How Government Regulations Made Healthcare So Expensive

“Those who cannot remember the past are condemned to repeat it,” declared philosopher George Santayana.

The U.S. ”health care cost crisis” didn’t start until 1965. The government increased demand with the passage of Medicare and Medicaid while restricting the supply of doctors and hospitals. Health care prices responded at twice the rate of inflation (Figure 1). Now, the U.S. is repeating the same mistakes with the unveiling of Obamacare (a.k.a. ”Medicare and Medicaid for the middle class”).

Figure 1: An Indexed Comparison of Health Care Inflation and Consumer Price Index in US from 1935 to 2009 (Source: US Census 2013

Nobel Prize-winning economist Milton Friedman wrote that medical price inflation since 1965 has been caused by the rising demand for health-care coupled with restricted supply (Friedman 1992). Robert Alford explained the minority view: “”The market reformers wish to preserve the control of the individual physician over his practice, over the hospital, and over his fees, and they simply wish to open up the medical schools in order to meet the demand for doctors, to give patients more choice among doctors, clinics, and hospitals, and to make that choice a real one by public subsidies for medical bills”” (Alford 1975). The majority of policymakers support either monopolization (e.g. typically Republicans) or nationalization (e.g., typically Democrats).

Both have claimed “”physician supply can create its own demand,”” which means increasing the supply of doctors and hospitals will just motivate them to convince “”ignorant”” consumers to order more unnecessary and expensive health care.

During the 1970s, Frank Sloan, a Vanderbilt University health care economist, explained the success of the most influential pro-regulation health care economist, Uwe Reinhardt: ""His theories are highly regarded because he is so clearly understood. Unfortunately the evidence for them is not good; it is not bad either, it is just not there. And it would be a shame to see federal policy set on such a poor, unscientific basis."" Since the early 1900s, medical special interests have been lobbying politicians to reduce competition. By the 1980s, the U.S. was restricting the supply of physicians, hospitals, insurance and pharmaceuticals, while subsidizing demand. Since then, the U.S. has been trying to control high costs by moving toward something perhaps best described by the House Budget Committee: "In too many areas of the economy " especially energy, housing, finance, and health care " free enterprise has given way to government control in "partnership" with a few large or politically well-connected companies" (Ryan 2012). The following are past major laws and other policies implemented by the Federal and state governments that have interfered with the health care marketplace (HHS 2013):

In 1910, the physician oligopoly was started during the Republican administration of William Taft after the American Medical Association lobbied the states to strengthen the regulation of medical licensure and allow their state AMA offices to oversee the closure or merger of nearly half of medical schools and also the reduction of class sizes. The states have been subsidizing the education of the number of doctors recommended by the AMA.

- In 1925, prescription drug monopolies begun after the federal government led by Republican President Calvin Coolidge started allowing the patenting of drugs. (Drug monopolies have also been promoted by government research and development subsidies targeted to favored pharmaceutical companies.)
- In 1945, buyer monopolization begun after the McCarran-

Ferguson Act led by the Roosevelt Administration exempted the business of medical insurance from most federal regulation, including antitrust laws. (States have also more recently contributed to the monopolization by requiring health care plans to meet standards for coverage.)

- In 1946, institutional provider monopolization begun after favored hospitals received federal subsidies (matching grants and loans) provided under the Hospital Survey and Construction Act passed during the Truman Administration. (States have also been exempting non-profit hospitals from antitrust laws.)
- In 1951, employers started to become the dominant third-party insurance buyer during the Truman Administration after the Internal Revenue Service declared group premiums tax-deductible.
- In 1965, nationalization was started with a government buyer monopoly after the Johnson Administration led passage of Medicare and Medicaid which provided health insurance for the elderly and poor, respectively.
- In 1972, institutional provider monopolization was strengthened after the Nixon Administration started restricting the supply of hospitals by requiring federal certificate-of-need for the construction of medical facilities.
- In 1974, buyer monopolization was strengthened during the Nixon Administration after the Employee Retirement Income Security Act exempted employee health benefit plans offered by large employers (e.g., HMOs) from state regulations and lawsuits (e.g., brought by people denied coverage).
- In 1984, prescription drug monopolies were strengthened during the Reagan Administration after the Drug Price Competition and Patent Term Restoration Act permitted the extension of patents beyond 20 years. (The government has also allowed pharmaceuticals companies to bribe physicians to prescribe more expensive drugs.)

