

# THE HEALTHCARE CRISIS

A Crisis of Artificial Scarcity

By Kevin A. Carson



*Illustration courtesy Patricia Downs Berger, of Mass-Care*



**Introduction.** “Grocery insurance” is a popular analogy among free market advocates, for explaining why third party payments eliminate price competition and contribute to medical inflation: when your insurer only requires a small deductible for each trip to the supermarket, you’ll probably buy a lot more T-bones.

Unfortunately, what we have now is a system where the government, Big Pharma, the license cartels, and bureaucratic high-overhead hospitals act in collusion to criminalize hamburger and make sure that only T-bones are available, and the uninsured wind up bankrupting themselves to eat. A lot of uninsured people would probably like access to less than premium service that they could actually afford.

And despite rising deductibles and copays—exactly the kind of incentives the libertarian “grocery insurance” critics would regard as ideal for encouraging frugality—low-cost alternatives are simply unavailable in many cases.

A central problem of all the healthcare reform proposals circulating in Congress is that they focus almost entirely on finance—giving the uninsured the wherewithal to buy insurance and otherwise increasing insurance coverage to pay for healthcare—without addressing the cost of healthcare itself. But if healthcare itself were cheap, much of the debate on finance and insurance would be moot.

Dr. Arnold Relman, in *Tikkun*, argued that the versions of health care reform currently proposed by “progressives” all primarily involve financing health care and expanding coverage to the uninsured rather than addressing the way current models of service delivery make it so expensive:

What are those inflationary forces? . . . [M]ost important among them are the incentives in the payment and organization of medical care that cause physicians, hospitals and other medical care facilities to focus at least as much on income and profit as on meeting the needs of patients. . . . The incentives in such a system reward and stimulate the delivery of more services. That is why medical expenditures in the U.S. are so much higher than in any other country, and are rising more rapidly. . . . Physicians, who supply the services, control most of the decisions to use medical resources. . . .

The economic incentives in the medical market are attracting the great majority of physicians into specialty practice, and these incentives, combined with the continued introduction of new and more expensive technology, are a major factor in causing inflation of medical expenditures. Physicians and ambulatory care and diagnostic facilities are largely paid on a piecework basis for each item of service provided.<sup>1</sup>

And as *Reason's* Jesse Walker points out, even the most “progressive” healthcare proposals, right up to and including single payer (or even direct government delivery of service, along the lines of the British National Health), leave the basic institutional culture of healthcare entirely untouched. A single-payer system, far from being radical,

would still accept the institutional premises of the present medical system. Consider the typical American health care transaction. On one side of the exchange you’ll have one of an artificially limited number of providers, many of them concentrated in those enormous, faceless institutions called hospitals. On the other side, making the purchase, is not a patient but one of those enormous, faceless institutions called insurers. The insurers, some of which are actual arms of the government and some of which merely owe their customers to the government’s tax incentives and shape their coverage to fit the government’s mandates, are

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<sup>1</sup> Arnold Relman, “Waiting for the Health Reform We Really Need,” *Tikkun*, September 24, 2009 <<http://www.tikkun.org/article.php/20090924083334396>>.

expected to pay all or a share of even routine medical expenses. The result is higher costs, less competition, less transparency, and, in general, a system where the consumer gets about as much autonomy and respect as the stethoscope. Radical reform would restore power to the patient. Instead, the issue on the table is whether the behemoths we answer to will be purely public or public-private partnerships.<sup>2</sup>

The main reason healthcare is perceived as a crisis today, as opposed to forty years ago, is the escalation of costs for actual delivery of service. The main driver behind rising insurance premiums is not the misbehavior of the insurance industry itself, but the rising cost of healthcare. Any finance reform that fails to address this will be a temporary fix at best.

**Insurance regulations.** Of course there's no getting around the fact that the present model of healthcare finance plays an important role in the problem.

Long before the modern model of health insurance became prevalent, self-organized working class mutuals functioned to spread healthcare risks and costs among their members. It was part of a broader movement, a welfare state organized voluntarily and from the bottom up by workers for themselves—sick benefit societies, burial societies, and myriad other friendly societies. Although volunteerism and civil society are currently buzzwords of the right wing, they have impeccable left-wing credentials: they are central themes of Pyotr Kropotkin's *The State and Mutual Aid*, as well as extended chapters in E.P. Thompson's *The Making of the English Working Class*. To grasp their essential difference from the bureaucratic welfare state and the plutocrats' charities, Colin Ward wrote, one need only look at their respective names:

On the one side the Workhouse, the Poor Law Infirmary, the National Society for the Education of the Poor in Accordance with the Principles of the Established Church; and, on the other, the Friendly *Society*, the Sick *Club*, the Cooperative *Society*, the Trade *Union*. One represents the tradition of fraternal and autonomous association springing up from below, the other that of authoritarian institutions directed from above.<sup>3</sup>

The welfare state and the tax-exempt charitable foundations of the rich are integrated into the larger state capitalist system, and serve its ends. They couple the relief of destitution, homelessness and starvation, to the extent necessary to prevent political threats to the power of the corporate ruling class, with social discipline and supervision of the lower orders.<sup>4</sup>

The workers' own libertarian welfare state, on the contrary, served the ends of workers themselves. David Green writes:

The friendly societies were self-governing mutual benefit associations founded by manual workers to provide against hard times. They strongly distinguished their guiding philosophy from the philanthropy which lay at the heart of charitable work. The mutual benefit association was not run by one set of people with the intention of helping another separate group, it was an association of individuals pledged to help each other when the occasion arose. Any assistance was not a matter of largesse but of entitlement, earned by the regular contributions paid into the common fund by every member and justified by the obligation to do the same for other members if hardship came their way.<sup>5</sup>

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2 Jesse Walker, "Obama is No Radical," *Reason*, September 30, 2009 <<http://reason.com/archives/2009/09/30/obama-is-no-radical>>.

3 Colin Ward, *Anarchy in Action* (London: Freedom Press, 1982), p. 123.

4 See Frances Fox Piven and Richard Cloward. *Regulating the Poor* (New York: Vintage Books, 1971, 1993).

5 David Green, *Reinventing Civil Society* (London: Institute of Economic Affairs, Health and Welfare Unit, 1993), p. 30.

In short, the friendly societies of the nineteenth century were part of an emerging, distinctively working class culture with its own institutions.

In regard to healthcare in particular, as Ward writes, history shows that "the self-organisation of patients provided a rather better degree of consumer control of medical services" than was achieved under the NHS.<sup>6</sup>

The Tredegar Medical Aid Society, founded in 1870, was a good example. It was funded by a subscription of "three old pennies in the pound from the wage-packets of miners and steelworkers," and at one time employed "five doctors, a dentist, a chiropodist and a physiotherapist," along with a hospital that served 25,000 people.<sup>7</sup>

Tim Evans quoted an estimate by the Chief Registrar of Friendly Societies in 1892 that 3.8 million of 7 million industrial workers were insured against sickness through a registered friendly society, while at least another 3 million belonged to unregistered societies.<sup>8</sup> Membership in registered friendly societies grew from 2.8 million in 1877 to 6.6 million in 1910 (in addition to those in unregistered societies), and Greene estimates total friendly society insurance coverage in 1910 at 9 to 9.5 million out of the 12 million covered by the National Insurance Act of 1911.

The first nail in the coffin of the workers' self-organized healthcare system was the National Insurance Act. Lloyd George originally envisioned it as "a way of extending the benefits of friendly society membership, already freely chosen by the vast majority of workers, to *all* citizens, and particularly those so poor they could not afford the modest weekly contributions."<sup>9</sup> Or as Ward put it, the goal was to create "one big Tredegar."

George's original proposal was distorted beyond recognition in the House of Commons by a coalition, "hostile to working-class mutual aid," of the British Medical Association and an insurance industry trade association known as the Combine. Amendments obtained under their influence eliminated all vestiges of democratic self-organization, and instead vested administration in "bodies heavily under the influence of the medical profession." They limited panel doctors to registered practitioners, thus greatly strengthening the licensing bodies' monopoly. They also eliminated any threat that working-class bargaining power would be used to keep physicians' fees within a range affordable to ordinary manual workers—from the physicians' standpoint, the worst outrage of the old friendly societies. Instead, doctors' incomes were doubled and financed by a regressive poll tax.<sup>10</sup> The organized medical profession also used the GMC, the primary licensing body, to "ban conduct which helped the consumer to differentiate between doctors," like advertising.<sup>11</sup>

The final blow came from the National Health Service, established in 1948, which nationalized delivery of service in addition to finance.

Although mutual provision of healthcare was not as extensive in America, it still included a

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6 Ward, "The welfare road we failed to take," in *Social Policy: An Anarchist Response* (London: Freedom Press, 1996), p. 14.

7 *Ibid.*, p. 15.

8 Tim Evans, "Socialism Without the State." Political Notes No. 99 (London: Libertarian Alliance, 1994) <<http://www.libertarian.co.uk/lapubs/polin/polin099.pdf>>.

9 David Green, *Working-Class Patients and the Medical Establishment: Self-Help in Britain from the Mid-Nineteenth Century to 1948* (Aldershot, UK: Gower/Temple, 1986), p. 2.

10 *Ibid.*, pp. 2, 108.

11 *Ibid.*, p. 132.

considerable portion of the population. Certainly, as David Beito points out, self-help efforts organized through mutuals "dwarfed the efforts of formal social welfare agencies."<sup>12</sup> An 1891 study by the Connecticut Bureau of Labor Statistics found that membership in fraternal insurance orders was 15% of the general population. Of these, 60% were sick and funeral benefit orders, and 28% life insurance societies. But the study included only bodies specifically formed for the provision of insurance, and not other fraternal orders (like Masons, Elks, Patrons of Husbandry, etc.) which provided health insurance or medical care as a standard benefit of membership. If the latter were included, the total membership was greater than the total male population.<sup>13</sup> Putting all the figures together, and accounting for overlap, it's quite plausible that a majority of the male population belonged to organizations which provided sick benefits (although wives and children were often eligible, they did not count toward membership totals). In Chicago, a 1919 study by the Illinois Health Insurance Commission found that 38.8 percent of wage-earning families carried life insurance through fraternal organizations, which suggests—if the Connecticut ratios are taken as typical—that an even larger portion had sick benefits.<sup>14</sup> Black families at that time were noted for obtaining life insurance from private firms, but sick benefits from fraternal societies. In Chicago over four in ten blacks had sick benefits. Similar figures obtained for black populations in Philadelphia and Kansas City.<sup>15</sup>

The provision of healthcare through fraternal orders was not limited to insurance. Both finance and delivery of service were mutualized. Many lodges kept a physician on retainer for their membership, financed by a modest subscription fee: the so-called "lodge practice" or "contract practice." This evoked strong antipathies from the medical community ("lodge practice evil" was a stock phrase in the medical journals).<sup>16</sup>

The United States lagged behind both the British and Australians in lodge practice. In the latter countries more than half of wage earners before World War I may have had access to physicians' services through lodge practice.<sup>17</sup> It was, nevertheless, quite prevalent in America. The New York City health commissioner, in 1915, observed that in many communities, lodge practice was "the chosen or established method of dealing with sickness among the relatively poor."<sup>18</sup> In Seattle, lodge members eligible for treatment by a lodge physician amounted to some 20% of the adult male population.<sup>19</sup> This was, remember, in addition to the number of people who obtained medical *insurance* through friendly societies and mutuals.

The cost of coverage through lodge practice averaged around \$2 a year—roughly a day's wage—and some lodges offered coverage for family members at the same rate. And this was the typical charge for a single house call by a fee-for-service physician at the time. What's more, the competition from lodge practice probably resulted in lower fees for the services of physicians in private practice.<sup>20</sup> That was, perhaps, one reason for the medical profession's strong resentment. Nevertheless, the practice appealed to many doctors, especially those starting out, by offering a large and stable patient

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12 David Beito, *From Mutual Aid to the Welfare State: Fraternal Societies and Social Services, 1890-1967* (Chapel Hill and London: The University of North Carolina Press, 2000), p. 19.

13 *Ibid.*, pp. 14-15.

14 *Ibid.*, p. 22.

15 *Ibid.*, p. 25.

16 This is the subject of an entire chapter in Beito's book, pp. 109-129. See also Roderick T. Long, "How Government Solved the Health Care Crisis: Medical Insurance that Worked — Until Government 'Fixed' It," *Formulations*, Winter 1993/94.

17 Beito, *From Mutual Aid to the Welfare State*, pp. 109-110.

18 *Ibid.*, p. 110.

19 *Ibid.*, p. 111.

