
Economics and American Health Care

BY KIRBY R. CUNDIFF

Americans spend more money on health care than any other country in the world, and despite most having health insurance, many are pushed into bankruptcy because of their health-care bills.¹ Americans are told they have the best medical system in the world, but they have fewer medical resources than most of the 30 member countries of the Organization for Economic Co-operation and Development (OECD). For example, in number of nurses per thousand of population, the United States ranks 18th and in number of acute-care beds it ranks 23rd. It is clear that Americans are not getting their money's worth.²

The modern American health-care system has its roots in World War II. As part of the war effort the U.S. government imposed wage and price controls on its citizens. It was illegal for American employers to compete for scarce employees by offering them better salaries, so employers came up with a new concept—we now call it the “benefit.” One such benefit was health insurance. When the IRS realized what was being done, it ordered that this benefit be taxed. But that regulation was countermanded after a backlash from voters resulted in congressional legislation. The pre-tax benefit was born.³

As the system is structured, if employers pay for their employees' insurance, they make the payments with pre-tax dollars. If employees pay for their own health insurance, they do so with post-tax dollars—an extra 30 percent expense for the typical American taxpayer. As a result, most employers buy for their employees insurance

that covers not only catastrophic illness, but also lesser medical expenses. This is the equivalent of people buying auto insurance for oil changes. Since employers pay for most of their employees' medical expenses (or appear to be doing so), employees have little incentive to shop around and control health-care costs; demand for health care is not very price sensitive. Sometimes employees pay into a pool that is then used to cover the company's

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medical bills, but the result is the same. A third party is responsible for most patients' medical bills. This is one of the reasons health-care costs have increased so drastically in the United States since World War II.

Another reason for increases in health-care costs is the creation of Medicare and Medicaid in the 1960s. Again due to third-party payments, eligible Americans could demand health care at someone else's expense.

There is little incentive for patients to be sensitive to cost in their health-care demands.

The percentage of health-care expenditures covered out of pocket has decreased from about 65 percent in 1950 to 55 percent in 1960 to 40 percent in 1970 to only 15 percent in 2002.⁴ During the same period, health care has gone from absorbing only about 4.5 percent of GNP in 1950 to 5 percent of GNP in 1960 to 7 percent of GNP in 1970 to about 15 percent of GDP in 2002.⁵

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This expense increase can be seen explicitly by looking at physicians' salaries. In 1940, in inflation-adjusted 2004 dollars, the mean income for American physicians was about \$50,000, or a little over 6 times U.S. per capita GNP. By 1950 this had increased to about \$100,000, or 6.5 times U.S. per capita GNP. By 1960, physicians' mean net income had increased to \$150,000, or 8 times U.S. per capita GNP, and by 1970 to \$200,000, or somewhat over 8.5 times U.S. per capita GNP.⁶ In the 1960s there was much more demand for physician services thanks to Medicare and Medicaid, but little change in the number of physicians, and doctors no longer needed to worry as much about charity cases—the government would pick up the tab.

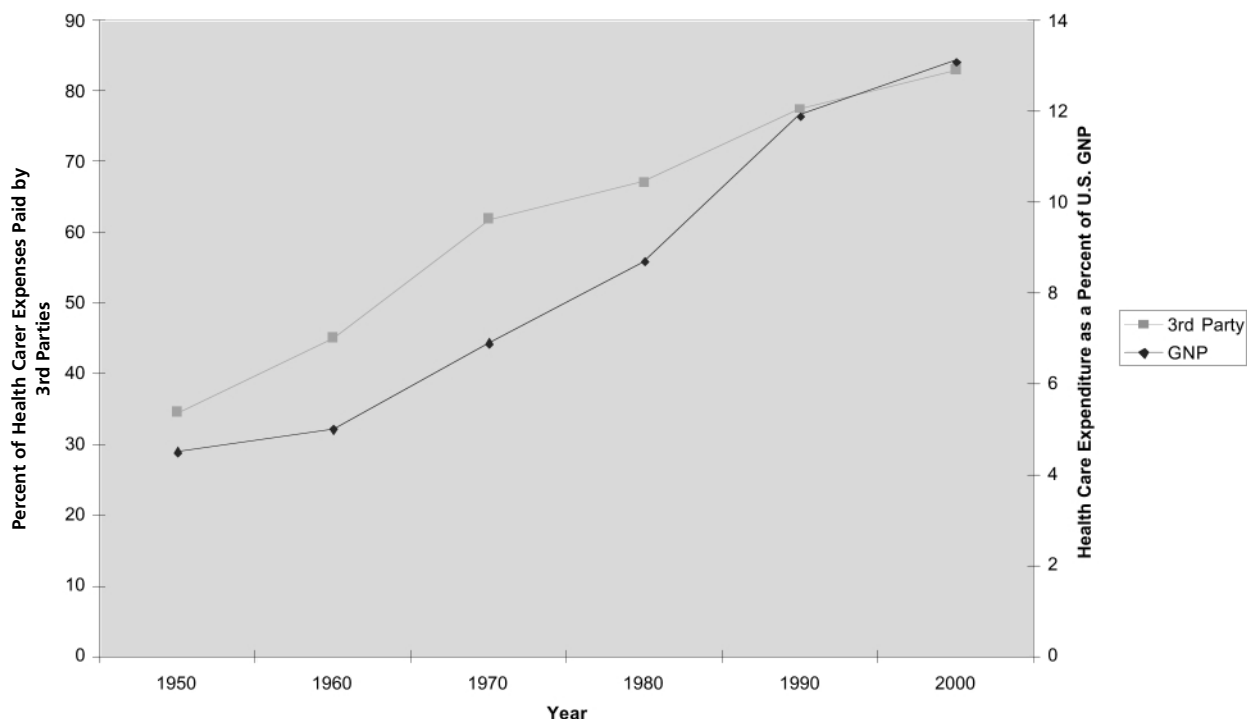
With this massive increase in physician incomes, many more Americans chose to attend medical school. The number of physicians in the United States increased from about 1.5 per 1,000 in both 1950 and 1960 to 1.7 in 1970 to about 2.5 in 1995.⁷ Physicians' salaries continued to increase in the '70s, '80s, and '90s, but not nearly at the same rate as in the 1960s. Today physicians'