- In 2003, prescription drug monopolies were strengthened during the Bush Administration after the Medicare Prescription Drug, Improvement, and Modernization Act provided subsidies to the elderly for drugs.
- In 2014, nationalization will be strengthened after the Patient Protection and Affordable Care Act of 2010 (”Obamacare”) provided mandates, subsidies and insurance exchanges, and the expansion of Medicaid.

The history of medical cost inflation and government interference in health care markets appears to support the hypothesis that prices were set by the laws of supply and demand before 1980 and perhaps 1990. Even the degree of monopolization and nationalization promoted by politicians before 1965 was not enough to cause significant cost inflation and spending increases (Figure 2) until demands created by Medicare and Medicaid outstripped the restricted supply of physicians and hospitals.

Figure 2: Health Care Spending in U.S. by Sector from 1960 to 2005 (Source: US Census 2013)

Spending on prescription drugs didn’t accelerate until after pharmaceutical monopolies were strengthened in 1984. Spending has increased even less for administrative, net cost of private health insurance and nursing home care, and not much at all for dental, structures, equipment, public health, other personal and professional care, home health care, research, non-prescription drugs and durable medical equipment. Since the 1980s, the government has used its buyer monopoly power, through its Medicare and Medicaid programs, to effectively set price and quality controls (e.g., underpayments) on physicians and hospitals (Stagg-Elliot 2012). For the same purpose, the Federal and state governments promoted the concentration of private insurance into buyer monopolies (e.g., HMOs).

The government has also encouraged clinics and hospitals to

respond by merging into concentrated provider monopolies (while continuing to limit the supply of doctors and hospitals). These government-private partnerships called “”managed competition”” resemble centrally-planned fascism (Richman 2013). Government sets prices, which has predictably led to reduced quality, rationing and other perverse gaming. Moreover, the bureaucracy has brought standardized care, higher administrative costs and high executive salaries. Although costs have continued to rise at the same double the rate of inflation, it is questionable the extent to which prices are now set by the laws of supply and demand. Obamacare is expected to expand coverage by about 22 million people with subsidies and another 17 million through Medicaid. Regardless how the current problems with mandates play out, demand will likely skyrocket without increasing supply proportionately (Fodeman 2011). Higher prices and costs and/or lower quality can be expected to result in calls for nationalization (e.g., ”single payer”) by Democrats while Republicans counter with private insurance and tort reforms. The search for alternative economic systems should include free markets through a closer reexamination of the health care marketplace before 1980 to 1990 to determine whether prices offered by physicians and hospitals were ever set by the laws of supply and demand.

Economist Henry Hazlitt provides the following description:

> *Prices are fixed through the relationship of supply and demand. … When people want more of an article, they offer more for it. The price goes up. This increases the profits of those who make the article. Because it is now more profitable to make that article than others, the people already in the business expand their production of it, and more people are attracted to the business. This increased supply then reduces the price.*

1) Hazlitt: Prices are fixed through the relationship of supply and demand.

In 1965, Congress enacted the Medicare and Medicaid programs (Figure 3). From 1966 to 1980, Medicare provided health insurance for about 20 million elderly. By 1980, Medicaid was covering about 12 million poor people. (U.S. 1985) M. Stanton Evans claimed that by dumping “”demand into our medical system, these government programs bid up all the factors of supply”” (Evans 1977).

