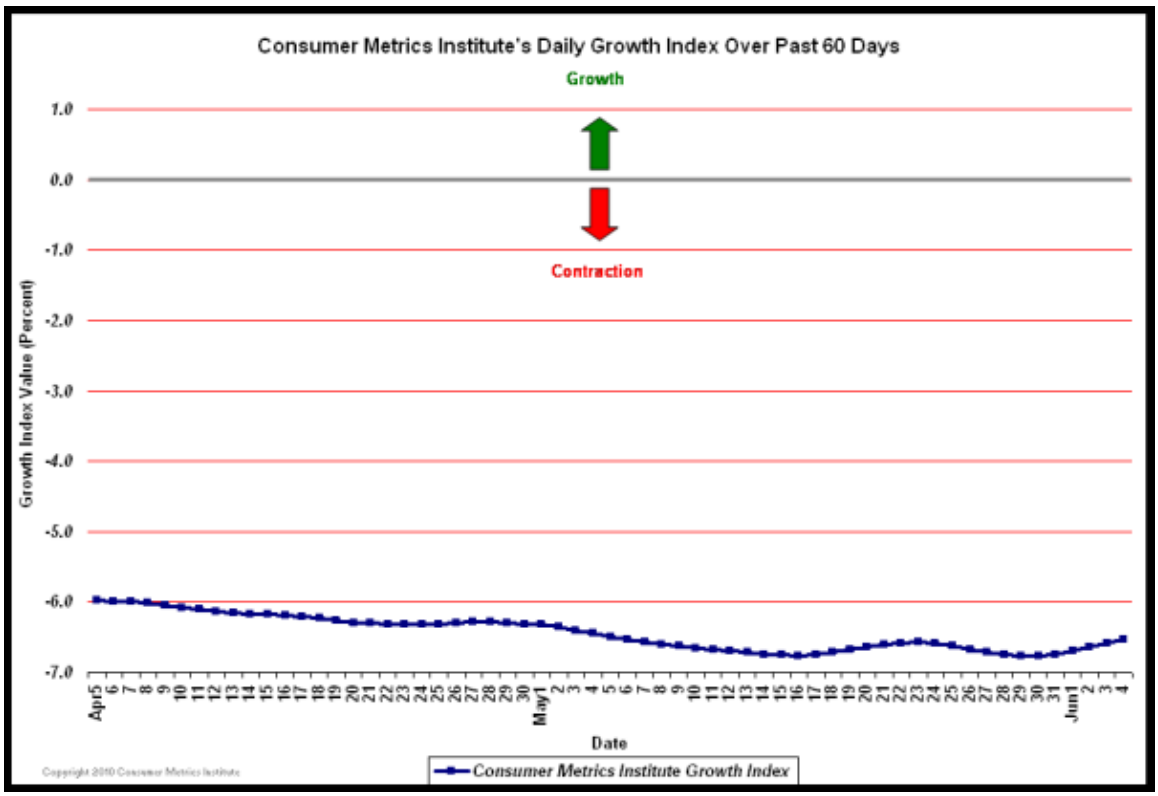
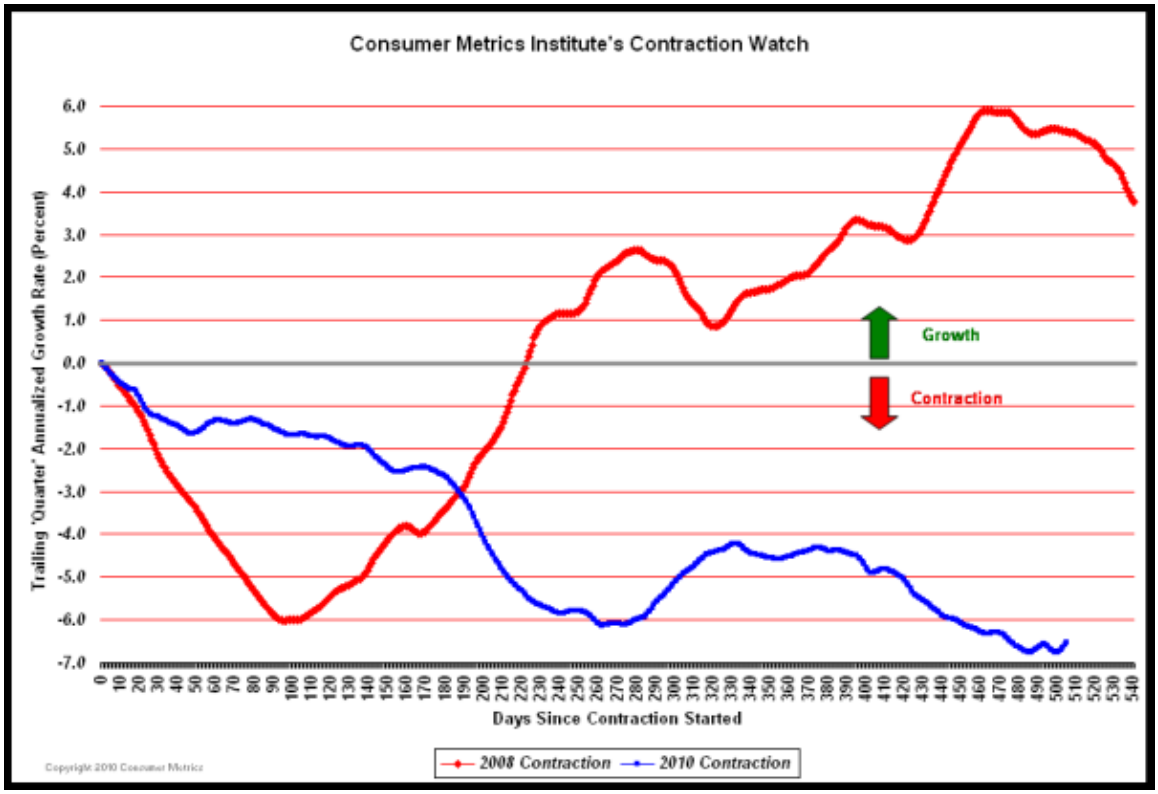
Consumer Metrics Institute Members News

