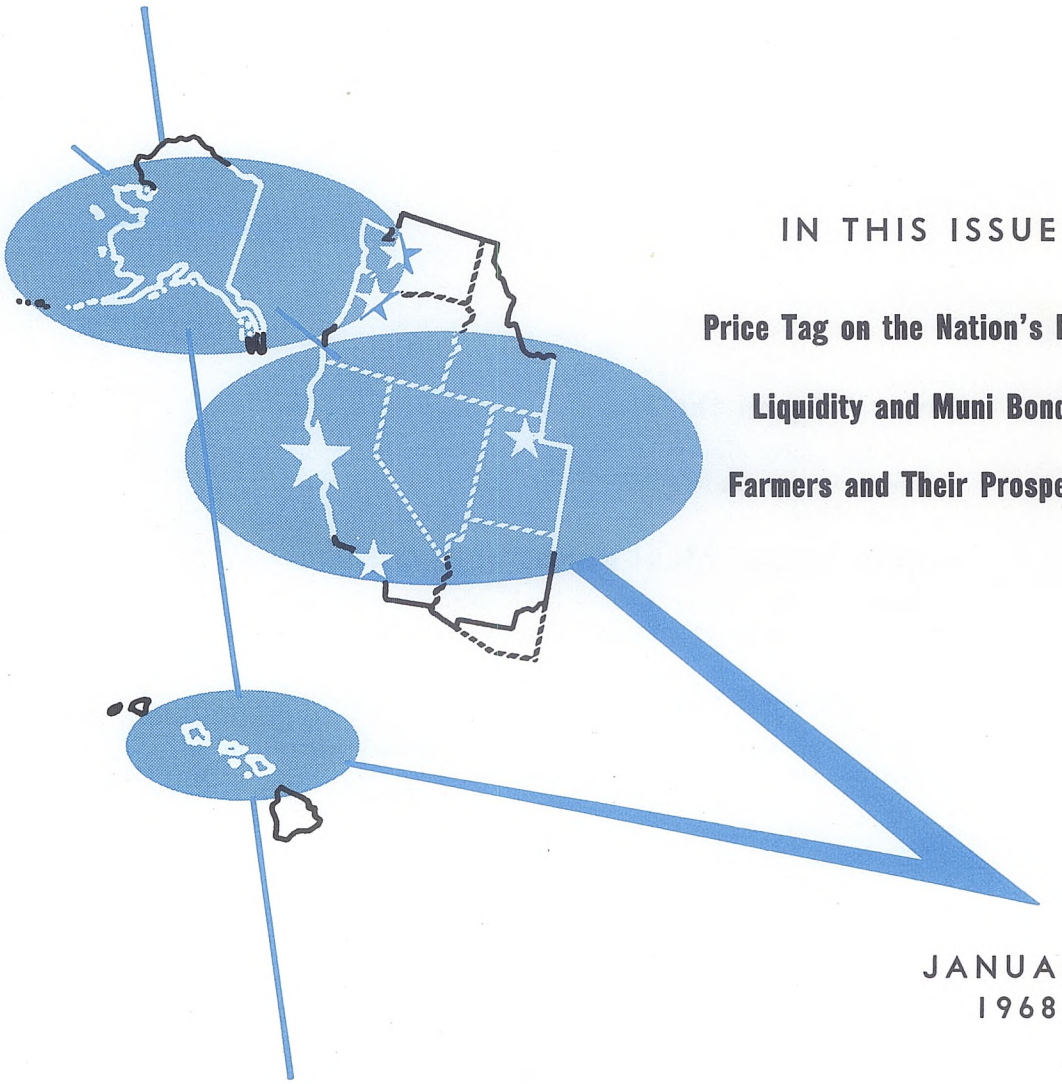
FEDERAL RESERVE BANK OF SAN FRANCISCO

MONTHLY REVIEW



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JANUARY
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Price Tag on the Nation's Health

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Liquidity and Muni Bonds

. . . Liquid short-term issues account for 25 percent of District bank municipal portfolios, as against only 17 percent elsewhere.

Farmers and Their Prospects

. . . Western farmers look for higher crop and livestock production in 1968—and pray for higher prices.

Editor: William Burke

Price Tag On The Nation's Health

"In the beginning is the end," it's true, but science has done much to delay the inevitable hour for most of humankind. In the first half of this century in particular, the nation's health measurably improved as medicine's increased control over infectious diseases caused a decline in the nation's death rate from 17 to 9 per 1,000. In more recent years, with the increasing stability of the death rate, scientists have focused more on the quality of life rather than the actual length of life as the best overall measure of health. In other words, they have attempted to isolate the economic, demographic, and sociological factors that lead to concentrations of illness in order to determine the adequacy of health manpower and physical plant for servicing the needs of the nation's citizens.

Information on the quality and quantity of health care has become increasingly available in recent years, beginning with the National Health Survey of the mid-1950s. By now, under the impetus of Medicare and Medicaid programs, health information has reached flood stage. This material, aside from providing a profile of health conditions and resources, has also revealed areas of inefficiency and thus has fomented interest in mitigating the growing costs of medical and hospital care.

