THE WHITE HOUSE

WASHINGTON

January 10, 1985

MEMORANDUM FOR RICHARD G. DARMAN
ASSISTANT TO THE PRESIDENT

FROM: JOHN G. ROBERTS
ASSOCIATE COUNSEL TO THE PRESIDENT

SUBJECT: Draft Chapters 3 & 4 of the 1985 Economic Report

Counsel's Office has reviewed the above-referenced chapters, and finds no objection to them from a legal perspective.

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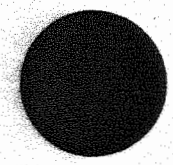
WHITE HOUSE
CORRESPONDENCE TRACKING WORKSHEET



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Name of Correspondent: Richard Darman

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Subject: Draft Chapters 3 + 4 of the 1985 Economic Report

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EXECUTIVE OFFICE OF THE PRESIDENT

COUNCIL OF ECONOMIC ADVISERS

WASHINGTON, D.C. 20500

January 8, 1984

MEMORANDUM FOR RICHARD DARMAN, WHITE HOUSE
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FROM: William S. Haraf
Special Assistant to the Council

SUBJECT: 1985 Economic Report -- Chapter 4

Attached is the first galley of Chapter 4 of the 1985 Annual Economic Report of the Council of Economic Advisers which will accompany the Economic Report of the President. Please let us have your comments by c.o.b. Thursday, January 10, 1984.

These should be delivered to Room 315 Old Executive Office Building. Should you or your staff members have specific substantive questions about major issues, please feel free to contact Roger Feldman (395-5614).

Attachment

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CHAPTER 4

Public Policy To Control Medical Care Costs

IN 1965 A MAJOR CHANGE occurred in the United States medical care system. That year marked the enactment of the medicare and medicaid programs. For the first time, the Federal Government made a major commitment to finance the medical care needs of its elderly and poor citizens. The purpose of medicare was to reduce the financial burden of illness on the elderly; the legislated goal of medicaid was to improve the access of the deserving poor to medical care.

Despite the political appeal of these objectives, the price tag was not expected to be great. The medicare hospital insurance program was expected to cost the Federal Government about $1 billion in its first year, with growth to $7 billion in 1985, according to medicare's actuaries.

This estimate was wrong, of course. Federal spending on medicare reached $57.4 billion in 1983. Spending for the hospital portion of medicare in 1983 surpassed the original projection by six fold. Medicaid and other Federal and State or local medical care programs consumed an additional $67.1 billion in 1983.

Experience with medicare and medicaid vividly illustrates the dilemma of health insurance. The goal of health insurance is to reduce the risk that consumers will face large medical bills. The means by which this is accomplished is to provide low-cost or free medical care at the point of purchase. However, individual consumers tend to purchase more medical care when the price of additional care to them is reduced. Because of this additional demand, the cost of the insurance program is driven up. Thus, the goal and the means of health insurance are in conflict. How to resolve this conflict is the central problem of public policy toward medical care.

Increasing costs are not limited to public health insurance programs. Most nonelderly people in the United States have private health insurance, usually provided as an employment-related fringe benefit. Employers are experiencing rapid escalation in their health benefits costs; in some cases, the percent of gross payroll spent on health benefits has increased by 50 percent from 1976 to 1983. The

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consequences of this increase may be higher prices, lower corporate profits, or lower wage increases for employees.

Increasing medical care spending might be viewed favorably if it made a significant contribution to public health. The link between more spending and better health appears obvious. If people buy medical care to prevent illness or to cure illness, surely medical care spending of $355.4 billion in 1983, which represents 10.8 percent of the 1983 gross national product (GNP), must have a significant positive impact. However, some critics contend that developed countries spend too much on medical care; they argue that unnecessary medical care may be harmful to a patient's health. Defenders of the system admit that it is difficult to identify the point at which additional spending on medical care fails to contribute to better health.

There is also widespread concern that the unit costs of medical care are too high. The cost of a day in the hospital was $369 in 1983, up from $41 in 1965 ($119 in 1983 prices), and the average cost per hospital admission increased from $311 ($901 in 1983 prices) to $2,789 over the same period. Widespread calls are heard to curb the increasing costs of medical care. Policymakers have a wide array of options, ranging from increased regulation to unfettered competition, from which to choose. The only agreement among the advocates of competing policies is that continuation of the present system is unacceptable.

Therefore, on the twentieth anniversary of medicare and medicaid, it is appropriate to review the present condition of public and private health insurance programs in the United States. Positive steps can be taken toward the goals of delivering appropriate medical care at reasonable prices. However, policies must be chosen carefully to promote consumers' incentives for healthy behavior, reasonable levels of health insurance coverage, and careful use of medical care services. Producers must also face incentives to deliver medical care services efficiently at competitive prices.

HEALTH STATUS OF THE AMERICAN POPULATION

The life expectancy of the American population has improved steadily since 1900, when the average American could expect to live for 47.3 years. At the turn of the century, females lived 2 years longer than males, on average, and blacks lived 33.0 years, substantially fewer than the 47.6 years for whites. By 1982, average life expectancy had increased to 74.5 years. The male-female gap had widened to 7.4 years, but the black-white gap had narrowed to less than six years.

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Most of the increase in life expectancy during the first half of this century was due to the prevention of death at early ages. The factors mainly responsible for dramatic declines in mortality were improved sanitation, heating, and other amenities, along with significant breakthroughs in immunization against communicable diseases. Those Americans lucky enough to live to age 65 in 1950 could expect to live for 13.9 more years. This was only a modest gain from 1900, when they could expect 11.9 more years of life. As of 1982, however, the life expectancy of older adults had increased to 16.8 years.

Increasing life expectancy at older ages, along with declining birth rates, has led to the well-known "graying" of America. The age distribution of our population has shifted markedly since 1965, when the over-65 population represented 9.5 percent of the total population. In 1983, the elderly accounted for 11.7 percent of the total population. Since the elderly spend about 3.4 times as much per capita on medical care as do the nonelderly, population aging has profound implications for medical care spending. Greater demands are placed on medicare and on that part of the medicaid program which finances long-term care for the elderly.

Increasing life expectancy at older ages in evidence of improved health status of the American population. Additional evidence is that infant mortality rates and fetal death rates have fallen since 1950. (Infant deaths occur within the first year of life; fetal deaths are the deaths of fetuses of 20 weeks or more gestation.) Large declines have occurred for both blacks and whites. However, in 1981, the infant and fetal death rates for blacks remained substantially above those for whites.

Between infancy and age 65, there are distinct differences in the causes of death by age, sex, and race. The leading cause of death for both races and sexes below the age of 15 is accidents. In fact, accidents are the leading cause of death below the age of 45. Among teenagers and young adults, accidents are the leading cause of death for whites, whereas homicide is the leading cause of death for blacks. Cancer is the leading cause of death for black females between the ages of 25 and 44 and for white females of ages 25 to 64. After age 65, heart disease is the major cause of death.

The dominant role of accidents and homicides makes clear that behavior or "lifestyle" factors play an extremely important role in mortality. Moreover, since many of these deaths occur at early ages, accidents and homicides have a disproportionate impact on life expectancy at birth

Other than through mortality statistics, there are problems in measuring the public's health status. For example, people's willingness to report certain nonfatal diseases may change over time. The

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health status indicators must also be adjusted for the age distribution of the population, since the population is aging, and many diseases appear more frequently among the elderly.

Even with these qualificaitons in mind, it is important to examine trends in the self-reported health status of the American population from nationwide surveys of households. One measure of health status is "restricted activity days," which are days that a person cuts down on his usual activities because of illness or injury that occurred during the 2 weeks prior to the survey. A day spent in bed at home or in the hospital ("bed-disability day") is, of course, a restricted activity day.

Surveys indicate that the number of restricted activity days decreased among all age groups from 1957 until the middle or end of the 1960s, after which the trend has reversed. The number of bed-disability days per person fell during the late 1950s and early 1960s and has remained roughly constant since then. Some increase occurred among the 45 to 64 and over 75 age groups.

Another health status indicator is activity limitations due to chronic conditions that began more than 3 months before the week of the survey. A striking trend emerges from these surveys: the proportion of males of ages 45 to 64 who are unable to perform their major activity has more than doubled—from 4.4 percent of that age group in 1960 to 11.5 percent in 1981. Smaller, but very noticeable increases are shown for this activity limitation among males of ages 17 to 44 and females of ages 45 to 64.

Trends in reported activity limitations may be explained, in part, by the expansion of disability cash benefits and the number of beneficiaries between the mid-1960s and the mid-1970s. During 1965–75, cash payments to disabled persons increased from $9.7 billion ($28.1 billion in 1983 prices), or 1.1 percent of GNP, to $33.9 billion ($58.0 billion in 1983 prices) or 2.2 percent of GNP. During the same period, the number of social security disability insurance beneficiaries grew by 150 percent while the covered workforce grew by only 55 percent. It appears that persons with severe chronic conditions could leave the work force with greater disability benefits, whereas a decade earlier they might have continued to work. Changes in mortality patterns may also partly explain increases in activity limitations. As mortality rates drop, some people who stay alive longer have chronic diseases that cause disability.

TRENDS IN MEDICAL CARE SPENDING AND UTILIZATION

In 1983, Americans spent $355.4 billion on medical care. Table 4–1 breaks down national health expenditures in 1983 by type of ex-

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penditure and source of funds. Spending on hospital care accounted for 41.4 percent of total medical care spending and 47.0 percent of "personal health care spending" (a category that includes most payments to medical care providers). Following hospital care in importance were physicians' services and nursing homes with 22.0 and 9.2 percent, respectively, of personal health care spending.

TABLE 4–1.—*National health expenditures by type of expenditure and source of funds, 1983*

[Billions of dollars]

Type of expenditure	Total	Private funds					Government funds		
		Total	Consumer			Other[1]	Total	Federal	State and local
			Total	Direct payment	Private insurance				
Total	355.4	206.6	195.7	85.2	110.5	10.9	148.8	102.7	46.1
Health services and supplies	340.1	199.8	195.7	85.2	110.5	4.1	140.3	96.8	43.5
Personal health care	313.3	188.8	185.2	85.2	100.0	3.7	124.5	93.0	31.5
Hospital care	147.2	68.8	67.3	11.1	56.2	1.5	78.4	60.6	17.8
Physicians' services	69.0	49.7	49.7	19.6	30.1	(2)	19.3	15.6	3.7
Dentists' services	21.8	21.2	21.2	13.9	7.4		.6	.3	.3
Other professional services	8.0	5.6	5.5	3.3	2.1	.1	2.5	1.9	.5
Drugs and medical sundries	23.7	21.6	21.6	18.4	3.2		2.1	1.1	1.1
Eyeglasses and appliances	6.2	5.2	5.2	4.5	.7		1.0	.9	.1
Nursing home care	28.8	14.9	14.7	14.4	.3	.2	14.0	8.1	5.9
Other personal health care	8.5	1.8				1.8	6.6	4.5	2.1
Programs administration and net cost of private health insurance	15.6	10.9	10.5		10.5	.3	4.6	2.6	2.0
Government public health activities	11.2						11.2	1.2	10.0
Research and construction of medical facilities	15.3	6.8				6.8	8.4	5.9	2.6
Research[3]	6.2	.4				.4	5.8	5.2	.6
Construction	9.1	6.5				6.5	2.6	.7	2.0

[1] Spending by philanthropic organizations, industrial in-plant health services, and construction financed privately.
[2] Less than $100 million.
[3] Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research," as the value of their research is included in the expenditure class in which the product falls.

Source: Department of Health and Human Services, Health Care Financing Administration.

Fifty-five percent of the money spent on medical care comes from private funds paid directly by consumers and by private insurers. Of the private funds, insurance is the dominant mode of paying for hospital services and, to a lesser extent, for physicians' services. Consumers pay for most drugs and dental services out of their own pockets. Private insurance provides virtually no coverage for nursing home care.

Government funds constituted 41.9 percent of total medical care spending in 1983, of which the Federal Government contributed 69 percent. Federal spending dominated that of State and local govern-

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ments in most personal health care categories and in medical research, while State and local governments were dominant in expenditures for construction and government public health activities.

The percentages of medical care spending devoted to hospital and nursing home care have risen over time. This trend has implications for how these services are financed. Briefly speaking, hospital and nursing home care occur infrequently and are expensive. Both considerations tend to increase consumers' demands for third-party reimbursement to cover the cost of hospital and nursing home care. Thus, it is not surprising that third-party payments increased from 69.2 percent of hospital care spending in 1950 to 92.5 percent in 1983.

Another trend has been an increase in the Federal share of medical care spending from a minimal 3.4 percent in 1935 to 29.7 percent in 1983. The largest portion of this increase occurred between 1965 and 1970. The share of private sector payments fell rapidly from 1965 to 1970. The drop appeared almost entirely as a decline in consumer direct payments.

Table 4–2 shows aggregate and per capita trends in medical care spending from 1965 to 1983. In 1965 the average American spent $207 ($599 in 1983 prices) on medical care. Total medical care spending in that year accounted for 6.1 percent of GNP. By 1983, medical care spending had grown to $1,459 per person. Despite an expansion in the economy during this period, medical care spending consumed an increasingly large share of the GNP. In 1983, 10.8 percent of GNP was spent on medical care.

Neither the level nor the rate of increase in medical care spending in the United States in unique compared to those in other advanced democratic countries. For example, Sweden spent 8.7 percent to its GNP on medical care in 1975 and 9.7 percent in 1980. Comparable figures for the United States are 8.6 percent in 1975 and 9.4 percent in 1980. Other countries have attempted, for the most part unsuccessfully, to control medical care spending by regulation rather than through market forces. One exception appears to be the United Kingdom, where strict central controls have limited medical care spending to 5.6 percent to GNP in 1975 and 5.8 percent in 1980. The success of this approach might be questioned however. Consumers in the United Kingdom national health system face long waiting times for nonemergency hospitalization, and the quality of service in that system may be declining.

FACTORS RESPONSIBLE FOR RISING MEDICAL CARE EXPENDITURES

The factors responsible for rising medical care expenditures can be broken down into changes in price and changes in quantity. Price

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TABLE 4-2.—*National health expenditures, by source of funds and as percent of gross national product, 1965–85*

Year	Total			Private funds			Government funds		
	Amount (dollars)		Percent of GNP	Amount (dollars)		Percent of total	Amount (dollars)		Percent of total
	Total (billions)	Per capita		Total (billions)	Per capita		Total (billions)	Per capita	
1965	41.9	207	6.1	30.9	152	73.8	11.0	54	26.2
1966	46.3	225	6.1	32.7	159	70.7	13.6	66	29.3
1967	51.5	248	6.4	32.5	157	63.2	19.0	91	36.8
1968	58.2	278	6.7	36.1	172	62.0	22.1	105	38.0
1969	65.6	310	7.0	40.7	192	62.0	24.9	118	38.0
1970	75.0	350	7.5	47.2	221	63.0	27.8	130	37.0
1971	83.5	386	7.7	51.8	239	62.1	31.7	146	37.9
1972	93.9	429	7.9	58.5	268	62.3	35.4	162	37.7
1973	103.4	468	7.8	64.0	290	61.9	39.4	178	38.1
1974	116.3	522	8.1	68.8	309	59.1	47.6	214	40.9
1975	132.7	590	8.6	76.3	340	57.5	56.4	251	42.5
1976	150.8	665	8.8	87.9	388	58.3	62.8	277	41.7
1977	170.2	743	8.9	100.1	437	58.8	70.1	306	41.2
1978	190.0	822	8.8	110.1	476	57.9	79.9	346	42.1
1979	215.1	920	8.9	124.2	531	57.7	90.9	389	42.3
1980	248.0	1,049	9.4	142.2	601	57.3	105.8	448	42.7
1981	285.8	1,197	9.7	164.2	688	57.4	121.7	510	42.6
1982	322.3	1,337	10.5	186.5	774	57.9	135.8	564	42.1
1983	355.4	1,459	10.8	206.6	848	58.1	148.8	611	41.9

Note.—Per capita amounts are based on July 1 Social Security Area population estimates, which include the resident U.S. population and that of the outlying territories, plus Federal military and civilian employees and their dependents overseas, plus an estimate of the census undercount.

Source: Department of Health and Human Services, Health Care Financing Administration.

changes can be subdivided further into general inflation and medical care price increases in excess of general inflation. Quantity changes can be partitioned into three elements: changes in aggregate population, changes in quantity per capita, and changes in the nature of services provided per visit or per admission. The sum of the percentage changes of these five factors is equal to the percentage change in total expenditure.

General inflation (as measured by the GNP deflator) accounted for 51.7 percent of the rise in hospital inpatient spending between 1971 and 1981. The remaining sources of increased hospital spending were increases in hospital input prices in excess of the GNP deflator, 11.7 percent; population growth, 7.2 percent; growth in admissions per capita, 8.6 percent; and growth in real expenses per admission, 20.8 percent. Real expenses per admission are a proxy, albeit an imperfect one, for changes in the nature of hospital care.

The share of hospital spending growth due to rising real expenses per admission increased to approximately 39.4 percent from 1981 to 1982 and 46.1 percent from 1982 to 1983. Those increases occured at a time of lower general inflation and flat or declining demand for hospital admissions. Real spending growth per admission fell back to 26.7 percent of hospital spending growth in the first 6 months of 1984, compared to the same period in 1983. This rate, however, remains above the 1971–81 trend value.

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Fifty-eight percent of the increase in expenditures for physicians' services from 1971 to 1981 was due to general inflation. Other causes were the price index for physicians' fees in excess of the GNP deflator, 10 percent; visits, 5 percent; and real expenses per visit, 27 percent.

Experts disagree over the proper interpretation of these increases. Some analysts have emphasized the fact that most of the growth in medical car spending is due to general inflation. While technically correct, this view is seriously misleading. If spending grew only 2 percent faster than inflation, real expenses per unit of service would quadruple during the average person's lifetime, holding other factors constant.

The significance of these numbers is that the extraordinary increase in medical care expenditures results from changes in the nature of the product: the scope, complexity, and hence, the prices of medical care products have risen in relation to the products of other industries. In the hospital sector, this trend is reflected in the growing number of hospitals that provide highly specialized services. In the physicians' services sector, the volumes of out-of-hospital laboratory tests and surgical procedures have been growing much faster than the number of physicians' visits.