20 *Ibid.*, p. 117.

base.<sup>21</sup>

The medical profession launched a full-scale assault on lodge practice, causing it to decline steeply by the 1920s. State medical societies imposed sanctions on doctors who accepted lodge contracts, in some cases barring them from membership.<sup>22</sup> The campaign was still more strident at the county level, with pressure to sign anti-lodge practice pledges, or pledges not to charge fees less than the standard, and expulsions or boycotts of offenders. Hospitals were also pressured into boycotting those who engaged in lodge practice.<sup>23</sup> The profession also attacked the "problem" from the other end, remedying the perceived "oversupply" of doctors that made the terms of lodge practice so attractive to some physicians. Between 1910 and 1930, the number of physicians per 100,000 people shrank from 164 to 125, largely because of increasingly stringent state licensing requirements, and because of a reduction in the number of medical schools (by more than half between 1904 and 1922).<sup>24</sup>

Finally, the rise of group insurance, starting with the Equitable Life Assurance Society's first large group insurance policy in 1912, was another major blow to both lodge practice and friendly society insurance. Lodges were in part responsible for bringing on their own eclipse by attempting to suppress group insurance rather than embracing it, but even in those cases where they embraced it they were hurt by preferential tax treatment for employer-based insurance. Lodges were for the most part hostile to group insurance because, as they saw it, the lack of individual physical examinations and medical histories were an incentive to poor personal health practices; and with group insurance tied to employment, a worker might eagerly accept health insurance from his employer and drop his lodge insurance, only to be left altogether without coverage when he lost his job. This hostility extended, in some cases, to lobbying for state legislation prohibiting employer-based group insurance. In hindsight, the organization of friendly society insurance on a group basis, secure against loss of employment, would have been the obvious response. Some lodges, to their credit, experimented with dropping physical exams and adopting group insurance using the lodge membership as a pool. But the federal government encouraged the crowding out of lodge-based insurance by employer-provided insurance, making the provision of group insurance to employees tax deductible without giving similar tax treatment to lodge-based group insurance premiums.<sup>25</sup>

Some fraternal organizations also organized their own clinics and hospitals. The Workmen's Circle in New York City, for example, organized district clinics into a citywide Medical Department with a wide array of specialist services. The Independent Order of Foresters had a similar venture in, among other places, California and Ontario.<sup>26</sup> The Women's Benefit Association (formerly Ladies of the Maccabees, a women's adjunct of the Knights of the Maccabees) established health service centers with visiting nurses (38 of them by 1934, in seventeen states and one Canadian province).

The suppression of lodge practice is just one example among many of a larger general phenomenon: the suppression of self-organized alternatives by capital and the state.

The insurance industry recently attempted to suppress a revived version of contract practice by New York doctor John Muney:

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21 Ibid., pp. 117-118.

22 Ibid., p. 124.

23 Ibid., p. 125.

24 Ibid., p. 128.

25 Ibid., pp. 211-214, 231.

26 Ibid., p. 165.

A New York doctor is offering flat-rate health care for the uninsured for \$79 a month, but he has run afoul of state insurance regulations in a case that challenges the established norms of the U.S. health system....

Dr. John Muney, president of AMG Medical Group, said he started the program in September after noticing that many of his patients were losing their jobs, and therefore, their health insurance coverage.

About 500 people have registered for Muney's \$79-a-month plan, accounting for 15 percent of patients at the practice, which has offices in each of New York's five boroughs.

The monthly \$79 fee... covers unlimited preventive visits and onsite medical services such as minor surgery, physical therapy, lab work and gynecological care.

Ilana Clay, a 28-year-old who works in marketing for a jewelry firm, said she signed up in March because she could not afford her employer's health insurance, which would have cost around \$300 a month.

"I hadn't been to a doctor in a couple of years at that point," she told Reuters. She had a scar removed in a quick onsite procedure that was covered by the plan.

Muney said another patient came in with a tumor on her finger: "Somebody else asked \$3,000 to remove it. The first visit, we were able to remove it, 15 minutes it took us."

So far the program has not turned a profit, but Muney said he estimates that it could be profitable with 4,000 patients. In the meantime, he said, his motive is to give something back and provide a model of how healthcare can be more efficient.

"Our healthcare system lends itself to abuse, fraud and waste," he said, adding that bypassing insurers saved on administrative costs, which he said were about 25 percent of the price of care. "With this model, we're bypassing all that."

Muney said he received initial complaints from state insurance authorities in November. "The law says you can do preventive checkups unlimited, but if they come for sick visits you have to charge your overhead costs," he told Reuters.

In February he received a letter instructing him that he must charge that minimum cost, which he calculates at \$33 a visit—a price he says will deter people from signing up.

Troy Oechsner, deputy superintendent of the state insurance department, said the rules were designed to protect consumers.

"Our concern is ... making sure that consumers can rely on any promises made to them and that they will get the services they paid for when they need them," he said.<sup>27</sup>

Protecting consumers by making them pay \$33 per visit instead of \$10. As Cool Hand Luke would say, "Wish you'd stop being so good to me, Cap'n."

Muney's comments on the savings from bypassing insurance, by the way, are suggestive of the ways that reforms in delivery of service—say, by incorporating finance into the cooperative organization of service—may also be a solution to the insurance crisis. The provision of most primary care through such member-financed setups with no insurance paperwork cost, no incentive to pile on

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<sup>27</sup> Claudia Parsons, "N.Y. Doctor offers flat rate care for uninsured" (Reuters), May 7, 2009 <<http://www.reuters.com/article/idUSTRE5467KE20090507>>.



additional services, and strong incentives to minimize overhead given the inability to profit from 10,000% markups for supplies and drugs, may well be the future of medicine. Absent the perverse incentives and high overhead that prevail in bureaucratic hospitals, it's really not surprising Muney can do it for \$79.

Qliance, a new clinic in Seattle, is attempting to provide primary care outside the insurance system on something like Muney's contract practice model.

A Seattle clinic for people fed up with insurance, started by doctors fed up with insurance, has gotten \$4 million in private venture capital money to expand, it announced on Monday.

Qliance says it has a profit-making solution to the problems of long waits, rushed doctors and cursory care that bother patients, at the same time that it eliminates the paperwork and pressure that plague primary care doctors....

The new venture funding comes from Second Avenue Partners with participation by New Atlantic Ventures and Clear Fir Partners, bringing total capital raised to about \$7.5 million.

Co-founder Norm Wu said per-patient revenue is triple that of insurance-based clinics. He said many costs are fixed so the firm, now losing money, will turn to profit as business grows.

More than 50 noninsurance clinics operate in 18 U.S. states, based on different business models, Wu noted....

Qliance says it is a private alternative to the failures of insurance, which have made health care President Obama's top legislative priority in Congress, with a price tag of \$1 trillion or more.

Qliance customers pay \$99 to join, then a flat monthly rate of \$39 to \$119, depending on age and level of service. Patients can quit without notice and no one is rejected for pre-existing conditions....

Qliance patients get unrestricted round-the-clock primary care access and 30-minute appointments....

[Clinic co-founder Dr. Garrison] Bliss said dumping rigid, convoluted insurance requirements and paperwork saves large amounts of money.<sup>28</sup>

The Ithaca Health Alliance, a cooperative health insurance system created by Paul Glover and other founders of the Ithaca Hours community currency, has also experienced considerable difficulty with the insurance regulators.

Ithaca Health was created in 1997, beginning simply as a discount network in which, in return for the \$100 annual fee, members would receive discounts from participating providers. The next step, when the system accumulated sufficient funds, was to begin offering payments for a list of specified conditions. As funds continued to accumulate and membership increased, Ithaca continued to expand its list of covered conditions and the scale of payments on claims from one year to the next. The Alliance's choice of conditions to cover has been based on "an assessment... of the frequency of selected injuries" by the New York Department of Health. Conditions covered began with fractures and stitches, and expanded to include burns. The list has since further expanded to include appendectomies, ambulance rides, rabies inoculations, Emergency Room visits, and a number of dental procedures. Some indication of the IHA's success may be inferred from the fact that the city of Ithaca

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<sup>28</sup> David Lawsky, "Seattle doctors try flat-rate no-limit primary care," Reuters, July 8, 2009 <<http://www.reuters.com/article/idUSTRE5660N620090707>>.

enrolled 400 municipal employees in Ithaca Health.<sup>29</sup>

Eventually IHA reached an accommodation with the New York authorities by designating its payouts as “discretionary grants” rather than claims pursuant to an insurance contract.<sup>30</sup>

An attempt to create a system in Pennsylvania modeled on the Ithaca Health Alliance, PhilaHealthia, failed when Glover was unable to reach an understanding with the Pennsylvania Insurance Department. The Pennsylvania state government rejected Glover's proposal as an “unauthorized insurance policy.” Glover describes the ways in which PhilaHealthia violated Pennsylvania's insurance regulations:

First, PID requires a \$2,500 nonrefundable application fee. This is nearly the highest such State payment in the nation, and far above New York's \$10.00. We request waiver of this fee.

Secondly, PID requires \$1,500,000 initial capitalization. As in Ithaca, NY, we proceed by gathering small membership fees. In Philadelphia we will begin with \$100,000, by gathering \$100/each from our first 1,000 pledges. This will suffice as foundation upon which to build as Ithaca did....

Thirdly, PhilaHealthia's grassroots process enables us to pay for gradually expanded categories of medical and dental need as more members join and renew. We do not begin with capability to cover mandated categories. Nor do we grow pyramidally, but stabilize the payment menu when enrollment stabilizes. Administrative staff are paid not more than twice the region's livable wage, regardless how big this plan gets.<sup>31</sup>

So ordinary people cannot organize a cooperative health insurance system with their own money, without meeting a high initial capitalization burden, paying a high application fee, and covering the entire range of mandated conditions. Any such cooperative program must raise the capital to operate on a large scale at the outset, or not be allowed to operate at all; it must be able to cover the full range of mandated conditions, or cover nothing. To start small, with the capital available to members, and then gradually expand coverage as the system grows, is illegal.

Apparently a voluntary, affordable insurance policy that covers fewer conditions than the state mandates is *worse* than nothing, because the choice facing Philadelphia's uninsured was not between PhilaHealthia and a more comprehensive system, but between PhilaHealthia and nothing at all. So if an uninsured person can't afford what the state considers a minimum acceptable level of coverage, he's not allowed to have any coverage at all.

This is just another example of how the mendacity of regulated industries intersects with the naivete of liberal do-gooders, in the “Bootleggers and Baptists” model of public policy. “Better than nothing” is not in the liberal vocabulary. Hence, for example, local restrictions on homeless people living in their cars. Living in a car is substandard housing. Never mind that, from the standpoint of the person whose life is affected, a car is about as much of a step up from the sidewalk as a house is from a car. All that matters is that a car is substandard housing; whether it's better than the alternative, or

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29 Paul Glover letter to John McGinty (Special Investigator, Pennsylvania Insurance Department), March 31, 2006, in “History of correspondence between PhilaHealthia and Pennsylvania Insurance Department (PID)” <<http://www.healthdemocracy.org/pid.html>>. “Health Care grants available to Health Alliance members through the Ithaca Health Fund,” Ithaca Health Alliance Website <<http://www.ithacahealth.org/grants.html>> (accessed March 9, 2010).

30 Ibid.

31 Paul Glover, letter to Rosemary Placey, July 1, 2007, in “History of correspondence between PhilaHealthia and Pennsylvania Insurance Department (PID).”

whether such coercive mandates have unintended consequences, is beside the point.<sup>32</sup>

As Glover's experience suggests, coverage mandates are an enormous barrier to the provision of affordable, bare-bones insurance plans.

The recently passed healthcare legislation sets federal standards—i.e. mandates—for access to the exchanges and to insurance subsidies, which means that lower-cost plans will be available only to those who pay premiums entirely out of pocket. Cooperative insurance plans like IHA may well still be attractive to those who receive hardship exemptions from the insurance mandates. And contract practice arrangements like Muney will, we can hope, still be valuable to those who buy high deductible plans through the exchanges.

Any suggestion of returning to a reliance on friendly societies or mutuals as the primary source of healthcare funding today will likely meet with the objection that per capita costs are far higher, as a percentage of per capita income, than they were in the heyday of sick benefit societies and lodge practice. It's a valid point, but those who raise it approach the issue from the wrong direction. They use the present level of healthcare costs to argue that only government financing can meet the challenge. In fact, however, before we address the question of finance at all, we must first address the reasons *why* the present cost of healthcare is so inflated.

Finance, therefore, is a secondary issue. Healthcare finance is an issue primarily because of the cost of healthcare itself, and increasing insurance premiums are driven mainly by the cost of care: specifically the high cost of drugs, treatments and equipment.

The root of the problem is that the state, through artificial scarcity, makes certain forms of practice artificially lucrative. In other words, it creates a honey pot. Given the existence of that honey pot, physician standards of practice and hospital business models gravitate toward the money the same way water runs downhill.

As enthusiastic as I am in support of cooperative healthcare finance, a cooperative approach to finance alone is inadequate. We must also organize alternative methods for delivery of service, and eliminate the state-supported monopolies that affect the price of medicine, medical technology and service providers. Muney's remark quoted above, that financing healthcare through direct membership fees eliminates the 25% of cost that goes to insurance paperwork, is suggestive. The direct organization of risk- and cost-pooling mechanisms by service providers is potentially a way of bypassing the insurance industry altogether.