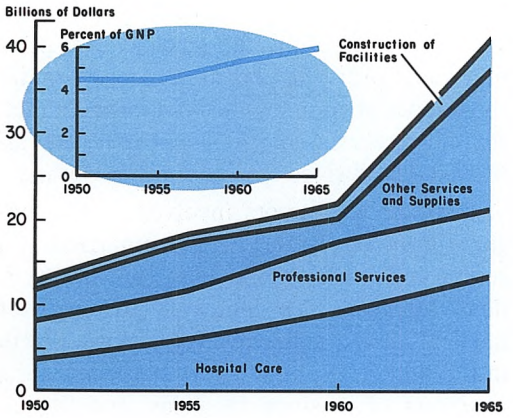
Demand and zooming prices

The national health bill tripled in dollar terms in the 1950-65 period, and thereby jumped from 4½ to 6 percent of GNP. Expenditures have risen sharply in all categories, especially in the areas of hospital care and the construction of medical facilities. Much of this of course has been due to higher prices, especially in the last several years. In 1966 alone the medical care price index rose over 6½ percent, especially under the impact of zooming hospital costs; in fact, the daily service charge in hospitals has almost doubled since the start of this decade.

Some of the factors involved in this upsurge in medical prices are summarized in a recent health-care report requested by President Johnson. The increased demand for medical services, the relatively slow growth in the supply of physicians, rising wage costs in excess of productivity gains, and the increased complexity of medical care generally —all have combined to create severe upward pressures on the price level.

Much of the increased demand for physicians' services is due simply to rising population and income. The growing population has better health-insurance coverage than before and is also more affluent—an important consideration since each 3-percent increase in income tends to generate about a 1-percent increase in demand for physicians' services. Demand is also increased by a shift

U. S. health spending accelerates and takes larger share of GNP



in population structure in favor of those groups which are most likely to be found sitting in doctors' offices—women, city dwellers, and educated people.

Cost of Western health

The West, being proportionally more affluent, more educated, and more urban-oriented than the rest of the country, consequently pays proportionally more for health care. According to a recent Labor Department study of urban family budgets, the "average" American family of four paid $468 (5.1 percent) of its $9,190 budget for medical care in 1966, but the "average" Western family paid considerably more. The typical Los Angeles family spent 34 percent more than the national average of $468, and expenses in San Diego, San Francisco, and Seattle were 24 percent, 18 percent, and 6 percent, respectively, above the national figure. The medical-care budget measured here includes the family's share for premiums for group hospitalization and surgical insurance plus out-of-pocket expenses for other medical services and supplies.

The higher cost of Western medicine is not exactly new; the regional and national price indexes have risen roughly in tandem since the beginning of this decade. In mid-1967 the national cost for medical care was 36 percent above the 1957-59 base, while the San Francisco and Los Angeles figures were 38 percent and 32 percent, respectively, above their base-period levels.

Hospitals: focal point

The nation's hospitals are at the center of much of the controversy over the cost and quality of the nation's health. The emphasis is quite understandable, since each general hospital provides a focal point for community health efforts, a training ground for health personnel, and a center for medical research. In 1873, when the first count was taken, there were only 178 hospitals in the nation, and many of these were nothing but almshouses for the care of the indigent sick. Today, however, the count has reached 7,123 hospitals, of which 5,736 are non-Federal short-term general hospitals.

The first burst of hospital building took place around the turn of the century, as the private fortunes amassed during the nation's Industrial Revolution supported the construction of facilities which made available new medical discoveries and new concepts of adequate medical care. By 1909 there were 4,359 hospitals in operation.

During the Great Depression, hospital construction practically ceased; in fact, 700 hospitals closed their doors for lack of operating funds during that period. But the war period brought about a new awareness of health-care requirements, culminating in another burst of hospital construction under the aegis of the (Hill-Burton) Hospital Survey and Construction Act of 1946. In 1965, Hill-Burton construction funds amounted to $600 million, or roughly one-third of that year's total spending for hospital construction.

The present decade has seen a massive upsurge in hospital building, most of which

has occurred under non-Federal rather than Hill-Burton auspices. New hospital construction was no higher in the late 1950s than it was in the early part of that decade, but construction boomed thereafter, rising from $1.0 billion in 1960 to $1.9 billion in 1965. Over that period, non-Federal construction expenditures tripled to $1.0 billion.

The Hill-Burton Act was designed initially to assist the construction—especially in rural areas—of public and non-profit hospitals as well as public health centers and related hospital facilities. But, according to a recent evaluation survey, the emphasis now has shifted to the refurbishing of outmoded and inadequate facilities in the core cities of densely populated areas. The survey indicated a total national need for 4.11 beds for each 1,000 population—but today only 3.79 beds are available overall and only 2.58 meet Public Health Service standards of adequacy.

