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Analysis of 1993 Commerce Department Health Expenditure Data

Embargoed until 5:00 PM Monday January 4, 1993
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ANALYSIS OF 1993 COMMERCE DEPARTMENT HEALTH EXPENDITURE DATA

PUBLIC CITIZEN HEALTH RESEARCH GROUP
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U.S. Commerce Department: $939.9 Billion Health Costs for 1993; $1.066 Trillion by 1994: $2.009 Trillion by 1999

In a Commerce Department report, U.S. Industrial Outlook 1993, embargoed not to appear in print until Jan. 5, 1993, the government estimates that **national health expenditures will increase to $939.9 billion in 1993**, a 12.1% jump from 1992 for yet another year of double digit increases in this, the largest industry in the United States.

This astounding figure provides incontrovertible evidence of a national health care crisis, and demands political leadership to cure this festering wound in our country.

A RECORD INCREASE IN HEALTH EXPENDITURES

The estimate of $939.9 billion for 1993 health expenditures is, to our knowledge, the largest estimate yet made by any governmental agency for 1993 health expenditures and is accompanied by revised 1992 figures--$838.5 billion--which are higher than the $817 billion the Commerce department had estimated would be spent in last year's report. The report also estimates that outlays for hospital care will increase 12.4% to 363.4 billion in 1993. Expenditures for physicians services will amount to an estimated $175 billion, an 11.5% increase over 1992, while spending for nursing homes and home care will approach $92.5 billion, a 15.6% increase.

In addition, because of the still weakened U.S. economy and the very small projected increase in the Gross Domestic Product (GDP) from 1991 to 1992, **the percent of the GNP which went for health expenditures was an all-time record in 1992 and "surpassed 14 percent of the GDP"**. In other words, one out of every seven dollars in our economy was spent for health, despite the fact that, according to data we made public several weeks ago, 35.4 million Americans were without health insurance in mid-1991 and the number is, by now, probably 37 million or more. As more and more people are unemployed, the ranks of the uninsured will grow even more rapidly.

Other extremely troubling aspects of the Commerce Department

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report are the projections for increasingly uncontrolled health expenditures for the next five years. It states that **"Expenditures are expected to rise by about 12-15 percent per annum during the next five years unless significant changes in the healthcare delivery system occur."** This estimate, with a mid-point of 13.5% healthcare inflation a year, is clearly larger than the five-year projection in last year's report which stated that **"expenditures on health care are expected...to increase at an average annual rate of 12 to 13 percent during the next five years."** (mid-point of 12.5%)

Assuming increases of 13.5% each year, the mid-point of the Commerce Department projections for the next five years, we have calculated that this would result in 1994 national health expenditures of $1.066.8 trillion with projected expenditures of $2.009 trillion by 1999. **This would mean that in just six years, 1993-1999, there will be almost a doubling of expenditures with an increase of more than $1.06 trillion, an increase which exceeds the projected total U.S. health expenditures in 1993 of $939.9 billion.**

AN EPIDEMIC OF ADMINISTRATIVE WASTE

Somewhat buried in last year's U.S. Industrial Outlook Report was the statement that "Employment has grown fastest in offices of physicians and surgeons--by 200,000 between 1988 and 1990." Given that the number of physicians in the U.S. only increased from 538,000 in 1988 to 570,000 in 1990, it is likely that most of this increase is in administrative personnel, needed to push the mega-tons of paperwork generated by having more than 1000 different private health insurers in this country. Similarly, there were 409,000 new hospital employees added between 1988 and 1990, many of whom are also engaged in administrative activities.

In this year's report, the Commerce Department reveals that "employment in the healthcare industry rose from 7 million in 1988 to approximately 10 million in 1992." In other words, this average 9.3 percent annual growth rate, or overall 42.8% in the last four years accompanies the increase in the number of people without health insurance. Most of these jobs are not for people who are actually delivering medical care but are largely administrative jobs, producing or delivering paperwork (the numbers do not include people employed in the insurance industry itself). The Commerce Department goes on to say that "During the past decade, the industry's employment growth surpassed that of the rest of the private economy--a trend which should continue for the remainder of this decade."

THE CASE FOR A SINGLE PAYER SYSTEM

As we have stated previously, there would be enormous annual administrative savings from going to an improved American version

of Canada's single payer system--which eliminates the wasteful role of the private insurance industry and all of the paperwork it foists on hospitals, doctors, nursing homes and the rest of the health care system. Estimates of these savings range from $93 billion a year (GAO estimate) to $140 billion a year (estimate of Physicians for a National Health Program).