TRENDS IN USE OF MEDICAL CARE SERVICES

Significant trends have occurred since 1964 in the use of particular medical services by different demographic groups. Hospital days of care fell from 1964 to 1981 for younger age groups, but rose for older people, especially those over 65. This change may be attributed, in part, to the medicare program, which has provided hospital insurance coverage for the elderly since 1965.

In 1964, poorer people, as measured by family income under $2,000, had the lowest rate of physicians' visits. Poorer people (family income less then $5,000 in 1976 and less than $7,000 in 1981) had the highest rate of physicians' visits in 1976 and 1981. The hospital discharge rate among poor people increased, while discharge rates among other income groups fell. These changes may be attributed, in part, to the medicaid program, which has improved the access of poor people to physicians and hospitals.

DOES MORE MEDICAL CARE PRODUCE BETTER HEALTH?

The previous sections showed that trends in medical care spending have been paralleled with improvements in some measures of health status in the United States. It would seem natural then to assume that more medical care produces better health. Spending some

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money on medical care is indisputably worthwhile. But this does not imply that, beyond some point, spending more money on medical care necessarily leads to further improvements in health.

Statistical studies, for the most part, indicate that differences in mortality and morbidity among States or regions in the United States cannot be explained by differences in the distribution of medical care resources. One such study examined the relationship between an area's medical resources and physiological measures of health. In the context of the health conditions and levels of resources considered by this study, it was found that additional medical resources made little or no contribution to a person's health.

The strongest evidence that an "across-the-board" increase in medical care use will not improve the health of the average person comes from the RAND health insurance experiment. About 4,000 nondisabled people between the ages of 14 and 61 were randomly assigned to a set of insurance plans for 3 or 5 years. One plan provided free care; the others required enrollees to pay a share of their medical bills. The experiment showed that when cost-sharing was higher, visits to physicians and adult hospitalizations were fewer. However, the only significant positive health effect of free care was that for corrected vision. Other measures of health were similar among the cost-sharing groups and the free care group.

Numerous studies of Health Maintenance Organizations, which are prepaid medical care plans, also show that more medical care does not necessarily lead to better health. Prepayment gives physicians an incentive to practice conservative styles of medicine. As a result, enrollees in prepaid plans use up to 40 percent fewer hospital days than enrollees in fee-for-service health insurance plans. No charges have been substantiated that the conservative style of medical care in prepaid plans is inferior to that in the fee-for-service sector.

A growing body of studies suggest that some types of medical care make a significant positive contribution to health. Research conducted in the United States and other countries has shown that hypertension (high blood pressure) can be controlled by appropriate medical treatment. This result is significant because hypertension is a key risk factor in cardiovascular disease, which accounted for approximately half of all U.S. deaths in 1980. Other studies have shown that hypertension control has improved significantly in recent years. Improved rates of hypertension control have been cited as a factor responsible for the dramatic decline in age-adjusted death rates for heart disease, which fell from 253.6 per 100,000 population in 1970 to 188.5 in 1983.

Evidence that poor people with hypertension can benefit from free medical care comes from a "natural experiment" in which medically

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indigent adults were terminated from the California medicaid program in 1982. Blood pressure levels among terminated people with hypertension deteriorated significantly during the 6-month study period, compared to a control group.

A growing consensus also suggests that infant and prenatal care can improve health outcomes. One study showed that neonatal death rates (deaths of infants in the first 28 days of life) were reduced by the medicaid program. Another study found that delay in seeking medical care during pregnancy had a substantial negative effect on infant birthweight. This finding takes on additional significance because women covered by medicaid seek medical care earlier than those with no insurance coverage.

Evidence from these studies, taken together, points to the following conclusions. First, an across-the-board increase in medical care use would do little to improve the health of the average person. Second, medical intervention makes a difference for some populations (the poor who are at high risk) and for some conditions (hypertension and neonatal mortality, to name two). Third, and as a consequence of the first two conclusions, programs of universal eligibility for general health services are inferior to programs targeted to particular conditions and at-risk populations.

THE EFFECT OF LIFESTYLE FACTORS ON HEALTH

If the effectiveness of medical care in producing health is questionable, the opposite can be said about the importance of so-called lifestyle factors such as smoking, consumption of alcohol, and diet. Five studies of middle-aged men identified three risk factors—smoking, cholesterol, and blood pressure—as determining the risk of death from any cause. These factors are all influenced by a person's lifestyle. This is particularly true of smoking, which is entirely a self-inflicted risk factor.

A number of investigators have estimated that 30 percent, or more, of coronary heart disease deaths can be attributed to cigarette smoking. Smoking is the major single cause of cancer deaths in the United States, and it is a contributing factor to deaths from stroke and emphysema. In fact, smoking has been implicated as a cause of so many diseases that the U.S. Surgeon General, C. E. Koop, calls it "the chief, single avoidable cause of death in our society, and the most important public health problem of our time." The total annual U.S. mortality from smoking is estimated to exceed the number of Americans killed in battle during World War II.

According to one estimate, the total direct medical care cost of smoking was $13.3 billion in 1972 (using 1983 prices). The discount-

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ed value of lost earnings attributable to sickness or death related to smoking was $31.4 billion. The total cost for smoking-induced illness represented 11.3 percent of all medical care costs in 1972. Focusing on the smoking-induced direct costs of cancer, there was a marked increase from 1972 to 1980—from $1.76 billion to $3.08 billion (in 1983 medical care prices).

Alcohol abuse also imposes enormous costs. Direct medical care costs due to alcohol abuse were estimated to be $19.4 billion in 1972 (1983 prices); discounted costs of lost production due to this cause were $33.5 billion. Alcohol abuse was responsible also for motor vehicle accident losses of $10.7 billion and violent crimes which cost $3.4 billion.

Automobile safety is another area in which health is affected by behavior. A study of data from 1970 to 1979 estimated that highway traffic fatalities were significantly reduced by the implementation of the 55 mile per hour national maximum speed limit. This study indicated that about 42,000 lives were saved by this policy between 1974 and 1979.

PUBLIC POLICY TO ENCOURAGE HEALTHY BEHAVIOR

Evidence shows that people can improve their health if they adopt healthy lifestyles. It would be premature, however, to conclude that government policy should attempt to promote healthy behavior. The legitimacy for public action rests on a finding that private markets do not provide incentives for individuals to adopt healthy behavior in appropriate situations. This may occur if consumers do not have access to relevant information or if there are externalities. In the first case, the government has a legitimate role in providing information, but the case of externalities is more complicated.

Negative externalities arise if the behavior of one individual imposes costs on other individuals. An example is unsafe driving, which leads to accidents that may involve other people. Cigarette smoking is another example in which the behavior of individual smokers creates negative externalities through smoke pollution.

One approach to correct these negative externalities is to tax the products that cause them. For example, the Federal excise tax on distilled spirits will be raised from $10.50 per proof gallon (64 ounces of ethanol) to $12.50, on October 1, 1985. The Federal excise tax per pack of cigarettes was raised from 8 to 16 cents by the Tax Equity and Fiscal Responsibility Act of 1982. The Tax Equity and Fiscal Responsibility Act tax increase is due to expire later this year, when the Federal cigarette tax will revert to its old level. Several studies have shown that consumption of alcoholic beverages and cigarettes would fall if the prices of these products were increased by

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an excise tax. These solutions are inferior to a system in which the tax is levied only on the behavior that results in the externality, e.g., smoking in public or driving while intoxicated. However, the costs of collecting such "ideal" taxes might be prohibitive.

The problem of externalities is sharply distinct from the problem of costs imposed on the smoker by his own behavior. These costs affect other people if the smoker's health insurance premium is not increased to reflect the expected additional health costs of smoking. Some individual insurance policies already practice risk-rating for poor health habits. In one instance, the insurance company gives a 10-percent discount to individuals who report that they do not smoke. Automobile insurance policies use age, sex, and previous accident history, among other factors, to distinguish among risks. Similar rating methods might be applied to the health costs of alcohol.

The role of the Federal Government in this area should be to ensure that legal barriers are not imposed that restrict the ability of private insurers to distinguish among risks. In one instance, an active policy may be recommended. This concerns premiums for enrollees in the Federal Employees' Health Benefits Plan, the Nation's largest, with approximately 9.2 million enrollees and dependents. As an example for the private sector, the premium for this health insurance plan might be adjusted to reflect the excess health costs due to smoking and drinking.

HEALTH INSURANCE AND MEDICAL CARE COSTS

Studies suggesting that an increase in medical care use would do little to improve the health of the average person might justify some concern that rapidly rising medical care costs are "excessive," but they could hardly explain the widespread belief among both analysts and policymakers that the medical care system is in a state of acute distress. In other industries, the principle of consumer sovereignty is generally the best guide to determine how many resources should be allocated to the industry. Why doesn't this principle apply to the medical care industry?

Medical care is different from other major industries because only about one-quarter of the cost of medical care is paid directly by consumers. The remainer is paid by public and private health insurance programs. Private health insurance arose because consumers of medical care are generally uncertain about when they are going to fall ill and require medical attention. This uncertainty, and the expensive nature of medical care, create a large degree of risk. In order to eliminate much of this risk, consumers buy insurance for their medi-

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cal care needs. By paying a fixed amount each month, consumers can protect themselves from large medical costs should they fall ill.

The foregoing rationale suggests that health insurance serves a useful function in the economy. However, the benefits of health insurance can be offset if the policy premium is not based on expected medical care costs incurred under the policy by specific risk classes of consumers. If premiums are not risk rated, then the costs of each individual's behavior are spread throughout the insurance pool and thus are negligible to the individual. Since the benefits of using more medical care, however, slight, accrue to the individual, each person will have little incentive to use medical services carefully and to buy services from the most cost-effective providers.

Perfect risk rating for every individual would be exceedingly complex. Nevertheless, certain observable characteristics—such as smoking—can be used to distinguish among health risks for the purposes of determining health insurance premiums. To the extent that such practices are not followed, the distorting effect of health insurance on individual choice is magnified by another feature of the health insurance policy. Policies which subsidize the cost of additional services or more expensive services will increase the consumer's incentives to use medical care without regard to costs. Since many policies provide such arrangements, including free care at the point of purchase, the undesirable effects of imperfect risk rating are magnified. Moreover, the subsidy for additional services reduces providers' incentives to hold down their price and to control the complexity of their products. These price increases make it more difficult for uninsured consumers to purchase medical care and may explain, in part, why public insurance programs have arisen.

Finally, the purchase of health insurance is heavily subsidized by the tax system. Even if perfect risk rating were achieved and the use of additional services were not encouraged by the policy, the tax subsidy would be a subject of public policy concern.

THE TAX SUBSIDY FOR PRIVATE HEALTH INSURANCE

Private medical insurance is a relatively recent phenomena in the United States. Prior to World War II the vast bulk of the population did not have such protection. However, in the 1940s and 1950s, the spread of employment-related health insurance was given special impetus after the Internal Revenue Service ruled that employer health insurance contributions are excluded from the wage base for determining income and social security taxes. Recent estimates indicate that 79.4 percent of the noninstitutional population have private

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health insurance and 85 percent of private health insurance is employment-related.

The tax exclusion can be viewed as a special Federal subsidy for the purchase of employment-related health insurance. From this perspective, the exclusion reduces the price of insurance to employed consumers and thereby provides an incentive for employees to purchase more health insurance than they would if they were using taxable income.

Several studies have used various measures of the tax subsidy to obtain estimates of the responsiveness of the demand for health insurance to price changes. Such studies have all concluded that the demand for health insurance would fall if the tax subsidy were reduced.

Numerous studies, conducted in the 1960s and 1970s, showed that demand for medical care services is directly related to the level of health insurance coverage. Data sources for these studies were regional (often statewide) aggregates, individual consumer data collected by surveys, and several "national experiments" in which the level of cost-sharing was changed for a particular group of consumers. All of these studies showed that people spent more on medical care when the cost to them was lower, although estimates differed among studies.

Reliable estimates of the impact of insurance on demand for medical care services have been provided by the RAND experiment. Interim results from the RAND ~~health insurance~~ experiment show that total medical expenditure per capita rises steadily as the fraction of the bill paid by the family falls. Controlling for other determinants of medical care spending, individuals with full insurance coverage spent approximately 60 percent more than individuals in families which paid 95 percent of the bill.

Individuals with health insurance may choose more expensive providers than those without insurance, either because the insured individual demands more complex services or because he devotes less time to searching for cost-effective providers. One study suggested that complete insurance coverage would raise the hospital room and board price by 23 percent and the price of the physician selected by 18 percent, compared to the prices of hospitals and physicians chosen by persons with no insurance.

Several studies have shown that physicians' style of practice is related to the average level of health insurance coverage. In one instance, it was found that more extensive insurance coverage leads physicians to provide more services per visit or to itemize charges that were previously included in the professional fee. Another study calculated that insurance was responsible for more than half of the

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rise in hospital prices from 1958 through 1967. This contrasts to general inflation, which accounted for only 10 percent of the increase.

Current insurance policies leave the consumer little or no incentive to find cost-effective suppliers. Nearly 100 percent insurance coverage weakens the concept of a competitive medical care market. Such high levels of insurance permit hospital prices to rise much faster than prices in less insured markets for drug, dental, and physician services. This suggests that health insurance creates a "vicious cycle" in which insurance drives up prices, causing consumers to demand more insurance to protect themselves against large health care bills, which leads to further price increases.

PROPOSALS TO REFORM THE TAX TREATMENT OF HEALTH INSURANCE BENEFITS

Several policy solutions have been proposed to reform the tax treatment of health insurance benefits. One proposed by the Administration would have limited tax-free health benefits paid by an employer to $175 per month for a family plan and $70 per month for individual coverage. These limits would have been indexed to increase yearly in proportion to the rise in the Consumer Price Index.

Some employers and employees with contributions over these limits would reduce their contribution to health benefits and increase cash wages or other benefits. Employers might also offer employees a choice of health care plans, with some of the plans having premiums below the limit. Both of these strategies would have an impact on total health insurance premiums and, therefore, on medical care costs. In addition, there would be a revenue effect, with increased income and payroll taxes. A study by the Congressional Budget Office estimated that a limit of $165 per month (about $171 in 1984 prices) would produce added revenues of $4.1 billion in 1984 and $7.8 billion in 1987. Removal of the subsidy altogether might have increased tax revenues by $25.7 billion in 1983. Thirty-five percent of this amount would have been paid by households with annual incomes above $50,000, who made up 18 percent of all households in 1983.

The Administration tax cap proposal might also improve the efficiency of the group health insurance market. The tax cap would encourage employers to make a fixed contribution to the health insurance premium. One study showed that companies currently following this policy have lower premium costs than companies that contribute a level percent (including 100 percent) toward the health insurance premium. This evidence implies a more careful plan choice by em-

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plovees who have to pav for additional premium costs out of their own pocket.

One alternative to the Administration proposal involves a limited tax credit (a credit which can be applied only to the purchase of health insurance) of 40 percent of the health insurance premium up to a maximum credit of $70 per month. This is identical to a $175 per month tax cap for a worker whose marginal tax rate is 40 percent. An advantage of the tax credit proposal is that it would equalize the subsidy across all income groups (holding health insurance premiums constant). In contrast, the tax cap would leave the regressive character of the present subsidy largely intact. The tax credit would also be neutral between workers who obtain health insurance through their employer and those who are self-employed or unemployed. A disadvantage of the tax credit is that it might encourages consumers whose marginal tax rate is less than 40 percent to purchase more health insurance.

Another proposal calls for tax-free rebates up to a ceiling amount. Workers would be affected by the rebate in one of three ways: workers in firms with insurance premiums substantially above the limit would be unaffected by the rebate; workers at or near the limit would view the rebate mainly as an increase in the relative price of insurance and would, therefore, choose a lower insurance premium; and workers substantially below the limit would view the rebate mainly as extra income and would tend to increase their premium. The net effect on the quantity of insurance purchased is unclear. Thus, a rebate proposal amounts to a "bet" that the first two types of workers dominate, in terms of numbers or the magnitude of their adjustment to the rebate. Given that the tax cap proposal is certain to reduce the quantity of health insurance purchased, a bet on the tax-free rebate does not seem advisable.

Although multiple choice of medical care plans is not necessary in order to implement a tax rebate plan, it is often included as an element in such plans. Two issues have arisen which cloud the debate over mandated multiple choice. The first of these is whether this proposal would promote the development of Health Maintenance Organizations (HMOs). Proponents of HMOs view mandated multiple choice as a means of promoting HMO growth and have suggested that at least one of the plans offered must be an HMO if one is available. This viewpoint is an expression of a philosophical preference and is not based on economic analysis. More to the point is the question of whether an HMO would be chosen if it were offered and if its premium were lower than the premium for a competing fee-for-service insurance plan. A recent study of firms that offer their employees a choice between a fee-for-service insurance and HMOs has found

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that small changes in employee cost-sharing for health care premiums have a sizable impact on HMO enrollment.

The second issue is whether the low-coverage plans offered under the multiple choice proposal would be more attractive to low-risk individuals. If so, premiums for these plans would fall and the premium for people remaining with the high-coverage plan would increase. This possibility concerns those who view health insurance as a means for providing a subsidy from low risks to high risks. The extreme version of this argument is that the premium for high risks would continue rising and relatively good risks would continue bailing out of the full-coverage policy until all that is left are a pool of people who are essentially uninsurable. If policymakers do not like this outcome, they should consider an explicit income transfer to those persons who are chronic high risks.

INDEMNITY INSURANCE AND PREFERRED PROVIDER ORGANIZATIONS

Even if the tax subsidy for health insurance were reduced or eliminated, health insurance would continue to have a distorting effect on medical care markets, as long as the policy paid for the costs of additional medical services. Most health insurance policies currently incorporate this undesirable feature. However, some insurers and self-insured employers are experimenting with indemnity insurance, in which the insurance company makes a fixed payment per unit of care. An indemnity payment provides protection against risk without encouraging the consumer to choose expensive providers. The reason is that the cost of services in excess of the indemnity is paid entirely by the consumer.

Ideally, indemnity payments would be based on episodes of illness, rather than units of medical care. This system would reduce the tendency of insured consumers to use additional services as well as to choose expensive providers. However, the difficulty of defining illness might make an ideal system exceedingly complex. Therefore, indemnity payments based on units of care may represent an acceptable, albeit imperfect, alternative.

