationship between costs and the quantity and quality of care. Without this information, neither patients or providers have sufficient knowledge to address the difficult issue of whether health care should be provided to all who could potentially benefit, regardless of anticipated cost. Competition for limited public resources prevents categorical assumption of the financial burden for treatments and procedures whose prohibitive costs preclude private financing. Yet, until society determines what level of health care is to be provided and what proportion of GNP can be allocated to health care, ad hoc cost containment measures and increased competition will have minimal impact on restraining health care costs.

TABLE 1

Fiscal Year	State Government Health Expenditures	Total State Budget	Expenditures As Percent of Total Budget
1978	$1,588.6 million	$ 8,031.1 million	19.8 %
1979	1,791.5 million	8,965.3 million	20.0 %
1980*	1,986.8 million	9,720.3 million	20.4 %
1981*	2,218.6 million	9,878.6 million	22.4 %
1982*	2,452.7 million	10,430.3 million	23.5 %

SOURCE: OHMA and Executive Budget, 1983.

*Estimated appropriations.