A 'MEDICALLY INDIGENT' MIDDLE CLASS

Whereas in the past, it was mainly the poor who did without health care, a dominant concept of this decade is becoming that of **medical indigence**. Millions of middle class people, not poor by traditional standards of poverty, are rapidly becoming medically indigent as health costs vastly outstrip wage increases. In 1991, the latest year for which data are available, there were over one million more middle class people (incomes of $25,000 to $50,000) uninsured than in the previous year with actually fewer poor (incomes under $25,000) and better-off (incomes over $50,000) uninsured than in 1990. It is a national disgrace about which a rich country such as ours should be profoundly embarrassed.

THE PRESIDENT-ELECT'S RESPONSIBILITY

President-elect Clinton has given no indication that he will offer a health plan with any chance of curing this crisis. In fact, he and his advisers have suggested "managed competition" platitudes as their answer to the crisis, even though these grim Commerce Department predictions are based on the supposition that "Rapid growth is seen for...managed care organizations in the years ahead."

Until and unless we abandon the private insurance industry's involvement and place caps on what doctors and hospitals charge or spend and thus halt other out-of-control cost increases, the dire predictions of the Commerce Department will come true, driving millions more Americans into the ranks of the uninsured.

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PRINT EMBARGO = Jan 5, 1993

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Health and Medical Services

Expenditures on healthcare (SIC 80) in the United States are expected to rise 12.1 percent to $939.9 billion in 1993. Rapid growth is seen for home health care, nursing home care and for managed care organizations in the years ahead. Expenditures are projected to rise by about 12–15 percent per annum during the next 5 years unless significant changes in the healthcare delivery system occur.

Before reading this chapter, please see "How to Get the Most Out of this Book," on page 1. That section will answer questions you may have concerning data collection procedures, forecasting methodology, and sources and references. For other topics related to the healthcare industry, see chapter 43 (Drugs and Biotechnology), chapter 44 (Medical and Dental Instruments and Supplies), and chapter 52 (Insurance).

The healthcare industry consists of public, private and non-profit institutions. These institutions are hospitals; offices and clinics of medical doctors; nursing homes; other specialized healthcare facilities; managed care consisting of pre-paid plans such as health maintenance organizations (HMOs), preferred provider organizations (PPOs), and independent practice associations (IPAs).

The nation's healthcare services industry currently includes thousands of independent medical practices and partnerships, as well as public and non-profit institutions, and many private corporations. The industry is labor intensive, employing approximately 10 million people of whom more than 600,000 are physicians. America's complex healthcare system relies on some of the most sophisticated and expensive technology in use by any domestic industry.

Health Care Expenditures

Total healthcare expenditures rose 11.5 percent from 1991 to 1992, to reach an estimated $838.5 billion. On a per capita basis, these expenditures exceed $3,160. By 1992, the nation's health and medical care sector outlays surpassed 14 percent of the Gross Domestic Product (GDP). This amount is substantially higher than what is found in other leading industrialized countries. The rate of growth for U.S. healthcare expenditures continues to surpass GDP growth rates.

The rising costs of health care are attributable to many factors, including:

- The use of sophisticated and high-priced equipment;
- Increases in variety and frequency of treatments;

Trends and Forecasts: Health and Medical Services (SIC 80)

(in billions of dollars)