Private indemnity plans typically allow providers to bill consumers for amounts above the indemnity. However, some insurers have expressed an interest in concluding agreements with providers who will accept the indemnity as payment in full. The insurer would channel patients to these providers. This is the basis of the "preferred provider organization," which is springing up around the country in increasing numbers. A preferred provider organization represents a method for determining the insurer's indemnity payment at a level equal to the full-billed charge of the low-priced providers. In prac-

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tice, other criteria, such as quality, can also be used to select the preferred providers.

Many employers have expressed an interest in the preferred provider organization concept as a means to control their soaring health benefit costs. The major barrier to the development of preferred provider organizations appears to be restrictive State insurance laws. Therefore, a number of States have passed enabling legislation that permits the development of preferred provider organizations.

PUBLIC POLICY TOWARD DISCOUNTS

Although the basic preferred provider organization concept does not involve a discount, i.e., payment less than the hospital's full-billed charge, many insurers are attempting to negotiate discounts as part of the preferred provider organization arrangement. If successful, they will join some of the Nation's 90 Blue Cross plans, which have already obtained discounts from hospitals. Many HMOs have also negotiated hospital discounts.

These discounts have, for two reasons, recently become an important public policy issue. First, hospitals claim that discounts force them to "shift" costs by making up charges to other insurers. This has led to suggestions that discounts be banned, in favor of so-called "all payers rates," where all insurers would pay equal rates. Second, some critics have claimed that the size of the Blue Cross discount appears to be related to and is perhaps a consequence of Blue Cross's relatively large market share. Noting this relation, the less concentrated commercial insurance industry has sought, unsuccessfully, to obtain relief from antitrust laws which prohibit joint insurance company negotiations with hospitals.

There is little economic justification for banning discounts. When one insurer negotiates a discount, cost-shifting is not the only possible outcome. The discount may also reduce the hospital's net operating margin; the hospital's operating efficiency may improve; and the level of real expenses per admission may fall. All of these outcomes might be viewed as positive responses. In particular, since hospital costs are artificially inflated by insurance, some reduction in real expenses per admission may be desirable.

This does not imply, however, that commercial insurers should be encouraged to negotiate together for a discount. In the first place, a large market share is not necessary in order to obtain a discount. Many HMOs recently have negotiated hospital discounts even though their market shares are small relative to Blue Cross's. Second, any insurer, regardless of its size, can form a preferred provider organization. Through the preferred provider organization the insurer can selectively determine its payments to hospitals so that hospitals with

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excessively high costs will lose customers in the marketplace. Third, giving the Federal Goernment's blessing to countervailing market power sets a dangerous precedent. Countervailing power arguments could, for example, be used by hospitals seeking to band together to escape relief from legitimate, but vigorous, price pressure from the insurance industry.

The large market shares commanded by Blue Cross plans are most probably not attributable to anticompetitive conduct by those plans. State insurance acts usually exempt the Blues' policyholders from State taxes on insurance premiums. These premiums generally range from 2 to 4 percent. In addition, the Blues are not subject to the reserve requirements of their commercial rivals. Two empirical estimates suggest that each one percentage point difference in premium tax rates may contribute between 3.35 and 5.4 percent to Blue Cross's market share.

Several studies have indicated that Blue Cross plans with premium tax advantages have relatively high administrative costs and exhibit other characteristics indicative of poor market performance. Although insurance regulation is a matter best left to the States, these studies suggest that competition among health insurers might be promoted if regulatory advantages favoring Blue Cross were reconsidered by the States.

THE ROLE OF INFORMATION IN HEALTH CARE MARKETS

Most experts agree that, in order for the medical care market to function properly, consumers must have the right incentives and they must be informed about the available choices. The discussion thus far has concentrated on incentives, e.g., the health insurance tax cap and indemnities. The problem of inadequate or inaccurate consumer information must also be addressed. Critics of pro-competition medical care proposals often point to consumer information as the weak link in the proposal.

Such objections miss the point that a competitive medical care system would tend to produce more reliable information than the present one. For example, many participants in the RAND health insurance experiment lacked certain facts that seem relevant to choosing a particular provider. Few of them correctly answered the following two statements: "If you have to go into the hospital, your doctor can get you into any hospital you prefer"; and "Doctors are checked every few years, before their licenses are renewed." (The correct answer, in both cases, is "false.")

When the same questions were posed to a group of over 5,000 employees in Minneapolis, researchers found significantly better answers to the question on hospital admitting privileges. This suggests that

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consumers in Minneapolis—where many employees have a choice among competing HMOs—are aware that choosing a closed-group HMO limits one's ability to choose any hospital.

One area where information is currently poor concerns the prices charged by different providers. Inadequate price information is, to a large extent, a wound that the health care system has inflicted on itself. Most price advertising of medical services has been banned by State laws or regulations. The prohibition of price advertising was the result of organized medicine's determined effort to ban such behavior. Evidence shows that bans on advertising have raised the prices of eyeglasses, eye examinations, and prescription drugs. Recent court rulings, however, have substantially lifted these prohibitions on advertising.

It should also be pointed out that not all consumers have to be perfectly informed for markets to function effectively. If enough people are well-informed, the remainder can judge medical care quality by observing price differences in the market.

Finally, the problems of poor incentives and poor information are related: when consumers have complete insurance, they have little reason to shop for low-priced providers and, thus, they will be poorly informed about medical care prices. This point is substantiated by a survey of individuals regarding their health insurance premiums. Families with individual insurance coverage were more likely than families with group insurance to respond correctly that they paid out-of-pocket premiums. This occurs because individual policyowners are more likely to purchase the health insurance policy themselves; thus, they have a stronger incentive to learn about the price of the policy.

MEDICARE: PUBLIC HEALTH INSURANCE FOR THE AGED

In 1983, spending for the medicare program was $57.4 billion. This represented 46 percent of total government medical care spending in 1983 (Table 4–3). Medicare has expanded at a rapid rate since 1967, when it consumed $4.5 billion ($12.3 billion in 1983 prices). Even during this Administration, which has been committed to austere budgets for other domestic programs, medicare spending rose by 17.5 percent from 1981 to 1982 and 12.1 percent from 1982 to 1983.

The impending crisis in medicare concerns the Hospital Insurance Trust Fund, which finances hospital, home health and skilled nursing care for 30 million aged and disabled persons. Spending from the trust fund is expected to grow at the rate of 11.8 percent per year from fiscal 1985 through fiscal 1995. Given the projected growth of revenues, the trust fund balance is expected to decline, starting in 1990. Under baseline projections developed by the Congressional

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TABLE 4-3.—*Sources of funds for personal health care expenses, selected years, 1950–83*

(Billions of dollars)

Year	Total	Private			Government		
		Direct payment	Private insurance	Other	Medicare	Medicaid [1]	Other
1950	10.9	7.1	0.9	0.3			2.4
1960	23.7	13.0	5.0	.5			5.2
1965	35.9	18.5	8.7	.8			7.9
1970	65.4	26.5	15.3	1.1	7.1	5.2	10.1
1975	117.1	38.0	31.2	1.6	15.6	13.5	17.2
1980	219.1	62.5	67.3	2.6	35.7	25.2	25.8
1981	253.4	70.8	78.8	3.0	43.5	29.0	28.4
1982	284.7	77.2	90.8	3.4	51.1	31.3	31.0
1983	313.3	85.2	100.0	3.7	57.4	34.0	33.1

[1] Includes medicaid purchase of medicare coverage for eligible medicaid recipients.

Source: Department of Health and Human Services, Health Care Financing Administration.

Budget Office, the trust fund will be exhausted in 1994 and will face a negative balance of $56 billion in 1995. Therefore, it is clear that dramatic reforms are required to save the medicare program from financial insolvency. Fortunately, however, policymakers have time to consider carefully the proposed solutions to medicare's financial crisis.

MEDICARE BACKGROUND INFORMATION

Medicare was enacted in 1965. It consists of two parts: Hospital Insurance, also called Part A; and Supplementary Medical Insurance, also called Part B. Medicare Part A provides benefits that help most aged and certain disabled individuals, who qualify for social security cash benefits, to pay for inpatient hospital and other institutional services. Medicare Part B helps beneficiaries pay for physician and other outpatient services. Part B is a voluntary program, although 97 percent of Part A participants are also in Part B. Medicare is administered by the Health Care Financing Administration, an operating component of the Department of Health and Human Services.

Medicare Part A covers 90 days of hospital care per spell of illness and allows an additional 60 "reserve days" to be used over the beneficiary's lifetime. Part A also covers 100 days of skilled nursing facility care per spell of illness and, since 1980, an unlimited number of home health visits. Hospital inpatient services are subject to a deductible equal to the cost of a day of hospital care (which increased from $356 to $400 on January 1, 1985) and coinsurance rates of one-fourth of the deductible for days 61 to 90 of hospital care, one-half of the deductible for each reserve day, and one-eighth of the deductible for days 21 to 100 of skilled nursing facility care. Services cov-

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ered by medicare Part B are subject to a $75 annual deductible and 20 percent coinsurance.

The principal source of funding for the Hospital Insurance Trust Fund is payroll tax contributions, at rates periodically modified by the Congress. The trust fund is financed on a pay-as-you-go basis, that is, current workers pay the costs of current beneficiaries. The Supplementary Medical Insurance Trust Fund is financed primarily through a combination of premiums from beneficiaries and general revenue contributions. The calendar year 1984 premium was $14.60 per month, which was raised to $15.50 per month on January 1, 1985. These rates were projected to equal 25 percent of the supplementary medical insurance program costs, as required by the Social Security Amendments of 1983.

ISSUES IN MEDICARE PHYSICIAN REIMBURSEMENT

Medicare reimbursement for Part B services is based on reasonable charges. Private insurance carriers which administer the Part B program determine the reasonable charge by comparing the amount actually billed with the billing physician's customary charge and the locality's prevailing charge. The lowest of these three amounts for any claim submitted is the reasonable charge. After the Part B deductible is met, medicare generally pays 80 percent of the reasonable charge and the beneficiary is responsible for the remaining 20 percent.

Increases in reasonable charges are limited by the medicare economic index, a formula based on increases in physicians' practice costs. The rate of increase in the medicare economic index has been consistently lower than the rate of increase in customary and prevailing charges. Therefore, the medicare economic index places a binding limit on increases in reasonable charges, in effect converting them into indemnity payments. Estimates are that about 60 percent of medicare Part B charges are constrained by the medicare economic index.

Physicians can decide on a claim-by-claim basis whether to accept medicare's reasonable charge as payment in full for the service. If so, the physician receives payment directly from the program. The patient is responsible for the 20 percent coinsurance and any remaining deductible. If not, the physician bills the patient directly and the program reimburses the patient for 80 percent of the reasonable charge (after the deductible has been satisfied). The percentage of claims paid directly to the physician declined steadily from 61.5 percent in 1969 to 50.5 percent in 1976, after which it has slowly increased, reaching 54 percent of claims in 1983.

The Deficit Reduction Act of 1984 imposed a 15-month freeze, effective October 1, 1984, on medicare physicians' fees. All physicians

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were required to say by October 1 whether they would accept direct payment for all of their medicare patients for the following year. The freeze and other provisions in the Deficit Reduction Act were expected to reduce the rate of increase in medicare physician spending in fiscal year 1985 from 14.5 percent to 11.1 percent.

There are three related issues in the area of medicare physician reimbursement: mandatory direct payment, determination of the indemnity payments, and supplementary private insurance. As noted above, physicians currently have the option of accepting or rejecting direct payment on a claim-by-claim basis. Some observers have argued that this amounts to a license to overcharge patients and have, therefore, proposed mandatory (all-or-nothing) acceptance of direct payment. This is not a sound proposal. Some physicians who had previously refused direct payment would simply cease to treat any medicare patients. Other physicians who continue to treat medicare patients, but would select fewer medicare patients and more private patients. The total volume of services produced per physician by both types of physicians would also fall.

The second issue concerns how medicare's indemnity payments should be determined. Few observers would defend as reasonable the present payment system, which freezes in place the existing distortions in physicians' prices. For example, because insurance coverage of inpatient services predated coverage of outpatient services and is still more extensive, procedures provided in hospitals have tended to be introduced at higher prices and to move upward in price more rapidly than outpatient procedures.

Numerous proposals have been advanced to reform the medicare indemnity payment system. A successful proposal would use market mechanisms to set the values of the medicare indemnities. This is desirable because values set at competitive levels should assure continued access to quality medical care for beneficiaries. For example, the performance of certain high-volume procedures might be put up for competitive bids. The winning low bids would become the basis of a comprehensive scale that assigns weights to all procedures. Finally, the multiplier (a number that converts the weights into reasonable charges) could be auctioned to all willing physicians in the community.

The third issue concerns supplementary medicare insurance. In 1967, 45.5 percent of medicare beneficiaries also had private, supplementary insurance; by 1977, this fraction had grown to two-thirds. Medicare supplement policies tend to protect consumers against medicare cost-sharing. This calls into question the effectiveness of medicare payment strategies based on cost-sharing, e.g., physician indemnity payments. At another level one may ask why the demand for

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medicare supplementary insurance is so strong, particularly in the light of allegedly high premiums for these policies.

The answer may be that medicare supplementary insurance is highly leveraged. That is, the supplementary policy that pays 20 percent of the physician's reasonable charge may cause policyholders to use more services, for which medicare Part B is obligated to pay 80 percent of the bill. Therefore, consumers may regard supplementary policies as highly attractive, even though they may create substantial excess use of services for the system as a whole. In the absence of more fundamental reforms, a tax on medicare supplementary insurance may be required to correct this problem. The tax should equal the amount that Part B otherwise would pay on additional visits that are induced by the supplementary policy. This would place Part B second in line, after the supplementary policy pays for the additional visits.

MEDICARE HOSPITAL REIMBURSEMENT POLICY

Until October 1983, medicare reimbursed hospitals for their "reasonable costs" of providing care, subject to some limits and exclusions. To constrain the rapid increase in medicare costs for hospital inpatient care, major changes in medicare reimbursement were recently enacted. The Tax Equity and Fiscal Responsibility Act of 1982 placed limits on total operating costs per discharge, subject to a rate of increase ceiling one percentage point above hospital input price increases. The Social Security Amendments of 1983 marked a major departure from cost-based reimbursement by establishing the Prospective Payment System. Under this system, hospitals are paid a prospectively determined rate for each discharge. The amount of the payment is determined by the classification of the discharge into one of 468 diagnosis-related groups. During a 3-year transition period, reimbursement will be based on a decreasing percentage of hospitals' historical costs and an increasing percentage of the Federal prospective rate. Certain types of expenses, such as capital and medical education, are still paid on a cost basis.

Data indicate that hospitals are responding to financial pressures to control costs and admissions. Hospitals showed reductions in personnel and staffed beds from the second and third quarters of 1983, respectively, to the second quarter of 1984. The introduction of the prospective payment system has also coincided with a leveling in the upward trend of hospital admissions and a sharper rate of decline in the length of stay for people age 65 and over. Hospital admissions for people under age 65 have fallen more rapidly since the first quarter of 1983 and the under-65 length of stay has continued to decline slightly.

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The virtue of the prospective payment system is that it "uncouples" prices from the costs of individual hospitals. This idea, which lies at the heart of the prospective payment system, is that hospitals will strive to reduce their costs below the level of these fixed prices. The major problem with the prospective payment system is that the system of prices it established has no relation to the prices that would cause hospitals to produce the amount of services that consumers desire to buy, at the right quality, and the minimum cost. A price that is too low may cause producers to reduce investments so that the quality of service declines. Of more relevance to hospital services, a price that is too high in a market with competing suppliers will lead hospitals to compete in dimensions other than price, driving costs up to prices.

Achieving the right set of prices will not be easy. The approach currently favored by the Health Care Financing Administration is to revise the existing system to account for unusual cases, hidden differences in the severity of cases among hospitals, and the like. However, the prospective payment system—no matter how finely tuned—creates incentives for cost increases that could be substantial. For example, hospitals have incentives to increase net revenues by increasing admissions, unbundling services to shift costs to other parts of the medicare program, and by diagnosing and treating patients in the most-highly reimbursed diagnostic categories.

The Health Care Financing Administration may attempt to thwart these cost-increasing tendencies by setting up regulations to detect and punish excessive use of services under the prospective payment system. However, without incentives on the part of consumers, it is doubtful that extra regulations will be effective. This is because individual consumers have no stake in saying "no" to extra admissions, unbundling of services, or reclassification of admissions into higher priced diagnosis-related groups. In addition, they have no reason to shop among hospitals on the basis of price. An efficient hospital can gain patients by offering higher quality care, but not by offering a lower price. This will lead to excessive quality competition. The system is basically one of price control, with all the usual disadvantages of that approach. As a transitional measure to a market-based system, however, current arrangements may be superior to the previous system of cost reimbursement.

There appear to be two possible solutions for the longer run. First, medicare Part A could be turned into a prefered provider organization in which the program pays in full for admissions at low-priced hospitals. Consumers choosing more expensive hospitals would have to pay the balance of the hospital's bill. This arrangement would not

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preclude using medicare's substantial buying power to obtain discounts from high-priced hospitals.

The advantage of this approach is that it could be set up quickly in most parts of the country, including those where organized alternative delivery systems do not exist. The disadvantage is that it would not address the structural incentives of hospitals to increase admissions, unbundle services, and diagnose patients in profitable diagnosis-related groups. In order to solve these problems, it may be necessary to adopt the alternative approach of combining medicare into a single program and letting organized provider groups bid to serve the medicare population at competitive rates.

Under this alternative proposal, each medicare beneficiary would receive a "voucher," that would enable him/her to purchase both physician and hospital services from an approved medical plan. A successful voucher system would seem to have four characteristics: (1) it would be based on capitation; (2) the medicare contribution would be determined by competitive bidding; (3) consumers would have a choice among alternative plans; and (4) it would be mandatory.

Medicare payment based on capitation, that is, a fixed payment per enrollee per month, would eliminate the problems of excessive admissions, unbundling of services, and diagnosis-related groups reclassification which affect the present system. Competitive bidding would address the fundamental problem that the Health Care Financing Administration does not know in advance what hospitals' costs truly are.

