The Popular Capitalist View: Economics of Medicine

By Carl Peter Klapper

There seem to be some persistent and wrong assumptions about policy issues that are used to frame positions and prescriptions such as mine, particularly in the currently volatile subject of medical or health care reform. So, in order to better the understanding and serious consideration of what I have presented here, I have decided to take a step back and place medicine and its reform in an economic context.

Medical care has not always been a market. Because of the pressure of history and long tradition, it is not exactly a real market even today. Doctors still make decisions contrary to cost-benefit analysis but consistent with the Hippocratic Oath. Hospitals still treat indigent patients, though the for-profit hospitals do so because of laws written in memory of the mission of their predecessors: municipal and charity hospitals. We even have federal government programs to pay for the medical expenses of the poor and elderly, not by giving them X dollars to spend in a market where the doctors and patients are bidding and offering, but by giving the doctors a more or less blank check. There was never such a market for healthcare, so there was not a basis and history of market pricing for public or private insurance to go on.

Instead, what has been used by insurers to dispute or challenge the medical fees has been the usual and customary rates (UCRs). This is fundamental to understanding the economics of medicine both with and without insurance. In insuring anything traded on an actual market, current prices and price history on that market for that commodity or service, or a near-substitute, would be used to appraise the value of a commodity insured or of the need for a service insured against and thus the payout for loss or need, respectively. UCRs are an admission that this is not the case in medicine and that something quite different applies, namely a rate schedule. Such a schedule is arbitrary in the particular, leading to fees which are in whole dollars divisible by 5, like $15 or $20 rather than $17.43. If he has too many of one kind of case to his liking and there is another doctor in town he can push some of those cases to, he can raise the rate for that service. At least, he could do that before the insurers took over. Now he has to remove the bunion and take the UCR, or refer all of the cases to a podiatrist. The UCR, however, is based on an a la carte view of medicine which misinterprets the rate schedule as particular charges for each service and thus considers the portion of the fee which incorporates general physician preferences or distastes as actual costs.

A more serious criticism of UCRs as a measure of cost pertains to the aspect of the rate schedule which is less arbitrary. The array of doctor's fees are, in the aggregate, more finely tuned to what the typical patient in his community can afford, than any particular fee to actual cost or even affordability. This is how doctors' fees in the larger towns would generally increase or decrease as a group for all doctors in the town. When the townsfolk are more prosperous, or inflation has set in, the fees for the typical patient

would go up. When the iron mill closes and half the town is out of work, the fees would go down. Sometimes there was a divide between the rich and the rest, so that affordability was worked out through a sliding scale. In that case, there is no one UCR schedule, even for a single community, but one for each wealth group. With their basis in affordability, the general level of the community rate schedules bore no relationship whatsoever to costs.

When insurance comes into the equation, the fees are not entirely paid directly by the patients, as they had been in the past. Instead, the insurer pays a portion of each fee and the patient pays the rest. Thus, the schedule of rates to the patient is a fraction of the schedule of rates to the insurer. Doctors know, then, that they can charge higher fees to the insurer without any change in the affordability to the patient. For example, if the patient pays 20% and the insurer pays 80%, the doctors can charge five times their pre-insurance fees without a change in the affordability of their rate schedule to the patient. This provides an inexorable opportunity which the insurer's adoption of a formalized process of determining a uniform UCR schedule can only delay but not prevent. The higher rates in wealthy urban and sprawl communities supplant the cheaper ones in rural and poor communities. Further, new procedures and new services can be introduced at already inflated rates as uncontested UCRs.

This, then, is how insurance causes an escalation of medical fees. Note that the nature of the insurer is immaterial. This happens with both private and public insurers. Among the private insurers, it happens with both non-profit and for-private companies. It is a logically inevitable, mechanical outcome to the imposition of insurance onto an affordability-based fee schedule. Thus, the high price of medicine under insurance is not caused by greed. In fact, the causality is in the opposite direction.

Doctors, by creed and long tradition, are concerned only about their patients. They do not care about insurers or whether they can save them a dime. Thus, they have no qualms about overcharging insurers as long as their patients are not hurt. With employers providing health insurance as a benefit, indeed being considered a “good” employer on the basis of that benefit alone, even the higher premiums resulting from the inflated fees did not hurt the patients, as long as they remained employed by an employer who remained “good”. And so the doctors overcharged, took payments from the insurers and thereby got the taste of money themselves. Then, just as they were getting greedy from the windfall that insurance produced, other more traditionally greedy groups saw an opportunity to grab a little bit of the action for themselves. Private educational institutions, with their sanctimonious greed for grander buildings and facilities in the advancement of learning and their own research interests, saw an alliance with a fledgling professional association as an opportunity to advance their development plans and offer a lengthier medical program with exorbitant tuitions which the new doctors could pay back with the inflated fees. Greedy trial lawyers saw a new class of people to sue on the flimsiest of grounds and tried to appear sanctimonious as they brought malpractice suits against medical teams for not saving one life out of a hundred in peril. Private companies bought hospitals and ran them like businesses, with hefty salaries for management and huge returns for the investors. The insurers, led by sleazy businessmen or corrupt

government officials, feeling left out, started going for-profit, for-graft or for-power, and saw how they could pocket some of this wealth in higher salaries, lavish office complexes and innumerable employees to lord over. All they had to do was deny claims on technicalities, force doctors to prescribe from the formulary of cheaper but less effective or inappropriate medicines and increase deductibles and co-pays, in short, create "bean counter medicine". In every part of the new medical establishment, insurance has introduced greed and fostered corruption.

Therefore, there cannot be any medical reform without the elimination of insurance from all facets of medicine. Nor can there be any reduction in medical fees without ending the insurance windfall. It does not matter whether there is one insurer rather than ten, single-payer or public option or the same cast of sorry characters. None of these represents real change because none removes insurance from medicine. To use a self-referential metaphor, insurance is the disease which is killing medicine. And there is no homeopathic response here, insurance being like a cancer. There is no cure but to remove it.

That is why I am so insistent on direct and free provision of medical services. If your local medical department sends a doctor on a house call to see your sick child, there would be no payment, just as there would be no payment for the fire department to send a truck to put out the fire in your house. With no payment, there would be no cost to insure against and thus no need or avenue for insurance. The medical department would pay the doctor a salary, like the fire departments, other than the volunteer ones, pay their firefighters. Of course, doctors would be paid more than firefighters. They may even find themselves earning more than they do now, if municipal workers are exempted from civil lawsuits. Not having to pay malpractice insurance would be a huge savings for the doctors. It would also be a huge savings for the public since many malpractice-inspired and medically unnecessary tests would no longer be performed. In these and so many other ways that municipal medical departments supplant insurance, they show that they are the only true cure for the ills of our medical system, the only true health care reform.