Item	1987	1988	1989	1990	1991[1]	1992[2]	1993[3]	Percent Change 1987-88	1988-89	1989-90	1990-91	1991-92	1992-93
National Health Expenditures	494.2	546.1	604.3	675.0	751.8	838.5	939.9	10.5	10.7	11.7	11.4	11.5	12.1
Health Services and Supplies	476.9	526.2	583.6	652.4	728.6	813.9	914.0	10.3	10.9	11.8	11.7	11.7	12.3
Personal Health Care	439.3	482.8	530.9	591.5	660.2	739.0	830.2	9.9	10.0	11.4	11.6	11.9	12.3
Hospital	194.2	212.0	232.4	258.1	288.6	323.2	363.4	9.2	9.6	11.1	11.8	12.0	12.4
Physicians' Services	93.0	105.1	116.1	128.8	142.0	157.1	175.2	13.0	10.5	10.9	10.2	10.6	11.5
Dentists' Services	27.1	29.4	31.6	34.1	37.1	40.4	44.2	8.5	7.5	7.9	8.8	9.0	9.5
Other Professional Services	21.1	23.8	27.1	30.7	35.8	41.7	47.4	12.8	13.9	13.3	16.6	16.6	13.7
Home Health	4.1	4.5	5.6	7.6	9.8	12.7	16.5	9.8	24.4	35.7	28.9	29.5	30.0
Non-Durable Medical Products	43.2	46.3	50.5	56.6	60.7	66.4	72.6	7.2	9.1	10.1	9.2	9.4	9.4
Durable Medical Equipment	9.1	10.1	10.4	11.7	12.4	13.2	14.2	11.0	3.0	12.5	6.0	6.3	7.5
Nursing Home Care	39.7	42.8	47.7	53.3	59.8	67.3	76.0	7.8	11.4	11.7	12.2	12.5	13.0
Other Personal Health Care	7.8	8.7	9.8	11.5	14.0	17.0	20.7	11.5	12.6	17.3	21.4	21.7	21.8
Administration	23.0	26.9	33.8	38.9	43.9	48.6	54.3	17.0	25.6	15.1	12.9	10.7	11.7
Government Public Health Activity	14.6	16.6	18.9	22.0	24.5	26.3	28.4	13.7	13.9	16.4	11.4	7.3	11.8
Research and Construction	17.3	19.8	20.7	22.7	23.2	24.6	25.9	14.5	4.5	9.7	1.8	6.0	5.3
Research[4]	9.0	10.3	11.0	11.9	12.6	13.3	14.1	14.4	6.8	8.2	5.8	5.5	6.0
Construction[5]	8.2	9.5	9.7	10.8	10.6	11.3	11.8	15.9	2.1	11.3	-1.8	6.6	4.5

[1]Preliminary
[2]Estimate
[3]Forecast
[4]Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures," but they are included in the expenditure class in which the product falls
[5]Benchmark data by HCFA
NOTE: Numbers may not add to totals because of rounding
SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA), Office of the Actuary, U.S. Department of Commerce, International Trade Administration (ITA). Estimates and forecasts by ITA

- Innovative, but costly treatment of some illnesses such as heart ailments, end stage renal disease, AIDS, and cancer;
- Increased longevity of the population;
- Labor-intensiveness in the health care industry and the high earnings of professional, administrative, and technical workers.

In June 1992, the prospective Payment Assessment Commission in a report submitted to Congress indicated that rom 1985 to 1990, population growth, economywide nflation, medical price inflation, utilization, and intensity f services were factors that contributed to the sharp rises n health care costs (Table 1).

Table 1: Factors Accounting for Growth in Healthcare Spending, 1985–1990
(percent distribution)

Services	Population	Economy-wide price inflation	Medical/ price inflation	Utilization[1]	Intensity[2]	Total
Inpatient	12.7	44.6	24.5	−23.2	41.4	100
Outpatient	6.0	21.2	11.6	30.6	30.6	100
Physicians	8.3	29.2	21.4	3.7	37.4	100
Nursing homes	10.9	38.4	15.4	2.6	32.7	100

[1]Days or visits per patient.
[2]Services per visit.
SOURCE: U.S. Department of Health and Human Services, Health Care Financing Administration, Office of the Actuary.

Cost Factors

From 1980-90, the share of household personal income llocated to healthcare rose from 4 percent to 5 percent. 'his figure does not include indirect expenditures such as ayroll, income taxes, and other taxes that finance public ealth care programs. In 1991 the estimated healthcare bill or the average U.S. family was $4,296. Of this amount, eneral taxes accounted for 39 percent of the total, out-of-ocket (consumer) costs were 32 percent, insurance premiums 17 percent, Medicare payroll taxes 9 percent, with ledicare premiums accounting for the balance, 3 percent.

Industry sources estimate that, in 1990, the average nployer's share of medical and medically-related costs per nployee surpassed $3,100. Sharp increases in this amount re cited as a main reason for the rise in uninsured people, om 33.6 million in 1988 to approximately 37 million by 992.

During the past two decades many strategies have been nplemented by the Federal Government, states, and businesses, to control escalating costs. Yet healthcare expenditures have risen from $74.4 billion in 1970 to $838.5 billion 1992, at an average annual rate of 11.5 percent.

Among measures taken thus far to address this situation e the following:

- strategies to reduce the use of out-of-pocket share of payment;
- programs to restrict choice of provider;
- programs limiting providers' selection of services;
- direct controls over prices of services;
- policies encouraging increased competition in health insurance markets;
- regulatory policies.

rofit Margins

There is no uniform way of reporting the industry's ofitability. Fragmentary information indicates that fewer an 13 percent of all hospitals, the dominant group of ealthcare providers, are profit-making corporations.