The problem with using bidding to determine the capitation rate is that of specifying the product to be delivered and ensuring that the winning bidder actually delivers that product and not an inferior substitute. To overcome this problem, it is necessary for consumers to have a choice among competing plans. Then, if a plan did not deliver its promised services or otherwise inconvenienced its enrollees, they could go elsewhere. Such plans would require a bad reputation so that consumers need not be harmed before switching to another plan. In order to ensure an adequate number of competing plans, it would be necessary to define eligible plans quite broadly. In some instances, the capitation payment might be given to a primary care physician who becomes the patient's case manager and is at risk for additional expenses.

However, choice among health plans entails its own problems—those of preferred risk-selection and self-selection. Preferred risk-selection refers to the tendency of a health plan to pick off good risks, thereby making a profit at the standard capitation rate. There are two ways to prevent this. First, if the plan can charge consumers more than the standard capitation rate, then it will be willing to enroll all

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applicants, with marginal payments tailored to the applicant's risk. This system may be perceived as unfair to high risks, who have to pay positive marginal premiums. An alternative is to risk-rate the capitation payment itself. Using certain predetermined demographic factors which are related to health care expenditures, the Health Care Financing Administration can vary the capitation payment. Although this system would not be perfect, it is exactly the technique that a private insurer would use to risk-rate its enrollees.

Standard medicare could remain as one of the choices under this system, but not as an open-ended choice. Those who remained with standard medicare would have to pay for expenses greater than their risk-rated premium. Otherwise, medicare would be forced to subsidize those individuals who prefer the less efficient delivery system.

The Tax Equity and Fiscal Responsibility Act marked a significant step toward the goal of medicare vouchers. That legislation amended the medicare statute to permit payments on a risk basis to HMOs and other competitive medical plans. However, the current law has significant shortcomings. One of these is a requirement that, if medicare payments exceed the estimated cost of serving medicare enrollees, the savings must be passed on to enrollees in the form of additional benefits or reduced cost-sharing. This regulation is unnecessarily restrictive. It leads to allocative inefficiency, since medicare enrollees might rather have cash rebates than additional benefits. A second flaw of the existing system is that medicare payment to competitive medical plans is determined by the 95th percentile of risk-rated expenditures in the standard medicare plan. The competitive approach to setting this payment would have plans bid on the payment rate for each distinct risk class of enrollee.

The choice between the prospective payment system and vouchers boils down to the question of the appropriate unit of service for paying providers. The prospective payment system favors payment for each admission, whereas the voucher system is based on payment per enrollee. On balance, the argument for vouchers seems to be stronger, but both systems face similar problems in determining the appropriate payment rate: the prospective payment system must make appropriate distinctions between different types of admissions, whereas the voucher system must distinguish among different risk classes of enrollees.

In deciding between the competing proposals, policymakers should keep two points in mind. First, competitive bidding might be used to help set the value of the medicare payments. Second, both systems should include strong incentives for consumers to select efficient providers. This can be done through a preferred provider arrangement or by making the voucher system mandatory. Without con-

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sumer incentives, the medicare program will continue to experience the cost-increasing pressures of insured medical care.

SHOULD MEDICARE MAKE SPECIAL CONSIDERATIONS?

Whatever prospective payment system is chosen, if effective, will lead to lower medicare payments than would have prevailed in the absence of the Tax Equity and Fiscal Responsibility Act. This has caused widespread concern that some consumers and some types of hospitals, particularly teaching hospitals, may be disadvantaged by prospective payment. On closer examination, however, the arguments for special consideration under the medicare prospective payment system are surprisingly weak.

Part of the medicare price reductions may be shifted to other third-party payers. Some analysts argue that the cost-shift is a hidden tax paid by the private sector because the Federal Government is unwilling to pay the full cost of the hospital care it has promised to medicare beneficiaries. Other methods of financing the shortfall, e.g., through increased payroll or income taxes, are said to place less of the burden on lower income families. This view is seriously flawed. It would be self-defeating if any savings due to the prospective payment system were given back to the hospitals by income or payroll tax-financed rebate. This would be tantamount to a return to cost reimbursement. In addition, such a proposal would reduce the incentive of private payers to control costs. If all third party payers attempt to control hospital costs, the whole system will benefit.

Prospective payment may also reduce hospitals' willingness to provide charity care. Although prospective payment does not preclude hospitals from using net operating revenue to finance charity care, some hospitals may lack the necessary revenue. Any proposal to deal with this problem should maintain strong incentives for hospitals to collect their bills and for patients to pay them. For example, a Federal program to pay for charity care would cause hospitals simply not to bill any patient who appears to be a bad payment risk. This type of perverse incentive should be avoided.

The legislation which created the prospective payment system gave special consideration to teaching costs. The salaries of residents and teaching physicians are fully reimbursed. It is also alleged that teaching adds indirectly to costs, because residents order more tests than fully trained physicians, and because the presence of residents puts extra demands on other staff which may not show up in time directly allocated to teaching. These costs are reimbursed according to a Health Care Financing Administration estimate that indirect expenses increase by approximately 5.79 percent for every 0.1 increase in the ratio of residents to beds. The law mandated that this factor be dou-

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bled in setting the diagnosis-related groups' payment rate for teaching hospitals.

The impact of the teaching adjustment on diagnosis-related groups payment rates is substantial. It has been estimated that 118 "heavy" teaching hospitals would receive $736 per admission in direct teaching payments and $2,158 in indirect payments. The total teaching adjustment would amount to 71.4 percent of the basic payment of $4,079.

The teaching cost adjustment is probably excessive. The Health Care Financing Administration analysis, on which the adjustment is based, used seven variables in the estimating equation: teaching intensity, case mix, hospital wages in the local area, bed size, and three measures of city size. Since other factors that contribute to indirect costs may also be positively correlated with teaching, it is likely that the teaching intensity estimate is too large. No attempt was made to compare the results to those of other studies which have found smaller teaching effects.

Much of the fault for the teaching adjustment lies with the Congress, which doubled the Health Care Financing Administration's estimate of the indirect teaching effect. The rationale for this action was twofold: first, hidden case mix differences between teaching and nonteaching hospitals may not have been controlled; second, some factors considered in the study (standard metropolitan statistical area size and bed complement) are not used in setting payment rates but are positively correlated with teaching; thus, using the teaching coefficient alone to adjust for the indirect costs of teaching would adversely affect large, urban teaching hospitals.

Neither of these reasons is convincing. An econometric study of teaching costs found no hidden case mix differences between teaching and nonteaching hospitals. The argument for increasing the adjustment because other cost-increasing factors are correlated with teaching is also faulty. If large, urban teaching hospitals were underpaid by the prospective payment system, this would occur because they are large and urban, not because of teaching.

Finally, special consideration is given to capital costs under the prospective payment system. Interest and depreciation for fixed and movable capital equipment represent only about 6–7 percent of total costs for the typical hospital. However, the capital cost percent varies widely among hospitals, leading to claims that including a flat percentage payment for capital in the basic diagnosis-related group rate would be unfair to some hospitals. Nevertheless, for two reasons, flat "add-on" to the diagnosis-related group rate is the appropriate method to pay for hospital capital. First, a simple add-on, unlike most other proposals for reimbursing capital, would not distort the

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choice between capital and labor. Second, when one examines the alleged differences in capital expenses among hospitals, one discovers a cycle: those hospitals with low reported capital expenses often have old physical plants which need replacement. Thus, temporary "overpayments" will disappear as these hospitals acquire new capital. The losers under a flat add-on will be those hospitals which have recently borrowed funds in the capital market. Even for this group, the discounted value of the loss will be fairly small. This is because the proper discount rate for most long-term hospital projects is the real rate of interest on tax-exempt bonds, which has averaged only about 0.5 percent for the last 20 years.

CARE FOR THE DYING

Much concern exists about the necessity and appropriateness of medical care services. Nowhere is this concern more relevant than for the medicare program. In 1978, medicare enrollees in their last year of life accounted for 28.2 percent of total program spending, although they represented only 5.2 percent of all enrollees. An earlier study had shown that medicare decedents in 1967 comprised 5 percent of enrollees and accounted for 22 percent of total program spending. Therefore, a disproportionately small number of enrollees accounts for a large, and apparently rising, share of program expenditures.

Much of this medical care is rendered in short-term hospitals, which critics suggest are an inappropriate site to care for the dying. The validity of this claim rests on the ability of medical science to determine, before care is rendered, whether or not expensive lifesaving measures are likely to succeed. Although this is an unresolved question, some research suggests that a large part of care rendered in hospitals' intensive care units is of low lifesaving value. As an alternative to expensive hospital treatment, careful attention should be given to innovative proposals for addressing medical needs during the last year of life. One promising step was taken by the Tax Equity and Fiscal Responsibility Act, which extended medicare coverage to hospice benefits, effective November 1983. Under this provision of the Tax Equity and Fiscal Responsibility Act, beneficiaries suffering from terminal illness may elect to receive hospice benefits.

The medicare hospice benefit recognizes that the purpose of end-of-life medicare care is to provide for the comfort and well-being of the patient. In these areas, he may be the best judge of what is good medical care. The most difficult question is this: Under what conditions does a mentally competent patient have the right to refuse life-sustaining medical treatment? It is beyond the realm of economics to attempt to answer this question. It is clear, nevertheless, that expen-

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sive medical care, devoted to extending life by weeks or days, will come under increasing scrutiny by both patients and third-party payers.

COVERAGE FOR NEW MEDICAL TECHNOLOGY

An issue closely related to care for the dying is coverage for new medical technology. Recent advances in technology have enabled physicians to repair or transplant numerous organs, but at very high costs and with uncertain long-term outcomes. Should new medical technology be covered by health insurance programs? This question is being addressed by private health insurers who have, in some cases, extended coverage to include organ transplants. These insurers have developed estimates of the costs of new coverages and, if consumers are willing to pay, the firms offering such options will succeed in the marketplace. Unfortunately, no counterpart to this process exists in the medicare hospital insurance program, since the program is not financed by premiums and since consumers cannot express their preferences by choosing among different medicare options. These problems might be solved by medicare vouchers, but only if the standard voucher does not include expensive new technologies. Patients wishing to cover these services could then do so at their own expense. The alternative of covering new technologies in the standard voucher would provide protection for all medicare beneficiaries, but it would tend to add further cost increases to the medicare program. These increases might exceed the ability of our society to pay for all new medical technologies.

MEDICAID: PUBLIC HEALTH INSURANCE FOR LOW-INCOME PEOPLE

The public image of medicaid is that of a welfare medical program oriented largely toward children and other members of families receiving Aid to Families with Dependent Children (AFDC) payments. Allegations abound that these clients abuse the program. Other critics point to abuses by medicaid providers; and policymakers have become increasingly concerned about "medicaid mills" in which low-quality care is provided.

None of these perceptions is accurate. In fact, medicaid has successfully met its legislated objectives. The primary emphasis of medicaid was intended to be on persons whose economic status is beyond their control—dependent children, and the aged, blind, and disabled. Access to medical care for these groups has markedly improved and with it have come improvements in the health of the poor.

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MEDICAID BACKGROUND INFORMATION

Medicaid was enacted by the Social Security Amendments of 1965 to pay for the medical care of specific categories of low-income people. It is administered by States and jointly funded by the Federal Government and States. The Federal share of medicaid is determined by a formula related to the State's per capita income. For 1982 and 1983, the Federal share ranged from a statutory minimum of 50 percent in 13 states to 77 percent in Mississippi.

With some exceptions, to be eligible for medicaid, an individual must receive or be eligible for federally assisted cash welfare payments. States, at their option, may cover specific groups of people who do not receive cash assistance. Because of medicaid's multiple criteria for eligibility, about 12 million people with income below the Federal poverty threshold are ineligible for medicaid. At the same time, about five million of those eligible have annual family incomes at least twice the poverty standard.

Medicaid covers a broad range of benefits, including some, such as nursing home care, which are not often found in private insurance contracts. Many States have also chosen to cover optional services, such as dental care and eyeglasses, which accounted for 40 percent of all medicaid outlays in 1978.

Medicaid patients receive most services free of charge. The exception is nursing home care. Since this is a catastrophic expense (exceeding $40,000 for the average admission) and is not covered by private insurance, many nursing home residents "spend down" their resources and income until they become eligible for medicaid.

The overwhelming emphasis of the medicaid program is on institutional care. Of $32.3 billion spent on medicaid in fiscal 1983, hospitals received 27.2 percent for inpatient care and nursing homes accounted for 42.9 percent (up from 23.4 percent in fiscal 1972). Payments to physicians represented only 6.7 percent of all medicaid payments in 1983.

The number of medicaid recipients increased from 18.3 million in fiscal 1972 to 23.9 million in 1977 and has declined slightly since then. The largest group of recipients are people who are eligible for Aid to Families with Dependent Children (5.5 million adults and 9.4 million children). However, this group accounted for only $9 billion of spending in 1983. A much larger amount—$23.3 billion—was spent on the aged, blind, and disabled. This is a reflection of the medicaid program's emphasis on institutional and, particularly, long-term care.

Nearly 60 percent of all medicaid patients treated in private physician practices are seen by practices whose patient volume is composed of at least 30 percent medicaid-eligible patients. However,

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these "large medicaid practices" do not fit the stereotype of medicaid mills. Ancillary services are not abused; nor is there evidence of excessive markups over cost. Visit length in large medicaid practices is comparable to that in other practices. Physicians in these practices often earn less than other physicians. However, physicians in large medicaid practices tend to be older, nonboard certified, and graduates of foreign medical schools.

ISSUES IN AID TO FAMILIES WITH DEPENDENT CHILDREN MEDICAID

Proposals for medicaid reform fall into four broad areas: to change the eligibility criteria and coverage of the poor; to trim medicaid benefits; to adjust reimbursement policies; and to modify the Federal role. For example, the Federal role might be changed from that of providing matching grants to payment of block grants to States. The argument behind this proposal is that block grants give the States greater flexibility in deciding how to use medicaid funds.

One problem with this approach is that it may lead medicaid-eligible people to migrate from States with poor benefits to States with generous benefits. If that is the case, some States will not be able to set benefits as high as they might desire for their current residents, because to do so would invite excessive immigration. Thus, the best strategy for all States is to provide levels of benefits lower than they might otherwise desire.

In short, the block grant approach may not be well-suited to the medicaid program, which involves income redistribution among States. One alternative choice is to tie the Federal contribution to a program of "basic" medicaid benefits judged to be necessary in all States. Those States desiring to add more benefits, or to extend coverage to more people, could do so with their own funds. Another alternative is to cap or reduce Federal payments by a fixed percentage amount. This method was used by the Omnibus Budget Reconciliation Act of 1981, which reduced Federal payments to each State in fiscal 1982, 1983, and 1984 by 3 percent, 4 percent, and 4.5 percent, respectively.

Proposals to change medicaid eligibility criteria and coverage of the poor should be given serious consideration, but the first principle for any change is that it should not reduce the incentives of medicaid recipients to work. A program that replaces the present categorical definition of eligibility with an income test would in effect simply add another tax on the earned income of poor people.

Any proposal to trim medicaid benefits should also be examined carefully, in order to rule out unanticipated perverse incentive effects. For example, one proposal considered by this Administration would have imposed nominal copayments that would have raised the

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relative price of medicaid outpatient services. This might have led medicaid beneficiaries to choose more expensive hospital care. A study indicated that the poor are very sensitive to outpatient copayments and that the imposition of even small copayments may lead to increased overall program costs.

An alternative to medicaid cost-sharing is for the program to contract with selected hospitals on a competitive bid basis. The State of California is experimenting with this program. Arizona is also conducting a demonstration of a substantially different method of providing medicaid benefits. Virtually all beneficiaries must choose among competing prepaid, capitated organizations. All care must be received or authorized by the prepaid capitated organization which is at financial risk for the provision of care. This system is similar to the HMOs voluntarily selected by many employees under their private insurance plan options.

Both of these programs limit the patient's freedom to choose any provider without regard to costs. This may raise the claim the medicaid is becoming a "second-class" medical program, but the hard reality is that we cannot afford to send public patients to high-cost hospitals and physicians.

ISSUES IN LONG-TERM CARE MEDICAID

Long-term care Medicaid presents a different set of issues. Foremost among these is the growing demand for long-term care for the aged. The elderly population doubled between 1950 and 1980 and will double again by 2030, accounting for almost one-fifth of the U.S. population. Moreover, the elderly population is becoming older. In the two decades from 1990 to 2010, the 85 and over age group will increase three to four times as fast as the general population. This will create increasing demands for long-term care.

Most of the long-term care population resides in the community. Only 29 percent are in institutions. However, since institutional care is very expensive and many experts believe that it may be unnecessary in some cases, many proposals emphasize community care for the elderly. Among these are formal sources of care (paid providers of home care, adult day care, etc.) and informal support by family members. Some have proposed giving families tax deductions or credits if they maintain severely disabled family members at home rather than placing them in an institution.

Other approaches would seek to strengthen private, voluntary financing mechanisms for long-term care. One of these is the "life care contract," in which the beneficiary is guaranteed a lifetime continuum of care in a community that combines residential living with specialized long-term care services. The resident usually pays a lump

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sum initial fee and monthly charges thereafter. This contract represents a capitated approach where the provider is at risk and, therefore, has an incentive to provide a cost-effective mixture of services including alternatives to institutional care.

CONCLUSION

Medical care spending is rising at an alarming rate, seemingly beyond our ability to control it. This dispairing attitude is not justified. It is possible to control medical care costs without harming the health of the average person. This is because many of today's health problems are more-closely related to eating, drinking, and smoking habits, and to accidents, than they are to lack of medical care. Thus, people can significantly improve their health by taking responsibility for healthy lifestyles. The private sector can encourage this trend by establishing insurance premium savings for healthy behavior.

This does not mean, of course, that medical care does no good for anyone: in selected cases, such as medical treatment of hypertention, or medical services for the poor who are at high risk, the beneficial impact of medical care can be substantial. The best approach, therefore, is one that concentrates on serving these high-risk beneficiaries.

Much of the rise in medical care spending is due to health insurance, which insulates both individual consumers and providers from the costs of using or prescribing additional services. Numerous proposals would introduce price sensitivity into the market for medical services. The use of indemnity payments, which remove the insurance subsidy from the marginal units of health care or health insurance, is especially promising. The indemnity concept underlies the tax cap on health insurance, prefered provider organizations, physicians' fee schedules and diagnosis-related group payments to hospitals, and vouchers. The indemnity payment for each of these services might be set by competitive bidding.