May 26, 2011: An Evolving Bottom; Healthy Debt/GDP End-Games

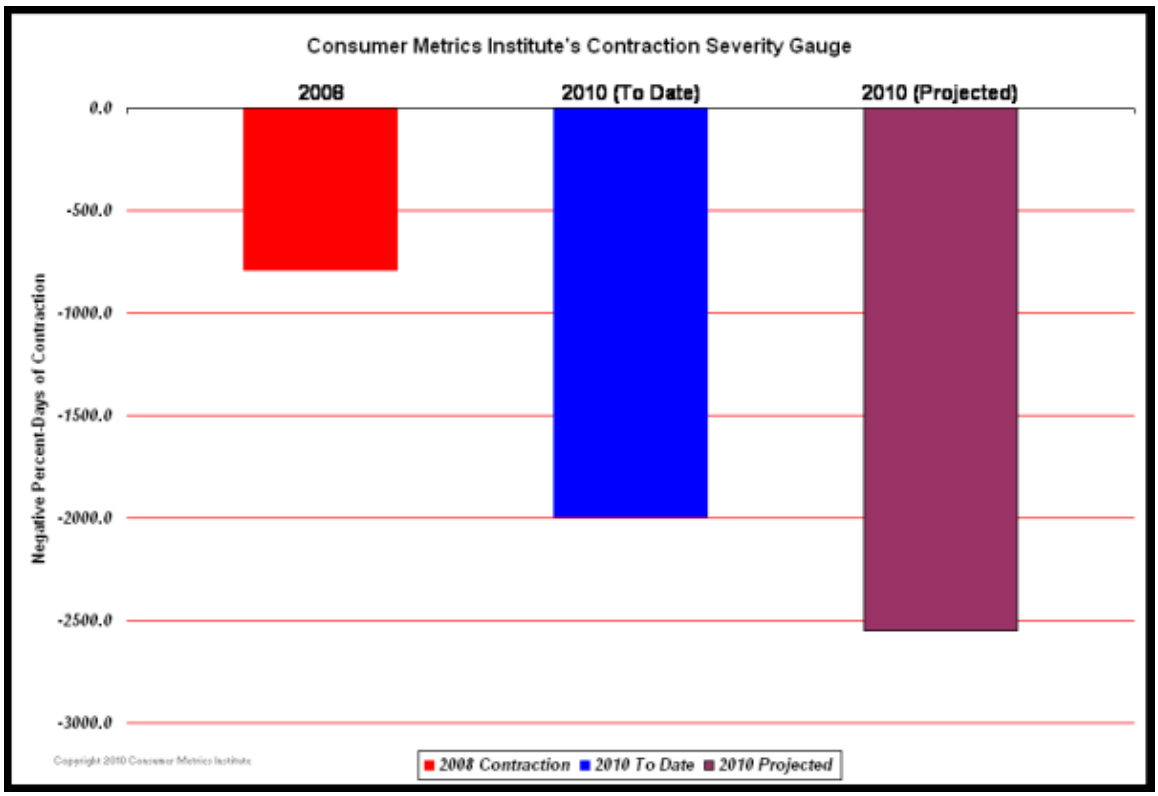
The "bottom" that we had previously seen in our Daily Growth Index has become better defined, and we feel that any celebrations may still be a bit premature**:**