Any analysis of provider services should take into consideration that most hospitals operating for profit or on a on-profit basis *do* make a profit. This enables them to nerate sufficient revenues to buy the latest technology, y competitive salaries, and cover other costs. According the Prospective Payment Assessment Commission, ofit margins have fluctuated since the mid-1970's, when they were 2 percent. They reached 6 percent in 1984, and declined to under 4 percent in 1990.

Profit information on other health care providers (physicians, dentists, nursing homes, management care organizations, and health insurance companies) is sparse. Attempts to secure better data are impeded by a wave of industrywide mergers and buyouts. However, HMOs, which are part of managed care organizations, realized after-tax net income of more than $1 billion in 1990 and again in 1991.

Medicare

Medicare is a Federal program that pays hospitals and other medical providers who care for patients aged 65 years and older, for certain disabled people, and most persons with end-stage kidney disease. There are approximately 34 million Medicare enrollees, including more than 3 million afflicted with disabilities. Total Medicare outlays are projected to rise from $131 billion in 1992 to $145.5 billion in 1993 representing an 11 percent increase.

Medicare consists of two parts, Hospital Insurance (HI) and Supplementary Medical Insurance (SMI). HI is funded primarily by Social Security payroll taxes. HI pays for care provided by hospitals, skilled nursing facilities, home health agencies, and hospices. HI outlays are likely to reach $84.8 billion in 1993, an increase of $7.4 billion over the previous year.

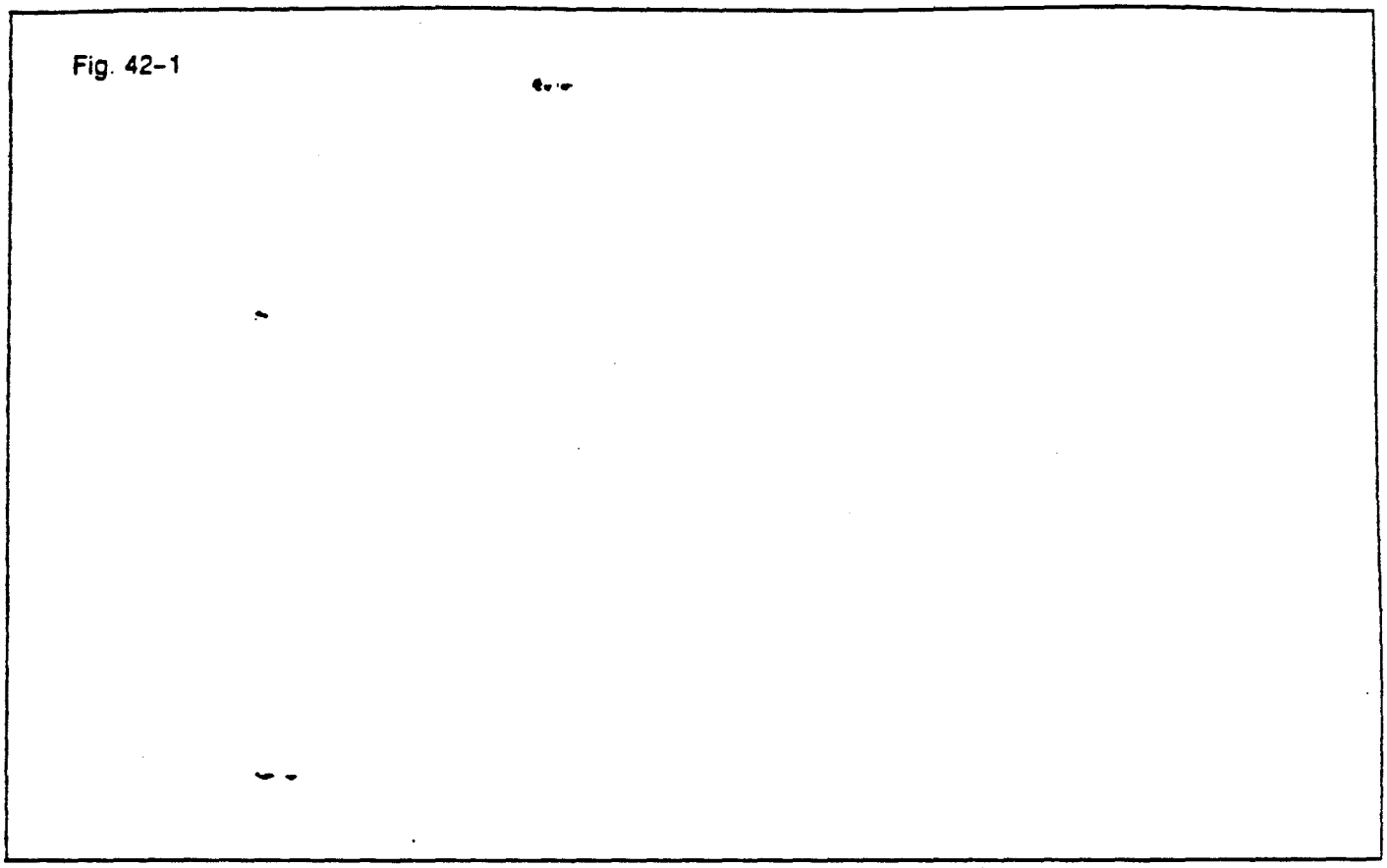
SMI pays for physician services, laboratory services, hospital inpatient costs, treatment for end-stage kidney disease, and for durable medical equipment. SMI outlays are expected to grow from $53.6 billion in 1992 to $60.7 billion in 1993, a 13.2 percent rise. Enrollees pay about 35 percent of costs through premiums, but a subsidy from general revenues finances the bulk of the entire program.

