Donald J. Senese

Government, Heal Thyself

A belief is growing among supporters of free market economics: "There is nothing wrong with the American system of medical care that more governmental intervention could not make worse." As we examine governmental intervention in the health care field, we discover it has inflated health care costs to the patient and has failed to deliver a better medical product. If the advocates of more governmental control have their way, a program such as hospital cost containment or a program of nationalized health insurance (socialized medicine) will skyrocket health care costs, increase bureaucratic regulations, turn medical care into a "public utility" to be dispensed by government, and reduce the quality of health care.

The U.S. government uses the dollars of taxpayers to provide health care to the elderly (Medicare), to aid states via grants to provide aid for the poor (Medicaid), and to subsidize hospital construction (e.g., Hill-Burton). The federal government also operates hospitals to provide care to veterans, merchant seamen, military personnel, and American Indians.[1]

Advocates of government regulation in the health care field maintain that health care is a "unique good" and that the principles of the free market, especially the law of supply and demand, do not apply to it. Since it is "unique," only those wise and all-knowing government bureaucrats are qualified to plan and allocate health resources. These officials demean the free market and

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promise, through more governmental intervention, better health care services at lower costs. The performance, however, never meets the promises. As governmental regulations increase, a poor medical product is delivered at greater and greater costs to the patient, either directly through higher premiums or indirectly through higher taxes.

The health care field is not immune to the laws of the market place. Experience has shown that more governmental intervention leads only to chaos and confusion.

Cost Containment

The major effort of the current national administration to deal with rising health care costs was by placing government-mandated price restraints on the nation's hospitals. While outwardly rejecting controls for other sectors of the economy, the federal government imposes on one industry its "inflation control" program. Citing hospital costs as rising faster than the Consumer Price Index, these advocates of expanded centralized control would set an amount for cost increases before mandatory federal controls would go into effect.

The proposed solution, by ignoring certain economic facts in the health field, would create more problems than it would solve.

It is a fallacy to compare the hospital cost increases with the rate of increase of the Consumer Price Index. The comparison ignores two important factors in the health care field: (1) the provision of services to a growing population, and (2) the growth in "service intensive" costs including capital investment in diagnostic and remedial equipment. The great advances in medical services in the United States such as kidney transplants, cardiac surgery, and coronary care and burn treatment units have come about because the incentive has been available to develop and produce new medical technology. Better and more effective treatment increases the cost of specialized care; such a climate of freedom to develop new medicines and better machines for health care prevents stagnation in the health care field and brings about greater advances for mankind.

The United States devotes about nine percent of its Gross National Product to health care, a percentage similar to that of other countries like Germany, Sweden, and the Netherlands.[2] Despite the claims of some politicians that the poor in the United States do not receive adequate health care, Dr. Harry Schwartz of the research department of the Department of Surgery at the Columbia University College of Physicians and Surgeons has documented that the poor in the U.S. get on the average at least as much medical care from physicians

in hospitals as do those in higher income groups.[3]

Regulatory Measures

Restrictions on costs in patient care and on development of new health care equipment can lead to a rationing of health care. This rationing will place the best interest of a free people secondary to the cost policies of government bureaucrats.

Even in the hospitals where waste and inefficiencies exist, government-mandated controls will only have a limited effect because relative cost cuts will look impressive on the surface. It will be the efficient and cost-conscious hospitals which will be forced to cut costs to meet governmental guidelines—and the area for the quickest cost cutting will be in the area of serving patients.

A large measure of the health cost increases comes not from deficiencies in the free market but as a direct result of governmental controls. Personnel costs occupy a significant part of a hospital's budget, and government-mandated increases in the minimum wage have significantly increased costs in the hospital industry. Increasing governmental regulations through Medicare and Medicaid have placed additional costs on hospitals through an abundance of new regulations. A two-year study by the Hospital Association of New York state revealed that government regulation was a major factor in increasing health costs. This study, focusing on hospitals in the state of New York, estimated that twenty-five percent of hospital costs were attributable to meeting government regulatory requirements at an annual cost of one hundred fifteen million man hours or over one billion dollars per year! The report noted that each of four hospital departments (administration, personnel, social services, and utilization review) devote over fifty percent of their costs to complying with government-ordered regulations.[4]

Additional Government Controls

A careful examination of the health care industry shows a myriad of government controls which hamper the operation of the free market in medical care—and drive up costs for the consumers.