**Institutional culture.** In *People or Personnel*, Paul Goodman contrasted the fundamental difference in organizational styles between the large, bureaucratic, hierarchical organization and the small, self-managed, ad hoc organization. He defined the typical culture of the large organization largely in terms of those qualities, which stem largely from the nature of hierarchy, with work being divorced from responsibility, power or intrinsic motivation (as suggested by the contrasting spontaneous and frugal style of bottom-up organizations):

To sum up: what swell the costs in enterprises carried on in the interlocking centralized systems of

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<sup>32</sup> See Charles Johnson, "Scratching By: How Government Creates Poverty as We Know It," *The Freeman: ideas on Liberty*, December 2007 <<http://www.thefreemanonline.org/featured/scratching-by-how-government-creates-poverty-as-we-know-it/>>.

society, whether commercial, official, or non-profit institutional, are all the factors of organization, procedure, and motivation that are not directly determined to the function and the desire to perform it. Their patents and rents, fixed prices, union scales, featherbedding, fringe benefits, status salaries, expense accounts, proliferating administration, paper work, permanent overhead, public relations and promotions, waste of time and skill by departmentalizing task-roles, bureaucratic thinking that is penny-wise pound-foolish, inflexible procedure and tight scheduling that exaggerate contingencies and overtime.

But when enterprises can be carried on autonomously by professionals, artists, and workmen intrinsically committed to the job, there are economies all along the line. People make do on means. They spend on value, not convention. They flexibly improvise procedures as opportunity presents and they step in in emergencies. They do not watch the clock. The available skills of each person are put to use. They eschew status and in a pinch accept subsistence wages. Administration and overhead are ad hoc. The task is likely to be seen in its essence rather than abstractly.<sup>33</sup>

Goodman's description of the bureaucratic organization dovetails very closely with Max Weber's description of bureaucracy, characterized by job descriptions and work rules. In contemporary terms, the jargon is "standard operating procedures" and "best practices." It coincides, as well, with Frederick Taylor's belief that there is one best way to do everything—with the correlaries that it is the job of the manager to discover this one best way, in his infinite wisdom, and the job of the worker to obey it without question. It ignores the whole Hayekian idea of tacit or job-specific knowledge.

Most importantly, Goodman's typology of organizations "cuts across the usual division of profit and non-profit," as shown by the prevalence in the latter of "status salaries and expense accounts..., [and] excessive administration and overhead..."<sup>34</sup> The organizational style of the large corporation and the centralized government agency defines the general culture, and contaminates the nonprofit and cooperative. If your natural foods co-op has a mission statement, or the pastor of your mega-church calls himself a "CEO," you're seeing this tendency in action.

The large corporation and centralized government agency do not exist just as discrete individual organizations. Beyond a certain level of proliferation, such large organizations crystalize into an interlocking system. Even the small and medium-sized firm, the cooperative, the non-profit, must function within an overall structure defined by large organizations.

A system destroys its competitors by pre-empting the means and channels, and then proves that it is the only conceivable mode of operating.<sup>35</sup>

...[T]he genius of our centralized bureaucracies has been, as they interlock, to form a mutually accrediting establishment of decision-makers, with common interests and a common style that nullify the diversity of pluralism.<sup>36</sup>

Far from the system of "countervailing power" hypothesized by Galbraith, the large for-profit corporation, large government agency, and large non-profit in fact cluster together into coalitions: "the industrial-military complex, the alliance of promoters, contractors, and government in Urban Renewal; the alliance of universities, corporations, and government in research and development. This is the great domain of cost-plus."<sup>37</sup>

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33 Paul Goodman. *People or Personnel*, in *People or Personnel and Like a Conquered Province* (New York: Vintage Books, 1965, 1967, 1968), p. 113.

34 *Ibid.*, pp. 114-115.

35 *Ibid.* p. 70.

36 Goodman, *Like a Conquered Province*, in *People or Personnel and Like a Conquered Province*, p. 357.

37 Goodman, *People or Personnel*, p. 115,

The importance of Goodman's use of “cost-plus” is impossible to overestimate. Artificial scarcity, artificially inflated overhead and cost-plus markup are, in my opinion, the defining characteristics of the corporate economy. The practical effect, as Goodman described it:

We seem to put an inordinate expense into maintaining the structure. Everywhere one turns... there seems to be a markup of 300 and 400 per cent, to do anything or make anything....

Consider it simply this way: One visits a country where the per capita income is one quarter of the American, but, lo and behold, these unaffluent people do not seem four times "worse off" than we, or hardly worse off at all.<sup>38</sup>

Goodman's organizational typology is central to our analysis of healthcare. Cost competition between hospitals is limited by their shared pathological institutional cultures.

And a major component of this sick culture is the perverse incentives created by the dominant model of management accounting. The prevailing management accounting system in use in most large American corporations is derived from the management accounting innovations of Donaldson Brown, who developed them at DuPont and brought them to General Motors when Alfred Sloan brought him in as part of the management team there. William Waddell and Norman Bodek, in *The Rebirth of American Industry*, use “Sloanism” as a shorthand term for it.<sup>39</sup> The central defining features of Sloanism are the treatment of labor as the primary variable and direct cost, the treatment of administrative overhead and capital expenditures as fixed costs, and the treatment of inventory as a liquid asset. Under Sloanism, overhead cost is of minor significance because it can be incorporated as a markup into the price of goods sold to inventory, through the miracle of “overhead absorption.” Waddell and Bodek argue that it is impossible to implement lean manufacturing practices in a firm governed by Sloanist management accounting methods. By definition, nothing is *muda* (i.e. waste) under Sloanist accounting rules: since anything that adds to overhead cost is incorporated into the price of the final good, it's a source of “value added.” As in the old Soviet planned economy, the consumption of resources is *defined* as value-added to the extent it adds to final price; institutions profit by converting the maximum number of inputs into outputs, regardless of the actual utility of the outputs.

Since only labor counts as a direct/variable cost, and capital expenditures and administrative costs go to general overhead, the MBAs obsessively cut hospital staffing to the bone—meanwhile spending money on the kinds of wasteful white elephant capital projects you might have seen in the old USSR, and maintaining levels of administrative overhead rivaling that of the Ministry of Central Services in *Brazil*.

Regarding wasteful capital expenditures in particular, Hayek's predictions concerning the irrationality and uneven development in a planned economy are relevant:

There is no reason to expect that production would stop, or that the authorities would find difficulty in using all the available resources somehow, or even that output would be permanently lower than it had been before planning started . . . [We should expect] the excessive development of some lines of production at the expense of others and the use of methods which are inappropriate under the circumstances. We should expect to find overdevelopment of some industries at a cost which was not justified by the importance of

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38 Ibid., p. 120.

39 William H. Waddell and Norman Bodek, *Rebirth of American Industry: A Study of Lean Management* (Vancouver, WA: PCS Press, 2005).

their increased output and see unchecked the ambition of the engineer to apply the latest development elsewhere, without considering whether they were economically suited in the situation. In many cases the use of the latest methods of production, which could not have been applied without central planning, would then be a symptom of a misuse of resources rather than a proof of success.

As an example he cited “the excellence, from a technological point of view, of some parts of the Russian industrial equipment, which often strikes the casual observer and which is commonly regarded as evidence of success.”<sup>40</sup>

On the hospital ward where I work, thousands of dollars were sunk in a new telephone system when the one it replaced was satisfactory in every way. Thousands were spent replacing a perfectly acceptable photocopier. The hospital spent an enormous sum of money remodeling the postoperative care ward, changing the entire floor plan within the limits set by the location of girders, in a way that made it less functional than before; the staff on that ward are unanimous in hating it. Several years ago the administration remodeled another floor and furnished it with the most luxuriously appointed rooms in the hospital, at enormous cost, in order to house an ACE (Acute Care of the Elderly) ward; but because the ward was designed with insufficient input from physicians, it was subsequently judged inadequate for the purpose and closed off for several years. Most recently, the hospital announced an \$8 million expansion of ER. That \$8 million would have been enough to increase staffing to the pre-downsizing levels of the early '90s—five or six patients for each nurse and orderly—for five years.

Nationwide, according to Maggie Mahar, “[i]n the past two years the hospital industry has embarked on a building boom, the likes of which we haven't seen since 1969.” Between 1999 and 2005, hospital construction expenditures increased by more than half, from \$14.4 billion to \$22.6 billion. Then in the following two years, they increased by another third, from \$22.6 billion to \$30.6 billion. That means construction expenditures more than doubled in eight years.<sup>41</sup>

Hospital administrators' focus is on being the first to offer new, ultra-expensive specialties that benefit only a small percentage of the population, or buying extremely expensive high-tech equipment of limited use (like a Da Vinci surgical robot that cost several hundred thousand dollars). The idea is that you can experience the world of the *Jetsons* in surgery — and then experience life in a Third World country on the squalid, understaffed patient care floor, where you soil yourself waiting an hour for a bedpan, and go five days without a bath or linen change because there's one orderly for twenty patients. They hire committees of high-salaried consultants to write mission statements (and vision statements and core values statements) about "extraordinary patient care," "going above and beyond" and “enriching the lives in the communities we serve,” while gutting the patient care staff. If a hospital could provide “extraordinary patient care” by writing about it in mission statements, without actually spending any money on patient care staff, the place where I work would be the best hospital in the history of the universe.

But the problem is by no means limited to for-profit hospitals. During my last job search, I put in an application at my current employer's main competitor, a large community nonprofit in the neighboring county seat town. On visiting the newly built hospital campus for the first time, I was reminded of one of those 1950s magazine illustrations of “The City of the Future.” The architecture was reminiscent of something by Albert Speer, or an illustration from some H. G. Wells story like *The*

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40 Friedrich Hayek, “Socialist Calculation II: The State of the Debate (1935,” in Hayek, *Individualism and Economic Order* (Chicago: University of Chicago Press, 1948), pp. 149-150.

41 Maggie Mahar, “Health Care Spending: The Basics; How Much Do We Spend on Hospitals? Part I,” *Health Beat*, April 4, 2008 <<http://www.healthbeatblog.org/2008/04/health-care-spe.html>>.

*Shape of Things to Come.* The main entrance opened on a multi-story atrium with skylights and a giant fountain. Looking at the surrounding landscape design, I couldn't help thinking of the hanging gardens of Babylon. But from what I hear on the grapevine from those who've worked there, the staffing levels are even worse than where I work, with nightmarish work shifts that recall the Bataan Death March. The fact that it's officially a "non-profit" is beside the point: it's got the same high overhead culture and the same enormous CEO salaries to support, and if something has to give it's patient care staff.

But none of this waste and irrationality matters, because under the prevailing management accounting paradigm such enormous capital expenditures are not direct costs. Since labor hours are the only real direct cost, the only way to "increase productivity" is to minimize staffing ratios. And overhead doesn't matter because, under the Sloanist rules of "overhead absorption," it just gets passed on to the customer as a markup. Hence the \$3 bag of saline solution that's billed for \$300—not to mention the infamous \$10 aspirin.

It's the same organizational culture that gave us the \$600 toilet seats at Pentagon contractors. As Seymour Melman described it, the military-industrial complex is a privately owned planned economy with a government-guaranteed market for its output and cost-plus pricing set to guarantee a profit on any expenditure, no matter how wasteful. As a result, military contractors—unlike businesses in a free, competitive market—have every incentive to maximize costs rather than minimize them. Just as hospitals have every incentive to pad bills with unnecessary testing, Pentagon contractors have every incentive to gold-plate weapons systems; whatever it costs, the contractor will receive a profit on that amount. Military contractors, like hospitals, are notorious for bloated administrative overhead, even by the standards of management-heavy American large corporations.<sup>42</sup> And if anything, the cost-plus culture is even more prevalent in hospitals than in military contractors.

Recently Dr. Sanjay Gupta went over a hospital bill on CNN and found a bag of saline solution that cost \$288, a \$3,000 incision stapler and a \$10,000 spinal screw.<sup>43</sup> It's quite common for discharged patients perusing their bills to find two tablets of Plavix, which normally cost \$8, billed for \$497, or a \$3 Crestor tablet for \$65.<sup>44</sup> In another case, two bags of intravenous electrolytes (\$5 apiece) were billed at \$1,082; Demerol was marked up 1400%.<sup>45</sup> In yet another, a unit of Ampicillin that cost a hospital \$10 might be marked up to \$378, or a one-gram Vancomycin injection that cost the hospital \$9.75 billed to the patient for \$387. The patient billed the latter charges received a total medication bill of \$5,625 for drugs that cost the hospital \$187.54—a 2999% markup. The hospital defended the markup, in a classic demonstration of bureaucratic duckspeak, by saying their "charges are based on the cost of delivering high-quality healthcare and are comparable with charges generated in similar facilities offering like services in our geographic area."<sup>46</sup> Translated into English, that means the other hospitals in the local market have no competitive incentive to minimize costs, because they all have the same pathological organizational culture. To the contrary, "[h]ospitals that charge the most tend to make the most profits or net income."<sup>47</sup>

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42 Seymour Melman, *The Permanent War Economy: American Capitalism in Decline* (New York: Simon and Schuster, 1974).

43 Eliza Browning (AC360 associate producer), "Morning Buzz: That screw costs how much?" *AC360 Blog*, February 24, 2010 <<http://ac360.blogs.cnn.com/2010/02/24/morning-buzz-that-screw-costs-how-much/>>.