Medicaid

Medicaid is a Federally-supported and state-administered assistance program providing medical care for certain low-income individuals and families. Medicaid covered about 28 million people at a cost of $100 billion in 1991.

Medicaid as well as Medicare programs are subject to periodic changes in laws and regulations. All such changes may materially increase or decrease payments to hospitals, physicians, and other medical providers. As Medicaid and Medicare programs have become costlier in recent years, the tendency by Congress and state legislatures has been to reduce Medicaid and Medicare financing.

Fig. 42-1



While Medicaid programs cover a small fraction of the U.S. population, many compare it to a national healthcare program. Medicaid serves many groups. For poor people with Medicare, Medicaid actually serves as a medigap policy, paying coinsurance, deductibles, and services not covered by Medicare. For all income groups, Medicaid is the ultimate payer for long stays in nursing homes or intermediate care facilities for the mentally retarded. Long-term care for these recipients accounts for 44 percent of all Medicaid spending. Medicaid provides catastrophic coverage for people who have episodes of a variety of problems and have no cash assistance. It automatically pays after both family cash reserves and private insurance are exhausted.

Nursing Home Care and Related Care Homes

Nursing homes are an integral feature of the American healthcare system. They provide medical, social, and residential services to chronically disabled people over an extended period of time. Because chronic disability increases with age, the elderly are the primary recipients of nursing home care.

There are 31 million persons aged 65 and over in the United States. An estimated 7 million require continuous assistance for routine daily functions. In cases where family members are absent, an institutional setting becomes essential. In addition, many of the chronically disabled require intensive medical assistance, and often are served by nursing care on an around-the-clock basis.

Long-term care facilities are of three basic types: (1) nursing homes certified by Medicare and Medicaid as skilled nursing care facilities (SNFs); (2) nursing homes certified for chronically disabled patients or the mentally retarded; and (3) all other facilities that furnish some degree of long-term nursing care.

In 1986, the latest year in which data are available, there were 16,388 nursing homes, and 9,258 residential facilities. Also there were 734 hospital-based facilities providing nursing care services in addition to other forms of treatment. In total, there were 1.8 million beds and 1.6 million residents. The occupancy rate for skilled nursing facilities was 94 percent, and for hospital-based facilities it stood at 92 percent.

Medicare payments to SNFs fluctuated from $3.4 billion in 1989 to $2.4 billion in 1990 and $2.5 billion in 1991. The fluctuation was due to the Medicare Catastrophic Coverage Act of 1988. Following its repeal, those payments and services were decreased. State Medicaid programs provide 45 percent of payments and cover more than 60 percent of all nursing home patients. Medicare covers less than 5 percent of nursing home payments. Future Medicaid policies will greatly influence access to nursing home services for prospective beneficiaries.

Home Health Care Services

Home healthcare is a method of providing healthcare services to disabled people within their homes. There are more than 5 million people in the United States who require such services. These include physicians' care, part-time or intermittent skilled nursing care, physical therapy, and speech therapy. Medical supplies and durable medical equipment used in providing these services are also elements of this system.

In 1990, there were about 11,000 home health service providers in the United States. More than half, 5,700, were Medicare-certified and about 1,780 were provided by hospitals. Home healthcare expenditures rose from $7.6 billion in 1990 to $9.8 billion in 1991, a 28.9 percent increase. Since 1980, they grew at average annual rates of approximately 26 percent. Government financed three-fourths of the total, while out-of-pocket payments accounted for about 12 percent and most of the balance was paid by private health insurance.