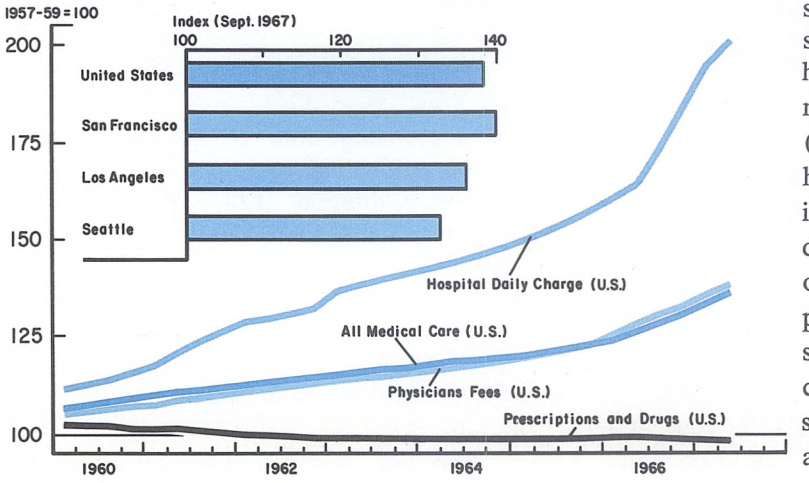
Western hospitals: not enough?

District states in 1965 accounted for 14.4 percent of total U.S. population but for only 12.8 percent (94,732) of the nation's general hospital beds. In terms of the number of beds available for each 1,000 population, California had fewer than any other state, and other District States — Idaho, Utah, Washington, Alaska, Hawaii — were also somewhat short of beds. However, hospital occupancy rates are lower in the West than in the country as a whole; California's rate, for example, is 72 percent as against a national figure of 76 percent.

Despite the region's difficulty in building hospitals as fast as it builds population, it has at least kept pace with the rate of construction elsewhere. The West in 1966 accounted for more than 17 percent of the value and 20 percent of the floor space of the nation's new health facilities. Among other projects now in the planning or early construction stages, Phoenix has a $12-million county hospital, Portland a $20-million medical center, Anchorage an $8-million hospital annex, and San Jose a massive $45-million complex which includes a 175-bed hospital and two medical office buildings.

Hospital expenditures in the West run considerably above the national average; in 1966, costs per patient day were $55.00 in the West and $44.50 nationally. These costs tend to be higher because hospital stays in Western hospitals tend to be shorter and more expensive per patient-day, with heavier weighting of the more costly initial day. (The average length of hospital stay is 6.7 days in the West as against 7.8 days nationally.) Moreover, the lower occupancy rates result in the spreading of the fixed costs of hospital construction, maintenance, and staffing over a fewer

Medical-care prices rise sharply, in West as elsewhere, under impact of zooming hospital costs



Tomorrow's Costs

In the first paragraph of its recent report, the National Advisory Commission on Health Manpower recited some of the factors that called it into existence last year: the expectation that the health industry would become the nation's largest employer by 1975, the fact that health costs are rising at twice the rate of other prices, the fact that the total health bill is already around $50 billion—and the "widespread discontent with the unavailability of professional health services, despite greater numbers of health workers and more medical facilities than ever before."

On the basis of recent trends, the commission estimated that hospital costs and physicians' fees would at least double in the decade ending 1975, as against a 20-percent increase in the overall consumer price index. By 1975, then, the average cost for a day of hospital care might rise from the current figure of $50 to about $100, and the nation's total health-care expenditures consequently would jump from $50 billion to $94 billion.

The commission uncovered substantial cost variations in a special study of twelve major hospitals scattered from coast to coast. Adjusted for geographical wage differentials, the cost spread ranged between $46 and $95 per day, with differences occurring in every area of hospital administration—housekeeping, food, nursing service, and so on down the list.

After evaluating this and similar studies, the commission concluded that the health-care crisis is not simply one of numbers. "If additional personnel are employed in the present manner and within the present patterns and 'systems' of care, they will not avert, or even perhaps alleviate, the crisis."

Yet the commission argued that substantial improvements could be expected nationwide if a system of economic incentives or penalties were imposed to improve the levels of efficiency and quality of health-care institutions. If its suggestions are followed, the group foresees a slowdown in the rapid rate of rising costs for health services, an improvement in their quality, and a reduced need for major increases in Federal outlays.

number of patient-days, with consequent higher costs.

On a staff per patient-day basis, the District is ahead of the national average of 2.46 employees, with California reporting 2.65 personnel per patient-day.

Calling Doctor . . .

The West, with 46,000 doctors (33,000 in private practice) boasts a greater concentration of physicians than the rest of the country. Four large lightly-populated states (Alaska, Idaho, Utah, Nevada) fall below the national average of 99 per 1,000 population, but California (128 per 1,000) and the other four District States have a somewhat heavier concentration. Yet this area, like all other areas of the country, is worried about the shortage of physicians and supporting personnel, despite the rise in the nation's doctor population from 233,000 in 1950 to 305,000 in 1965.

The doctor shortage has become a subject

of increasing concern over the past decade, partly because of the declining trend of applications for medical-school admission, and partly because of the med schools' failure to turn out graduates as fast as the patient population demands. The problem is not eased by the long period of preparation required for the M.D.; on the average, a medical career requires 8 to 15 years' preparation after high school.

To remedy the situation, some medical schools have shortened their training period —for example, by eliminating some undergraduate liberal-arts courses—and this year, 23-year-old interns may be seen staffing hospitals in some areas. The med schools' job of selecting students is made easier by the growing size of the age group from which applicants are drawn and by the increased financial aid available to students under the Health Professions Educational Assistance Act of 1963.

These and other factors have helped to increase the number of medical-school graduates to more than 8,000 in 1966, up some 36 percent from the 1950 level. The number should rise to 9,200 in 1975 as old medical schools expand and new schools are constructed. Moreover, the physician population should continue to benefit from the brain drain which has added so much to the American stock of professional talent in general; as early as 1960, foreign graduates accounted for 38 percent of staff physicians in hospitals unaffiliated with medical schools.