44 Libby Smith, "Patient Disputes Mark Up in Medication," *CBS4Denver*, September 25, 2009 <<http://cbs4denver.com/recession/hospital.medicine.markup.2.1209196.html>>.

45 Nathan Welton, "Shock Treatment," *The Tribune*, May 8, 2005 <<http://www.nathanwelton.com/stories/health/maybelle.html>>.

46 Faith Ozan, "Do Hospital's Charges Make Sense?" *Santa Barbara Independent*, January 6, 2010 <<http://independent.com/news/2010/jan/06/all-marked/>>.

47 Ibid.

Hospital administrators defend such markups by pointing to average hospital profit margins of 5% or less. But the beauty of cost-plus culture is that the 5% accrues on whatever costs you can run up. And 5% on a \$300 bag of saline is a lot more than on a \$3 bag.<sup>48</sup> But more importantly, the administrative overhead *itself* is a profit, *from the standpoint of management*. Shareholders may regard it as a cost, but then shareholder ownership is a myth. From the standpoint of management, the real owners and the only stakeholders who really count, management salaries and perks—administrative overhead—are the *purpose* of the organization.

Others point out the number of hospitals running in red ink. But such claims treat fixed costs and overhead as a fact of nature, when they really result from a choice of organizational model. A hospital that spends the typical amount of money on white elephant capital projects and administrative overhead that a typical hospital spends *deserves* to go bankrupt.

The enormous overhead cost resulting from bloated administrative bureaucracies, capital spending boondoggles, and so forth, are the main reason for all these enormous markups. Administrative costs and capital projects are considered part of general overhead rather than direct costs. And in an environment of third-party payments and near-zero price competition between hospitals—to repeat—there is little restraint on hospitals' ability to pass on such overhead cost by simple markup, with no competitive ill effect.

Hospital management, typically, pays lip service to Philip Crosby's "cost of low quality,"<sup>49</sup> without any sign it grasps the significance of the idea. They regurgitate statistics, in employee propaganda handouts, about how MRSA infections, medication errors, and falls increase costs. They might admit, in theory, that understaffing is a contributing factor to such costs, and maybe even admit that such side-effects of understaffing more than offset the ostensible savings on direct labor. But they don't really internalize the practical implications; their accounting metrics militate against it. If such costs were included on the same ledger with the direct labor savings from downsizing, to create a unified cost-benefit metric for staffing cuts, the accounting metric would provide a healthy incentive. But given a management accounting system that maximizes ROI by minimizing direct labor hours in isolation, management will minimize direct hours—*ruat coelum*. Even if the resulting increase in infections, falls and med errors more than offsets the savings on labor costs, those other numbers don't show up anywhere that matters under the conventional accounting rules. They are entirely academic. What's "real" is the metric they learned at MBA school, by which labor cost savings and increased costs of poor quality from understaffing don't show up on the same bottom line. This means the MBAs are unable to understand, in practical terms, that understaffing *increases* costs.

Rather than thinking of increased staffing as a human capital investment that would quickly pay for itself through reduced errors and complications, they count it as an operating cost. But capital expenditures, no matter how wasteful or counterproductive, are an *investment*, so they're OK. And since capital expenditures and capital projects go to overhead, they are invisible. There is no separate line-item on a patient bill for his pro rata share of the \$8 million ER expansion, or for the salary of the person who oversaw Fish! Philosophy or rewrote the mission statement for the umpteenth time.

The conventional business model in healthcare is riddled with perverse incentives. Besides the lack of management incentives to minimize overhead or any cost other than direct labor, a central cause of healthcare inflation, is the insulation of the purchaser from price signals. Between 1970 and 2007, the

48 Welton, "Shock treatment."

49 Philip Crosby, *Quality is Free: The Art of Making Quality Certain* (New York: McGraw-Hill Book Company, 1979).



average portion of healthcare costs paid out of pocket fell from 40% to 14%.<sup>50</sup> The direct result has been the relentless creep of standards of practice toward the highest-cost tests and procedures.

In the February 25, 2010 healthcare summit with Congressional Republicans, President Obama dismissed GOP proposals for high-deductible health insurance policies limited mainly to catastrophic care, with most routine care and non-catastrophic costs being paid out of pocket. Obama asked, in response, how practical such a proposal would be for someone with a \$40,000 annual income. That's a good point, as far as it goes; but it reflects something of a Catch-22 situation. The typical hospital stay or procedure cost a lot less, in terms of an average day's pay, back in 1970 when 40% of expenses were paid out of pocket; but one reason costs have risen so fast in real terms is precisely because the purchaser is insulated from the real cost. A healthcare finance model based on insurance for catastrophic care, with most ordinary costs paid out of pocket, is unsupportable precisely because the costs of the most routine procedures are so enormous compared to their prices in constant dollars a generation or two ago. But one reason for this enormous cost inflation, and for the constant creep toward more expensive technology and more tests even when they're not necessary, is the consumer's insulation from direct cost comparisons.

Obama's remarks assumed the continuation of a conventional healthcare model in all aspects except the narrow GOP finance proposal. But if combined with an innovative, low-cost vehicle for delivering primary care (like Dr. Muney's clinics bypassing the insurance system altogether and offering flat fee coverage), high-deductible catastrophic plans might work very well.

Under the present healthcare business model, the consumer's main contact with rising costs is in the form of rising premiums. The state, through regulatorily cartelized systems of insurance and delivery of service, breaks the direct market relationship between purchaser and supplier. The system runs on third party payments and cost-plus accounting, which means that those making the decisions regarding healthcare delivery have precious little incentive to economize. It is almost never standard practice, in making healthcare decisions, to be informed of both the costs and benefits of a test or procedure at the time of the decision, or for the patient to be given a choice between higher and lower cost options with the attendant risks explained. Far from it.

Michael Cannon and Michael Tanner argue that third-party payment distorts or conceals the price signals that would be sent in a free market by patients shopping for services with their own money. As "patients take less care to weigh the expected costs and benefits of medical care," providers have far less incentive to minimize costs per unit of service in order to offer a competitive price. Rather, with fixed payments for service from third-party payers, providers have an incentive to minimize quality and pocket the difference. "It should come as little surprise, then, that in practice, patients often receive substandard or unnecessary care." An *NEJM* study found that patients received "the generally accepted standard of preventive, acute, and chronic care" only 55% of the time. And third-party payments increase the incentive to pad the bill with unnecessary procedures, since patients do not bear the cost.<sup>51</sup> The medical ethic is replaced by a "veterinary ethic, which consists of caring for the sick animal not in accordance with its specific medical needs, but according to the requirements of its master and owner, the person responsible for paying any costs incurred."<sup>52</sup>

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50 "Health Care Costs: A Primer" Key Information on Health Care Costs and Their Impact (The Henry J. Kaiser Family Foundation: March 2009), p. 13.

51 Michael F. Cannon and Michael D. Tanner, *Healthy Competition: What's Holding Back Health Care and How to Free It* (Washington, D.C.: The Cato Institute, 2005), pp. 55-56.

52 *Ibid.*, p. 57

Anyone who's ever been in the hospital or made a trip to the ER is familiar with this phenomenon. The hospital bill will be padded with long lists of tests and procedures that the patient has no memory whatsoever of authorizing, and will be followed by a long series of bills from clinics for tests and consultations which the patient likewise never explicitly approved. And as someone who's experienced the system both as a hospital worker and as a patient, I'm quite familiar with the practice of mutual logrolling between physicians, calling each other in for consultations. The patient sees one white coat after another poke his head in the door, and sees an endless series of techs drawing one bodily fluid after another, with no idea whatever what it's about until he gets home and his mailbox is filled daily with bills from clinics and insurance company refusal of payment notices. He receives bills from doctors he couldn't identify in a police lineup (and probably vice versa).

The incentive, both for hospitals and practitioners, is to maximize the number of procedures charged for, which means it is the opposite of their rational interest to inform the patient of his options and their relative cost at the time of the decision.

These perverse incentives are reflected in the shift from what Arnold Kling calls “empirical medicine” to “premium medicine” (see below). According to a *New York Times* article by Alex Berenson and Reed Abelson, hospitals invest in extremely expensive CT scanners, despite the fact that most CT scans are unnecessary and have little or no proven benefit. “CT scans, which are typically billed at \$500 to \$1,500, have never been proved in large medical studies to be better than older or cheaper tests.” But hospitals nationwide have invested in thousands of the million-dollar machines; and as San Francisco cardiologist Andrew Rosenblatt says, “[i]f you have ownership of the machine, ...you’re going to want to utilize the machine”—even if it means a provider has to “give scans to people who might not need them in order to pay for the equipment.” This pressure to full utilization of capacity on the Sloanist model may have something to do with American per capita healthcare costs being about twice the average in the developed world.

No one knows exactly how much money is spent on unnecessary care. But a Rand Corporation study estimated that one-third or more of the care that patients in this country receive could be of little value. If that is so, hundreds of billions of dollars each year are being wasted on superfluous treatments....

The problem is not that newer treatments never work. It is that once they become available, they are often used indiscriminately, in the absence of studies to determine which patients they will benefit....

Already, more than 1,000 hospitals and an estimated 100 private cardiology practices own or lease the \$1 million CT scanners.... Once they have made that investment, doctors and hospitals have every incentive to use the machines as often as feasible. To pay off a scanner, doctors need to conduct about 3,000 tests, industry consultants say.

Fees from imaging have become a significant part of cardiologists’ income — accounting for half or more of the \$400,000 or so that cardiologists typically make in this country, said Jean M. Mitchell, an economist at Georgetown University who studies the way financial incentives influence doctors....

Mitchell said cardiologists simply practice medicine the way the health system rewards them to. Given the opportunity to recommend a test for which they will make money, the doctors will.

“This is not greed,” she said. “This is normal economic behavior.”<sup>53</sup>

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53 Alex Berenson and Reed Abelson, "The Evidence Gap: Weighing the Costs of a CT Scan's Look Inside the Heart," *New York Times*, June 29, 2008 <<http://www.nytimes.com/2008/06/29/business/29scan.html>>.

The incentive to maximize use of the CT scanner, by the way, is exacerbated by its high cost—which in turn results from the role of patents (about which more below) in driving up their price. The artificially high, patent-driven cost of medical equipment—like the high cost of product-specific machinery in a mass-production auto factory—creates an incentive to maximize ROI by increasing throughput.

But even given the high capital outlay for patented machines, it's still absolutely ridiculous to claim that it's necessary to charge thousands of dollars per CT scan to amortize that cost. In India, where American-made CT scanners are subsidized some 40% below their price in the North American market, the average scan ranges from \$90 for a straight scan and \$115 for contrast in a small city, to \$200 or so in major metropolitan areas. Compare that to \$6500 billed for a CT scan in an American hospital.<sup>54</sup> Regardless of the price of the CT scanner, the price the hospital charges is a cost-plus markup resulting from the lack of competition in a local market in which a few large hospitals share the same organizational culture, and the patient is a captive client with no ability to shop around for price comparisons. (One partial solution might be the increased transparency the Internet makes possible, with consumer websites comparing the cost of various services at competing hospitals in an area.)

Overuse of such testing also results, to some extent, from “defensive medicine”: i.e., “what happens when doctors order too many tests because they are afraid of missing a diagnosis and later losing a multi-million dollar lawsuit for malpractice. Defensive medicine these days is so pervasive, some estimate its yearly cost at more than \$100 billion.”<sup>55</sup>

For example, CBS News reported the story of a doctor who was astonished to find that his daughter had been diagnosed with an ovarian cyst via a \$6500 CT scan, even though a \$1400 ultrasound would have worked just as well. The ER's medical director defended the use of a CT on the grounds that the ultrasound might have missed appendicitis or a kidney stone. That's defensive medicine, and the risk of a malpractice suit makes it understandable. But is defensive medicine, by itself, responsible for the standard practice by which ER physicians don't even raise the issue of cost or give the patient the choice of waiving excessive tests? The college student at the heart of the controversy says she was left completely out of the picture:

Experts tell CBS News you should ask basic questions.

First: Why is this test needed? Ask about the cost and if there's a less expensive, alternate test. Ask if the test results might change your diagnosis - or treatment. And, "what is the risk if I don't have the test?"

“They didn't really talk to me about doing anything else,” Alexandra Varipapa said.

In Varipapa's case, the hospital insists her CT scan was medically required, given her symptoms.

But in the end, the hospital did present an \$8,500 dollar bill - for a condition that went away on its own.<sup>56</sup>

What's more, the father mentioned in the story (again, himself a doctor) weighed in in the comments to a blog post about the story, suggesting the attending physicians never did even the minimal investigation to determine risk of appendicitis or kidney stones before ordering the CT:

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54 Vijay, “Why does a CT scan cost so much in the USA?” *A scan man's notes*, October 29, 2007<<http://www.catscanman.net/blog/2007/10/why-does-a-ct-scan-cost-so-much-in-the-usa/comment-page-2/>>.