Another promising development is that States have recently begun to take action to control medical care costs. State laws have been changed to permit the development of preferred provider organizations and to remove barriers to price advertising of medical care products and services. State attention should also be given to eliminating regulations which favor one type of insurance company over another.

Some private health insurers have been able to negotiate discounts from hospitals. Discounts benefit the policyholders of these insurers and place pressure on other health insurers to control their premium costs. However, it would be unwise to encourage insurance industry concentration in order to obtain discounts. The negative conse-

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quences of market concentration might outweigh any benefits from this policy.

Finally, policymakers should not use single instruments to correct multiple problems. The foremost example is using insurance premiums to transfer income from the healthy population to the less healthy. This defeats the purpose of insurance, which is to protect against the risk of illness at a premium which represents fair actuarial costs.

Document No. _____

WHITE HOUSE STAFFING MEMORANDUM

DATE: 1/8/85 ACTION/CONCURRENCE/COMMENT DUE BY: 12:00 Noon 1/10/85

SUBJECT: DRAFT CHAPTERS 3 and 4 OF THE 1985 ECONOMIC REPORT

	ACTION	FYI		ACTION	FYI
VICE PRESIDENT	☐	☐	MURPHY	☐	☑
MEESE	☐	☑	OGLESBY	☑	☐
BAKER	☐	☑	ROGERS	☐	☐
DEAVER	☐	☑	SPEAKES	☐	☐
STOCKMAN	☑	☐	SVAHN	☑	☐
DARMAN	☐P	☑SS	VERSTANDIG	☑	☐
FIELDING	☑	☐	WHITTLESEY	☑	☐
FULLER	☑	☐	_____	☐	☐
HERRINGTON	☐	☐	_____	☐	☐
HICKEY	☐	☐	_____	☐	☐
McFARLANE	☑	☐	_____	☐	☐
McMANUS	☐	☐	_____	☐	☐

REMARKS:

May we have your comments no later than 12:00 Noon on Thursday, January 10. Thank you.

RESPONSE:

Richard G. Darman
Assistant to the President
Ext. 2702

1985 JAN -3 PM 4:41

EXECUTIVE OFFICE OF THE PRESIDENT

COUNCIL OF ECONOMIC ADVISERS

WASHINGTON, D.C. 20500

1985 JAN -3 PM 4:41

January 8, 1984

MEMORANDUM FOR RICHARD DARMAN, WHITE HOUSE
BERYL SPRINKEL, TREASURY
MANUEL JOHNSON, TREASURY
GREGORY BALLENTINE, OMB
SIDNEY L. JONES, COMMERCE
ALLEN WALLIS, STATE DEPARTMENT
STEPHEN AXILROD, FEDERAL RESERVE

FROM: William S. Haraf
Special Assistant to the Council

SUBJECT: 1985 Economic Report -- Chapter 3

Attached is the first galley of Chapter 3 of the 1985 Annual Economic Report of the Council of Economic Advisers which will accompany the Economic Report of the President. Please let us have your comments by c.o.b. Thursday, January 10, 1984.

These should be delivered to Room 315 Old Executive Office Building. Should you or your staff members have specific substantive questions about major issues, please feel free to contact Richard Freeman (395-5086).

Attachment

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CHAPTER 3

The United States in the Global Economy: Progress and New Opportunities

THE CRISIS ATMOSPHERE that has marked the global economy in recent years has been dispelled considerably by economic developments in 1984. Progress in several areas—notably on the international debt problem and economic stagnation in the industrialized nations—has provided the global economy with more breathing room than it has enjoyed in recent years.

The events of 1984 have also demonstrated, once again, the extent to which national economies are linked to one another through international trade and financial relations. Many recent positive international developments can be traced to vigorous economic recovery in the United States. A growing, open U.S. market has provided strong stimulus to our trading partners in both the industrialized world and in debt-ridden developing countries. For those countries in the latter group, increased export demand has been a critical factor in their return to improved economic health.

While there has been some tendency for the benefits of faster U.S. growth to spread throughout the global economic system, the strength of the U.S. recovery also has resulted in increased divergence between the United States and its partners on several related aspects of economic performance. Two developments—the growing U.S. current account deficit and the high level of the dollar—merit closer examination of their causes and effects.

Compared to progress on growth and international debt, improvements in other problem areas have been less dramatic. Economic stagnation in many countries in the early 1980s provided an environment well suited to the advance of protectionism. Reversing this trend has turned out to be difficult. The recent marked improvement in economic conditions and the occasion of a new Presidential term provide a good opportunity for evaluation of progress made so far in this most challenging area of international economic policy and for consideration of steps that can be taken to ensure the success of a new round of multilateral trade negotiations that are currently under discussion.

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EXTERNAL DEFICITS AND THE U.S. ECONOMY

In 1984 the U.S. current account position—the difference between the value of goods and services that the United States sold abroad and those bought from foreign residents, minus net transfer payments made to foreign residents—declined by about $60 billion to more than $100 billion, or almost 3 percent of U.S. gross national product (GNP). Most of this decline was accounted for by a $50-billion expansion of the U.S. merchandise trade deficit, which reached $110 billion in 1984. Movements in the U.S. current account position and its main components are shown in Chart 3-1.

In consequence, there have been increased calls for protection and other types of market intervention. Although protectionist measures might provide a limited short-run advantage to affected sectors, they would do so only at great cost to the U.S. economy and to the integrity of the global system of free-trade relationships. Moreover, such steps are difficult to reverse. Accordingly, it is important to understand the origins of the present large external deficits in order to evaluate correctly their associated costs and benefits and to establish proper policy priorities. Recent large external deficits and associated capital inflows may be in large part the consequences of successful recovery in the United States, rather than a problem requiring separate, new policy actions.

A current account deficit is not necessarily a negative factor for the economy as a whole. Depending on its underlying causes, a deficit in the current account may bring distress to some sectors of the economy as they have to adjust to changed conditions, but it typically brings some benefits as well. For example, in many industries import competition has prompted additional expenditure on new plant and equipment and greater attention to controlling wages and other costs. Some producers are making greater use of "outsourcing"—the importing of less expensive parts and components—and are acting more as designers, assemblers, and marketing agents for foreign producers. Such shifts are the competitive response to changed market conditions and, on the whole, work to the benefit of U.S. producers and consumers.

Viewed more broadly, a current account deficit simply means that (ignoring transfer payments) U.S. residents are purchasing for consumption or investment more goods and services than they are now producing. The counterpart of the current account deficit is the capital account surplus, which measures the net claims on the United States that foreign residents have accepted in payment. Net capital inflows provide the financing for the excess of current expenditure

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over output. These inflows have been important in financing the recent U.S. investment boom.

Chart 3-2 shows how various aggregate financial flows have shifted during the past 2 years. The entries in Chart 3-2 are related to one another by the accounting requirement that private investment must be equal to, or in effect financed by, total savings from three sources: private savings, government savings (the negative of government borrowing), and capital inflows from abroad (the capital account surplus). The chart shows that the approximately 50-percent increase in U.S. private investment by $224 billion between 1982 and 1984 was financed by an increase in private saving by about $150 billion. Greater private saving was offset partly by a small increase in total government borrowing. But, almost $90 billion of the increased investment flow, or about 40 percent, was financed by net capital inflow from abroad.

Large deficits in U.S. current external expenditure on goods and services and corresponding cumulation abroad of claims on the United States are not likely to go on indefinitely. Although there is a good deal of uncertainty about how long a current account deficit (or surplus) can be sustained, most industrialized countries, including the United States, when observed for a period of several years or more, have not varied very far from balance in their current account positions. When deficits or surpluses have emerged, either their underlying causes were temporary, or natural market forces (or policy responses) arose eventually to bring about adjustment. In these episodes, whether or not the entire process of deficit and adjustment is judged to have been beneficial depends in large part on whether or not the increased current expenditure is used productively. If, for example, the additional current expenditure is mostly consumed, then the gains from greater current expenditure may be slight and subsequent adjustment is likely to be painful. However, in the recent period during which the U.S. current account deficit has increased, private saving has been maintained and investment has been very strong. This suggests that the elements are in place for a sustained expansion with less likelihood of a difficult future adjustment.

Although the U.S. trade balance has fallen sharply in this recovery, U.S. exports as a whole have not experienced unusually slow growth. Real exports have actually increased at an annual rate of about 5¼ percent since the end of 1982 (about 7½ percent in 1984 alone), about the same rate as in comparable stages of recent previous recoveries. The recent decline in the trade balance has not arisen from any deterioration in U.S. productive efficiency. Since the beginning of the recovery, U.S. output per work hour has advanced at an annual rate of 3¼ percent, easing earlier concerns about declining

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productivity growth. Wage increases have also decelerated, with the result that there has been a marked performance in U.S. unit labor costs. The strong performance of investment in the present upswing is a positive sign for the continuation of this trend.

CAUSES OF THE TRADE DEFICIT

In last year's *Economic Report*, three factors were singled out as leading causes of the large trade deficit at that time: the relative strength of the dollar, reduced U.S. exports to heavily indebted developing countries, and faster growth in the United States compared with growth in its industrialized trading partners. These three factors still are present, but the emphasis that each deserves has shifted somewhat. Improved conditions in many developing countries have allowed them to resume import growth, though certainly not at pre-1981 levels. Although the growth-rate gap between the United States and its industrialized partners widened earlier this year, some convergence has been evident lately as U.S. growth has slowed and expansion has accelerated somewhat in Europe. The dollar, however, continued to strengthen in 1984.

Estimates of how much each of these factors contributed to the recent decline in the U.S. trade balance are inherently inexact, in part because they are not independent of one another. Nonetheless, rough estimates give a general impression of their relative importance. Since 1981, U.S. real growth has exceeded that of its main industrialized trading partners by about three-quarters of a percentage point per year on average; in 1984 the gap in growth rates was more than three times as large. Even at unchanged relative prices, with faster growth of U.S. production and demand, U.S. purchases of imported materials and products normally will increase. On this score alone, one can account for roughly one-quarter of the $85 billion decline in the annual U.S. trade account position since 1980. Slower growth in U.S. exports to debt-ridden developing countries, which have been obliged by financing constraints to reduce their imports, accounts for a slightly smaller share of the decline. This factor has been especially significant in our trade with Latin America where the United States has a large stake in export markets.

On the other hand, not all external developments have increased the U.S. deficit. The dollar price of oil has moved downward by more than 20 percent since 1981, and shifts to other energy sources and conservation have meant that annual payments for imported oil by the United States have been cut by about $20 billion in the past 4 years. When these gains in the bill for imported oil are included, a net decline of about $60 to $70 billion remains—much of which is attributable to the strength of the dollar.

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THE STRONG DOLLAR

One of the most striking features of the present recovery in the United States is that it has been associated with a pronounced and persistent rise in the value of the dollar. The top panel of Chart 3-3 illustrates the extent to which the dollar has gained against a weighted average of other major currencies in recent years. Since 1980, the latest year in which the U.S. international current account was roughly in balance, the dollar has advanced steadily, until by late 1984 it was about 65 percent above its average in 1980 and at its highest level since flexible exchange rates were adopted in 1973. The largest increases in the dollar's value occurred in 1981 and 1982 from an unusually low level in 1980, but during the eight quarters since the latest recession in the fourth quarter of 1982, the dollar has strengthened by about 20 percent.

These gains were not a reflection of weakness in any individual foreign currency, as has sometimes been the case in past episodes of dollar strength. The dollar has risen significantly against all other major traded currencies. (Three of these—the German mark, Japanese yen, and British pound—are shown in the lower panel of Chart 3-3). Recent movements of exchange rates do not appear to have occurred in response to any particular external events, analogous to the sharp oil price increases that disrupted foreign exchange markets in the 1970s. This suggests that U.S. economic developments are responsible for the dollar's strength.

Our understanding of how exchange rates are determined is still quite incomplete. Given enough time, exchange rates and the factors on which they depend ought to adjust so that a representative bundle of goods costs roughly the same in countries linked by open trading. There is ample evidence, however, that this relationship of purchasing power parity need not hold over the short or medium term. The upper panel of Chart 3-3 shows how the dollar's real exchange rate (i.e., the nominal exchange rate adjusted for consumer price levels here and abroad) has moved in recent years. Changes in the real exchange rate have generally been less pronounced than changes in the nominal exchange rate, but it has decidedly not been the case that changes in the latter have merely compensated for relative price performance. Since 1980 the dollar's real rate of exchange has risen by about 60 percent, only slightly less than the nominal exchange rate. From the fourth quarter of 1982 to the fourth quarter of 1984 the dollar's real exchange rate appreciated by about 18 percent.

Over the shorter term horizons that are relevant to many important market and policy choices, exchange rates are determined in asset markets. Large international investors and borrowers allocate their portfolios among assets of various currency denominations in

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highly integrated international markets. Vast volumes of financial assets can be traded in a matter of minutes at virtually any time of day. Accordingly, asset prices, including the exchange rate, can change quickly in response to changing expectations about fundamental characteristics that influence asset demand and supply.

International investors can be expected to make their portfolio decisions mainly on the basis of expected rates of return, including expected exchange rate changes, adjusted for risk and other special factors. It is useful, therefore, to compare expected real interest rates on dollar and nondollar assets (i.e., nominal interest rates adjusted for expected inflation) to understand what has been happening in foreign exchange markets.

The upper panel of Chart 3–4 shows that starting in 1979 U.S. expected real interest rates moved sharply upward and peaked in 1982. Although they have fallen since then, they still are at relatively high levels. Foreign real interest rates also experienced a similar upward movement starting in 1980, as can be seen in the upper panel of Chart 3–4. However, the rise in real interest rates abroad was much less pronounced than in the United States, leaving a substantial positive gap between U.S. and foreign real interest rates. That gap is shown in the lower panel of Chart 3–4.

Why have U.S. expected real interest rates and the dollar been so high? The answer can be found largely in the character of the recent successful U.S. recovery, as discussed in Chapter 1. The initial increases in U.S. real interest rates were associated with the 1979 change to a tighter U.S. monetary stance. Subsequent declines in inflation, which were systematically underpredicted in most forecasts, contributed to a strengthening of the dollar between 1980 and 1982, as the expected real return to holding dollar assets rose and improved inflation performance itself justified a higher nominal dollar exchange rate.

More importantly, as emphasized in Chapter 1, the Economic Recovery and Tax Act of 1981, together with reduced inflation, significantly raised the after-tax rate of return on new business investment. This increase in the real rate of return on U.S. business investment spilled over to the return on dollar-denominated assets generally and to the level of the dollar itself. After 1981, expanding Federal budget deficits may also have raised the level of U.S. real interest rates and helped to strengthen the dollar. The extent of upward pressure on real interest rates and on the dollar through this channel, however, is of uncertain size.

Higher real returns and lower inflation account for some but not all of the observed upward movement of the dollar. In the lower panel of Chart 3–4, it is evident that while the real exchange rate has

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been rising steadily since 1980, the real interest rate gap in favor of the dollar has narrowed since 1982 and occasionally has been negative. This suggests that other factors may have continued to push up the demand for dollar assets. A number of additional explanations have been put forward, but what seems most persuasive is that the combination of increased after-tax profitability of U.S. corporations, the demonstrated strength of the U.S. recovery, the reversal of international lending outflow from U.S. banks, and the generally more favorable longer run prospects for the U.S. economy have prompted an additional increase in demand for dollar assets. Just as in 1980 when the relatively low level of the dollar probably reflected a more pessimistic view of future U.S. performance than could be measured by the real rate of interest and other available indexes, in 1984 the relatively high value of the dollar probably reflects more optimistic assessments than can be captured by these indices.

The recent strength of the dollar has had a number of important effects—some positive and some negative. As the dollar has risen, some U.S. industries that compete in internationl markets have experienced difficulties. Many of these problems are concentrated in the manufacturing sector, where declines in trade balances across industries have been widespread. In 1984, only 6 of the 20 major U.S. manufacturing industries had positive merchandise trade balance, and even these 6 experienced declines or no increase. Some manufacturing industries are troubled by problems beyond those arising from dollar strength, however. The four industries with the largest trade deficits in 1984—autos, steel, consumer electronics, and petroleum—also have relatively high labor costs, raw material costs, and other factors that have contributed to a loss of comparative advantage.

Trade problems are not limited to the manufacturing sector. The traditional U.S. surplus in agricultural products has contracted by about $9¼ billion from its level of 3 years ago, as dollar appreciation and slower demand growth have kept dollar prices and export volumes down. Large declines have also occurred in U.S. exports of raw materials.

In many respects, however, the dollar's rise in value has been beneficial. Production and investment in sectors less involved in international trade have been stimulated. In some cases, external pressures have accelerated needed changes and had a positive effect on the economy as a whole. The strong dollar has also meant that prices of traded goods and close substitutes have been kept lower than they would have been otherwise, thereby benefiting both U.S. consumers and U.S. producers who use imported inputs. Undoubtedly, the dollar's rise since 1980 has made the task of bringing inflation under

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control considerably easier. In addition, to the extent that dollar strength has arisen from a shift in demand toward dollar assets, U.S. interest rates have been lower and real investment has been higher than would have been the case otherwise. Stronger U.S. investment has important longer run consequences, since it will ultimately mean higher productivity, faster potential growth, and more employment in the future.

THE DEBTOR COUNTRIES: RECENT PROGRESS

Earlier we noted that economic adjustment in debt-burdened developing countries was an important cause of the widening U.S. trade deficit. However, several favorable developments that became evident in 1983, and were reflected in improved external positions of borrowing countries, continued in 1984. As a result, the prospects for several major debtors are now much more favorable. These recent gains confirm that the strategies for economic adjustment and repayments that have been followed by these nations are basically sound. We have also learned a great deal in recent years about the factors that contributed to widespread debt-servicing problems. However, international debt problems have not been solved. Progress has been quite uneven, and some countries have not taken adequate steps toward adjustment in their domestic economies to benefit much from the improved international economic environment.

Recent experience has highlighted the degree to which economic growth and the successful servicing of foreign debt by developing countries is sensitive to external conditions. The continuation of progress at the pace of the past 2 years depends on a number of conditions in the global economy being met, including a reversal of the recent trend toward protection in both industrialized and developing countries. Although the pressures from impending international debt problems have lessened somewhat, with very few exceptions, sovereign borrowers in the problem group have not yet regained sufficient creditworthiness that they can resume normal borrowing in international financial markets.