And it is important to keep this upward movement, such as it is, in perspective. Although it is clearly visible in our "Contraction Watch," the significance of the upturn pales in comparison to the overall "area under the curve" that has been traced out by the Daily Growth Index for now well over a year**:**

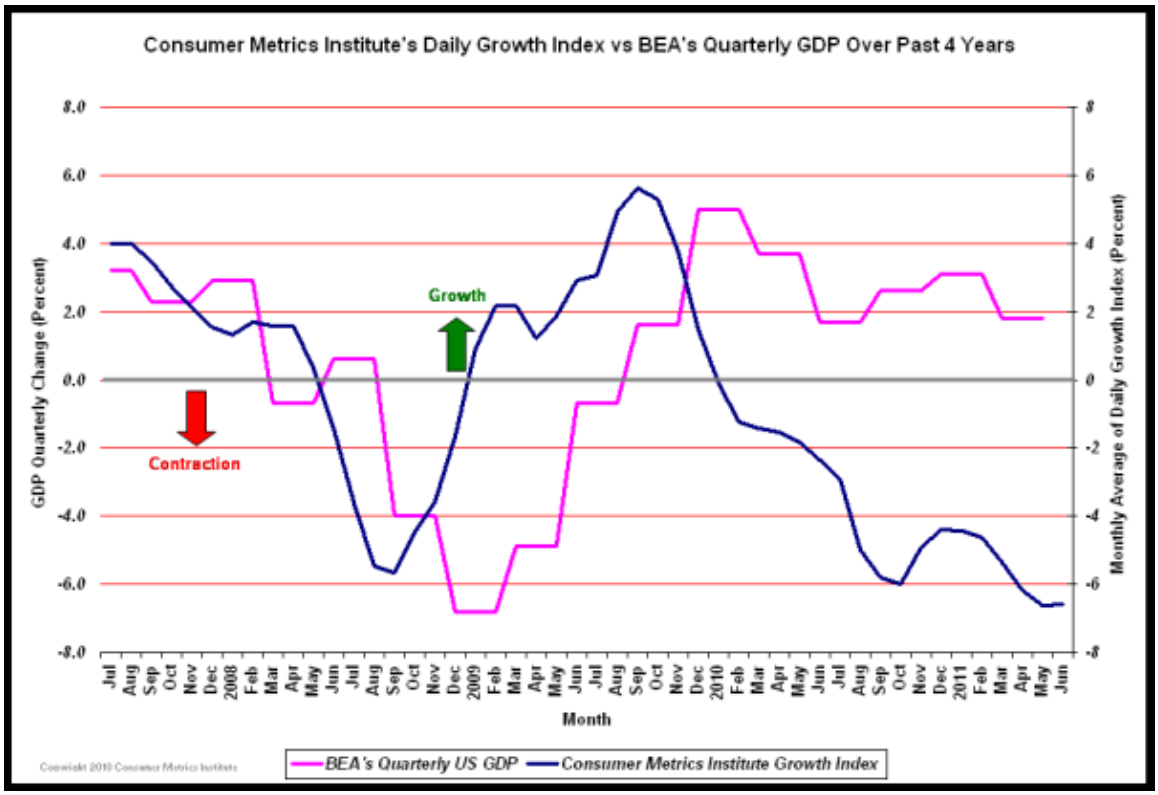


As for that "area under the curve," this particular contraction in on-line consumer demand is substantially worse than what we observed during the 2008 "Great Recession"**:**



The bottom line on this contraction is that, indeed, "this time is different." Our data indicates that the classically defined 2008 "Great Recession" was felt disproportionately in the finance and "large cap" business sectors, with consumers spooked by the headlines from "Wall Street" but largely un-impacted themselves. However, since then (even as the contraction was disappearing for "Wall Street") a shadowy extension of the "Great Recession" has evolved and become personal and deeply entrenched on "Main Street," where unemployment has proven to be more than a temporary inconvenience and real disposable incomes have continued to shrink.