Family doctors—and nurses

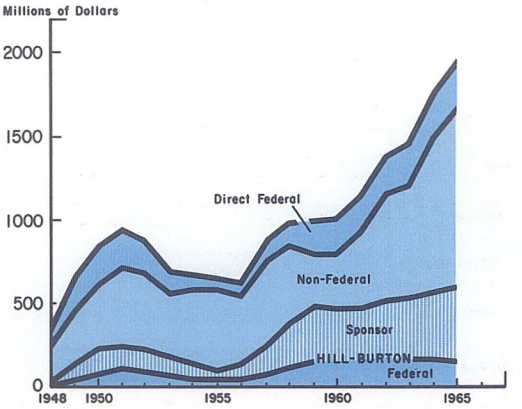
The composition as well as the size of the physician population has created concern in health circles. Question: What happened to the family doctor? Answer: He became a specialist. At least the statistics so indicate, since only one out of every six were full-time specialists a generation ago whereas four out of every six specialize today. But some medical authorities claim that the public would be better served if the "personal" physician (the general practitioner-pediatrician-internist category) ministered to 75 percent of his patients' needs and referred only 25 percent of his cases to specialists.

In other health categories — some 300 categories employing 3 million people — the concern today is not so much about future supply as about present wages and working conditions. After years of agitation over the low wages of health personnel, a breakthrough occurred in 1966-67. Pay increases in California hospitals ranged from 10 to 36 percent, depending on category, between mid-1966 and the spring of 1967, with nurses garnering the largest gains. In San Francisco Bay Area hospitals, the average pay of a beginning staff nurse rose from $420 to $500 in July 1966, and then to $575 in April 1967. But since wages and salaries account for two-thirds of hospital costs as against two-fifths in manufacturing, these higher wages are quickly translated into larger patient bills and insurance premiums.

Medicare's achievements

The need to expand the supply of medical workers and to increase their productivity

Hospital building boom
centered in non-Federal facilities

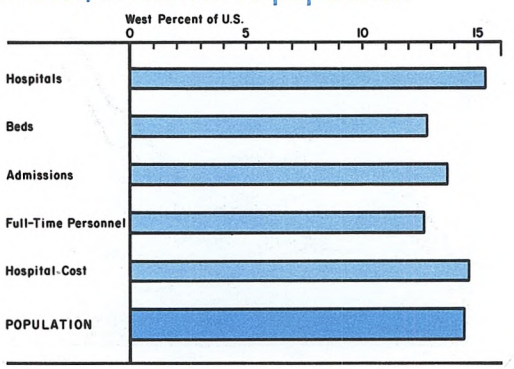


has been highlighted by the impact of Medicare. In the program's first year of operation, 4.4 million older Americans entered hospitals and the Social Security system paid $2.5 billion for their hospital care—and over $3 billion for their combined hospital and supplementary medical insurance benefits. In the first full year of the health-insurance program, 12 million people (two-thirds of those eligible) used covered medical services; 4 million of them used sufficient services to meet the $50 deductible in the last six months of 1966 and more than 5 million fell into this category in the six months ended June 1967. Utilization of the health-insurance program was concentrated among the elderly aged, among women, and among Western residents.

During the first six months of 1967, when this benefit first became available, extended-care facility admissions in the West averaged 22 per 1000 (Medicare) enrollees compared with 9 elsewhere. Availability of certified beds is a determining factor in the rate of admissions to extended-care facilities.

Although the Medicare program has been generally deemed successful, some difficulties are inevitable in such a vast and complex new program. Both physicians and hospital administrators have encountered problems in the initial stages of the program.

West short of beds, but high in cost, in relation to population



Medicare's problems

Hospital administrators object to the scale of reimbursement under the program, pointing out that the average reimbursement amounts to only 92 percent of the average cost. The Medicare formula is tied to costs specifically contracted by Medicare patients, which means that all services and facilities must be apportioned by actual patient usage. In contrast, hospitals traditionally have used a simplified internal rate structure whereby patients are charged on the basis of average per diem costs. Traditionally, too, where hospitals do utilize more precise yardsticks, such as fixed-charge to cost ratios, they normally adjust them to account for such factors as the amount of standby facilities available.

Hospital administrators also argue that the present Medicare allowance (cost plus 2 percent) is insufficient to cover replacement of facilities and the necessary costs of expansion. Moreover, administrators of non-profit hospitals argue that they fail to get the same consideration as proprietary hospitals, which are allowed a 7½-percent return on their equity capital. And they also contend that the existence of Federal Medicare payments discourages private individuals and corporations from continuing their traditional support of hospital operations.

Physicians, meanwhile, object to the need to file certificates of necessity before admitting their patients to hospital facilities. In addition, two out of every five doctors still refuse to take assignments — that is, accept the Medicare fee schedule — which means that they charge each patient directly and force the patient to file for repayment, thus creating difficulties for some patients because of the complex system of deductibles for different types of care. But the Medicare administration has attempted to meet these criticisms by reducing the burden of pre-admission hospital certification and by experimenting with new hospital reimburse-

ment procedures.