The source of recent problems in international lending is found not in one but in several underlying causes. The sizeable increase in the 1970s in international bank lending—mainly to the more advanced developing countries in Latin America and Asia as well as to Eastern Europe—was typically organized through consortia of large international banks, but also eventually included participation by smaller regional banks. It differed from previous international lending in several important ways. Loans were for relatively long terms, but were priced at variable interest rates, specified typically by spreads above a short-term interbank rate. Thus, changes in global

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money-market conditions were reflected very rapidly in the interest burden of the debtor countries.

Rather than being for specific project use or for short-term trade credit, bank lending was quite often intended for general use. Thus, a country's ability to service and repay borrowings depended not so much on its capacity to generate proceeds from identifiable projects, but rather on the overall export performance and import dependence of its economy—an outcome inherently more difficult to evaluate.

To many banks, thin profit margins on loans in the industrialized countries and prospective high rates of return in developing countries made such lending look highly profitable and relatively safe. The late 1970s was a period of relatively strong growth for the developing countries, and export demand for most of the borrowing countries was expanding. The inflationary environment then particularly encouraged investment in natural resource industries and lending to countries specializing in those products. It now seems apparent, however, that banks' ability to judge the soundness of this relatively new type of general-purpose borrowing was limited at best. Aggressive lending resulted in inappropriately high levels of bank exposure to some countries that threatened the stability of not only individual banks, but the international banking system as a whole.

The economic policies followed by borrowing countries also contributed greatly to the eventual crisis. Encouraged by the ready availability of external resources, many borrowing countries followed undisciplined policies—policies which subsidized consumption and discouraged productive investment, and which frequently resulted in excessive government spending and credit expansion to inefficient state enterprises. In most instances, the authorities showed little inclination to resist monetizing these deficits, and the exchange rate was not devalued rapidly enough to offset fully the ensuing inflation. In some cases, real appreciation of the local currency reflected a deliberate attempt to reduce inflationary pressures; in other cases, especially among the oil exporters in this group, strong capital inflows pushed the real exchange rate up. In either case, real appreciation caused resources to be diverted from the manufacturing and export-oriented sectors, leaving borrowing countries poorly positioned to deal with later declines in demand and increased payments burdens.

These developments set the stage for trouble, but the sharp recession in the industrialized countries in 1981 and 1982 made the problem immediate and acute. The combination of reduced demand for exports of developing countries, coupled with higher real interest rates as inflation was brought under control, placed a double burden on heavily indebted borrowers, the consequences of which had not been fully foreseen. The problem was compounded subsequently for

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the oil exporters among this group by a decline in the dollar price of oil. More generally, for many countries exporting primary products, appreciation of the dollar caused their terms of trade (the relative price of their exports to the price of their imports) to turn downward. Thus, at the same time that the interest burden was mounting, debtor countries found it increasingly difficult to generate additional hard currency through external trade. Capital flight further reduced available hard currency resources. In August 1982, the Mexican authorities indicated to U.S. authorities that they were unable to service their international obligations. Most of the major soverign debtors joined the ranks of problem borrowers soon thereafter.

Since then, improvements have occurred in all three areas that contributed to debt problems. Perhaps the clearest indicators of progress are the gains made by borrowing countries in reducing their external deficits. Although the majority of the large debtors are still in a deficit position in their current accounts—indicating that they are still increasing their net indebtedness to the rest of the world—external deficits have narrowed markedly in recent years for some key countries. Since 1981 the total annual current account deficit of the largest 17 debtors among the developing countries has declined by about $44 billion to a level this year expected to be about $20 billion, despite an increased interest burden. Some countries have made especially dramatic gains; Brazil and Mexico stand out in particular. The Brazilian current account deficit declined by more than $8½ billion in 1983 and is estimated to have fallen by another $6 billion in 1984 to only about one-half billion dollars. For Mexico, the gains have been even more dramatic—a total improvement of $19 billion between 1981 and 1983. The Mexican current account was in surplus by $5 billion in 1983, and the surplus is estimated to have been only slightly less in 1984.

Early improvements in the current accounts of borrowing countries were made primarily through cuts in imports. These cuts were necessitated by financing constraints that were associated with sharp declines in activity and income. Import declines continued in response to restrictive fiscal and monetary policies and exchange-rate devaluations that were part of programs supported by the International Monetary Fund (IFM). More recently, as the potential for further import reduction has been exhausted, continued improvement in borrowers' external positions has relied on expanding exports. Almost all of the major borrowing countries experienced export growth in 1984. Most have returned to real GNP growth as well. This has been important in maintaining enough political consensus to sustain their economic adjustment.

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Increased exports are largely a reflection of expanding demand in the industrialized countries, especially in the United States. As the leader in the global recovery, the United States with its comparatively open markets has played a disproportionate role in absorbing the output of the debtor countries. The United States now buys about 30 percent of the exports of the 17 larget debtors among the developing countries, as compared with 17 percent for comparable imports by the European Community (EC) and 14 percent by Japan. Even more striking is the fact that, of the increases in industrialized country imports from the large debtors in the past 2 years, almost 90 percent is accounted for by imports by the United States.

Although in 1983 and 1984, banks cut back their new lending to the debtor countries from earlier peaks, bank loans, together with official lending, still have been available at levels adequate to support adjustment programs. In consequence, the ratio of debt to exports—a measure that is often used as an indicator of a borrowing country's financial position and ability to pay—has stopped rising in most countries and has started to decline in many. The average ratio is only slightly below 2, however, still considerably above the average level of about 1½ in the mid-1970s.

Banks have also improved their positions noticeably. By increasing their capital and loan-loss reserves (by about 25 percent for U.S. banks over the past 2 years), banks have reduced their loan-to-capital ratios and are now in a better position to deal with any possible future debt-servicing problems.

Positive steps have also been taken in the restructuring of outstanding debt—the most notable development being a rescheduling agreement reached between Mexico and its private bank creditors in September 1984 on Mexico's outstanding public-sector debt of about $50 billion. Previous rescheduling of smaller amounts of sovereign debt and generally been on a 1-year basis; the Mexican agreement broke new ground in that it covered debt maturing over the following 6 years. Partly in view of Mexico's excellent performance under its adjustment program and continued good prospects, the lending terms in the new agreement were attractive—a quite low-interest spread and a generous grace period. The usual fees and commissions also were waived. In addition, greater flexibility is afforded the lending banks by a provision in the Mexican agreement that up to 50 percent of their outstanding credits to Mexico may be converted at the bank's option to their own home currency, thus enabling more secure funding. Significantly, the new Mexican multi-year agreement appears to have served as a prototype in later reschedulings including ones with Venezuela and Argentina.

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Although these developments have been encouraging, resolution of the debt problem is clearly a long-term matter. Debt-related difficulties still plague many of the smaller developing countries, some borrowers in Eastern Europe, and some Western industrialized countries. In some cases, their relatively poor performance arises from special factors. Countries that depend heavily on the prices of certain raw material exports (such as copper, rubber, tin, and oil) have been set back especially by recent price declines. In general, price trends for exports of developing countries have not been favorably lately; the average dollar price of industralized raw materials (excluding oil) has fallen by about 14 percent from its level at the end of 1983, and export revenues of countries specializing in these products have been eroded. In other cases, problems continue because essential domestic adjustments have not yet been made. The differing performance of these countries confirms that the extent of a debtor country's recovery depends closely on export growth, maintenance of competitive exchange rates, well-conceived investment plans, and noninflationary macroeconomic policies. These elements are typically part of adjustment programs developed in consultation with the International Monetary Fund. The important role of the Fund in providing new lending and overseeing adjustment cannot be overstated.

The events of the past 2 years clearly reveal the sensitivity of the performance of the debtor countries to the state of the global economy—including the level of interest rates, the value of the dollar, commodity export prices, and, especially, the rate of growth of the industrialized economies. The debtor countries have benefited particularly from extremely strong U.S. growth. A number of studies have suggested that with sustained real growth in the industrialized countries at roughly a 2 to 3 percent annual rate, the servicing of developing countries' debt is manageable. At faster rates it is easier, of course.

Sustained growth in the industrialized countries by itself, however, is not sufficient to ensure success. The markets in industrialized countries must remain open, not only to traditional exports from the developing debtor countries, but also to the more skill-intensive exports that emerge as their comparative advantage evolves. In recent years, increased protection has been directed at this latter class of products as these exports—particularly those from the so-called "newly industrialized countries"—have become more competitive.

It is important to recognize that the costs of such protection include not only the negative direct impacts of such measures in terms of misallocation of resources and distortions to patterns of spending, but also the broader damaging effect of such restrictions on the prospects for further debt repayment. Both production and the prospects for debt repayment would be further enhanced by expansion of for-

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eign direct and portfolio investment flows. These flows could increase if host countries were to provide a better investment climate. Increased foreign direct investments, in particular, not only would partly relieve borrowing needs but also would provide additional benefits, such as technological transfers, training, and improved exports marketing know-how.

OUR INDUSTRIALIZED TRADING PARTNERS

The performance of the major industrialized countries in their recovery from the 1980–82 global recession has been uneven. That divergence was still apparent in 1984. Although the United States, and to a lesser degree Japan and Canada, experienced further healthy expansion (albeit from a fairly deep trough in Canada), recovery in Europe still lagged well behind. Average real GNP growth in the four major European economics (Germany, France, the United Kingdom, and Italy) accelerated slightly in 1984 to about a 2½ percent annual rate, but this was less than half the average of the three non-European countries mentioned above and hardly represents a significant departure from their relatively stagnant condition since the mid-1970s. Although some progress has been made lately in revitalizing the European economies, it is clear that Europe still suffers the fundamental problems. The most visible symptom of these problems is the presence of persistent and rising unemployment, currently equivalent to almost 11 percent of the European work force.

Two factors are pointed to most often to explain the slow economic recovery in Europe: structural problems in European labor markets and disincentives to adjustment and growth. The former includes highly indexed wages, high nonwage labor costs and social charges, and arrangements for excessive job security that contribute to a low rate of both mobility and new hirings, while the latter refers to various government regulatory burdens, high marginal tax rates on labor and capital incomes, and large subsidies paid to agriculture and declining industrial sectors.

The combined result of these factors has been low levels of capacity utilization and low rates of investment. Expressed as a share of GNP, private investment in Europe has declined steadily since the first oil shock and is now well below the level of investment shares seen in Europe in the 1960s. There has also been essentially no net job creation in Europe in the past 15 years. In addition to disincentive effects and labor market rigidities, labor market conditions have been worsened by demographic factors—especially a heavy influx into the work force of younger workers, on whom the burden of unemployment has fallen most heavily. Labor force growth is expected to decelerate in coming years, but in the absence of a marked pickup

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in investment and productivity, achieving a significant reduction in European unemployment will be difficult.

High priority has been given recently in Europe to reducing large government deficits and limiting the swelling share of government expenditure in total demand. Considerable progress has been made in contracting public-sector deficits, but the hope that deficit reduction and curbs on public spending, by themselves, would contribute significantly to higher growth by releasing resources to the private sector has been realized so far to only a limited degree.

ON balance the external sector has provided very little net stimulus to growth in Europe. This is not to say that European exports to the United States have been weak. On the contrary, EC exports to the United States have grown at a 15 percent annual rate since 1982. However, the U.S. market presently makes up a relatively small share of total EC export sales (about 16 percent, not including intra-EC trade). Trade within the Community has declined since 1981, and other important EC export markets—Organization of Petroleum Exporting Countries (OPEC), the Eastern Bloc, and major developing countries—have been stagnating or declining. In these latter markets, however, even the market shares of European exporters have not increased, despite significant gains in competitiveness vis-a-vis the United States in the past 2 years.

Although recent progress has been slow in Europe, there are grounds for increased optimism. Unemployment is related to deep structural problems, but nominal wages have decelerated in several countries. As inflation has been brought under control, there are a few signs of greater flexibility in real wages and more willingness on the part of labor to compromise on nonwage issues. In some cases, performance in 1984 has been affected by special factors, such as persistent inflation in France and sectoral strikes in the United Kingdom and Germany. The rapid rebound of activity in Germany after the strike there was settled suggests that the underlying German growth potential is strong. Performance in the other countries may improve for similar reasons once their particular difficulties are dealt with successfully. Finally, continued good performance on control of inflation and reduction of budget deficits may provide many European countries with a foundation for more stable economic growth.

In comparison with the European economies, the Canadian and Japanese economies have performed well. The U.S. market is relatively much larger for both countries (70 percent of total exports for Canada, and 30 percent for Japan), and recent export growth to the U.S. market has been robust (since 1982, about 20 percent annually for both). The fact that Japan also exports heavily to the rapidly expanding newly industralized countries of Asia (South Korea, Taiwan,

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Hong Kong, and Singapore—where about 14 percent of Japan's exports now go) also has contribued to its largely export-led recovery.

Our trade relations with Japan have sometimes been singled out as a special problem. In a period in which the United States is running the largest trade deficit of any nation, Japan is in quite the opposite position with an estimated trade surplus of more than $40 billion in 1984. Furthermore, the deficit in U.S.-Japanese bilateral trade has expanded significantly in 1984 to an estimated annual deficit of over $30 billion this year.

Undue emphasis on the bilateral balance in a multilateral trading system is misplaced, however, and can be misleading—just as would be inferences about a person's financial standing based on his or her relationship with only one creditor. In fact, the decline in the U.S. bilateral trade position with Japan since 1981 has been less than that with either the EC or Latin America. Although some problems have arisen in the past in relation to foreign access to particular markets in Japan, the agreement reached in early January 1985 between President Reagan and Japanese Prime Minister Nakasone to establish high level talks to seek ways of opening Japanese markets further is a sign of possible progress in this area.

RECENT U.S. ACTIONS IN INTERNATIONAL TRADE

A review of U.S. actions during 1984 on a wide range of issues in international trade provides a useful background for the discussion of new free trade initiatives in the next section. U.S. actions in 1984 represent a mixed record of protectionism and limited progress toward freer trade. Significant actions include the passage of a major trade bill by the Congress in cooperation with the Administration, decisions on several important import relief cases, and the extension or modification of existing import restrictions in several sectors.

THE TRADE AND TARIFF ACT OF 1984

Despite unusual protectionist pressures, the Congress and the Administration put in place an omnibus trade law that is generally supportive of free trade. The major provision of the Trade and Tariff Act of 1984 is the renewal of the Generalized System of Preferences (GSP). The GSP provides for a reduction of tariffs to zero for imports from qualifying developing countries, although some imports (notably textiles) are not covered by the program. The new law also authorizes negotiations with Israel (and other countries) to establish a free trade zone. Other provisions include tariff reductions on about 100 products and various revisions of trade law.

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GSP Renewal

The Trade and Tariff Act extends the GSP program until 1993, enabling the President to continue to grant duty-free treatment to many exports from 140 developing countries. In addition, it removes quantitative limits on the exports eligible for GSP from the poorest countries. Continuation of GSP is linked to the recipient's enforcement of exclusive rights in intellectual property (patents, trademarks, and copyrights) and its respect for the rights of workers. Several products, including leather apparel, were added to the list of articles ineligible for GSP, a list that already includes clothing and textiles. The new law also requires the graduation from the program of countries with a per capita GNP exceeding $8,500 per year. This figure is indexed to one-half the rate of U.S. economic growth. As a step toward freer trade, GSP renewal benefits American consumers and producers, as well as participating developing countries.

U.S.-Israel Free Trade Agreement

The Trade and Tariff Act provides authority for negotiations to establish a U.S.-Israel Free Trade Agreement. The trade-creating effects of such a free trade zone will benefit both Israel and the United States. The President, however, will retain the power to impose quotas or to negotiate export restraints if the International Trade Commission determines that increased imports threaten national security or injury to domestic industries. The President is also empowered to negotiate reductions in tariffs and nontariff measures with all countries, subject to congressional approval. The President, therefore, can enter into negotiations with any country desiring a free trade zone with the United States.

Other Provisions

The "reciprocity" measures in the new law extend the Trade Act of 1974 to provide specific authority for the President to retaliate against a wide range of barriers to U.S. exports, including services and investment, as well as to negotiate to reduce or eliminate barriers to U.S. foreign investment and U.S. exports of services, semiconductors, and other high technology goods. The U.S. Trade Representative, moreover, now has explicit authority to initiate investigations of unfair trade practices and to impose import restrictions in response to foreign export performance requirements.

The new law expands the countervailing duty statutes to include specifically products that benefit from using subsidized inputs and requires the International Trade Commission to assess cumulatively the volume and effect of imports of like products from two or more countries for purposes of injury determination.

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The definition of "industry" is also modified to allow grape producers 2 years to file petitions against foreign trading practices affecting the wine industry. Aside from raising the risk of countervailing duties on European wines and possible EC retaliation against the United States, this provision deviates from the established principle of only allowing petitions from firms with like or directly competing products. The President is also required by a related provision to seek reductions in foreign barriers to American wines and encouraged to establish a wine export promotion program.

The criteria for determination of injury due to imports under Section 201 of the Trade Act of 1974 are also revised. Section 201 provides procedures for domestic industries to petition for relief from import competition. The changes require the International Trade Commission to consider plant closings and producers' inventories of imports in its escape clause cases. Moreover, the law specifies that the profitability of the domestic industry will not preclude an injury finding, nor will the presence or absence of any one factor. The effect of these changes remains to be seen, but there may be an overall increase in both the number of new cases filed and the number of injury findings.

Finally, the bill provides explicit authority for the President to implement his recently announced steel trade program, which is discussed below in more detail. The U.S. Customs Service is to enforce import agreements, including voluntary restraint agreements (VRAs), between the United States and steel exporting nations.

ESCAPE-CLAUSE, ANTIDUMPING, AND COUNTERVAILING-DUTY CASES

The International Trade Commission investigated several Section 201 "escape-clause" cases during 1984. After a finding of injury due to imports by the International Trade Commission, the President is charged with making the final decision based upon the national economic interest. The International Trade Commission determined that imports were not a substantial cause of serious injury, or threat of serious injury, to three small domestic industries. In the unwrought copper and carbon steel cases, however, the Commission did find injury and recommended import relief in the form of various trade restrictions. Import restrictions were terminated during the past year in two previous escape-clause actions.