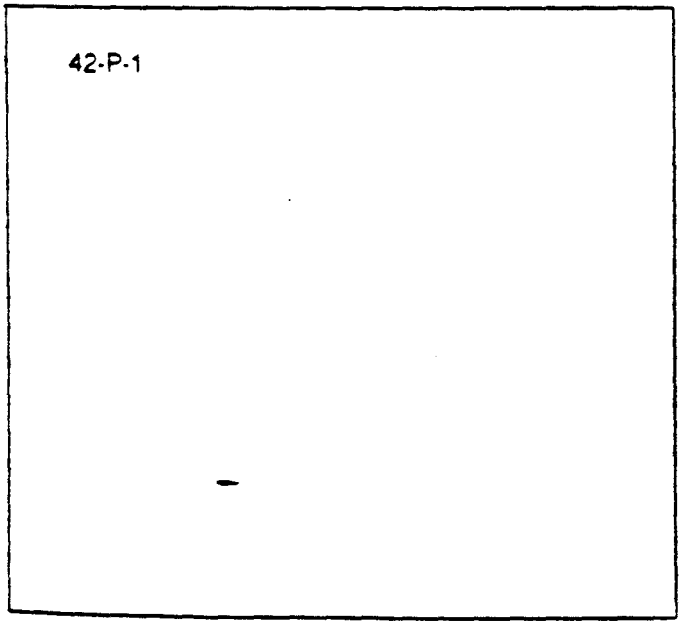
The number of home visits by industry professionals to the afflicted and/or disabled increased from 16.3 million in 1980 to more than 17.8 million in 1991. During the same period, numbers of patients served more than doubled (from 726,000 to an estimated 1.7 million).

Private Health Insurance

Health insurance premiums have increased sharply during the past years. Insurers have raised their rates by 8 to 60 percent, citing escalating healthcare prices, ineffectiveness of cost-cutting efforts, and possible discriminating pricing practices by health providers.

In 1990, private health insurance plans disbursed $216.8 billion, an amount which was more than $20 billion above disbursements for 1989. Private health insurance covers three-fourths of the total non-institutionalized population. There are approximately 71 million workers with 69 million dependents, all of whom obtain coverage as an employment benefit. The remaining 44 million people purchase their own coverage.

More than 1,000 private insurance companies in the United States write individual or group health insurance plans. The private health insurance industry has been growing rapidly because (1) consumers seek to reduce risks of high-out-of-pocket expenses, and (2) business health insurance premiums receive preferential tax treatment, estimated at $60 billion annually.



Equipment Leasing Association

Increasing reliance on sophisticated technology has been a contributing factor to sharp increases in medical costs.

Private coverage is available through insurance companies, hospitals, through medical service plans, and through group medical plans operating on a prepayment basis. The prepayment plans, such as those that managed care organizations provide, have grown rapidly and are creating competition among healthcare insurers.

Private health insurance companies sometimes deny coverage to individuals because they suffer from AIDS, alcoholism, diabetes, coronary artery disease, or cancer. In addition, coverage may be denied to people in high-risk categories, such as drug abusers, older people, and those in certain occupations. The principal reasons for lack of private insurance coverage are that the offer price is more than the uninsured can pay and/or the coverage is not available at any price.

Hospital Waste Disposal

The contamination of New Jersey beaches in 1988 highlighted potential threats to public health arising from improper medical waste disposal procedures. This issue is having a profound impact on healthcare. Since then, Federal and state governments are monitoring the situation far more vigorously, focusing on hospital-generated medical waste and disposal practices. The Environmental Protection Agency, has introduced regulations (and mandated penalties) for hospitals which dispose of substances into the environment. Those substances and materials include red bag waste, incinerator emissions, radioactive waste, laboratory waste, and storage tanks.

The Medical Waste Tracking Act of 1988 forces States to enact or modify regulations dealing with disposal of medical and infectious waste. The Clean Air Act imposes tough restrictions on medical waste incinerators that burn over two tons of waste material daily.

One of the few new technologies available to dispose of medical wastes appears to be cost-effective. It compacts potentially dangerous substances, shredding, granulating, and chemically treating the waste material.