This can be seen most clearly by viewing the continuing disconnect between what our consumers are doing and the official GDP reports from the BEA**:**



The levitation effect provided by the Federal fiscal stimulus packages will begin to wilt soon, as will Mr. Bernanke's monetary magic when QE-2 lapses in June. At some point in time the GDP will revert to tracking the 70% of the economy provided by consumer spending. When that happens the glaring gap in the above graph will close, and most likely with the upper line converging towards the lower, rather than the other way around.

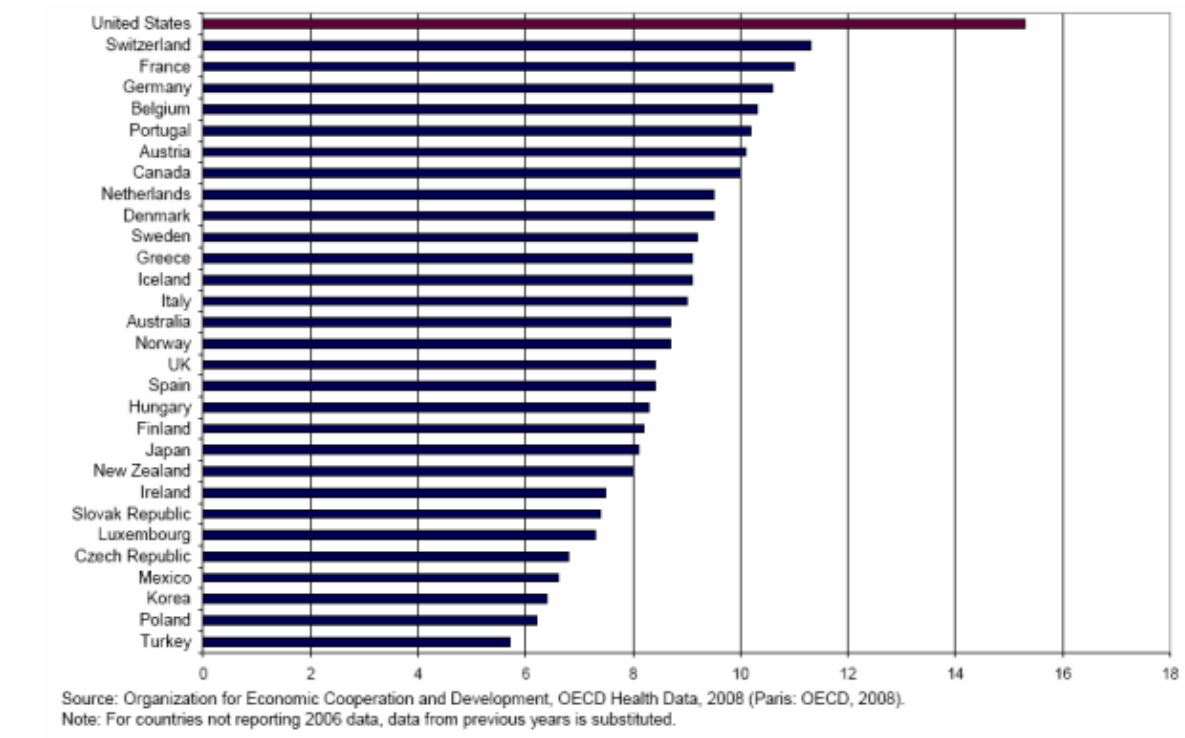
We have said before that our consumers seem to know that the headline recovery in the S&P 500 has not yet been fully shared with the them, their neighbors or their local merchants. Until unemployment materially decreases and the residential housing market returns to at least pre-2005 levels of activity, the "Great Recession" isn't over, despite what the National Bureau of Economic Research (NBER) would have us believe.