Figure 3. Medicare and Medicaid spending as part of total U.S. healthcare spending as percent of gross domestic product. (Source: Congressional Budget Office)

Other factors that also contributed to an escalation in demand for physician and hospital services before and after 1965 have included a growing and later aging population, rising personal incomes, private health insurance, breakthroughs by the American drug industry, and advances in electronic and mechanical devices. Unmet demand for physician services have persisted in rural and poor urban areas, preventive care, geriatrics, house calls, cost management, computerized medicine, entrepreneurism, medical supply, environmental, public-health services, mental institutions, prisons, drug programs, and military and foreign service. Physician services became the number one growth industry.

Health-care industry experts agree that the major service provided by the health care industry is rendered or overseen by physicians. Protected by licensure laws from competition by non-physicians, physicians control an estimated 80 percent of all health care expenses (Goodman 2013), including 70 percent of hospital costs (Norman 2013). While some proposed reforms for reducing excessive demand have merit, their unpopularity has only served as an excuse to delay a supply response. Some have blamed government for subsidizing health care, and call for taxing employee benefits and even eliminating government

programs. Others have blamed the unhealthy living habits of consumers, but it has proved difficult trying to deny them the freedom to choose how to live their life. Between 1965 and 1980, it is unlikely physicians and hospitals were creating their own demand since they were busy meeting the additional demands created by government.

In addition, patients subsidized by Medicare remained concerned purchasers that spent an average of 20 percent of their income on medical care, including purchasing insurance. Many blame third-party insurance for making consumers less accountable for spending. But consumers seek to spread risk by purchasing health coverage from third-party payers. Moreover, third-party insurance existed long before the health care cost crisis (Figure 4). Since the 1930s, hospital groups like Blue Cross and physician groups like Blue Shield had been offering fee-for-care insurance programs to employers, who then offered them to their employees for premiums. The non-profit Kaiser Permanente contracted with companies to meet all of the medical needs of employees for premiums.

Figure 4 Number of people with employer-provided health insurance 1940 to 1960. (Source: Sourcebook of Health Insurance Data 1965)

A free competitive market can still exist with third-party payment. Consumers want the most benefits for the lowest health care premiums and also want to limit employee wages assigned to health care coverage. Insurance companies and self-insured employers want to pay the lowest amount possible to physicians and hospitals. If the health care industry was indeed competitive at all supply levels, suppliers would aggressively offer insurers competitive prices for high quality services.

Insurers would have no trouble selecting health care policies for their policyholders that encouraged them to obtain the

best service they could for the lowest cost. Consumers would protect themselves from unethical providers by taking their business to those who had a good reputation for quality work at reasonable prices without unnecessary services. In a competitive market, providers are forced to obtain this reputation or they go out of business. The supply and demand curves are both price-inelastic, as illustrated by mostly vertical plots (Figure 5). The demand for physician care is a classic example of a necessity with no close substitutes (i.e., licensing restrictions prevent substitutions from non-physician practitioners).

The price elasticity of demand is only 0.31 for medical insurance (Samuelson 1992). This means the quantity that consumers demand will not change much with changes in price or the method of financing (i.e., people will pay whatever they can). The supply curve is also price-inelastic and not very responsive to price because physicians require many years of training. Since 1965, the demand curve has shifted toward more quantity demanded at each price. For example, the equilibrium point as shifted from E1,1 to E2,1. Since the supply and demand curves are price inelastic, increases in demand are amplified into larger increases in medical prices.

(2) Hazlitt: The price goes up. This increases the profits of those who make the article.

Since 1965, medical prices have exploded with physician fees (Figure 6). From 1965 through 1993, the price for medical care increased by 699% and physician fees 675% compared to only 359% for all goods and services measured in the Consumer Price Index. Today, medical prices and physician fees continue to grow at about twice the rate of inflation. Hospital prices have increased at almost four times. U.S. health-care spending

has increased from 6% of the Gross Domestic Product in 1965 to 18% ($3 trillion) today.