To provide import relief for the copper industry, two Commission members recommended a quota, two an increased tariff, and one no relief. An additional option, which was favored by the domestic industry, was to negotiate restraints on production with the major members of the copper producers' association, the Consejo Intergubernamental de Paises Exportadores de Cobre. The President, how-

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ever, rejected all three relief options. The first two were rejected on the grounds that they would create a differential between domestic and world copper prices which would damage the U.S. copper fabricating industry and result in a significant net loss in domestic employment. The last option, negotiations to limit foreign production, was rejected by the President, as both impractical and contrary to free market principles.

In the petition from the steel industry for escape-clause relief, the International Trade Commission found injury in five of the nine categories of products produced by the steel industry and recommended a combination of market-share quotas and tariffs to restrict imports. In September, the President rejected the proposed remedy and opted instead to negotiate VRAs that would cover all nine steel products for a period of 5 years. The President acted in response to sharp surges of steel imports during the year, which were the result in part of foreign government subsidies to their domestic industries. The restrictions are expected to limit imports to roughly 20 percent of domestic steel consumption. Agreements for new export restrictions have been reached with Japan, South Korea, Spain, Australia, South Africa, Mexico, and Brazil. An existing restriction agreement with the EC will continue through 1985, although the Administration seeks modifications in the restrictions for pipe and tubes. In November the Administration announced an embargo of all imports of pipe and tube from the European Community.

As of late 1984, the International Trade Commission, in conjunction with the Department of Commerce, had finished antidumping investigation on 17 products imported from 12 countries. The Commission concluded that import sales at less than fair value had materially injured domestic industries for ten of the products. Many of these cases involved steel imports from South Korea, Brazil, and Taiwan. In addition, South Korea and Taiwan were found to be dumping color television sets in the United States, and the People's Republic of China to be dumping various chemicals.

OTHER TRADE ACTIONS

The 3-year Japanese VRA on automobiles announced in 1981 was extended an additional year, until April 1985, at a slightly higher limit of 1.85 million cars per year. Following the automobile manufacturers' $4 billion in losses in 1980, Japanese automobile exports to the United States were restricted, beginning in April of 1981, to 1.68 million cars per year. The rationale for the restriction was that the U.S. automobile industry needed time to adapt to world competition. During the period of Japanese export restraint, the industry was

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to adjust through investment in new technology and cost-cutting measures.

In agriculture, the United States maintains a number of significant import restrictions, including restrictions on cotton, peanuts, dairy products, and sugar. With the exception of the quota on sugar, these restrictions remained unchanged in 1984. The sugar quota for 1984–85 was reduced by 17 percent to be consistent with domestic sugar policies. The rationale for the reduced sugar quota includes reduced demand, increased use of sugar substitutes, increased domestic production, and surging imports of products containing sugar from Canada and Mexico.

New interim rules governing U.S. textile imports were announced in August 1984 in order to tighten the "country-of-origin" provisions of the textile quotas. U.S. textile producers charged that traditional textile exporters, such as Taiwan, had been "transhipping" their products through other nations in order to have the products charged against the quotas of those nations. For example, textile imports from Taiwan and Hong Kong were less than 10 percent higher during the first half of 1984 compared to 1983. Imports from Thailand and Indonesia, however, were up 94 and 227 percent, respectively. The U.S. textile industry claimed that most of the increase was due to transshipped goods. In fact there is some evidence that entire factories are moved to circumvent individual country quotas. The new rules state that only products wholly manufactured or substantially transformed in a nation can be counted toward that country's quotas. Opposition from foreign producers and domestic retailers resulted in a delay in the complete implementation of the rules until the end of October.

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ACTIONS IN INTERNATIONAL FINANCE

Just as restrictions on trade generate inefficiencies in production and distortions in consumption, capital controls on international financial transactions induce other undesirable distortions in the allocation of funds across investment projects and in the allocation of resources over time. In the major industrialized countries, controls that once were quite elaborate as recently as a decade ago have been gradually eroded. The process has been accelerated by the emergence of offshore financial markets, such as the Euromarkets, that are generally beyond the reach of national authorities' control, as well as by the more recent surge of deregulation and innovation in domestic financial markets. The United States now maintains a full array of essentially open financial markets for international investment and fundraising. To a great extent, other countries have shared the experiences in the 1970s and 1980s that led to financial changes here,

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and they have responded similarly by liberalizing and accepting changes in their own domestic and international financial markets. In recent years, capital controls and other related restrictions have been removed in Germany, Switzerland, the United Kingdom, and more recently in Japan.

In May 1984, an agreement was reached between the Japanese and U.S. Governments on a set of measures designed both to liberalize domestic and international financial transactions in Japan and to provide greater foreign access to Japanese financial markets. The agreement accelerates changes that were already under way. Although Japanese financial markets are not yet fully open, the agreement marks an important stage in Japan's continuing movement toward fully liberalized financial markets.

The U.S. objective of unrestricted capital flow is also evident in the removal in 1984 of the U.S. withholding tax on interest earned by nonresidents on U.S. bonds and other financial instruments. The new tax rules now enable U.S. corporations to issue securities directly to foreigners without having to go through the previous cumbersome and costly procedure of issuing indirectly through an offshore shell subsidiary. Shortly following the U.S. rule change, both Germany and France dropped their own corresponding taxes on interest payments to nonresidents.

The United States has also been at the forefront of efforts in the Organization for Economic Cooperation and Development (OECD) to restrict the use of subsidized financing for exports. In the case of so-called "mixed credits"—the use of concessionary loans for development aid to boost exports through tied sales—the OECD prohibits the aid element from being below 20 percent. The United States has asked that this figure be raised to 50 percent to limit abusive trading practices.

THE CHALLENGE OF COMPREHENSIVE FREE TRADE

Despite substantial reductions in tariffs among industrialized countries since World War II, many trade restrictions and distortions remain. In fact the world is now moving away from comprehensive free trade. In the troublesome area of nontariff barriers, for example, the proportion of total manufacturing consumption in major industrialized countries subject to nontariff restrictions rose to about 30 percent in 1983, up from 20 percent just 3 years earlier. Even tariffs remain high in some sectors (textiles, footwear, steel, wood products, and shipbuilding, for example) and among less developed countries. Outside manufacturing, trade is subject to severe restrictions and market distortions, especially in agriculture and services.

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If we are to sustain the post-World War II momentum toward comprehensive free trade and the world economic growth freer trade has fostered, new international initiatives are required. Speaking to the International Monetary Fund and World Bank Joint Annual Meetings on September 25, 1984, President Reagan called for just such initiatives:

"For the millions around the globe who look to us for help and hope, I urge all of you today: Join us. Support with us a new, expanded round of trade liberalization, and, together, we can strengthen the global trading system and assure its benefits spread to people everywhere."

What follows in the remainder of this chapter is first, a restatement of the case for free trade, including a rebuttal of the myths of protectionism; second, a discussion of the obstacles to progress toward free trade; and, finally, a discussion of various strategies for surmounting these obstacles.

THE CASE FOR FREE TRADE

The persuasive power of arguments for free trade arises not only from abstract economic reasoning, but also from concrete historical comparisons of the achievements of free trade against those of protectionism. The conclusions to be drawn from such comparisons over the past two centuries are unambiguous: Countries that have followed the least restrictive economic policies both at home and abroad have experienced the most rapid economic growth and have enabled the greatest proportion of their populations to rise above subsistence living standards. Nevertheless, the demonstrated achievements of free trade cannot be taken for granted—the myths of protectionism persist, eroding the discipline of national economic policies around the world and frustrating new free-trade initiatives.

The Achievements of Free Trade

The power of free trade is easily demonstrated by a few historical examples: the free trade area established among the States of the United States by the U.S. Constitution, Britain's unilateral movement toward freer trade in the 19th century, the successive rounds of multilateral tariff reductions since World War II, the emergence and expansion of the European Community, and the remarkable growth in the past several decades of less developed countries that have followed open, market-oriented trading policies.

The Articles of Confederation, the first compact among the United States after independence from Britain was won, did not prohibit the States from erecting barriers to interstate commerce. In the absence of an interstate commitment to free trade, protectionist interests in each of the individual States quickly succeeded in restricting the flow

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of competing products from other States. The debilitating effects of this protectionism on the States' economies was a major impetus to the replacement of the Articles of Confederation by the U.S. Constitution, which explicitly forbids the States from levying tariffs. Federal courts have generally protected the integrity of the prohibition on State tariffs, ruling as recently as 1981, for example, that a Louisiana tax on natural gas passing through the State was an illegal tariff. The U.S. Constitution also prohibits the Federal Government from imposing export duties.

Aside from immediately establishing a free trade area among the original 13 colonies, the constitutional prohibition against State tariffs has been crucial to the development of the U.S. economy in two additional ways. First, the free-trade area was *automatically* expanded as new States joined, expanding the scope of the domestic market. Second, the unrestricted trade in the large domestic market tended to reduce the economic costs to the United States of its protectionism against the rest of the world. The high tariffs characteristic of U.S. commercial policy from the early 19th century to almost the middle of this century would have imposed a much greater burden on the U.S. economy if the scope of the domestic market had not been protected by the Constitution.

A second episode that illustrates the power of open markets is Britain's movement toward freer trade in the middle of the 19th century. There are two salient features of this experience. First, Britain's move was *unilateral*. The repeal of the Corn Laws by Robert Peel's government in 1846 was not conditional upon "concessions" from Britain's trading partners. Rather, the repeal was motivated by the growing recognition that the tariffs on imported grain set by the Corn Laws were a barrier to the advancement of Britain's own economy. Second, the results of free trade were exactly opposite from the predictions of supporters of protectionism. Protectionists had argued that a decline in the prices of imported grains from repeal of the Corn Laws would lead to a corresponding decline in wages. Rather than falling, however, wages rose dramatically. Thus, Britain was very much an "engine of growth" in the 19th century world economy, and freer trade fueled the engine.

More recent experiences sustain the point. The slide of the world economy into the Great Depression of the 1930s was accelerated by unprecedented tariffs imposed by the Smoot-Hawley Act of 1930 and by similar policies abroad. The U.S. Secretary of State, Cordell Hull, was instrumental in passage of the Reciprocal Trade Agreement Act of 1934, which became the basis for multilateral trade liberalization, even though further trade liberalization was delayed until after World

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War II. Significantly, 1984 marked the 50th anniversary of the Trade Agreement Act.

Since World War II, successive rounds of multilateral trade liberalization have demonsrated the power of open markets through almost four decades of world economic growth. After full implementation of the current Tokyo Round tariff cuts in 1987, import tariffs among major industrialized countries will average below 5 percent on industrial products, down from averages of more than 50 percent at their peak in the 1930s. The profile of average tariff rates in the United States from 1900 to 1979 (just prior to the beginning of the Tokyo Round cuts) is exhibited in Chart 3-5. Few deny the central role these cuts have played in the post-World War II expansion of the world economy.

During the same period, the emergence and expansion of the EC liberalized trade even further among Western European countries. As the United States had done almost two centuries earlier, the members of the EC accelerated their economic growth by establishing a large, relatively unrestricted common market. Numerous studies identify the opening of the European market as central to Western Europe's economic success.

A final illustration of the achievements of freer trade is particularly important. As former colonies gained independence after World War II, they typically sought to achieve economic independence as well, and many embarked upon extensive import substitution policies to reduce their dependence on imports from former colonial trading partners. The overwhelming conclusion of studies of these policies, however, is that they severely stunted economic growth. In contrast, those newly industrializing countries that pursued more open economic policies have experienced truly remarkable records of economic growth. Beginning with Japan, the list of examples continues on to include Hong Kong, Singapore, Taiwan, and South Korea, among others. As a digression, another important characteristic common to all these examples (i.e., the United States, Britain, the European Community, Japan, and the more successful developing countries) should be noted—the reliable enforcement of contracts.

Acknowledging the record of free trade as a development strategy, President Reagan made the following commitment on his departure to the International Meeting on Cooperation and Development in Cancun, Mexico in 1981:

"Free people build free markets that ignite dynamic development for everyone. We will renew our commitment to strengthen and improve international trading, investment, and financial relations, and we will work for more effective cooperation to help developing countries achieve greater self-sustaining growth."

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The Myths of Protectionism

Despite the observed achievements of open markets, several erroneous myths regarding the benefits of protectionism persist. The worst of these, perhaps, is the claim that import restrictions save jobs at home. While employment in one sector may be higher with protection than without, job losses in other sectors of the economy are often even larger in the near term and about the same magnitude in the longer term. Thus, import restrictions have little or no effect on total employment, although they do affect the distribution of employment among sectors. Moreover, estimates of the annual cost of each job saved in protected sectors are as high as $250,000 for some sectors. Finally, the influence of protection on employment in an industry is usually small relative to other determinants, such as the general prosperity of the economy.

A second argument offered for protection is that it can provide an industry a breathing period during which to modernize and to become more competitive. A less optimistic version of the same argument is that protection permits a smooth "run-down" of existing production in the industry. Most of the evidence on either version runs to the contrary. Although it is possible for protection to increase resources available for modernization and increased competitiveness, it also reduces the pressure for any adjustment to occur. It is common for productivity and unit costs to deteriorate even further relative to other industries once protection is granted.

Paradoxically, more recent forms of protection (in particular, VRAs) help *foreign* producers by enabling them to charge higher prices for the restricted exports. United States protection on steel in the 1970s, for example, is estimated to have increased the annual profits of Japanese steel producers by about $200 million—or about half of the Japanese expenditures on research and development in steel (the world's highest).

By the same token, protection does not simply facilitate a smooth run-down of existing activity—it often frustrated adjustment by attracting new resources to the sector. In many countries it is clear that a disproportionate amount of entrepreneurial activity is devoted to protected sectors. Fully one-third of all the clothing and textile establishments in the United States at the end of 1982, for example, had not been in the industry just six years earlier, and more than one-fifth of all new manufacturing firms in France in recent years have been in the clothing and textile industry. Thus, it is not surprising that the "temporary" protection many industrial countries sought for textiles beginning in the early 1960s has resulted in a formal, long-term policy of protection.

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Another myth of protectionism is that protection is a "fairer" policy than free trade for lower and middle-income families. The burden of protection, however, typically falls greatest on lower income consumers. The tariffs (explicit or implicit) embodied in U.S. trade barriers are more regressive than any other major tax, including sales taxes. Trade restrictions in industrial countries are skewed toward restriction of those basic, labor-intensive goods that comprise a disproportionate share of lower income budgets. As a more specific example, the proportionate burden of Canadian restrictions of textile imports on lower income consumers is estimated to be four times greater than on higher income consumers.

There is also the argument that we should restrict the flow of imports to protect our economy from unfairly subsidized exports from other countries. Generally, this argument is also incorrect. Permanently subsidized exports to the United States obviously make our imports cheaper than they otherwise would be. Thus, rather than being a "beggar-thy-neighbor" trading policy, subsidies are an "enrich-thy-neighor" policy. Moreover, we do not permit a State within the United States to restrict imports of goods produced in other States that provide "unfair" tax subsidies.

There are two special cases in which the argument for restraint can be correct, however. One is when the foreign subsidy is not permanent. Countries might, for example, use subsidies to expand domestic production in some industries during the down period of a business cycle. In this case the importing country suffers recurring adjustment costs as its own domestic industry responds over the business cycle to variations in the level of subsidized imports.

A second theoretical possibility is where oligopolistic profits might be large. In such an industry a country could attempt to increase its share of the potential oligopoly profits by subsidizing its own industry, either directly or indirectly. This case may be so rare, however, that it is best treated as an academic curiosity. Furthermore, in both of these special cases the best solution is an international compact on acceptable subsidization policies, rather than protectionism.

Another argument offered for protection is that we must restrict imports in order to protect our "basic" industries. Because the United States has been characterized by certain industries since the Great Depression, the argument runs, these same industries must be protected from foreign competition to ensure continued economic growth. This argument mistakes the prospects for continued vitality of our economy as a whole with the prospects of particular industries. So-called "basic" industries can always be identified at a point in time, but the hallmark of a dynamic economy is that basic industries can change. Most importantly, there are numerous examples of

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countries that have failed with the strategy of propping up weak industries, with no apparent successes.

Finally, there are, of course, legitimate national security considerations in some industries, but as a practical matter, security issues are rarely a major factor in protectionist actions, except under the U.S. policy of strategic *export* restrictions.

OBSTACLES TO COMPREHENSIVE FREE TRADE

Before concrete free-trade initiatives are proposed, the obstacles to new international commitments to free trade should be clearly identified and understood, since initiatives that do not address the real obstacles to liberalization are doomed to failure. The following discussion of these obstacles focuses on several issues: the inertia of existing trade barriers and distortions, the appeal of new trade barriers, the participation of developing countries in multilateral trade negotiations, and the presence of domestic policy constraints.

The Inertia of Existing Trade Barriers

Existing trade barriers carry a life of their own, as political inertia works against their elimination. In heavily protected sectors, adjustment to liberalized trade is especially painful unless the overall economy is expanding. As a consequence, it is imperative that free-trade initiatives be comprehensive enough to ensure each country that at least some sectors of its economy will expand rapidly enough to cushion the adjustment of other sectors. Expanding sectors not only often reduce the extent of the contraction in formerly protected sectors, but also provide new opportunities for any displaced workers and resources. This strategy has worked reasonably well for the multilateral tariff reductions among industrial countries since World War II, and should be a key element in any new initiatives.

The comprehensiveness of trade liberalization, however, is itself threatened by extraordinary pressures to retain existing trade barriers. Remaining barriers have been revealed as those most difficult to eliminate, since these are the restrictions that negotiators have been forced to ignore. Nontariff barriers, in particular, pose difficult problems. Quantitative restrictions, import licensing, exchange controls, technical standards misused to restrict trade, and the like are much more difficult to compare, to evaluate, and to negotiate than tariffs. Without strong incentives on all sides to make mutual progress toward free trade, negotiation of nontariff barriers can be excruciatingly slow and tedious. A new, formal round of multilateral trade talks to deal with such barriers, for example, is expected by some to take several years to complete successfully, if at all.