Healthy Stimulation

(In several recent articles we have explored a number of potential "unthinkable" solutions to both the U.S. sovereign debt problem and the fiscal consequences of a suddenly balanced U.S. Federal budget -- given that a balanced budget would suck about 14% out of the country's GDP, meeting the clinical definition of a depression. We discussed solutions that were mundane, some more imaginative, others requiring modest regime change, yet more that involve radical regime changes, one that uses regime change to de-securitize the mortgage industry, and another that would selectively stimulate "Main Street" America and the small businesses that live there. As a point of reference we have used the report from the Simpson-Bowles commission as a sample framework for how to balance the budget, and have assumed that to prevent a Simpson-Bowles induced depression some form of non-fiscal stimulus would be needed that could provide excess growth to the U.S. economy on the order of 3% per annum over 5 or more years.)

We often chide John Maynard Keynes for his occasionally cavalier attitude about how deficit monies should be spent -- perhaps epitomized by his 1936 observation that governments could stimulate economic investment by filling "old bottles with bank notes, bury them at suitable depths in disused coal mines ... and leave it to private enterprise to dig the notes up again." Even as he was writing those words it was becoming clear that the Roosevelt administration's public works agenda of new court houses, parks and amphitheaters would provide new jobs only so long as they were still being built. Ultimately it was Roosevelt's post 1938 investments in the "Arsenal of Democracy" that created the new factories and truly self-sustaining jobs that contributed to ending the "Great Depression."

Just as some types of governmental spending are more "productive" than others, some portions of GDP spending contribute more to ongoing GDP growth than others. One sector of the U.S. economy that has grown spectacularly of late is health care, which represented 17.6% of U.S. GDP in 2009. As the following chart shows, even by 2006 the U.S. had far surpassed the health care spending (as % of GDP) of any other developed country:



In fact, *U.S. health care spending grew by 4.7% in 2008, even as the total GDP shrank by 2.8%.*

At minimum one could conclude that what benefited U.S. health care in 2008 did not simultaneously benefit the entire economy. And one might also conclude that rapid expansion of health care expenses did not commensurately expand the rest of the economy. We could take that argument a step further and assert that increasing health care expenses -- however necessary or defining as a measurement of a nation's "quality of life" -- are at best only marginally productive for *(and at worst parasitic on)* the overall growth of the economy. It could therefore be argued that *the growth of U.S. health care expenses to some extent cannibalizes the growth potential in other parts of the U.S. economy.*

We're making an economic argument here, not one addressing the fairness or efficacy of the U.S. health care system. Investments in health care infrastructure clearly create new jobs and new economic "product." Our question is whether the macro economic consequences of that investment on the net overall growth rate of the economy are positive, neutral or negative. If the added investments in health care are prolonging or improving the productive careers of U.S. workers, the answer is probably positive. If, on the other hand, in the early 21st century the U.S. has moved past the point where huge increases in health care expenses are producing corresponding increases in worker productivity, then the answer is probably neutral at best -- with the strong possibility that growth in health care expenses could be net parasitic on overall economic growth.