salaries are around \$205,700 which is only about 6.0 times the U.S. per capita GNP.⁸ The American Medical Association (AMA) responded by trying to control the supply of doctors, claiming there was a “doctor glut.”⁹ In 1997 the U.S. government's Federal Health Care Financing Administration responded by paying some medical schools not to produce doctors.¹⁰

A common justification for high physicians' salaries is the financial investment and the number of years of medical school, but doctoral degrees in the liberal arts take as much labor as medical degrees and many Ph.D.s in the liberal arts cannot even find employment. What determines salaries is supply and demand, not the labor that goes into developing a skill or product.

While the United States has more lawyers per 1,000 population than any other country, it has fewer doctors than many other countries. As of 2001 the United States had about 2.4 physicians per 1,000 population. France and Germany had 3.3, and Switzerland had 3.5. Most of the major western European countries have more doctors than the United States, but the United

Health Care Expenses Paid by 3rd Parties and Health Care Expenditures as a Percent of U.S. GNP vs. Year



States has more than Canada, which only has 2.1 doctors per 1000 population.¹¹ Physicians' salaries in Europe are generally significantly lower than those in the United States, but it cannot be said that countries with more doctors generally have lower physicians' salaries.¹² Medical services are heavily regulated, and the normal laws of supply and demand do not seem to completely apply.

Another common method for limiting competition in health care is the Certificate of Need program. "The Certificate of Need (CON) program is a regulatory process that requires health-care providers to obtain state approval before offering new or expanded services or making major capital expenditures. . . . The program prevents unnecessary duplication of services by selecting the best proposal among competing applicants who wish to provide a particular health service."¹³ The claim is that multiple businesses offering the same service in the same area, also known as competition, drives up costs.¹⁴ The pharmaceutical industry uses tactics similar to the AMA's to limit competition and keep profits high. For example, it lobbies to prevent the importation of less-costly drugs from Europe and Canada under the claim that "Canadian drugs are unsafe."¹⁵ Many of the "unsafe" Canadian drugs are the same drugs that are produced in the United States.

Not Malpractice Insurance

Despite what many people think, the primary cause of high health-care costs in the United States is not medical malpractice insurance, though it may be a problem in some states and some specialties. As of 2000 the mean liability premium for all physicians was \$18,400 per year. This is a large amount, but only about 9 percent of the mean physician net income of \$205,700 per year. That is significantly higher than the liability premium in the early 1970s, which was only about 2 percent of

mean physician net income.¹⁶ The highest liability insurance premium is in obstetrics/gynecology, at \$39,200, but this is still only 17 percent of the mean net income of \$227,000. The growth rate in malpractice insurance premiums for the last ten years has been about the same as the growth rate in physicians' salaries. Malpractice liability insurance premiums have increased by only about 1 percent per year for Ob/Gyn and at about a 2 percent annual rate for all physicians. The annual increase in physicians' salaries has been about 2 percent per year for the same period.¹⁷ Since someone making \$200,000 a year generally pays over \$60,000 a year in taxes, it would be far more appropriate to say that taxation is responsible for high health-care costs.


A common solution that is proposed for America's health-care problems is socialized medicine, but wherever national health insurance has been tried, rationing and long lines have followed.¹⁸ Single-payer systems are now being abandoned by many of the countries that have tried them. Recently Germany and Spain began selling state-owned hospitals to for-profit companies to raise money and increase efficiency,¹⁹ and last June the Canadian Supreme Court struck down two provincial laws in Quebec banning private health care and private insurance. According to Chief Justice Beverley McLachlin and Justice John Major, "The evidence in this case shows that delays in the public health-

care system are widespread, and that, in some serious cases, patients die as a result of waiting lists for public health care."²⁰

What will cure America's health-care problems is the free market. A patient can easily walk into a store and buy a bottle of aspirin, an over-the-counter drug, for less than \$10. To get a prescription drug, the patient must get a doctor's appointment, wait an hour at the doctor's office, and then wait in line at a pharmacy to get the drug. This process will probably cost the insurance company about \$100 and the patient about \$30 in co-pay-

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ments. In some circumstances, the patient may then get bills from the doctor's office and the insurance company for the next six months, as the parties argue over who pays what fraction of the expense. This is true even if the patient gets regular sinus infections and takes the same drugs every year. If the patient could buy drugs over the counter, the change would save money and time for both the patient and his employer.

Moreover, if people could buy their own health care and insurance pre-tax, they would have an incentive to shop around for the cheapest services. They would most likely be more interested than their employers are in the quality of their insurance. If patients could buy pharmaceuticals from whatever source they, not the government, deemed safe, competition would drive down drug costs. If patients could seek, and pay for, the advice of biology researchers, nurses, or whomever they trusted, rather than being forced to go to government-licensed physicians, they would save money and time. Were America's health-care system fully deregulated, the supply of doctors, as well as pharmaceuticals would increase, demand for health-care services would decrease, and that demand would be more price-sensitive. Health-care costs would go down, and the quality of health-care service would go up. 

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