The federal government adopted the certificate-of-need program as a control mechanism to prevent hospitals from putting resources into "excessive investment" in health care facilities. The passage of Public Law 93-641 in 1974 required states to establish certificate-of-need programs in order to qualify for federal subsidies for health planning and other federal grant programs. What has been the result of this government cost control program? The program did not reduce the total dollars for hospital investment but merely

changed the direction from investing in hospital beds to investments in more sophisticated medical equipment. In addition, the certificate-of-need program failed to reduce substantially the rise in hospital costs per capita and to bring about any significant savings in health care costs.[5]

Government intervention in the medical market place brings decisions by government bureaucrats rather than medical experts. These government bureaucrats have added non-health criteria before even granting the certificates-of-need. In the District of Columbia, a private nonprofit hospital received approval for a renovation and modernization project only on the condition it would change the sexual and racial composition of its governing body. In New Jersey, an attempt was made to coerce a certificate-of-need applicant to allow an outside organization to select members of its governing body. In Colorado, a hospital was told its certificate-of-need would be granted only if the applicant reduced its number of obstetric and pediatric beds.[6] All of these examples, as well as others, show that the certificate-of-need program has been used by government bureaucrats to do certain things which are unrelated to the original purposes of the program. These bureaucrats practice political medicine by imposing arbitrary and unfair requirements on those hospitals which seek renovation, modernization, or additional facilities.

Professional Standards Review

Another government-promoted cost containment proposal led to the adoption of the Professional Standards Review Organization (PSRO) as part of Public Law 92-603 in 1972. The promoters of this reform sought to reduce unnecessary medical procedures while minimizing the length of stay in hospitals; they sought to encourage the use of outpatient and extended care facilities. The omnipotent government regulators aimed to accomplish this objective through a detailed review procedure in implementing the PSRO. However, studies by the Institute of Medicine and medical procedure experts concluded that PSROs had not appreciably reduced costs or brought about a significant improvement in the quality of care. In fact, the limited amount of savings appeared insufficient to cover the cost of the review process.[7] Even government promoted tax incentives to employers to encourage individuals to buy health insurance policies have had the effect of promoting the buying of packages of health insurance without any careful analysis of needs or costs since the program is government subsidized.

During the very time a major ef-

fort was underway to promote the adoption of a hospital cost containment program, another branch of the Health, Education and Welfare complex issued preliminary regulations for a new government regulatory measure—the SHUR (System for Hospital Uniform Reporting) program. This totally new government-mandated method of keeping hospital records would have greatly increased administrative costs for all hospitals.

The other attempts to interfere with the free market in health care to contain costs have all been failures resulting in more regulations, additional costs, and a threat to the quality of medical care. It is assured that any hospital cost containment program will bring the same failure. One Congressman, Representative David E. Satterfield III of Virginia, predicted the failure of such a measure to his colleagues during debate on the bill on the floor of the U.S. House of Representatives:

> It is not a bill which would contain hospital costs. It is a hospital revenue control bill, and the real growth in hospital revenues is not due to inflation. The only savings [this bill] could achieve would be through reduction in the amount and quality of hospital care made available to the American people.[8]

The Intervention Record

Those advocates of increased government power over the health field prefer to ignore the lack of accomplishment and the new problems such intervention brings.

Voluntary efforts by the hospital industry succeeded in limiting the increases in health costs—a decrease from 15.6 per cent in 1977 to 13 per cent in 1978 and 13.4 per cent in 1979. Yet, the hospitals operated by the federal government experienced in 1977 a cost increase of between 19 and 22 per cent.

The federal government has a poor record in estimating and controlling costs even in programs it directly controls. The Department of Health, Education and Welfare estimated that the cost for Medicare hospitalization for the first year would be less than one billion dollars. The actual cost was three billion four hundred million dollars—more than three times the original estimated cost. The tenth year cost estimate was $1.7 billion but actually was $12.6 billion, or seven times the original estimate. The cost for Medicaid in 1977 was $17.1 billion or more than sixteen times the original estimate.[9] Viewing the Fiscal Year 1981 budget, the estimated outlays for Medicare are $37.3 billion and $15.9 billion for Medicaid.[10]

The evidence of experience with centralized medical systems such as those of Canada and Great Britain should be a lesson for Americans. While eliminating the price

barrier by a government controlled system, the government has caused the following long-term results: a net reduction of resources channeled to health care, an increase in the maldistribution of doctors, no new doctors produced, and no new hospitals built or even financed.[11] The lessons are clear that further intervention will increase, not decrease, health care problems. J. Enoch Powell, who served the British government as Minister of Health for three years, has pointed out that under a government-controlled medical system where demand is unlimited and where medical care is "free," there has to be a method to squeeze demand to equal supply:

> In brutal simplicity, it has to be rationed; and to understand the methods of rationing is also essential for understanding Medicine and Politics. The task is not made easier by the political convention that the existence of any rationing at all must be strenuously denied. The public are encouraged to believe that rationing in medical care is immoral and repugnant. Consequently when they, and the medical profession too, come face to face in practice with the various forms of rationing to which the National Health Service must resort, the usual result is bewilderment, frustration and irritation.[12]

He noted that the people desiring medical care are put on the waiting list. If they are on long enough, they will die, usually from some cause other than that for which they joined the line. Or, they "frequently get bored or better, and vanish."[13]

Conclusion

Government attempts to intervene further in the health field will erode the quality of medical care and will substitute bureaucratic decisions which should be made by health experts in the market place. Cost containment will result in "price control," leading to a rationing of health care. Considering the past record of governmental intervention in the health (and other) fields, the results will be negative and individual choice will be narrowed as the power of government is expanded in the decision-making process. Controls will not curb inflation or bring beneficial results to the U.S. economy; the prospect of failure is the same even if they are only applied to the hospital industry.