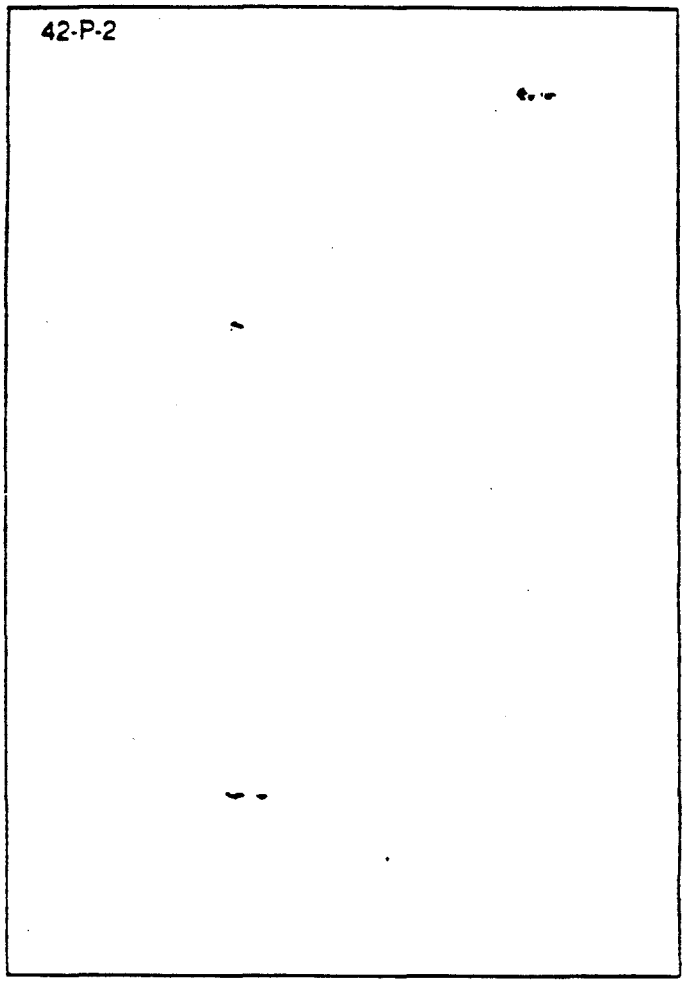
Employment

Employment in the healthcare industry rose from 7 million in 1988 to approximately 10 million by 1992. This represents average annual growth rates of 9.3 percent. During the past decade, this industry's employment growth surpassed that of the rest of the private economy—a trend which should continue for the remainder of this decade.

Healthcare workforce totals are exclusive of employment in the health insurance, medical equipment and supplies, and pharmaceuticals industries. There has been positive employment growth in all these sectors, especially in offices and clinics of medical doctors, as well as in nursing and personal care facilities. Hospitals and nursing homes account for about 62 percent of the total number employed in healthcare.

Allied Health Personnel

Allied health personnel are workers who assist physicians and other specialists. This job category is among the fastest growing occupational sectors of the entire healthcare industry. The Bureau of Health Professionals estimates there were 1.8 million allied health personnel in the United States



National Association of Public Hospitals

Healthcare industry professionals must be attuned to an array of complex issues surrounding public health and medical treatment.

in 1990, a 44 percent increase from 1980. These professionals play an integral role in the delivery of the nation's health services, with 300,000 employed in clinical laboratory positions. More than one-half of the latter are employed by hospitals.

Health Care Reform—A Priority for the Nation

Debate over healthcare reform is accelerating. Attention to this issue rose dramatically during the past decade, and major national healthcare associations—representing business, labor, and other constituencies—advocate modifications in existing policy.

Federal and state lawmakers have introduced proposals. One proposal would direct all employers either to provide medical coverage for their workers, or contribute directly to a government insurance fund ("play or pay"). The U.S. Bipartisan Commission on Comprehensive Health Care for All Americans (the Pepper Commission) recommended such a plan. The Commission also suggested overhauling the nation's private insurance system, and suggested ways of restructuring Medicaid.

Other proposed remedies abound. Some emphasize market competition, tax credits, deductions for the uninsured, capping malpractice awards, and encouraging electronic processing of medical claims. Among those who have made proposals are the American Medical Association, American Hospital Association, U.S. Chamber of Commerce, National Governors Association, Heritage Foundation, and academicians such as professors Uwe Reinhardt and Alain C. Enthoven.

Both business and government agree that the United States should seek to accomplish the following objectives:

- provide cost-effective healthcare services in an era when different factors contribute to high costs;
- design a comprehensive healthcare system that will include 37 million uninsured Americans;
- explore the effects of ever-greater reliance on modern medical technologies;
- review the impact of managed care on overall healthcare expenditures;
- examine access of various socio-economic groups to healthcare services;
- determine levels of healthcare in rural America;
- reduce costs of malpractice liability;
- determine what characteristics best assess quality of service;
- restructure Medicare and Medicaid programs;
- improve medical education as necessary;
- assess healthcare planning;
- explore primary care;
- enhance use of preventive care;
- evaluate issues of bioethics.