Medicare already has contributed to a marked improvement in some areas of medical care because of the standards it has set for institutions that wish to qualify for Medicare payments. (Cooperating hospitals account for 98½ percent of the nation's general-hospital bed capacity). Rising standards are most evident in the nursing-home category, where 1,800 agencies are now certified for Medicare payments as against the 250 agencies that would have qualified only four years ago.

In addition to these obvious benefits — assuring health-care protection for the elderly and contributing to the upgrading of medical care — the program has helped to improve the measurement of medical costs. Medicare's incorporation of out-patient coverage, extended care, home-health care, and physicians' home and office services into a single comprehensive package has improved public knowledge about the expense of health care, and it should thus help the public decide about the adequacy and the reasonableness of its future health coverage.

Medicaid's problems

Medicare is now, in most respects, a smoothly working program. The same, however, cannot be said for Medicaid—the state-administered Federal-aid program which pays the medical costs of the medically indigent of all ages. (The program was inserted as something of an afterthought into the basic Medicare legislation). In Medicaid's first year of operation, Federal payments to New York State alone were higher than the entire amount originally budgeted for the program in the nation as a whole. And in California, 1,200 of the state's 23,000 doctors received average payments of $70,000 apiece for their efforts during the program's first 16 months of operation, according to the program's administrator.

Medi-Cal, the California version of the Medicaid program, became embroiled last fall in a controversy created by the State Administration's attempts to make sharp reductions in program costs. At the national level, meanwhile, Congress moved to restrain the sharply rising costs of the Medicaid program by limiting projected payments in 1972 to $1.7 billion instead of the $3 billion presently estimated. The Senate bill would reduce the Federal share of the costs of medical aid to the needy on a state-by-state basis, while the House bill would bar Federal payments for persons with earnings above a certain income level.

Controversies aside, medical authorities agree that good health benefits the community as well as the individual, and that the community may well be expected to share in the costs of medical care. Yet as recent developments attest, there are limitations to the costs that the community can bear on behalf of medical attention. If costs continue to rise at their recent pace, health care may eventually absorb as much as 15 percent of the nation's total resources as against the present 6 percent of GNP. One way or another, the bill will be paid if the public so decides, but it will undoubtedly insist on maximum efficiency of health care in return for its agreement to meet that bill.

Joan Walsh

Publication Staff: R. Mansfield, Chartist; Phoebe Fisher, Editorial Assistant.

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Liquidity and Muni Bonds

In the last few years the composition of bank security portfolios has undergone a radical change. While banks have reduced the heavy over-hang of U.S. Government securities accumulated during World War II, they have meanwhile increased their investment in obligations of states and political subdivisions (commonly called municipals). They have acted in this fashion because municipals, with their tax-exempt feature, have recently offered a relatively attractive after-tax rate of return in comparison with yields on those other securities in which banks are permitted to invest.

Information on the maturity distribution of the municipal segment of bank portfolios has become more important as such holdings have increased. But, while data on the maturity distribution of U.S. Government securities have been available for more than a decade, detailed information on municipal holdings was not gathered (either nationally or regionally) until the mid-1967 Call Report of Condition. In light of the sharp decline in municipal bond prices in the latter half of the year, data from this survey are timely as a measure of the extent to which banks may be "locked-in" to long-term issues.

One-half of the total

As of June 30, 1967, Twelfth District member banks held $6.6 billion in state and local obligations. These issues accounted for 51 percent of District-bank security portfolios on that date, as against 44 percent for member banks elsewhere — and as against only 20 percent in the District a decade ago.

In every District state, municipals made up one-third or more of member banks' investment in securities on the call date. (Arizona data include Twelfth District banks only.) Large banks, however, showed the strongest interest in such tax-exempt issues. The smallest size-group of banks (those with under $2 million in deposits) had less than 3 percent of their investments in municipals, while the largest deposit-size group ($275 million and over) had 53 percent in such holdings. In fact, over 90 percent of all municipals were held by this large-bank group.

Most of the municipals held by District banks on the call date were for their own investment account. Only a small volume—4.5 percent of the total—was held by the banks as dealers or underwriters. Banks in only four of the nine District states reported dealer-held municipals, but these banks were in the larger deposit-size groups ($50 million and over). However, the single observation date may understate the actual amount of dealer and underwriting activities, since the volume of securities held by banks for this purpose fluctuates widely, dependent upon the timing of flotations of state and local issues.