55 Wyatt Andrews, “Defensive Medicine: Cautious or Costly?” *CBS Evening News*, October 22, 2007 <<http://www.cbsnews.com/stories/2007/10/22/eveningnews/main3394654.shtml>>.

56 Ibid.

I am the Dad-Doctor in the CBS piece. Here is more clarification:

1. No fever
2. cursory hx and exam by PA
3. No pelvic exam

In my experience, today's ER's have become CT Triage Centers<sup>57</sup>

But whatever specific incentives are behind the phenomenon, the tendency is the same: "technology creep."

First, a device, say, gets approved for a high-risk population in which there's a proven benefit. But its use then expands to lower-risk groups, changing the calculus of clinical and financial risk and reward. "I don't think we have a lot of technologies that aren't useful," says Paul Ginsburg, president of the Center for Studying Health System Change. "Our issue is that some of them are valuable but applied too broadly."

Take the implantable cardioverter-defibrillator, a battery-operated device that is surgically implanted in the chest. "These were first used for people who had survived" cardiac arrest, explains Rita Redberg, a cardiologist at the University of California-San Francisco. "Now they're being used for primary prevention"—that is, in people who face some risk of cardiac arrest but haven't experienced it.

Overstated benefits. A paper published last year in the *Journal of the American College of Cardiology* suggested the benefits of ICDs have been overestimated and the risks probably understated. In primary prevention trials, about 90 percent of ICDs will never save a life, but recipients still get exposed to risks such as infection and unnecessary shocks, says Roderick Tung, a cardiologist at the University of California-Los Angeles. And at \$30,000 each, ICDs are cost-effective only in patients most likely to suffer cardiac arrest, research shows.

Technology creep is also at work in imaging, where the number of CT and MRI scans charged to Medicare increased more than 15 percent annually between 2000 and 2004. Consider CT angiograms, which use multiple X-ray images to form a picture of blockages in arteries and can cost more than \$1,000. The most accepted use is to evaluate patients in the ER with chest pain, says Redberg, but some physicians use them to screen people with no symptoms. Yet there's no solid evidence they prolong or improve the quality of life or that they're cost-effective, according to Steven Nissen, chair of cardiology at the Cleveland Clinic.

The odd economics of health also abet the spread of technology. Healthcare providers are paid for each procedure or service rather than for improving the total health of patients, which means there's an incentive to offer more tests and treatments. Hospitals, meantime, compete to attract doctors and patients in part by buying advanced tools, whether or not they're needed in the community. "Say Hospital A has a PET scanner and an MRI. If Hospital B in the same locale doesn't have them, Hospital B loses in reputation and volume," says Melanie Nallicheri, a partner and member of the global health team at management consultancy Booz & Co.

Once a piece of expensive equipment is in place, it will be used. Proton-beam therapy, a kind of radiation requiring an investment of as much as \$150 million, has soared in popularity in recent years. "With the current regulations...you can use it for any malignancy that needs radiation," says Theodore Lawrence, chair of radiation oncology at the University of Michigan Medical School. It's being offered for pediatric cancers and certain rare tumors, which Lawrence feels is appropriate, but mostly for prostate cancer, for

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57 Robert Varipapa, quoted in Margaret Polaneczky, MD, "Was it Defensive Medicine or a Necessary Test?" *The Blog That Ate Manhattan*, October 23, 2007 <<http://theblogthatatemanhattan.blogspot.com/2007/10/was-it-defensive-medicine-or-necessary.html>>.

which it has never been compared in a head-to-head trial against conventional radiation treatments.<sup>58</sup>

Arnold Kling observes that medical conditions which, thirty years ago, would have been treated "empirically" at low cost, now routinely rely on expensive CAT scans and MRIs. He mentions the case of a patient with an eye inflammation. Thirty years ago the low-cost empirical treatment would have been to send her home, in the absence of a firm diagnosis, with antibiotics and prednisone and see if that took care of it. Thanks to modern technology, she was put through a battery of inconclusive tests, then given a series of CAT scans (also inconclusive)—and finally sent home, in the absence of a firm diagnosis, with antibiotics and prednisone.<sup>59</sup> Kling also describes his own experience:

During a routine physical examination, the lab that examined my urine sample found microscopic amounts of blood. This condition, known as microhematuria, can be a symptom of a number of serious illnesses, including bladder cancer.

However, the incidence of bladder cancer is very low among nonsmoking men under the age of 50. Moreover, microhematuria is present in between 10 and 15 percent of the healthy population. Finally, I had a history of occasional microhematuria, going back to my childhood. Using Bayes' Theorem..., I calculated that my chances of having bladder cancer were lower than that of a male age 60 *without* hematuria. Nonetheless, after much argument back and forth, my doctor insisted that I undergo a cystoscopy procedure. The results were negative.<sup>60</sup>

What Kling calls "premium medicine" has completely crowded out empirical treatment, and become the routine practice for everyone—even though it benefits only a very tiny minority of patients who would not have responded to empirical treatment. For example, everyone with a severe cough is likely to be subjected to a chest X-ray, despite the fact that 998 out of a thousand likely have a bronchial infection that will respond to simple treatment with antibiotics.<sup>61</sup> It's quite likely that the tens of millions of uninsured would love to have access to a policy that covered the low-cost, empirical options, provided at cost; but to return to our "food insurance" analogy, the system skews delivery of service so that only T-bones are available, even for those who can afford only hamburger.

Technology creep is the primary driver of healthcare cost increases, the primary reason for the increased capital expenditures described above, and also the primary area of competition between hospitals.

As Paul Ginsburg, President of the Center for Studying Health Systems Change, explained in the January/February issue of *Health Affairs*: "hospitals have been increasing capacity, not predominantly by adding new beds but by expanding specialized facilities (such as operating rooms and imaging facilities) needed to serve patients with the latest technology."

Consider, for example, what may be the world's most expensive medical device: a particle accelerator with a total price tag well over \$100 million. The machine, which employs protons to bombard cancerous tumors, can deliver higher and more precise doses of radiation, and we have evidence that it is effective in treating certain rare cancers.

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58 Katherine Hobson, "Cost of Medicine: Are High-Tech Medical Devices and Treatments Always Worth It?" *U.S. News*, July 10, 2009 <<http://health.usnews.com/articles/health/best-hospitals/2009/07/10/cost-of-medicine-are-high-tech-medical-devices-and-treatments-always-worth-it.html?PageNr=1>>.

59 Arnold Kling, *Crisis of Abundance: Rethinking How We Pay for Health Care* (Washington, D.C.: The Cato Institute, 2006), pp. 8-9.

60 *Ibid.*, p. 39.

61 *Ibid.*, pp. 12-13.

But we don't know whether it offers any benefits when it comes to treating common cancers. "That's far from established, and there's a good deal of controversy about it," said J. Frank Wilson, a professor of radiation oncology at the Medical College of Wisconsin recently told the Milwaukee Journal Sentinel.

Nevertheless, roughly a dozen proton therapy centers have been proposed throughout the country, including northern Illinois," the paper reported. "Central DuPage Hospital in Winfield, Ill., about 100 miles from Milwaukee, is seeking state approval to build a center at a projected cost of \$140 million. And more centers are likely to be announced in the coming year."

ProCure Treatment Centers, a privately held company founded in 2005 by a particle therapy physicist, plans to partner with hospitals and doctors throughout the country to build proton therapy centers. Tommy Thompson, the former governor of Wisconsin and former secretary of the U.S. Department of Health and Human Services, is a director of the company.

The pending boom was set off in part when Medicare and commercial health plans began paying for the treatment. Reimbursement for proton therapy is 30 percent to 50 percent higher than for current treatments.

ProCURE believes that the big market will be in treating prostate cancer. But so far, no clinical studies have been done that prove proton therapy is more effective than existing and less costly treatments. Yet hospitals are installing the equipment as if this were a done deal.

"There isn't any question that it is technology that should be explored," David Vanness, a health care economist and professor at the University of Wisconsin-Madison told the Milwaukee Sentinel. "But there isn't any evidence yet it performs better for common cases."

What is clear is the cost of the equipment—and the treatment. The particle accelerator, which fills a building as big as two football fields, requires major construction just to be installed. At Massachusetts General Hospital, 110-ton, three-story-high cranes reach up from the contraption and aim the radiation at patients lying on robotic beds. Each treatment then costs \$50,000. According to a recent report in Congressional Quarterly Weekly, Medicare reimbursements to hospitals for this service have soared by a factor of 50 in the past four years, from \$208,000 in 2004 to \$10.5 million in 2007.

"If the technology is not much better than what you have, is that a wise use of resources?" asks Vanness, whose research includes assessing new technologies....

But hospitals are eager to invest in big-ticket items that promise lucrative returns. Indeed, as Paul Ginsburg observed recently in Health Affairs: "Interviews with hospital executives suggest that the profitability of the services is the key to developing a service line, with cardiac procedures often topping the list. As one hospital chief executive officer (CEO) told me in response to a question about capital spending priorities: 'We just list the specialty lines by profitability and go down the list.' ...

In other words, decisions about what to build, and where to build, are driven not by a community's needs, but by a hospital's desire to compete for the most affluent patients seeking the most profitable services (whether or not those patients actually need those services.)

In February, CQ Weekly confirmed what both Reinhardt and Ginsburg are saying: "Experts are increasingly adopting the view that the biggest cause of rising costs is not the aging population, which has so often been blamed in the past, but the insatiable appetite doctors and their patients have developed for the latest devices and medicines: high-tech equipment such as particle accelerators, magnetic resonance imaging (MRI) and positron emission tomography (PET) machines, artificial joints, specialized stents, and the ever-expanding array of pharmaceuticals for treating hypertension, heart failure, HIV, depression and other chronic illnesses.

“The director of the Congressional Budget Office, Peter R. Orszag, is among the most influential people in Washington holding this opinion,” the report continued. “There’s been an overemphasis on aging and demographics,” says Orzag. “In his estimate, overuse of health care and technology is the main driver of medical inflation.”<sup>62</sup>

Perhaps not coincidentally, the hospital where I work was recently certified as a Cardiac Center of Excellence.

These trends are reinforced by the perverse incentives to waste capital and skimp on labor presented by conventional management accounting rules, which we considered above. Hospital competition in “quality” and “service” is largely in terms of the availability of the most costly, capital-intensive services to the high-end market—not in terms of staffing ratios:

In 2006, the Washington Post described what sounded like a very nice resort: “Walk past the free valet parking, past the woman at the front door welcoming visitors with an attentive smile and into the light-filled lobby, where soothing tunes waft from a baby grand piano and macchiatos are brewed at the coffee bar.

“Only the patients in wheelchairs give away that this is a hospital.

“All five of Montgomery’s community hospitals are in various stages of expansion,” the Post noted. “As they increasingly compete with each other . . . flat-screen televisions and CD players are standard in many rooms at Montgomery General in Olney.

“‘We want [patients] to leave here and then brag about it,’ John Fitzgerald, president of Inova Fair Oaks told the Post. ‘There’s a competitive nature to health care, and we want to be first. And part of that is the service.’”

(It’s interesting that they don’t mention patients bragging about staffing ratios or how frequently they were bathed.) The article continued:

“This trend has its critics,” the Post noted, “including industry consultants who caution hospitals to remember that their primary mission is to treat patients . . . Some hospital administrators, too, are leery of overspending on frills. Brian A. Gagnolati, president of Suburban Hospital in Bethesda, says: ‘I would rather put money into nursing care and staffing and making sure our doctors are there. At the end of the day, it’s about taking care of patients.’”

HealthBeat reader Lisa Lindell, the author of 108 Days, the story of her husband’s struggle to survive an accident which left him severely burned agrees: “When you’re at your darkest hour, ‘good service’ is no longer defined by valet parking, posh suites, waterfalls and gleaming marble. What you care about is staffing ratios.” There is “no legislative mandate with regard to nurse/patient ratios” in U.S. hospitals, Lindell notes.

As it happens, Lindell works as an accountant in the construction industry, and so, in a comment on HealthBeat, she offers an insider’s look at constructions costs: “I live in a city with a major health care industry, quite possibly the largest in the country. It’s nothing short of obscene the amounts of money pouring into the ‘Hospital Building Boom.’ There’s nothing wrong with growth and meeting the needs of the community, and I note how all the press releases boasting of these state-of-the-art works of art always make some reference to ‘serving the community.’”

“But nobody in my community cried out for a 90 million dollar vascular institute. Nobody in my community displayed a desperate need for custom imported marble. I made a comment to a co-worker of mine with regard to part of one large-scale project. I said: ‘You know, you and I are paying for this.’ He

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62 Mahar, “Health Care Spending.”

said: ‘Oh, this isn't even any part of the patient areas, this is the faculty room.’”

Lindell is right: much of the spending on amenities has nothing to do with promoting healing. And the costs are passed on to you and me in the form of higher insurance premiums and higher Medicare co-payments.<sup>63</sup>

Not to mention in the form of \$300 bags of saline solution.

According to a report from the Center for Studying Health System Change (HSC), “High and Rising Health Care Costs: Demystifying Health Care Spending,”

“too many small facilities” that invest in bleeding edge technologies run “well below capacity.”