Figure 5 Graphic Illustration of a Price-Inelastic Demand Increase to Higher Price for Health Care

Jay Winsten of the Harvard School of Public Health wrote: “”The solution lies … in examining the forces driving the medical-care delivery system. This examination must focus on physicians”” (Winsten 1983). Economist Lawrence Baker reported that HMOs aren’t achieving their goal of increasing the efficiency of the delivery of medical services because physicians have too much market power for the development of competition (Baker 1994). Cost control incentives encouraged by competition for clients has been limited in health care because client demands have grown more than physician supply since 1965. Even when physicians work for health institutions like hospitals, physician number can limit the volume of patient care rendered and thus the extent to which competition for patients occurs between institutions.

Figure 6 An Indexed Comparison of Inflation of Total Medical Prices (-) and Physician Services (- – -) from 1950 to 1993 with Base Year 1950. (Source: US Census 2013)

In the absence of competition, not only physician fees but prices for every element of health care that physicians control inflated because there was little incentive to efficiently manage costs. The highly paid and hurried work week has reduced cost-saving and quality-improving innovative incentives placed on physicians. The lack of competition between hospitals and other health care institutions also limited cost control incentives placed on executives. The lack of competition between both medical institutions and the doctors that control most of their spending could explain why hospital costs have been inflating twice as fast as even physician fees. Hospitals are loaded with waste and inefficiency. For example, a hospital stitch costs more than $500 today. Health care may be the only industry in which

suppliers blame technology for high costs. But researchers at the Robert Wood Johnson Foundation reported that small medical expenses controlled by physicians, such as blood tests and ordinary x-rays, were responsible for medical inflation, not complex technologies.

The article stated that if the annual operating costs of the nation's more complex technologies "kidney dialysis, coronary bypass, electronic fetal monitoring, and computerized x-rays " were reduced one-half, the net savings would be less than one percent of the nations medical bill. They proposed income incentives for physicians as motivation for cost control (Robert 1979). Some market opponents disputed that a free market could create competition since they claim a ""surplus"" of doctors in some medical fields and geographic areas had not brought price competition. However, evidence of this is limited to secondary care physicians, such as surgeons. Secondary care physicians, who derive more of their patient load from referrals, cannot compete on the basis of price unless the primary care physicians, that refer patients to them, are under competition to care about costs. Few primary care physicians would refer a patient to a physician taking aggressive price cutting steps because they would be viewed as ""rocking the boat."" The higher-paid secondary care physicians may experience some unemployment before a competitive surplus of primary care physicians can develop. Geographic studies involving cities with a ""surplus"" supply are based on physician-to-population ratios and do not take into account the fact that demand may be much higher in the cities. The collapse of demand during economic downturns has provided evidence that physicians cannot create their own demand. The AMA had to respond to low physician incomes caused by the Great Depression by cutting medical school admissions (and not creating their own demand).

During another temporary decrease in demand caused by the severe recession during the early 1980s, the Wall Street

Journal reported: “”good news, however to free-market advocates, who note that in a few cities price wars have cut medical costs … doctors are also alarmed by the increasing number of physicians … fear they won’t be able to compete with other doctors”” (Editor July 1983).

(3) Hazlitt: “”The People Already in the Business Expand Their Production of It.

The increase in demand allowed physicians to expand their practices to serve more patients. Since physicians actually worked a few hours less per week, the increased number of patients received far less attention and quality deteriorated. In 1972, the Journal of the American Medical Association reported that, “”The average patient load and the average volume of units of patient care for the average physician has increased dramatically in the last five to six years. Medicare, Medicaid and the increased coverage of medical and hospital insurance have produced a skyrocketing rise in effective demand for medical services … the demand could be met only by the existing number of physicians providing more units of patient care.”” They claimed the doctor shortage had increased the possibility of the kind of breakdown in the patient-doctor relationship that can lead to a lawsuit (Ribicoff 1973). Overworked practitioners have been rendering hurried, poor quality medical care, dangerously understaffed hospitals and medical facilities, waiting lines, and 36 hour shifts squeezed into 120 hour work weeks by many residents at hospitals. Many doctors have freely admitted to being too busy healing to keep abreast of new techniques and research ideas. It has been suggested that the long, hurried work week of physicians contributed to the high incidences of fatigue, depression, alcoholism, drug addiction, and suicide among doctors (Harris 2011). The lack of competition has failed to drive out the estimated five percent of the physicians

considered unfit to practice medicine. Recently, Harvard University's Lucian Leape has estimated there are approximately 120,000 accidental deaths and 1,000,000 injuries in U.S. hospitals every year.