Most liquid issues

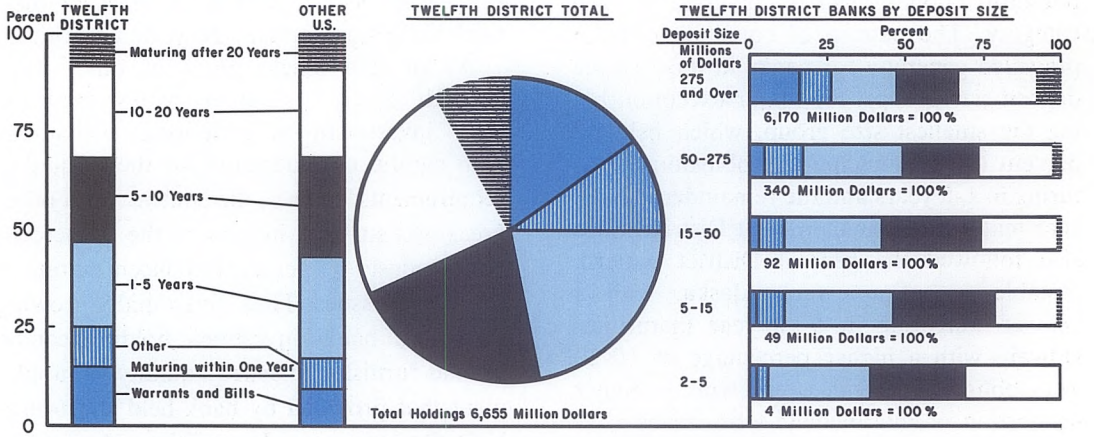
Municipals held for banks' own investment account were reported under two major categories: (1) warrants and short-term bills with original maturity of one year or less, and (2) all other obligations, segregated into five maturity categories measured from the date of the June Call. The composition of bank holdings varied widely by deposit size

MEMBER BANK HOLDINGS OF STATE-LOCAL GOVERNMENT OBLIGATIONS
June 30, 1967

Rank	State	Dollar Amount (thousands)	Percent of Total Securities
1	California	5,191,438	53
2	Washington	490,293	48
3	Oregon	349,918	46
4	Utah	175,475	54
5	Arizona	170,828	41
6	Idaho	104,241	43
7	Nevada	84,446	38
8	Hawaii	57,967	46
9	Alaska	30,143	36
	Twelfth District	6,654,749	51

Source: Federal Reserve Bank of San Francisco—Schedule J, "Supplemental Information on Obligations of States and Political Subdivisions," Call Report of June 30, 1967.

Western banks hold more short-term municipals than other banks . . . largest banks account for bulk of holdings—and for bulk of liquid issues



and by geographic location. For all District banks, warrants and short-term bills made up 15 percent of total municipal holdings, as against a 9-percent figure for banks elsewhere. However, the District figure was heavily weighted by the relatively high ratio (16 percent) of short-term issues held by the largest banks ($275 million and over in deposits). Short-term issues constituted from 0 to 6 percent of the municipals held by the other deposit-size groups.

Geographic diversity was also noticeable in the survey data. One sparsely populated state, Alaska, had the highest percentage of warrants and bills in its municipal portfolio (24 percent), while another relatively small state, Hawaii, held no short-term issues. Some of the diversity can be attributed to differences in the volume and timing of issues among the states and their local subdivisions. Here again, the one-day observation date may distort somewhat the extent to which District banks invest in short-term tax-exempt issues.

According to the broadest measure of liquidity—the total of warrants and short-term bills *plus* other municipals maturing within one year—District banks were in good shape on the call date, since short-term maturities then accounted for 25 percent of their municipal portfolios. The comparable figure for member banks elsewhere was only 17 percent.

In each deposit-size category, the larger the ratio of municipals to total securities, the higher was the percentage of short-term maturities held. The smallest deposit-size group, with less than 3 percent of its securities in state-local issues, had no short-term obligations. But the largest bank group, with 53 percent of all its securities in tax-exempt issues, had 26 percent of such issues maturing within one year. Those District banks which have invested most heavily in state-local obligations thus are also the banks most concerned with maintaining a high degree of liquidity in their municipal holdings.

Banks in six of the nine District states held 20 to 30 percent of their total municipals in short-term maturities. The remaining states (Nevada, Oregon and Washington) held 12 to 18 percent of their total holdings in short-term issues.

Least liquid issues

For all District member banks, municipal obligations were distributed among the 1-5

year, 5-10 year, and 10-20 year maturity categories on a roughly equal basis, with one-fifth to one-fourth of the total in each category. The pattern of equal distribution prevailed generally for banks in most of the deposit-size groups, the major exception being the smallest size group, which held 12 percent of its municipals in obligations maturing in 1-5 years and the remainder in 5-10 year maturities. Banks in most District states also followed the general District pattern. Notable exceptions were Alaska, with a heavier weighting in 5-10 year maturities; Hawaii, with a higher percentage of 10-20 year obligations; and Utah, with a higher proportion of intermediate-term issues.

Only the largest banks invested any appreciable amount in municipals with maturities of over 20 years, but their holdings were sufficiently large to bring the District average to 7.5 percent of total municipals. All other deposit-size groups held less than 3 percent in such long-term issues. However, banks in four states had 5 percent or more of their total obligations in over 20-year maturities.

As of that single point of time, then, Twelfth District member banks managed their investment in state-local obligations with careful consideration for their liquidity requirements. Indeed, the contrast with other areas was striking, in view of the 25-percent (as against 17-percent) concentration in short-term issues. Thus, this rapidly growing segment of banks' investment holdings can be seen as furnishing needed liquidity to supplement that provided by bank-held short-term U.S. Governments. In addition, the breakdown reveals a structuring of municipal holdings to provide an orderly distribution among intermediate and longer-term maturities.

Ruth Wilson

Reserve Requirements

The Federal Reserve Board raised reserve requirements on member-bank demand deposits by about $550 million in late December, in an attempt to curb inflationary pressures and to bolster the international position of the dollar. The addition to required reserves will bring a corresponding decrease in the funds that banks might otherwise use for lending or investing in securities.