The problem is this: rather than collaborating to share new technology, hospitals and outpatient centers all invest in the same equipment as they vie for well-insured patients. As a result, “costs in outpatient settings are higher” than they need be, and higher than in many hospitals “because of subscale operation of facilities.”<sup>64</sup>

All this is possible only in an atmosphere of little or no real cost competition between hospitals, in which overhead costs from idle capacity can be passed on to patients as a markup. The tendency toward consolidation in local hospital markets has been strongly associated with rising costs. As long ago as 1988, a study by Daniel Sherman found that “[c]osts for for-profit and government hospitals appear to be higher when these hospitals are either owned, leased, or managed as part of a hospital system.”<sup>65</sup> Event studies—i.e., empirical case studies before and after mergers, to determine the effect of consolidation on price—find 40% price increases are common following consolidation of hospitals in a single local market.<sup>66</sup>

And of course the debt burden from consolidation is another example of a phenomenon we considered earlier: the inflation of hospital costs by overhead from irrational capital expenditures. For example, the previous corporate parent of the hospital where I work, Triad, was bought out by CHS. The total debt incurred in the takeover was roughly two years' revenue for CHS. That kind of debt takes a lot of \$300 bags of saline solution to pay off.

Government acts in all sorts of ways to increase overhead and capitalization cost, and thereby to promote the concentration of hospital service among a handful of large providers in each market.

One important way is through the paperwork burden it imposes, which gives hospital administrations no choice over a major part of their administrative overhead. Enormous billing and medical records departments must exist in order to satisfy the documentation requirements of the state, private insurance companies, and government insurance programs like Medicare and Medicaid.

Government regulations also contribute directly to—indeed in some cases explicitly require—the

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63 Mahar, “Health Care Spending: The Basics; How Much Do We Spend on Hospitals? Part II,” *Health Beat*, April 28, 2008 <<http://www.healthbeatblog.com/2008/04/health-care-s-1.html>>.

64 Quoted in Mahar, “The Truth about Spiraling Health Care Prices in the U.S.: Medical Technology, Low Productivity and Paying More for Everything (Part 1,” *Health Beat*, October 21, 2008 <<http://www.healthbeatblog.org/2008/10/the-truth-about.html>>.

65 Daniel Sherman, “The Effect of State Certificate of Need Laws on Hospital Costs: An Economic Policy Analysis” Staff Report of the Bureau of Economics (Federal Trade Commission: January 1988), pp. Vi-vii.

66 Claudia H. Williams, William B. Vogt, Ph.D., and Robert Town, “How has hospital consolidation affected the price and quality of hospital care?” The Synthesis Project, Robert Wood Johnson Foundation, Policy Brief No. 9 | (February 2006).



kind of Dilbertesque culture Paul Goodman mocked in *People or Personnel*. It does it through its own mandates, imposing specific management fads on hospitals. According to documents I read in my employer's "quality improvement" handbook, Arkansas state law specifically requires every department in a hospital to have a "process improvement" committee. And despite the assortment of flavors of the week in that handbook—which amounts to a geological cross-section of every fossilized management theory fad from the '90s, including TQM and Six Sigma—from what I've seen the hospital administration doesn't have the slightest clue what Deming or other Quality thinkers are about. I've seen endless bulletin boards full of slogans and graphs parroting Quality jargon (including "Plan Do Check Act"), coupled—on the very same board—with behavioral approaches to minimizing variations that amount to what Drucker called "management by drives" and Deming called "slogans, exhortations and revival meetings." In short, the pointy-haired bosses parrot Deming the same way Soviet Party hacks parroted Lenin.

Government does the same thing indirectly, though quasi-independent bodies and processes like JCAHO whose certification is for all intents and purposes a mandatory condition for continuing to operate (JCAHO certification is a requirement for hospital licensing and Medicaid reimbursement in a most states<sup>67</sup>). JCAHO certification, as I have witnessed it in my workplace, involves among other things asking employees if they can regurgitate the company's mission statement, or regurgitate management happy talk about the policies in place to address quality problems (even when such policies reflect a total disconnect from the situation and a cultural atmosphere of CYA and plausible deniability). Seriously—every time JCAHO comes around, hospital management coaches us to memorize the mission statement in case they ask us; but I've never once heard, in all my years of working in healthcare, of JCAHO asking about hospital staffing ratios or whether nurses can provide adequate patient care without staying over three hours every night to catch up on their paperwork. ISO-9000 certification requirements, similarly, include often completely idiotic forms of documentation.

The problem is that such regulations *presuppose* a large bureaucratic hierarchy in which the people at the top of the pyramid are divorced from direct experience of the work process. Given this assumption, it stands to reason that senior management must rely on arbitrary metrics to make the production process "legible" to them, and rely on Weberian work rules and "best practices" to ensure quality in a process of which they have no direct knowledge. It presupposes the separation of management from production, the stovepiping of functions, and the lack of direct quality feedback from the work process itself—an environment in which quality feedback and the aggregation of knowledge between departments can only be achieved by reducing the knowledge of one department to paper for transmission to other departments. In short, it presupposes a particular bureaucratic form of organization, and then imposes paperwork burdens that can only be met with the resources of large bureaucratic organizations.

State hospital licensing requirements, and in particularly the "certificate of need" requirement, interact in complex ways with the above-mentioned centralizing tendencies. The ostensible purpose of certificates of need is to prevent excess bed capacity in any market from driving up costs. It's also to prevent "destructive competition" that might reduce profits for the owners of existing beds.

Methodist has proposed a 100-bed, four-story patient tower on a 20-acre site along U.S. Highway 78.

The Board of Health issues certificates of need to control costs, avoid duplication of services and protect existing health care providers from competition. The board also considers new medical projects based partly

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67 "Joint Commission," Wikipedia <[http://en.wikipedia.org/wiki/Joint\\_Commission](http://en.wikipedia.org/wiki/Joint_Commission)>.

on how much they are needed within a region.

Alliance HealthCare System and Baptist Memorial Health Care, two area hospital groups, have opposed Methodist's application.

The Board of Health also is considering allowing counties with more than 140,000 people and projected population growth of at least 10 percent during the next 10 years to immediately qualify for an additional hospital.<sup>68</sup>

The explicit objective of protecting existing providers from competition, by the way, is indicative of the theoretical incoherence of mainstream liberalism. The people who draft regulatory legislation with the express purpose of preventing the evils of "destructive competition" or "cutthroat comeption," by and large, are the very same people who complain of the evils of monopoly.

Nevertheless, *given* the preexisting tendencies toward concentration and cartelization of local healthcare markets, and given the failure of management accounting metrics to restrain wasteful capital expenditures, it may be that the certificate of need requirement serves a useful function—i.e., limiting the ability of a handful of large hospitals to overbuild and then collusively pass on the overhead from vacant rooms as a markup to their patients.<sup>69</sup> Market incentives are no doubt lacking, under present circumstances, to avoid wasteful capital expenditures and the construction of superfluous new capacity. Under present conditions, certificates of need may serve to ameliorate conditions created by the state in the first place.

But in a free market, "certificates of need" would be moot, at best duplicating the preexisting incentives of the market. The natural tendency, in a genuinely free market with vigorous cost competition, is toward conservatism in capital investments. It is only corporatist institutions, that can either count on a guarantee of sufficient demand to fully utilize their capacity or pass the overhead costs on as a markup to their customers, that carelessly sink money into new facilities without a high degree of confidence in market demand. In a local healthcare market with genuine cost competition among a large number of small hospitals and clinics, a small hospital would be restrained by realistic estimates of how many beds it could fill, and by the fear of being driven out of business by higher overhead costs than its competitors if it overestimated the need. In the case of small cooperative hospitals and clinics, the size of the membership would be a natural constraint on the number of beds.

And it's still by no means certain that the primary effect of certificates of need really *is* to reduce overhead cost. It may well be that the certificate of need, even given other incentives toward concentration and reduced competition, itself exacerbates the lack of competition. Indeed Daniel Sherman found, in a 1988 study, a correlation between the stringency of CON regulations and hospital costs. Stronger CON requirements correlated with increased costs.<sup>70</sup> Another 1991 study found CONs increased hospital spending by 20%.<sup>71</sup>

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68 Associated Press (Olive Branch). "Miss. board considers hospital licensing changes" *The Picayune Item*, January 20, 2009 <[http://picayuneitem.com/statenews/local\\_story\\_020185314.html](http://picayuneitem.com/statenews/local_story_020185314.html)> (link dead; recovered via Internet Archive).

69 Indeed, Daniel Sherman argues, CON regulations are predicated on the lack of price competition and cost control incentives among hospitals, and their tendency toward overinvestment and competition mainly in terms of adding services (especially competition in adding high-cost specialties). Sherman, "The Effect of State Certificate of Need Laws on Hospital Costs," p. 11.

70 *Ibid.*, pp. 7, 78.

71 J. Lanning, M.E. Morrisey, and R.L. Ohsfelt, "Endogenous hospital regulations and its effects on hospital and non-hospital expenditures," *Journal of Regulatory Economics*, 1991: (3)2, cited in Patrick A. Rivers, Myron D. Fottler, and Mustafa Zeedan, "Does certificate of need really contain hospital costs in the United States?" *Health Education Journal* 66:3 (2007), p. 231.

Depending on the sort of gamesmanship between hospitals that exists between large incumbent hospitals in a particular market, mutual forbearance in challenging CON applications by existing hospitals seeking to expand their capacity, coupled with incumbent hospital challenges to CON applications for proposed new hospitals, might plausibly increase the tendency toward concentration of hospital beds among a handful of providers. Although I've found no specific reference to collusion between incumbents to approve each other's expansions while shutting out new entrants, in general terms incumbents have indeed collusively exploited CON regulations as entry barriers to enforce cartel arrangements between themselves:

We have found that existing competitors, at times with the encouragement or acquiescence of state officials, go further and enter into agreements not required by the CON laws but nonetheless facilitated by them. Two examples arise from West Virginia, and a third comes from Vermont.

In the first West Virginia case, we found that a Charleston, West Virginia hospital used the threat of objection during the CON process, and the potential ensuing delay and cost, to induce a hospital seeking a certificate of need for an open heart surgery program not to apply for it at the location that would have well served Charleston consumers and provided greater competition for their business. Instead, the Charleston hospital successfully prevented the possibility of this competing open heart program. The state authorities never had the opportunity to decide whether under the CON laws that second program would have been approved because of the unlawful agreement among the hospitals.

In the second West Virginia case, two closely competing hospitals decided to allocate healthcare services between themselves. The informal urging of state CON officials led them to agree unlawfully that only the one hospital would apply for an open heart program and only the other would apply to provide cancer services. Again, the state took no official action and consumers were deprived of the potential competition between these hospitals.

A third example comes from the State of Vermont. There, home health agencies entered into territorial market allocations, again under cover of the state regulatory program, to give each other exclusive geographic markets. That state's CON laws prevented competitive entry, which normally might have disciplined such cartel behavior. We found that Vermont consumers were paying higher prices than were consumers in states where home health agencies competed against each other.<sup>72</sup>

And from what I've seen, it's fairly common for large hospitals to have high vacancy levels most of the time. My employer, a roughly 170-bed for-profit hospital serving a metropolitan area of several hundred thousand in Northwest Arkansas (along with two other large nonprofit regional hospitals and a VA hospital), typically has a patient census ranging from 80 to 110. If this is common, it seems likely that hospital licensure, ostensibly aimed at preventing an excess of beds, results instead in the concentration of excess beds among a few providers. The number of beds the state considers legitimate for a market, instead of being divided between thirty hospitals of twenty beds each, is divided between three hospitals of two hundred each. In that case, the effect is not so much to reduce excess supply of beds, as to divide up the excess beds among a smaller number of hospitals in a cartelized market that are able to pass the overhead cost on to patient without any real price competition.

The total effect of all these forces is the near-total absence of cost competition between hospitals. Competition between the large hospitals in a market is limited to imagery and atmosphere (local

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<sup>72</sup> Joseph M. Miller, Assistant Chief, Litigation I Section, U.S. Department of Justice Antitrust Division, "Comments on Competition in Healthcare and Certificates of Need." Statement of the Antitrust Division, US Department of Justice Before the Florida Senate Committee on Health and Human Services Appropriations. March 25, 2008 <<http://www.justice.gov/atr/public/comments/233821.htm>>.

television viewers are exposed to endless commercials with soft lighting, elevator music and beaming nurses and patients), and competition for high-end niche markets. Meanwhile, all the hospitals in the market mark up their bags of saline 10,000%.

**Licensing cartels.** Professional licensing regimes, in practical effect, are cartels, outlawing competition between multiple tiers of service based on the consumer's preference and resources. The licensing cartels outlaw one of the most potent weapons against monopoly: product substitution. Much of what an MD does doesn't actually require an MD's level of training. But to get any kind of treatment, no matter how simple and straightforward, you cannot simply pay a price that reflects the amortization cost of the level of training it actually requires to perform the service you need. You must pay the amortization cost of an entire medical school curriculum and residency.