(Among the economic consequences of the relative growth of the health care industry is a shift of GDP expenditures from consumer and small business discretionary funds to the "large cap" institutions

typical of the health care sector (pharmaceutical firms, insurers and hospital holding companies). If overall economic growth is determined to some extent by the mix of the velocities of the monies spent in various sectors, moving discretionary disposable spending from consumers and small businesses to the health care industry is probably decreasing those velocities on the basis of the institutional scale change alone -- even before the growth potential of discretionary spending is factored in.)

From a demographic perspective the question takes on a much sharper focus: can future generations afford to support increasingly expensive Medicare entitlements to a growing portion of the population? Or perhaps more analytically**:** at what percentage of GDP do health care expenses pass a "tipping point" of sustainability? At 17.6% of GDP, U.S. health care expenditures are over twice those of Australia, New Zealand or Japan -- and arguably already in uncharted waters of sustainability.

Under the Knife

If we are looking for ways to grow the economy by an excess 3% per annum without running further Federal deficits, and if the costs of the U.S. health care system (such as it is) are at least somewhat parasitic on economic growth, then decreasing them could provide just such a stimulation. The premise behind this is that shifting monies from health care expenses to the rest of the economy would not be a zero-sum-game, and instead would provide businesses (and consumers) with increased margins that should ultimately result in at least some excess aggregate economic growth.

This specific variety of "Health Care Reform" is directed solely at reducing the cost of providing unaltered levels of coverage and care. It is also, evidently, the kind of "Health Care Reform" that most U.S. voters have always wanted and would gladly support. It is a political issue with strong appeal to the electorate, even as it would face strong opposition from the health care industry's entrenched players. That said, what are some of the options?

-- "**The first thing we do, let's kill all the lawyers** ..." *(Henry VI, Part 2)***:** The Simpson-Bowles commission made several suggestions about ways to reform the current medical litigation environment, which they said "increased health care expenditures because of both direct costs (higher malpractice insurance premiums) and indirect costs in the form of over-utilization of diagnostic and related services (sometimes referred to as 'defensive medicine')." They recommended "an aggressive set of reforms to the tort system" that included:

- Imposing a statute of limitations (as short as one to three years) on medical malpractice lawsuits;

- Creating specialized "health courts" for medical malpractice lawsuits; and,

- Allowing "safe haven" rules for providers who follow best practices of care.

It should be noted that many members of the commission also favored statutory caps on punitive and non-economic damages, although that topic seems to have been a little too "unthinkable" to receive a full commission recommendation. We, of course, think that the "unthinkable" will likely happen anyway, and moderate statutory caps might be easily sold to a litigation wary electorate in exchange for lower health care premiums.

-- **Drug Abuse:** The cost of pharmaceuticals is a major part of the escalating costs of health care. Extending the tort reforms listed above to drug manufacturers would help, but even more would be needed to dramatically reduce the costs of this portion of the health care dilemma. One "unthinkable" option would be to modify the entire framework of patent law in the health care industry, similar to

what was done in 1917 by a young Franklin Roosevelt. At that time, as Assistant Secretary of the Navy, he pressured the struggling aviation industry to pool their patents into the Manufacturer's Aircraft Association, with cross licensing for the use of those patents in the production of new aircraft designs critical to the war effort. In other times of national emergency (notably during World War II) the government has imposed similar patent pool arrangements to restrict intellectual property rights for the greater good -- essentially an "eminent domain" argument applied to intellectual property.

A critical part of patent pool arrangements is automatic cross licensing, preventing the patent holder from maintaining a legal monopoly by withholding production rights from other manufacturers. Compulsory licensing is "unthinkable" in the U.S. now, even as it is a common feature of patent law in other countries. A sufficiently clever pooling arrangement could provide at least some offsetting benefits to the patent developer, including:

- Federal indemnification from "harmful drug" litigation;

- Pooled funding of new drug clinical efficacy and safety trials;

- Time-phased auctioning of the cross licensing rights, providing "market" priced compensation for additional production rights.