The Board's action, which takes effect in two stages this month, will lift the reserves required against each member bank's demand deposits (in excess of $5 million) from 16½ to 17 percent for reserve city banks and from 12 to 12½ percent for other member banks.

This is the first such increase since September 1966, when the reserves required against time deposits (other than savings) in excess of $5 million were raised from 5 to 6 per cent. Moreover, it is the first increase in reserve requirements on demand deposits since November 1960, when requirements on banks other than reserve city banks were raised from 11 to 12 percent, as a partial offset to the reserves resulting from the permission to count vault cash as reserves.

Twelfth District banks should account for about 14 percent of the total estimated increase in member-bank reserve requirements. This is slightly greater than the District banks' share of net demand deposits nationwide. In contrast, District banks accounted for 20 percent of the September 1966 increase in reserves required against time deposits, reflecting the relatively high proportion of time deposits held by District banks.

Farmers and their Prospects

The U.S. Department of Agriculture relaxed earlier restrictions on output during 1967, and production responded with a 5-percent gain for the year. But despite this rise in output, led by a 16-percent rise in food grains and a 12-percent gain in feed grains, cash receipts of the nation's farmers declined as government payments fell and as prices weakened in response to the increased output. Since production expenditures meanwhile continued to advance, net farm income fell somewhat below the previous year's level.

Little, if any, improvement in farm income is anticipated by the Department of Agriculture in 1968. Farm output may show little change, but some shifts may occur in the composition of output. Following the recent sharp gain in grain production, acreage allotments for the 1968 wheat crop have been reduced and the acreage-diversion program for feed grains has been restored to the 1966 level. However, this reduced output of grain crops may be offset in part by a heavier cotton crop.

The livestock sector, on the other hand, may record a modest increase in output, partly because lower feed-grain prices should stimulate the output of enterprises feeding livestock and poultry. At the same time, some increase in livestock prices may develop.

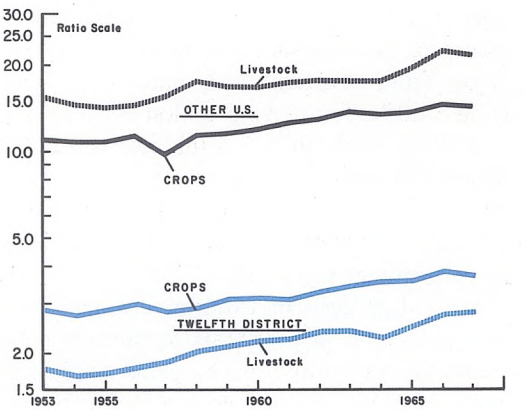
Given a modest gain in output and marketings and some improvement in prices, the gross flow of cash to farmers should rise during the year. Moreover, given a modification of the Federal grain program, direct government payments should expand. But the continuing advance in production expenses may offset most, if not all, of the increase in gross income, and thus may hold net farm income close to the 1967 level.

Western farming: '67

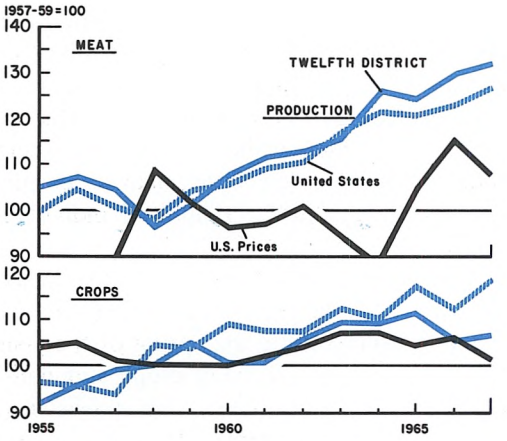
Western farmers, like their counterparts elsewhere, suffered some easing in net income during 1967; preliminary data point to a drop of perhaps 5 percent in Twelfth District net income. Meanwhile, cash receipts and total output showed little change, despite drastic changes in the output of individual products.

Unfavorable growing conditions plagued farmers more than usual in 1967. Cool and damp weather during the spring of the year delayed plantings of many crops and damaged the deciduous fruit crop extensively, particularly in California. In addition, unfavorable growing conditions and insect damage sharply reduced the prospects for the District's important cotton crop. But unfavorable weather for some crops proved almost ideal for others: the cool, damp weather improved barley and wheat yields significantly, and the delayed arrival of cold weather in the fall permitted harvest of the late-planted processing tomato crop.

Nation's farmers suffer decline in cash receipts



Prices weaken as output rises in both crop and livestock sectors



Diverse production changes also occurred in the livestock sector of the farm economy. Marketings of cattle from District feedlots were considerably below the year-earlier level, primarily as a result of fewer sales by California feedlot operators. In contrast, poultry and egg production was substantially higher—hatchings of both broiler chicks and turkey poults were above the 1966 figures—and milk supplies were also more abundant.