Take, for example, restrictions on independent practice by mid-level clinicians. Twenty-seven out of fifty states in the U.S. do not allow independent practice by advanced practice nurses and physicians' assistants without a doctor's "oversight or collaboration," although most allow nurse practitioners to write prescriptions.<sup>73</sup> In fact, the MD's "supervision," more likely than not, will consist of sanctifying the clinic with his presence somewhere in the building for part of the day (and adding the cost of his medical education and living expenses to the clinic's overhead cost) as the nurse practitioner single-handedly examines and evaluates the patient and prescribes treatment. State medical and dental associations fight, tooth and nail, state legislation to expand the range of services that can be performed independently by mid-level clinicians. A good example is the proposal to allow dental hygienists to clean teeth in independent practices: the dental associations are death on the subject. The mid-level clinicians themselves are equally venal, however, seeking state legislatively mandated education requirements for licensing that have little to do with performing their primary services. Mid-level clinicians associations, in many states, attempt to mandate masters degree or doctorate as a prerequisite for practicing.

For example, states increasingly require new NPs to obtain a master's degree. All states require physical therapists to have a master's degree. The American Association of Colleges of Nursing wants states to require a Doctor of Nursing Practice degree of all new advance practice nurses by 2015. A new law requires physician assistants to have a masters or higher degree to practice in Ohio. Every state has required a master's degree of occupational therapists since 2007.

Starting in 2012, California will require new audiologists to have obtained a doctorate (Au.D.), raising concerns that the legislation would exacerbate a shortage of audiologists. The legislation followed a move by the American Speech-Language-Hearing Association, the organization that accredits college audiology programs, to require a doctorate for professional certification. Questioning both why California legislators rushed to comply and whether even a master's degree is necessary to test someone's hearing, the Sacramento Bee called the requirement for a doctorate an "extraordinary and costly mandate."<sup>74</sup>

From a "lean" standpoint, the amortization cost for levels of training that are unnecessary to provide the care you need are *muda*. As in other areas of economic life, a majority of overhead costs result from the load-bearing infrastructure required to handle the last five percent of demand.

Part of the problem is the pecuniary interest of the professional education establishment. Nursing schools, for example, are set up on the same principle as the shadier sellers of vacation property, in

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<sup>73</sup> Shirley Svorny, "Medical Licensing: An Obstacle to Affordable, Quality Care," Cato Policy Analysis No. 621, p. 3. <<http://www.cato.org/pubs/pas/pa-621.pdf>>.

<sup>74</sup> Ibid., pp. 4-5.

which the buyer loses all his equity on default: a nursing student who drops out loses all his credits after a semester.

At any rate, all this licensing is of little avail. Licensing boards are frequently quite negligent in disciplining members of their professions.

A study of Florida physicians with malpractice payouts over \$1 million found that only 16 percent had been sanctioned by the state medical board. Among physicians who made 10 or more malpractice payments between 1990 and 2005, only *one-third* were disciplined by their state boards.

Further complicating the disciplinary process, state boards are reluctant to pull a license or make public the results of an investigation due to the financial consequences for the sanctioned professional. Just issuing formal charges against a physician, which become public record, affect a doctor's reputation and potential income.

As a result of these forces, formal disciplinary actions typically do not focus on improper or negligent care. Instead, the bulk of disciplinary actions involve inappropriate prescription of controlled substances, drug and alcohol abuse, mental illness, sexual improprieties and other issues....

The licensing system also comes up short in the area of reporting substandard care to the public. There are often long delays. California reports an average of 934 days in getting a case to judicial review. To avoid the high costs of lengthy hearings, boards routinely negotiate voluntary settlements for lesser offenses. In the Federation of State Medical Boards' database, the nature of the investigation is not recorded in more than 65 percent of cases that ended in sanctions between 1994 and 2002. In those cases, the state board and the physician entered an agreement without the physician being found guilty. These dynamics deny consumers information that would help them avoid low-quality physicians....

A closer look suggests that most patient protections are unrelated to state licensing. Concern over reputation and potential liability for medical malpractice creates incentives for private efforts to assess clinician knowledge, skills and competence that well exceed those associated with state licensing. Indeed, health care providers regularly review information on their clinicians that is broader and more up-to-date than information associated with licensure. At the point of care, hospitals and other institutions dictate what services each individual clinician may provide. On top of that, the structure of medical malpractice liability insurance rates creates some incentives for providers to avoid medical errors and other negligent care.<sup>75</sup>

Healthcare facilities must be licensed in many areas as well, as we saw above. Thirty-five states require a "certificate of need" before a new hospital can be built in an area—and as you might expect, existing providers have some of the loudest voices in the approval process.<sup>76</sup> The same is true of nursing homes, an industry in which new facilities cannot be built unless the government recognizes a sufficient unmet need—and an industry, perhaps not coincidentally, in which there are waiting lists and patients are frequently turned away.

In my town of Springdale, Arkansas a couple of years ago, the state closed down an unlicensed adult daycare facility (Reflections Memory Care)—a small operation run out of the home of its owner, Judith Hollows. It cared for only a couple of elders a day, at a modest price, and their family members described it as a "godsend." As you might expect, the state acted on the complaint of a nursing home administrator:

Deanna Shackelford, administrator of the Springdale Health and Rehabilitation Center, complained to

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<sup>75</sup> Ibid., pp. 7-8.

<sup>76</sup> Cannon and Tanner, *Healthy Competition*, p. 137.

city code enforcement that Hollows was operating without a permit.<sup>77</sup>

Although Hollows' facilities did not fall afoul of Office of Long Term Care regulations, her number of clients not exceeding three, Shackelford was able to appeal to the city's zoning ordinances. One of her neighbors, John Massey, explained: "It could potentially impact the value of the property."

Perhaps not coincidentally, one of Hollows' clients was formerly a resident of that same Springdale Health and Rehabilitation Center, under the direction of that same Deana Shackelford:

"Daddy has improved so much under Judith's care," Ervin said. This is the first time he's felt safe and secure in seven months."

Since Aug. 28, when he moved in with Hollows, Ward has regained 12 1/2 of the 40 pounds he lost at Springdale Health and Rehabilitation, Ervin said. His wheelchair is now in a closet. He is also drinking fruit juice and not a powdered concentrate.

This was yet another example of provision of goods in the informal household sector, with little or no overhead costs and little risk of going out of business, because of the fact that it operated mainly on the spare capacity of capital goods that the operator would have had to own for her own subsistence in any case. One of the central functions of licensing and regulation is to criminalize such self-organized production, using the spare capacity of ordinary household capital, in order to render us dependent on the services of "professionals" purchased with the proceeds of wage labor.

**Drug patents.** Drug patents create a pressure toward the use of new, patented drugs and the crowding out of older, generic drugs. Most drug company R&D is geared toward the production of "me, too" drugs, which involve only a minor tweaking of the same basic chemical formula as an existing drug, with at best marginal improvements. But these new drugs have the advantage of being patentable, so that they can replace what are essentially older versions of the same drugs whose patents are about to expire. The next step is for drug company reps to propagandize the delivery of service side of things. This is facilitated by the fact that most medical research is carried out in prestigious med schools, clinics and research hospitals whose boards of directors are also senior managers or directors of drug companies. And the average GP's knowledge of new drugs, after he gets out of med school, comes from drug company literature handed out by the Pfizer or Merck rep who drops by now and then. Drug companies can also pressure doctors indirectly through their influence on the medical associations' standards of practice, or even legislative mandates (see Gardasil). Any doctor who departs too far from the standard "drug 'em and cut 'em" model of practice (for example, using nutritional supplements—like Co-Enzyme Q-10 for congestive heart failure—as a primary treatment) had better remember the state licensing board has its eye on him.

Defenders of drug patents point to the need for recouping the high cost of research and development. But around half of all R&D expenditures for drugs are funded by tax money, and in some cases the most lucrative cash-cow drugs were developed entirely at government expense and the patents subsequently given away to private drug companies.<sup>78</sup>

And in fact, even when corporations pay their own R&D costs, most of those costs actually result

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<sup>77</sup> Richard Massey, "Springdale: Caregiver of Senile Fights City Hall," *Arkansas Democrat-Gazette* (Northwest Arkansas edition), December 2, 2007 <<http://www.nwanews.com/adg/News/209363/>>.

<sup>78</sup> Chris Lewis, "Public Assets, Private Profits," *Multinational Monitor*, cited in *Project Censored Yearbook 1994* (New York: Seven Stories Press, 1994).

from gaming the patent system to secure patent lockdown on as many possible variants of a drug as possible. “Quasibill,” a frequent commenter on my blog with personal experience in the drug industry, describes how it works:

In the rare instances that big pharma produces and markets [cancer] medicines, it has purchased them from small start-ups that themselves are the result normally of a university laboratory's work. When big pharma cites to billions of research costs, what it is talking about is the process whereby they literally test millions of very closely related compounds to find out if they have a solid therapeutic window. This type of research is directly related to the patent system, as changing one functional group can get you around most patents, eventually. So you like to bulk up your catalogue and patent all closely related compounds, while choosing only the best among them, or, if you're second to market, one that hasn't yet been patented.

This work is incredibly data intensive, and requires many Ph.D's, assistants, and high powered computers and testing equipment to achieve. But it is hardly necessary in the absence of a patent regime. In the absence of patents, (and of course the FDA), you could just focus on finding a sufficient therapeutic window, and cut out the remaining tests. It would be an issue of marginal costs to determine whether someone would go to the effort to find a "better" therapeutic window, or related parameter.<sup>79</sup>

As you might suspect, the recently passed healthcare bill does nothing to scale back drug patents. But beyond that, it does none of the things Obama promised to do in the 2008 election campaign, like allow drug reimportation or negotiating bulk prices on drugs. In fact, he negotiated a deal by which the drug industry would reduce their costs by a grand total of \$80 billion over ten years (which amounts to 2% of total revenues) in return for his promise not to include drug reimportation or Medicare bulk price negotiations in the healthcare bill.<sup>80</sup> Perhaps not coincidentally, Big Pharma funded a \$6 million advertising campaign to promote the healthcare bill.<sup>81</sup>

**Hardware cartels.** The costs of medical technology account for anywhere from half to two-thirds of annual increases in healthcare spending.<sup>82</sup> But that doesn't mean that “better care costs more,” in the simplistic formula of industry apologists. Aside from the perverse institutional incentives which we considered above to make *unnecessary use* of the most expensive technology, even when the benefits don't justify it, the cost of the technology itself results from artificial scarcities like patents. Technological innovation normally *reduces* the cost to perform a given function. It is only artificial property rights, which prevent market competition from passing on cost savings from increased efficiency to the consumer and enable the privileged owner of a monopoly to capitalize efficiency improvements as a source of rents, that increase costs. So the alternative to the present system is not to slow down the pace of technological advance and choose a lower-tech medical model. The alternative is to allow free market competition to distribute the advantages of increased efficiency and lower cost to the consumer, rather than to a class of state-privileged monopolists; this will, at the same time, reduce the perverse incentives to overuse such technologies when their use is artificially lucrative.

Thanks to patents, economist Dean Barker argued in an interview with *Nieman Watchdog*, medical equipment costs several thousand percent above its actual production cost.

79 Comment under Kevin Carson, “Intellectual Property Stifles Competition,” *Mutualist Blog: Free Market Anti-Capitalism*, May 21, 2006 <<http://mutualist.blogspot.com/2006/05/intellectual-property-stifles.html>>.

80 Ryan Grim, “Internal Memo Confirms Big Government Giveaways in White House Deal With Big Pharma,” *Huffington Post*, August 13, 2009 <[http://www.huffingtonpost.com/2009/08/13/internal-memo-confirms-bi\\_n\\_258285.html](http://www.huffingtonpost.com/2009/08/13/internal-memo-confirms-bi_n_258285.html)>.

81 Chris Frates, “PhRMA plans \$6 million pro-reform ad buy in 38 House districts,” *Politico.Com*, March 17, 2010 <[http://www.politico.com/livepulse/0310/PhRMA\\_plans\\_6\\_million\\_proreform\\_ad\\_buy\\_in\\_38\\_House\\_districts\\_\\_Kucinich\\_announcing\\_vote\\_decision\\_at\\_1.html](http://www.politico.com/livepulse/0310/PhRMA_plans_6_million_proreform_ad_buy_in_38_House_districts__Kucinich_announcing_vote_decision_at_1.html)>

82 “Health Care Costs: A Primer”; Katherine Hobson, “Cost of Medicine.”

Take for example the stent, which is a wire metal mesh tube used during the majority of coronary angioplasty procedures to prop open an artery, thereby increasing blood flow to the heart muscle and relieving chest pains. Typically, as Baker noted to us, these devices are billed to the patient at \$1,500 to \$2,000 each – “yet the actual cost of manufacturing one of these is more in the ballpark of \$15.”<sup>83</sup>

The cost savings that could be achieved through open-source, reverse-engineered versions of expensive proprietary technology like the CT scan machines are suggested by the work of hardware hackers in micromanufacturing machinery, who can frequently make homebrew versions of CNC tools like 3-axis milling machines and cutting tables with a Factor Twenty cost reduction.