Factors contributing to escalating costs are waste, fraud, malpractice and limited effective competition. Waste and fraud alone account for billions of dollars. For example, the Federal Bureau of Investigation uncovered evidence in 1992 that some drug companies were defrauding the Medicare/Medicaid system. Awareness of other abuses has spread, and the call for correction of these abuses will doubtless influence prospects of sectors within the nation's healthcare industry.

The International Health Care Market

The business climate in many foreign countries appears favorable for U.S. healthcare companies to expand into overseas markets. The prospects in Western Europe, Mexico, and in Japan are viewed as particularly promising.

Many foreign governments have designated healthcare as a cornerstone of their social policy, and they plan to provide steady yearly budget increases over the medium term in order to achieve stated objectives. A number of foreign countries strive to modernize both the public and private health sectors, while offering increased market opportunities for services and medical equipment. Others are contemplating privatization, or exploring options to decentralize existing systems for delivery of services. Despite the problems faced by consumers and institutions bearing the burden of escalating healthcare costs within the United States itself, American companies are recognized globally as industry leaders.

In both Western Europe and Japan, demographics (ageing populations as well as increased longevity) and high income levels create growing demand for healthcare services. According to industry specialists, the best prospects in these two regions exist for primary care, home care, and nursing home care services. Also, opportunities in hospital management, and in ancillary services, appear promising.

• The newly independent states of the former Soviet Union and countries of Eastern Europe may present some opportunities for U.S. companies. Success in such ventures, however, will demand that U.S. firms tailor their services to the specific needs of each country, while continued efforts by foreign governments to open domestic economies must occur to assure profitability. Although there has been considerable speculation concerning actual healthcare markets across the countries of Eastern Europe and throughout the former Soviet Union, highly volatile commercial and economic conditions prevail in both regions.

In Eastern Europe, U.S. healthcare service providers are frequently in a better position to enter country markets through small, "bite-sized" operations. These undertakings include diagnostic imaging, maternity centers, ambulatory care and surgery, and the sale of computer systems. Several U.S. firms are providing emergency health care services, consulting, and insurance coverage in Hungary. In addition, according to some observers, health maintenance organization (HMO) services may offer a prototype for reform of the still largely state-run health sector in these countries. U.S. government agencies are working to facilitate service providers with market entry through organized trade missions and encouraging liberal trade and investment environments in talks with Eastern European counterparts.

Outlook for 1993

Without modification in healthcare laws and practices, expenditures in 1993 will rise by 12.1 percent, reaching $939.9 billion. Outlays for hospital care are expected to increase 12.4 percent to $363.4 billion. Expenditures for physicians' services will reach an estimated $175.2 billion in 1993, a 11.5 percent increase over 1992, while those for nursing home care will total $76 billion, 13 percent higher than the 1992 total of $67.3 billion. Home care will continue to show strong growth. Its expenditures will rise 30 percent to reach $16.5 billion. Healthcare reforms will be seriously discussed and reviewed by policymakers. One possible outcome within the near term is that through tax incentives and government subsidization, most of the uninsured will gain access to healthcare.

Long-Term Prospects

Consumers, providers, and policymakers will most likely attempt to devise a healthcare system that could increase competition in the United States. The chief goal of any legislative package to emerge will, of course, be cost containment, access and efficiency. However, healthcare spending will continue to absorb a disproportionately high share of GDP. The elderly population already consumes a large share of total healthcare services.

Providing services to all, including the 37 million uninsured, will ultimately increase both the rate of spending and the volume of healthcare services. Health insurance companies may have to make adjustments in their health coverage to comply with any major national healthcare reform that might arise, while health care expenditures will continue to rise but at a slower rate.

Private healthcare institutions may initially realize a lower profit and will have to modify their modus operandi to cope with newly instituted government regulations. Managed care and home healthcare occupy important places in the market, and will undoubtedly continue to do so. Alternatives to institutional care—home healthcare, personal care services, hospice care, and adult care—will increase. Nursing home care will provide a major market for durable medical equipment, supplies and pharmaceuticals.

Efforts to reduce healthcare costs will generate better collaboration between physicians and hospitals in providing services.—*Simon Francis, Office of Service Industries, (202) 482-2697, August 1992.*

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