The physician's lack of time to communicate effectively depersonalized care. The *Wall Street Journal* reported, ""Many doctors concede that the increasingly impersonal tone of medical care makes bringing a (malpractice) claim easier"" (Editor, September 1983). In 1994, a study reported in the Journal of the American Medical Association found that doctors could reduce the chances of being sued for malpractice by not acting rushed or being impersonal with patients. The consumer revolt to the quality deterioration was dubbed ""the malpractice crisis."" While the total dollars spent on health care in the United States increased about 100% from 1966 to 1972, malpractice insurance increased 400% for all physicians and 425% for surgeons (Figure 7). Higher rates were a response to increased losses by insurance companies. For example, Aetna's indemnity losses for both doctor and hospital malpractice suits in the United States went from $300,000 to $9.5 million per year between 1965 and 1968, respectively.

Figure 7. Malpractice Insurance for Physicians and Surgeons from 1960 to 1972. (Source: U.S. Department of Health, Education and Welfare, Medical Malpractice Report)

Lawyers Sylvia Law and Steven Polan claimed, ""Doctors are primarily responsible…A consultant to the American Hospital Association reported in 1976 that hospital personnel-controllable claims, such as burns, medication mistake, and blood-transfusion error, were remaining relatively stable, but physician-controllable claims were increasing rapidly."" They add, ""In the enormous quantity of research and literature generated by the malpractice crisis there is not a shred of hard evidence suggesting that the injuries of successful claimants resulted from anything other than avoidable medical

negligence”” (Law 1978). To protect themselves against malpractice suits, physicians claimed they were practicing ”defensive medicine” by desperately ordering more and expensive tests and procedures for patients performed by other paramedical personnel.

Polls have shown a majority will also protect each other by refusing to testify against other doctors in lawsuits. Those who have claimed the laws of supply and demand do not apply to health care have noticed that as doctors are added, prices do not decrease. They sometimes fail to consider that doctors can expand their services by spending more time on each patient and restoring quality rather than competing for clients based on price. One problem is that the consumer price index used by economists to measure the rate of inflation cannot measure quality. After 1965, prices (for comparable quality) likely rose faster than that measured by economists. After 1972, an increase in the annual number of newly-licensed physicians meant more demand was met and the attention to patients was likely being restored. During the 1980s, the malpractice crisis began to level off.

Still, the U.S. has ”lowest life expectancy, at 78.2 years” among developed countries (Sauter 2012).

(4) Hazlitt: “”More People Are Attracted to the Business. This Increases Supply then Reduces Price””

As the laws of supply and demand would predict, the number of medical school applicants have consistently responded to increases in the demand for physician services and fees (Figure 8). In the seven years from 1967 to 1974 the number of medical school applicants for a given year increased by 127% compared to only 35% for the seven years from 1960 to 1967 (AAMC 2013). Today, medical school applicants are at an all-time high of over 48,000, as increases in physician fees

remain at twice the rate of inflation.

Figure 8. Comparison of Medical School Applicants and Physician Fees from 1932 to 1993. (Sources: US Census 2013 and AAMC 2013)

But the U.S. failed to allow physician supply to respond to meet consumer demand. From 1965 through 1972 the number of newly-licensed U.S. physicians graduated each year from medical schools in the United States and Canada increased from 7455 to 7815 or by only 360 physicians! From 1972 through 1980, this amount gradually doubled but the medical schools became even more restrictive as they annually rejected about 20,000 qualified applicants who tried to fill the unmet demand (Figure 9). Today, medical schools are rejecting 28,000 applicants.