**Conclusion.** The cumulative effect of all these policies is what Ivan Illich called “radical monopoly.”

Radical monopoly exists where a major tool rules out natural competence. Radical monopoly imposes compulsory consumption and thereby restricts personal autonomy. It constitutes a special kind of social control because it is enforced by means of the imposed consumption of a standard product that only large institutions can provide.<sup>84</sup>

Radical monopoly is first established by a rearrangement of society for the benefit of those who have access to the larger quanta; then it is enforced by compelling all to consume the minimum quantum in which the output is currently produced....<sup>85</sup>

This quote from Marilyn Frye, in "Oppression," is a good statement of how radical monopoly feels from the inside:

The experience of oppressed people is that the living of one's life is confined and shaped by forces and barriers which are not accidental or occasional and hence avoidable, but are systematically related to each other in such a way as to catch one between and among them and restrict or penalize motion in any direction.<sup>86</sup>

In addition, the goods supplied by a radical monopoly can only be obtained at comparably high expense, requiring the sale of wage labor to pay for them, rather than direct use of one's own labor to supply one's own needs.

The state-sponsored crowding-out makes other, cheaper (and often more appropriate) forms of treatment less usable, and renders cheaper (but adequate) treatments artificially scarce. Centralized, high-tech, and skill-intensive ways of doing things make it harder for ordinary people to translate their own skills and knowledge into use-value.

Subsidized fuel, freeways, and automobiles mean that "[a] city built around wheels becomes inappropriate for feet."<sup>87</sup> A subsidized and state-established educational bureaucracy leads to "the

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83 John Hanrahan, “Patent system adds hundreds of billions every year to health care costs,” *Nieman Watchdog*, October 13, 2009 <<http://www.niemanwatchdog.org/index.cfm?fuseaction=Background.view&backgroundid=402>>.

84 Ivan Illich, *Tools for Conviviality* (New York, Evanston, San Francisco, London: Harper & Row, 1973), pp. 52-53.

85 Illich, *Energy and Equity* (1973), Chapter Six (online edition courtesy of Ira Woodhead and Frank Keller) <[http://www.cogsci.ed.ac.uk/~ira/illich/texts/energy\\_and\\_equity/energy\\_and\\_equity.html](http://www.cogsci.ed.ac.uk/~ira/illich/texts/energy_and_equity/energy_and_equity.html)>.

86 Quoted in Charles Johnson, "Scratching By."

87 Illich, *Disabling Professions* (New York and London: Marion Boyars, 1977), p. 28.



universal schoolhouse, hospital ward, or prison."<sup>88</sup>

In healthcare, subsidies to the most costly and high-tech forms of medicine crowd out cheaper and decentralized alternatives, so that cheaper forms of treatment—even when perfectly adequate from the consumer's standpoint—become less and less available.

There are powerful institutional pressures for ever more radical monopoly. At the commanding heights of the centralized state and centralized corporate economy--so interlocked as to be barely distinguishable--problems are analyzed and solutions prescribed from the perspective of those who benefit from radical monopoly. So we see elites calling for "more of the same" as a cure for the existing problems of technology.

It has become fashionable to say that where science and technology have created problems, it is only more scientific understanding and better technology that can carry us past them. The cure for bad management is more management.

Illich described it as an "attempt to solve a crisis by escalation."<sup>89</sup> It's what Einstein referred to as trying to solve problems "at the same level of thinking we were at when we created them." Or as E. F. Schumacher says of intellectuals, technocrats "always tend to try and cure a disease by intensifying its causes."<sup>90</sup> More recently, Butler Shaffer put it this way:

In our carefully nourished innocence, we believe that institutions exist for the purposes they have taught us, namely, to provide us with goods and services, protection, security, and order. But in fact, institutions exist for no other purpose than their self-perpetuation, an objective requiring a continuing demand for their services.... If institutions are to sustain themselves and grow, they require an escalation of the problems that will cause us to turn to them for solutions.<sup>91</sup>

Radical monopoly also tends to perpetuate itself because large organizations select for new technologies adapted to their own needs and amenable to control by large organizations. "The left hand of society seems to wither, not because technology is less capable of increasing the range of human action..., but because such use of technology does not increase the power of an elite which administers it."<sup>92</sup> As Kirkpatrick Sale put it:

Political and economic systems select out of the range of current technology those artifacts that will best satisfy their particular needs, with very little regard to whether those artifacts are the most efficient or sophisticated in terms of pure technology.... The particular technological variation that becomes developed is always the one that goes to support the various keepers of power. Hence in an age of high authoritarianism and bureaucratic control in both governmental and corporate realms, the technology tends to reinforce those characteristics—ours is not an age of the assembly line and the nuclear plant by accident. Nonetheless, it must be recognized that there are always many other technological variations of roughly equal sophistication that are created but not developed, that lie ignored at the patent office or unfinished in the backyard because there are no special reasons for the dominant system to pick them up....<sup>93</sup>

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88 Illich, *Tools for Conviviality*, p. xxiv.

89 Ibid., p. 9.

90 E. F. Schumacher, *Small is Beautiful: Economics as if People Mattered* (New York, Hagerstown, San Francisco, London: Harper & Row, Publishers, 1973), p. 38.

91 Butler Shaffer, *Calculated Chaos: Institutional Threats to Peace and Human Survival* (San Francisco: Alchemy Books, 1985), pp. 46-47.

92 Ivan Illich, *Deschooling Society* (New York, Evanston, San Francisco: Harper & Row), p. 62.

93 Kirkpatrick Sale, *Human Scale* (New York: Coward, McCann & Geoghegan, 1980), pp. 161-62.

The main effect of radical monopoly on the individual is an increased cost of subsistence, owing to the barriers that mandatory credentialing erects against transforming one's labor directly into use-value (Illich's "convivial" production), and the increasing tolls levied by the licensing cartels and other gatekeeper groups.

People have a native capacity for healing, consoling, moving, learning, building their houses, and burying their dead. Each of these capacities meets a need. The means for the satisfaction of these needs are abundant so long as they depend on what people can do for themselves, with only marginal dependence on commodities....

These basic satisfactions become scarce when the social environment is transformed in such a manner that basic needs can no longer be met by abundant competence. The establishment of a radical monopoly happens when people give up their native ability to do what they can do for themselves and each other, in exchange for something "better" that can be done for them only by a major tool. Radical monopoly reflects the industrial institutionalization of values.... It introduces new classes of scarcity and a new device to classify people according to the level of their consumption. This redefinition raises the unit cost of valuable services, differentially rations privileges, restricts access to resources, and makes people dependent.<sup>94</sup>

The overall process is characterized by

the replacement of general competence and satisfying subsistence activities by the use and consumption of commodities; the monopoly of wage-labor over all kinds of work; redefinition of needs in terms of goods and services mass-produced according to expert design; finally, the arrangement of the environment... [to] favor production and consumption while they degrade or paralyze use-value oriented activities that satisfy needs directly.<sup>95</sup>

Radical monopoly, as Illich pointed out, is associated with a general shift in cultural values by which the individual comes to see services as naturally the product of institutions:

Many students... intuitively know what the schools do for them. They school them to confuse process and substance. Once these become blurred, a new logic is assumed: the more treatment there is, the better are the results.... The pupil is thereby "schooled" to confuse teaching with learning, grade advancement with education, a diploma with competence, and fluency with the ability to say something new. His imagination is "schooled" to accept service in place of value.... Health, learning, dignity, independence, and creative endeavor are defined as little more than the performance of the institutions which claim to serve these ends, and their improvement is made to depend on allocating more resources to the management of hospitals, schools, and other agencies in question....

[Schools teach the student to] view doctoring oneself as irresponsible, learning on one's own as unreliable and community organization, when not paid for by those in authority, as a form of aggression or subversion.... [R]eliance on institutional treatment renders independent accomplishment suspect....<sup>96</sup>

### **Appendix: A Hypothetical Alternative**

So what kind of low-cost healthcare model would the free market offer in place of this insanity? I'm convinced the only way to fix it is to tear it down and start over.

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94 Illich, *Tools for Conviviality*, p. 54.

95 Illich, *Vernacular Values* (1980), "Part One: The Three Dimensions of Social Choice," online edition courtesy of The Preservation Institute <<http://www.preservenet.com/theory/Illich/Vernacular.html>>.

96 Illich, *Deschooling Society*, pp. 1-3.

It would mean, almost certainly, a shift to decentralized delivery of service and cooperative finance: small, neighborhood clinics and associated small hospitals as the main source of primary care, bypassing the insurance system altogether and operating on the same flat-fee membership basis as John Muney's clinics in New York and Qliance in Seattle.

This would have two primary benefits: first, because of the flat-rate fee, there would be no incentive to mutual logrolling between specialists, or padding the bill with a \$6000 CT scan; second, as Muney pointed out, it eliminates the 25% or so of costs that come from insurance paperwork.

In addition, it would mean an end run around the internal bureaucratic culture of the large hospital. The vast majority of our healthcare should come from clinics and hospitals that are too small to justify separate departments of nursing, housekeeping, dietetics, etc.—let alone departmental staffs and interdepartmental committees. It would render superfluous, in most cases, the entire Weberian organizational culture of prestige salaries, mission statements, Weberian "best practices," work rules, and job descriptions. It would mean, instead of interdepartmental "quality improvement committees," empowering those actually providing the care to act on what's right in front of them without interference from pointy-haired bosses.

A federation of neighborhood clinics, funded on Muney's contract practice model, might support a small hospital of ten beds serving a few thousand members (thus filling in most of the gaps in Muney's menu of services). As we saw above, many fraternal orders provided regional hospitals as a direct extension of contract practice. The entire hospital "administration" might consist of a single office manager, perhaps with a couple of office assistants, directly responsible for hiring a part-time dietitian, a janitor, and a few nurses and orderlies.

The most expensive, high-tech and specialized forms of care might be offered at regional hospitals (but with far fewer beds and less bureaucratic overhead, since most primary care has been shifted to neighborhood facilities). These hospitals might be funded through some joint arrangement of the cooperative clinics, or operate independently of them with funding mainly by cheap, high-deductible catastrophic care policies.

Ideally, even if independently funded by patients' catastrophic care insurance, these regional hospitals would be organized as community facilities on some sort of stakeholder cooperative basis (and not, like most existing "community non-profit" hospitals, run by the same Rotary Club yahoos who run everything else in the community). Their chosen business model, instead of investment in the most expensive and costly facilities to compete in the high-end markets, would be to offer the kinds of basic medical care needed by most people, efficiently and affordably, with a high quality of personal service. Such a hospital would brand itself as a place where the vast majority of people could go for most medical problems, and get their call lights answered in a timely fashion and get a bath every day, without the high rates of MRSA, falls, and med errors that result from understaffing. As the slogan on the Heinz ketchup bottle says, they would do an ordinary thing extraordinarily well.

But regardless of the internal culture of these large regional hospitals, any tendency toward creeping bureaucracy would be mitigated and contained by the fact that the vast majority of patients were hospitalized in the small, low-overhead facilities operated by the cooperatives and mutuals.

Whatever financial machinery existed for funding these hospitals, it would specify flat payments based on the condition (with some flexibility, of course, for unusual severity or other extenuating

circumstances); hence no incentives to maximize the number of procedures performed or to multiply the number of specialists taking a cut. “Defensive medicine” would be mitigated by some combination of reasonable caps on punitive damages, contractual waivers of expensive CYA testing under the terms of membership, or placing the burden on the patient to explicitly approve additional tests after being counseled on their costs and benefits; hence absent some clear warning sign to the contrary, Dr. Kling’s “empirical” treatment rather than “premium” treatment would be the norm.

Even in the larger regional hospitals, costs would be limited not only by flat-rate fees but by the removal of patents on drugs and machinery.

In a genuinely free market, licensing cartels would no longer be a source of increased costs or artificial scarcity rents. There would be far more freedom and flexibility in the range of professional services and training available. Some of the neighborhood cooperative clinics might prefer to keep a fully trained physician on joint retainer with other clinics, with primary care provided by a mid-level clinician.

Or imagine an American counterpart of the Chinese “barefoot doctor,” trained to set most fractures and deal with other common traumas, perform an array of basic tests, and treat most ordinary infectious diseases. He might be able listen to your symptoms and listen to your lungs, do a sputum culture, and give you a run of Zithro for your pneumonia, without having to refer you any further. And his training would also include identifying situations clearly beyond his competence that required the expertise of a nurse practitioner or physician.

Professional licensing systems would be voluntary, based on competing certification regimes in a free market. The guild which trained and certified a practitioner, an independent certification body (like the competing bodies which certify kosher foods), or a networked rating system like *Consumer Reports* or RateMyDoctor.com, might provide market signalling for would-be consumers.

The idea is not to reduce the skill level or technological sophistication of healthcare where it is necessary, but to stop forcing the patient to pay for it when it's *not* necessary.

The emergence of such institutional forms is likely to be influenced by other intersecting trends: growing levels of unemployment and underemployment, the decoupling of the social safety net from both wage employment and the fiscally exhausted state, and the resulting tendency of people to aggregate into household income-pooling arrangements.