Emphasis needs to be placed on expanding the opportunity for competition in the health care field, not expanding government controls. The free market solution is to increase competition through such initiatives as certification of health providers rather than occupational licensure, repeal of fair practice laws, more advertising of services, and greater use (and direct reimbursement) of health professionals (e.g., nurse practitioners) and emphasis on preventive care and the

individual's responsibility to maintain his or her own health.[14] When government administrators come forth with a complex set of interventionist measures to "solve" the government-created health care crisis, advocates of freedom need to resist and give these government planners the admonition: "Government, heal thyself."

—FOOTNOTES—

[1]H. E. Frech III and Paul B. Ginsburg, *Public Insurance in Private Medical Markets: Some Problems of National Health Insurance,* Washington, D.C.: American Enterprise Institute for Public Policy Research, 1975, p. 1.

[2]Jack A. Meyer, *Health Care Cost Increases,* Washington, D.C.: American Enterprise Institute for Public Policy Research, 1979, p. 9.

[3]"The Health Care Myth," *Indianapolis News* (editorial), March 3, 1980.

[4]John D. Lofton Jr., "How Government Inflates Your Health Costs," *Conservative Digest* (February, 1979), p. 39.

[5]David S. Salkever and Thomas W. Bice, *Hospital Certificate-of-Need Controls: Impact on Investment, Costs, and Use,* Washington, D.C.: American Enterprise Institute for Public Policy Research, 1979, pp. 4, 75.

[6]Representative David E. Satterfield III, *Congressional Record,* July 19, 1979, H6235-H6236.

[7]"A Policy Analysis of Hospital Cost Containment Programs," Center for Health Services and Policy Research, Northwestern University, Evanston, Illinois, 1978, p. 7.

[8]Representative David E. Satterfield III, *Congressional Record,* November 15, 1979, H10821.

[9]"Nationalized Catastrophic Health Insurance is a Trap," Association of American Physicians and Surgeons, Inc., p. 12.

[10]*The United States Budget in Brief, Fiscal Year 1981,* Washington, D.C.: Government Printing Office, 1980, p. 48.

[11]Cotton M. Lindsay and Arthur Seldon, "More Evidence on Britain and Canada," in Cotton M. Lindsay (editor), *New Directions in Public Health: A Prescription for the 1980s,* San Francisco, California: Institute for Contemporary Studies, 1980, Third Edition, p. 76.

[12]J. Enoch Powell, *Medicine and Politics: 1975 and After,* London, England: Pitman Medical Publishing Ltd., 1976, pp. 37-38.

[13]*Ibid.,* p. 39.

[14]Rita Ricardo Campbell, "Your Health and the Government," in Peter Duignan and Alvin Rabushka, *The United States in the 1980's,* Stanford, California: Hoover Institution, 1980, pp. 300-337.

Arguments Against Socialized Medicine

IDEAS ON LIBERTY

It is a mistake for the government to consider the problems of the sick apart from those of society as a whole. . . . The broader problem is, in a moral sense, one of promoting respect for the individual and the furtherance of initiative and self-providence; in an economic sense, one of increasing production for the benefit of *all* citizens; and in a political sense, one of removing government as a battlefield for special favor and substituting cohesion and solidarity for division and disintegration.

DARRYL W. JOHNSON, JR.

Edmund A. Opitz

The Philosophy of Ludwig von Mises

AN invitation to speak at Grove City College is a great honor, doubly so, in that I've been asked to talk about Ludwig von Mises. But I am humbled when I contrast the size of the debt I owe to Mises with the meager gesture that is all I am able to offer as a token payment.

I had read Mises' major works before I met the man. I then had the rare privilege of getting to know one of the finest minds in our time, a man who belongs with the great masters of his discipline, Economics; a scholar who advanced that discipline in several particulars by his own genius. And not only that, Mises was an inspired teacher; from the days of his celebrated Vienna Seminar almost till the end of his life, men and women sat at his feet, and some of them have become famous in their own right. The Misesian influence spreads and will continue to manifest itself.

Mises lived his active life during the first two-thirds of this century—a period of world turmoil which affected him personally and tragically, forcing him out of his native land and finally out of Europe, losing most of his precious library and other belongings in the course of his escape. Some refugee scholars came to America in the late thirties and early forties and we rolled out the red carpet for them. But not for Mises. Mises had set his entire life resolutely against the ideological absurdities of the twentieth century which produced the

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This article appears here, by permission, from a lecture of February 26, 1980 at Grove City College as part of a series in tribute to Ludwig von Mises and his work.