The difficulty of negotiating reductions in nontariff barriers is exacerbated by another standard feature of international trade negotia-

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tions. Existing trade restrictions are the bargaining chips a country uses in international trade negotiations. Thus, countries are reluctant to liberalize completely their own trading practices for fear that their ability to obtain reciprocal liberalization from their trading partners will be reduced in the future. As a consequence, countries are in the paradoxical position of "needing" certain trade restrictions in order to eliminate others. To succeed fully, any new initiative must break through this paradox.

The Appeal of New Trade Barriers

Most countries are under increasing domestic political pressure to aid one or more ailing industries. Unfortunately, nontariff trade barriers are becoming the policy of choice. The reasons are not complicated. Quantitative restrictions and other nontariff restrictions are typically "off-budget," so that no explicit governmental appropriation is required to subsidize the industry. They are also often extra-legal, falling outside normal rules and restrictions of the General Agreement on Tariffs and Trade (GATT), and often requiring no formal legislative action.

Perhaps most importantly, nontariff restrictions are sometimes welcomed by the country's established trading partners. For example, VRAs transfer implicit tax revenues from consumers in the importing country (which would otherwise be collected domestically) to producers in the exporting countries (through the effect of restricted sales on prices). Although some progress has been made in a few areas in recent years, new international commitments that limit the discretion of individual governments to maintain or impose nontariff trade barriers are clearly needed.

Incentives for Developing Country Participation

Another very serious obstacle to comprehensive trade liberalization is the problem of encouraging the full participation of developing countries. In previous multilateral rounds of liberalization developing countries have not been required to reciprocate fully in multilateral tariff reductions by lowering their own trade barriers, and most still maintain substantial levels of both tariff and nontariff trade barriers. Futhermore, these countries will have little incentive to participate in further liberalization as long as key sectors in which they have a comparative advantage (especially textiles) are exempted from the liberalization process. In fact, the current trade preference schemes extended to developing countries by most industrialized countries give these countries a vested interest in maintaining the existing most favored nation tariff barriers, since the benefit their exporters derive from the perference schemes depends upon the level of most favored nation tariffs levied on goods from competing exporters in industrial

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countries. Sustained progress in opening the capital and service markets of developing countries is not likely, for exampe, without accompanying progress for these countries in opening world markets for their *manufactured* products.

Domestic Policy and Institutional Barriers

In some instances, the trade restrictions imposed by a country are determined almost entirely by domestic policies in a particular sector. Nowhere is this more obvious around the world then in agriculture. After World War II, the United States was successful at the outset in limiting trade negotiations to manufacturing and in excluding agriculture, despite strong U.S. comparative advantages in many agricultural commodities. The exclusion of agriculture was motivated by a desire to avoid possible conflicts with domestic agriculture programs.

The absence of strong international commitments to open markets in agriculture has fostered the development of restrictive domestic policies by the EC under the Common Agricultural Policy, by the United States and other industrial countries, and by developing countries. These costly domestic policies require an increasingly elaborate array of international restrictions on trade in agricultural products. Hence, little progress on liberalized trade in agriculture can be expected without reforms in related domestic policies. A country cannot, for example, maintain a direct price support program for a domestic agricultural product (sugar, grain, or dairy products, for example) that sets the price above the price of available imports without also imposing trade restrictions on imports either through quotas or variable import levies. Otherwise, the domestic price support would be an impossible expensive world price support.

Domestic industrial policies can pose similar barriers. Tariffs, preferential procurement, direct subsidies, preferential credit arrangements, exclusive market rights, and the like, are examples of explicit barriers to imports. Barriers can also be implicit, however. The complex and extensive relationship between the Japanese Ministry of International Trade and Industry in Japan and major domestic industries is often cited as an example of this phenomenon. Moreover, private Japanese trading companies control a substantial share of imports—at the same time they have very strong ties with domestic manufacturers. In some cases, these ties are reinforced by shared equity or other financial interests. Not surprisingly, therefore, trading companies do not typically market imported products that compete with those produced by domestic manufacturers with whom they already trade.

The emphasis on such institutional barriers to trade can sometimes be misleading, however. If institutional and commercial practices are not sustained by government policy (directly or indirectly), then prac-

tices that violate the fundamentals of a competitive marketplace are subject to challenge by new entrants. If no government trade restraints are present and no new entrants appear, then existing practices may be efficient.

In the case of Japan, for example, there are reasons to believe that the costs of successful entry of foreign products may be higher than for other countries. At the marketing level, Japan is still characterized by small shops and wholesalers. With roughly one-half the population of the United States, Japan has nearly as many retail establishments and wholesalers. The Japanese preference for shipping in small, neighborhood stores means that inventories must be small, deliveries frequent, and special services provided. While Japanese shopping patterns may change, to succeed in Japan exporters and new domestic producers alike must establish a distribution and service system, either by themselves or through Japanese partnerships. Thus, entry costs are high. The fundamental issue is whether and how governmental policies are used to raise these costs artificially. In some instances the artificial barriers are obvious (as in the official Japanese domestic monopoly in telecommunications), in others the barriers are less obvious (as in the case of import inspection).

A STRATEGY FOR FREE TRADE

Despite the obstacles to free trade, there is every reason to push now for comprehensive trade liberalization. First, the trend toward increasing protectionism at the national level may actually help mobilize a consensus for a new international initiative toward comprehensive free trade. Recovery of the global economy presents the opportunity to resist protectionist pressures and to reach just such a free-trade consensus.

Second, there is evidence that many countries around the world are increasingly willing to pursue domestic policies that emphasize open markets, market incentives and private control to a greater degree than before: members of the EC are under increasing pressure to find a less costly alternative to their current common agricultural policy, the United States is increasingly concerned about the large costs of its own domestic agricultural policies, and many developing countries appear to be at least more receptive to private, competitive markets in basic sectors. This change in the world temperament toward open, market-oriented policies poses the opportunity for successful new initiatives.

Third, at the Williamsburg Economic Summit, President Reagan and the heads of government of major U.S. trading partners agreed to consultations among their governments on a new multilateral round of trade negotiations under the auspices of the GATT. At the

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London Summit, they agreed to broaden these talks to include all GATT parties. A multilateral round of trade talks is the most effective vehicle for successful trade liberalization.

Finally, the U.S. Trade and Tariff Act of 1984 authorizes the President to enter into negotiations with any country desiring a free-trade area with the United States, although congressional ratification is required. This authorization, together with the call for a new round of formal multilateral trade negotiations, presents a good opportunity for trade liberalization.

A New Round of Multilateral Trade Negotiations

To exploit present opportunities the United States must pursue decisive, extraordinarily disciplined policies. At the most general level, a successful international strategy requires that the United States push aggressively forward on comprehensive multilateral trade negotiations under the auspices of the GATT. At a more detailed level, a successful international strategy requires that the United States itself be committed to comprehensive trade liberalization. In this context, comprehensiveness has several dimensions—products factors of production, countries, and types of trade distortions, including VRAs and various preferential treatments of domestic industry. Each of these dimensions is crucial to successful liberalization.

With regard to products, the Untied States should push especially hard for liberalized trade in agriculture, services, telecommunications equipment, advanced electronics, automobiles, textiles, wood products, and steel, to mention just some of the major problem areas. The United States has much to gain from liberalizing these areas, and developing countries in particular will have few incentives to participate without the promise of liberalized textile trade.

In the industries above where the United States has significant restrictions—automobiles, steel, textiles, and agriculture—the costs of the restrictions are large. The annual cost of each additional job saved through protection in the automobile, steel, and textile industries, for example, is in each case several times the average annual pay in the industry. For steel the cost of new restrictions is roughly $200 thousand per job. These costs arise from the cutbacks in steel-using industries and from increased prices to consumers. Moreover, in agriculture the annual cost of restrictions on sugar imports is in excess of $3 billion, and the consumer cost of import restrictions on dairy products is even higher.

With regard to the various types of distortions, some progress has been made in the GATT negotiations over subsidies, government procurement practices, and other nontariff barriers, but a new U.S. initiative at this time could accelerate and expand agreements in these an other areas.

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The Role of GATT

GATT was established in 1948 to foster liberalized trade and has sponsored several successful rounds of multilateral trade negotiations. An effective GATT is essential to further liberalization and expansion of international trade. In particular, GATT obligations can help to restrain protectionist trends around the world by providing a source of external discipline to national policies. Just as the U.S. Constitution puts interstate trading policy beyond the control of individual States, international commitments can put the use the tariffs and other major forms of nontariff barriers beyond the control of individual countries. Moreover, since no policy is likely to be completely successful in this regard, an ambitious program of automatic trade liberalization is needed to counter the inevitable individual lapses of protectionism at the national level.

The objectives of U.S. policy towards GATT are to strengthen the existing framework in the short term and to expand the scope of the agreement in the longer term. To achieve these goals, the United States supports the work program agreed to by the GATT Contracting Parties at the Ministerial meeting in 1982. Efforts to strengthen and expand the existing framework include working parties on safeguards and structural adjustment, quantitative restrictions and other nontariff measures, and dispute settlement procedures, as discussed below.

The United States supports the negotiation of an effective "safeguards" code that would discipline the use of temporary import restrictions as a method of dealing with domestic industry adjustment to import competition. A strong safeguards code is necessary to provide additional discipline over the trade-restrictive actions of GATT member countries, and the United States has been at the forefront of calls for strengthened provisions in this area. Unfortunately, little progress can be reported so far.

The continuing proliferation of quantitative and nontariff restrictions on trade is a major item of concern for the United States and many other GATT members. The working party on this issue has catalogued existing quantitative restrictions and other nontariff measures and judged their consistency with GATT principles. It is hoped that this information will facilitate negotiations to eliminate the restrictions, perhaps as part of the preparation for a new multilateral round of trade negotiations.

A major weakness of the GATT is its inability to resolve disputes effectively. A greater reliance on professional panelists to resolve disputes might lead to a more predictable settlement process less subject to control by member countries. If adopted, the recommendations of the GATT working party in this area would improve the

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process of forming panels, as well as the implementation of panel recommendations. Progress in this area is limited, however, by the absence of formal GATT codes covering a wide range of both products and trading practices, which could serve as objective criteria for resolving disputes, as in the case of the Standards and Government Procurement Code.

In an attempt to resolve this problem, the GATT Contracting Parties have discussed extension of the GATT framework into agriculture, services, counterfeit goods (and other issues of intellectual property rights), high technology goods, and textiles. GATT discipline over agricultural trade policies is much weaker than over trade in manufactured goods. Quantitative and nontariff restrictions and subsidies, in particular, are widespread in agriculture. Some countries have used export subsidies agressively to capture the market shares of other producers. Others, including the United States, restrict import of some agricultural products to avoid conflicts with domestic agricultural policies.

In order to bring agriculture more fully under the rules of GATT, the United States supports a reduction in quotas and licensing programs limiting agricultural imports and a general prohibition on export subsidies. The EC, however, opposes a general prohibition and believes that export subsidies should be permitted. Clearly, agriculture remains a major stumbling block to freer world trade. Although trade in services constitutes an increasing portion of international trade, it continues to remain outside the GATT framework. The United States believes that trade in services is inherently linked to trade in goods. Progress in this area has been slow, however, due not only to the complexity of the subject but also to intense opposition in principle, especially among developing countries. The service industries in these countries are usually small, and the governments argue that further growth of the industries would be impossible without restrictions on foreign competition. Despite such opposition, the United States has recently pursuaded other Contracting Parties to consider the issue of services and the possibility of establishing a GATT working group.

Trade in counterfeit goods has increased noticeably in recent years. In addition to the economic losses to trademark owners, trade in counterfeit goods presents potential safety and health hazards to consumers. The United States believes that GATT provides the best forum for negotiating and implementing an agreement to handle this problem and urges the formation of a working party on trade in counterfeit goods. Developing countries have opposed such a working party on the grounds that GATT is an inappropriate forum to discuss this issue. Their underlying fear, however, is that rules to re-

strict the trade of counterfeit goods will be used as a protectionist measure by developed countries to limit imports of legitimate goods. As required by the Trade and Tariff Act of 1984, the United States is preparing a survey of problems around the world with intellectual property rights in general. The study will provide the basis for U.S. efforts to negotiate an end to major abuses of such rights.

In 1982 the United States proposed that GATT examine the problem of trade in high technology goods. As a result of opposition, the study was transferred to the OECD. Two major findings have now emerged from this study. First, open international markets are necessary to capture fully the benefits of high technology industries. Second, restrictive trade practices are increasing trade frictions in these industries. Major issues include the role of preferential public procurement (especially in telecommunications), the role of product standards, limiting the access of domestic firms to government sponsored research, the influence of various types of government sponsored research and techonology on commercial and industrial technology, and the effect of government policies on investment.

Finally, we come to textiles, which are exempted from standard GATT rules. The Multi-Fiber Arrangement, which governs trade in textiles, is due to expire in July 1986. This agreement establishes rules governing quotas for textiles. A working party is examining the possibility of bringing textile trade into the GATT framework, perhaps through the negotiations on renewal of the Multi-Fiber Arrangement, which begin in 1985. Textile restrictions began in 1960 as a temporary expedient to give the textile industries in the United States and other industrial countries time to adjust but, perhaps predictably, have evolved into a permanent obstacle to freer trade.

Secondary Strategies

A potential problem with multilateral negotiations is that they may be stalled by a relatively small group of countries. If thos occurs, the United States and others may be forced eventually to resort to secondary strategies for liberalization. The new free-trade area (FTA) negotiating authority given the President offers one possible option. FTA negotiations tend to reverse the incentives in international trade negotiations, to make countries more eager to be among the first to agree to liberalize trade rather than among the last. The incentives for countries to be among the first to enter an FTA with the United States could be strong. Because no duties would be levied on intra-FTA exports of FTA members, the first entrants would enjoy substantial competitive advantages over outsiders in the large U.S. domestic market, especially if highly restricted sectors were to be included in the FTA agreement. In addition, as the number of countries joining an FTA grows the incentives for outsiders to join in-

crease, since unfavorable trade diversion increases and the size of the non-FTA market decreases, as the FTA expands.

One possible criticism of an FTA initiative is that it may appear to some as a regression to narrow, bilateral trade negotiations. However, a U.S. FTA strategy, if implemented, would be quite different from traditional bilateralism. First, the possibility of an FTA strategy would be considered only if multilateral negotiations stall. Second, an FTA initiative would not be the same as the narrow, complex trade "haggling" characteristic of the 1930s because there are GATT criteria for permissible FTAs. Third, an FTA initiative would be as multilateral as the number of countries that choose to join the agreement. There is nothing intrinsically bilateral about an FTA. Again any FTA initiative would at all times be subordinated to resumed progress in multilateral trade negotiations.

Perhaps most importantly, however the possibility of an FTA initiative offers the United States and others the option of using a free-trade instrument, rather than protectionism, as a threat against protectionist countries that are recalcitrant in multilateral negotiations. There are several fundamental difficulties with using protectionist trade sanctions as an instrument to try to persuade other countries to liberalize their own trading practices. First, trade sanctions hurt the country that imposes them, in some instances as much as, or more than, the foreign country. Second, the foreign trading partner knows that this is the case. As a consequence, threats of trade sanctions are often weak. The foreign country knows that a country will be reluctant to implement restrictions, and if the sanctions are implemented, that they will in fact hurt the home country's domestic economy. Then, of course, there is always the additional threat of foreign retaliation.

In contrast, a possible FTA poses a threat to FTA outsiders by diverting their exports through freer trade within the FTA. Thus, FTAs offer an alternative strategy to trade sanctions that emphasizes freer, rather than more restrictive, trade policies in dealing with major countries, or groups of countries, unwilling to participate in fully comprehensive trade liberalization.

In rare instances, however, the United States may be forced to use trade sanctions to force a particular trading partner or a group of trading partners to abandon especially restrictive trading practices. Although such sanctions raise the danger of retaliation and possible trade wars, there may be isolated instances where this danger is minimal relative to potential gains. However, sanctions should only be used in accordance with clearly established rules, not in frustration or as a pretext for protectionist actions. Thus, when threat of a sanction is introduced it should always be accompanied both by an unambig-

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uous explanation of which trading practice the sanction is aimed at eliminating and by credible assurances that any sanctions imposed will be removed immediately when the restrictive practice halts.

Typically, effective sanctions will not be possible in the same industry where the restrictive trading practice occurs, primarily because this forces a confrontation on ground where the trading partner is relatively strong and where the cost of the sanction to the United States may be large. For example, if we are seeking to eliminate substantial export subsidies in an industry where the U.S. competitive position is weak, a trade sanction in the same industry is unlikely to be successful. In addition, sanctions in weak industries are more subject to protectionist abuse and may raise legitimate concerns among trading partners. A sanction is more likely to succeed in an industry where the trading partner's exports to the U.S. market are more important to them than they are to the United States. Thus, trade sanctions must be carefully tailored to the specific needs of particular circumstances. One would also expect strategic sanctions to be used only at the discretion of the highest policy levels of the government.

Some Domestic Issues

Coordination of a new international initiative with possible reforms in related domestic policies seems opportune. The Administration will seek agricultural reforms 1985 farm legislation that will increase U.S. flexibility in negotiating freer trade in agricultural products. The agricultural policy of the EC is also under scrutiny within the Community.

On a somewhat different note, much could also be done to ward off protectionist pressures prior to crisis points. Trends in productivity and unit costs as early as the mid-1970s, for example, made clear that the steel and automobile industries in the United States were becoming less competitive with foreign producers. Publicizing such trends early could inform the public and the industry that government action will not be forthcoming at some crisis point in the future to redress the industry's own errors.

Finally, it is often assumed that opening markets abroad for U.S. exports by reducing trade barriers will necessarily improve the fundamental position of the U.S. trade deficit. While it may seem obvious to some that the trade deficit will decline if we reduce all the effective barriers to our exports in foreign markets, this is not necessarily the case. The fundamental position of a country's trade balance is determined by domestic investment opportunities and saving behavior (including government) relative to investment opportunities and saving behavior abroad. Changes in trade barriers will affect the trade balance in a fundamental way only to the extent that they change saving or the investment climate, either at home or abroad.

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Accordingly, the use of a target for the U.S. trade deficit (either with the rest of the world or with particular countries) as a measure of our success in liberalizing trade is likely to lead to frustration. Comprehensive free trade is a policy objective because of the proven benefits of open markets, not because it will lead to a particular balance of trade.