Figure 9. Number of Applicants and Successful Applicants from 1932 to 1994. (Source: AAMC 2013)

The doubling in the number of licenses meant a mere 3.5% annual increase in the 418,000 total physicians in 1980. Since much of the increase in medical school acceptances since 1965 has been necessary just to keep up with the increased level of demand, only a fraction of the increase in enrollment has gone toward filling the shortage or back-log of doctors created by the 1965 crisis. If only 10% of annual physician output fills this back-log, a further doubling in the output would achieve competition eleven times faster. In 1980, the U.S. Secretary of Health, Education and Welfare said there was no clear analysis showing whether health-care costs would be reduced if the nation achieved a “”surplus”” of physicians because “”we have never lived in an excess supply situation so we don’t have a model that would give us an answer.”” Medical schools have been rejecting applicants that could have increased the existing quality of doctors.

The average rejected applicant of 1975 had higher Medical College Admissions Test scores than the average accepted

applicant of 1955 (on the same test that was replaced in the 1970s).Â In the early 1980s, the handbook of the Association of American Medical Colleges stated that ""the number of qualified applicants from the United States alone is over twice the number of places available."" Admission remains so competitive today that only the very top students even bother to apply for limited places and most are rejected in a selection process that involves significant cronyism (Wellington 1974) . Meanwhile, the U.S. has granted medical licenses to the 25 percent of all doctors practicing in the United States that were educated abroad, often at inferior schools. The states allow the AMA to control total enrollment at medical schools by allowing them to determine the number of medical schools, the cost of medical education, and the amount of subsidies. The subsidies needed for medical education has been used as an excuse for rejecting qualified applicants.

But the high cost of medical education was grossly inflated by a more than doubling in the ratio of faculty to students, and faculty salaries that dwarf the salaries of other professors (made only necessary by the need to lure physicians from an overly lucrative medical market). (Roth 2011) Moreover, total medical school subsidies are insignificant compared to the money lost by an uncompetitive market. Milton Friedman wrote that physicians prevent health-care competition by limiting the number of entrants into the profession. (Friedman 1962) Another Nobel Prize-winning economist Paul Samuelson of MIT wrote: ""Because the demand for medical care is price-inelastic, restricting the number of medical students raises the price of medical care and increases the incomes of doctors"

Market opponents have not only claimed there are too many doctors but also too many hospital beds. In 1972, the federal government started restricting the supply of hospitals with certificate-of-need (followed by repeal of the Hospital Survey and Construction Act in 1974). Alaska House of Representatives

member Bob Lynn argued the true motivation was ""large hospitals are … trying to make money by eliminating competition"" under the pretext of using monopoly profits to provide better patient care.

Figure 10 Graphic Illustration by Paul Samuelson Showing How Limiting the Supply of Doctors Causes Higher Prices. (Source: Samuelson 1992

From 1965 to 1989, the number of hospital beds and occupied beds (per population) declined by 44 and 15 percent, respectively (Friedman 1992). Today, the U.S. and Canada have less than 25 doctors and 30 hospital beds (per 10,000 population), compared to over 35 and 50, respectively, in most countries in continental Western Europe. Mark Pearson, head of Division on Halth Policy at The Organization for Economic Co-operation and Development (OECD) discussed possible reasons the U.S. spends more than two-and-a-half times per person more than most developed nations in the world including relatively rich European countries: "The U.S. has fewer physicians and fewer physician consultations relative to its population. The U.S. also has fewer hospital beds for its population size and shorter average stays in hospital relative to other countries. Indeed the lower numbers of physicians could help explain why they cost more; there is less competition for patients."He adds that universities in other countries are still able to attract the best students to medicine (Kane 2012). SOLUTIONS The U.S. health-care market appears to behave according to laws of supply and demand (at least until the 1980s). Assuming government subsidy of the elderly and poor serves the public good the cause of

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