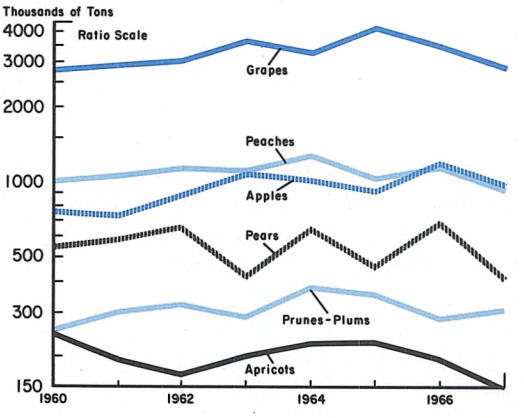
Government granary

Government payments, although less important in the Twelfth District's farm economy than elsewhere, must be considered in assessing farm-income prospects. Cash receipts from Western farm marketings rose from $4.8 billion to $6.5 billion between the late 1950's and 1966, but this rise was completely offset by advancing production expenditures. Yet net income rose by about $250 million—just about the same as the increase in government payments.

Several changes in 1968 government programs may boost payments to farmers substantially, with most of the gains nationally going to producers of feed grains for diverting acreage to acceptable soil-conservation practices. Since feed-grain sales account for only 7 percent of District marketing receipts, the change in this particular program should have only a minor impact on the direct flow of cash to District farmers. But if program participation is large enough to boost prices at the national level, it will tend to push up the costs of District farmers, as outlays for feed account for one-fifth of total production expenditures. District wheat growers meanwhile should receive a modest increase in payments because of the increased value of wheat marketing certificates.

On the other hand, a reduction in payments to District cotton producers should offset the higher payments anticipated as a result of participation in the feed-grain and wheat programs. Reductions are scheduled in both the acreage to be taken out of cotton production and the payment rate for such diversion. Western cotton farmers, being efficient producers of high-quality cotton, generally do not participate as heavily in the acreage-diversion program as growers elsewhere, but their income from the program is still quite sizeable, exceeding $100 million in 1966.

Weather causes severe damage to Western deciduous-fruit crops



Western farming: '68

Overall, District farmers hope to see some increase in net income in 1968, especially in view of a rising flow of gross cash receipts. With more normal growing weather, an increase in deciduous fruit production can be expected. In addition, some rise in cotton production is indicated if pests can be adequately controlled. Wheat production will undoubtedly decline because of a reduction in cultivated acreage but, even with that, total output of all District crops is likely to rise. Output prospects for the livestock sector are more uncertain, although abundant feed supplies should encourage rising production of livestock and poultry-feeding enterprises. And, if farm prices improve as is generally expected, Western farmers may be able to post an increase in cash receipts.

Production expenditures meanwhile should continue their inexorable advance. But the increase should be smaller than it was in 1967, when many crops had to be replanted and unusually heavy applications of pesticides and insecticides were required. Moreover, further mechanization of harvest operations and a more normal pattern of harvests should reduce peak labor requirements in California in 1968—in contrast to last year, when farmers attempted to import large number of Mexican nationals to help with harvest operations.

Much of course depends on the behavior of the non-farm economy, which is not only the major market for farm products but is also a supplier of such increasingly important inputs as insecticides, pesticides, and machinery and equipment. Hence, price pressures in the non-farm economy will be of importance to agriculture insofar as they tend to boost farm production expenses and thereby reduce net income.

Donald Snodgrass

TWELFTH DISTRICT BUSINESS

Year and Month	Condition items of all member banks (millions of dollars, seasonally adjusted)				Bank debits 22 SMSA's (billions $)	Bank rates: short-term business loans	Total nonfarm employment (1957-59 = 100)	Electric power consumption (1963=100)	Industrial production (1957-59 = 100)		
	Loans and discounts	U.S. Gov't. securities	Demand deposits adjusted	Total time deposits					Lumber	Refined Petroleum	Steel
1959	15,908	6,514	12,799	12,502		5.36	104		109	101	92
1960	16,612	6,755	12,498	13,113		5.62	106		98	104	102
1961	17,839	7,997	13,527	15,207		5.46	108		95	108	111
1962	20,344	7,299	13,783	17,248		5.50	113		98	111	100
1963	22,915	6,622	14,125	19,057		5.48	117	100	98	112	115
1964	25,561	6,492	14,450	21,300	501	5.48	120	112	107	115	130
1965	28,115	5,842	14,663	24,012	535	5.52	125	122	107	120	138
1966	29,858	5,444	14,341	25,900	618	6.32	132	134	103	123	140
1966: Nov.	29,538	5,267	14,800	25,318	642	.....	135	135	89	125	142
Dec.	29,858	5,444	14,341	25,900	634	6.62	135	140	97	120	141
1967: Jan.	30,274	5,468	14,437	26,134	638	.....	136	141	98	123	142
Feb.	29,923	5,889	14,376	26,425	644	6.28	136	136	96	119	135
Mar.	29,980	6,483	14,855	26,892	645	.....	136	143	99	121	123
Apr.	29,811	5,634	14,571	27,128	654	.....	136	141	102	124	137
May	29,729	5,852	15,035	27,168	658	6.00	136	145	92	131	133
June	30,071	5,265	15,181	27,460	681	.....	136	143	93	131	133
July	30,313	5,832	15,189	27,687	712	.....	137	145	94	130	129
Aug.	30,473	5,742	15,617	27,859	719	5.95	137	144	94	134	129
Sept.	31,034	5,885	15,632	28,008	709	.....	138	149	91	126	136
Oct.	30,951	5,867	15,633	27,993	728	.....	139	152	98	133	144
Nov.	30,964	5,609	15,588	28,433	738	5.92	139	147			148