- Extended patent protection within the confines of the pool, providing some additional income to the patent developer even after the original patent has lapsed.

-- **The Byzantine FDA:** Current FDA policies are also a major source of the high cost of health care. At first glance the highly risk-averse FDA might appear to be acting in the public's best interest. But Milton Friedman pointed out that the regulatory process is inherently biased politically against the approval of drugs, since mistaken approvals of harmful drugs are highly publicized while the consequences of wrongfully banning a truly useful drug will remain forever unknown -- meaning that a politically conscious FDA will take the action that will result in the least public condemnation, regardless of the health consequences. It is generally estimated that the current process adds $500 million to $2 billion to the cost of developing a new drug. And that scale of cost also removes incentives to create pharmaceuticals with limited market potential -- while excluding innovative smaller drug firms entirely from the process.

Among the "unthinkable" options that could bring those costs down are:

- Automatic cross approval of drugs already cleared by the European Medicines Agency;

- Removing the FDA from the political spectrum, similar to the Federal Reserve's status now;

- Accelerating the drug approval process through a full peer review mechanism that defaults to approval;

- The pooled funding of clinical trials for drugs with limited market appeal or from small firms;

- Allowing patient access to unapproved drugs after informed (and recourse waiving) acknowledgement of the risks involved.

Most currently proposed FDA reforms target the general coziness between the agency and the major pharmaceutical firms that the FDA is meant to regulate. If (as a practical matter) that coziness remains

difficult to expunge, a flip-it-on-its-head "unthinkable" alternative is industry self-regulation -- something that has arguably worked well for at least the isolated example of the National Association of Security Dealers (NASD), where the threat of regulatory banishment remains real and visibly enforced.

-- **Glass-Steagall Cares (again):** In the financial industry the Glass-Steagall Act of 1933 segregated depository institutions (e.g., banks) from investment houses (e.g., brokerage firms) on the premise that having a single institution provide both services involved an inherent conflict of interest. Time has proven that Senator Glass and Representative Steagall were correct, since the full demise of their act in 1999 (at the hands of the Gramm-Leach-Bliley Act) was credited by the "Financial Crisis Inquiry Commission" (FCIC, aka the "Angelides Commission") as the single most critical cause of the 2007-2009 Financial Crisis.

If conflicts of interest can become real in finances, we should expect nothing less in health care. Among the "unthinkable" solutions to cutting health care expenditures might be to invent some equivalent of Glass-Steagall for patient care:

- Totally segregate the ownerships of primary care, institutional care and diagnostic services;

- Isolate patient care decisions from the insurer's best interests;

The premise behind such separations would be to prevent conflicts of interest that might cause unnecessary diagnostic or institutional services, the crux of the "defensive medicine" cited in the Simpson-Bowles report. Meanwhile, the delivered quality of health care might actually improve if physicians were liberated from the financial consequences of their care decisions.

Medical Side Effects

Health care reform has recently proven to be politically divisive, largely because the reform agenda was not primarily cost reduction, but rather extended coverage. And if increased coverage was the overall objective, making end-user costs more affordable would seem to have been a reasonable first step to accomplishing that. Sadly, one consequence of the enacted health care reform package is that an opportunity to potentially stimulate the economy was lost -- and very probably the exact reverse was accomplished**:** an increased parasitic drag was lashed onto an already weakening economy.

The concept presented here is simple**:** take some of the monies that consumers and small businesses are spending on health care and let those monies be available for discretionary spending and/or investment in higher velocity portions of the consumer economy -- reallocating GDP spending to the areas of the economy most likely to stimulate the excess growth necessary to offset the crushing impact of a balanced Federal budget.

Maybe it's now time to rekindle the whole health care reform debate, but this time tightly focused on cost-cutting opportunities -- reforms that will appeal to the vast majority of American voters, while having as as happy medical side effect the avoidance of a Simpson-Bowles induced depression.
