The Medical Marketplace, Free and Unfree

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The idea of consumer sovereignty was central to Mises's understanding of the market economy. According to this understanding, consumers shape the pattern of resource use and the assignment of resource rewards according to their preferences. The outputs being produced at any date, the methods of production being employed, and the rewards being given to the various owners of productivity are those dictated by consumers.

Market prices are described by Mises as reflecting an "equilibrium of demand and supply." It is on this basis that Mises views any government interference with market prices as a disturbance to the equilibrium that will, in general, produce results that are worse than the conditions the government wished to improve. Government intervention in the provision of medical goods and services is a perfect example.

In a previous article (http://mises.org/daily/5320/How-the-Experts-Are-Wrecking-Healthcare) , I suggested that government intervention, not market failure, is responsible for today's out-of-control healthcare costs. There are a multitude of reasons why this is so, but the most important, in my opinion, is the loss of consumer sovereignty brought about by government intervention, which would not have occurred under market conditions.

"If we returned purchasing power to patients — in effect, restored consumer sovereignty — healthcare spending would decline dramatically."

Prior to the advent of Medicare and Medicaid, individuals paid for the majority of medical goods and services out of their own pocket (Figure 1) and utilized health insurance as a rational tool for mitigating financial risk posed by catastrophic events.[1] (#note1) During this time a real market existed for the vast majority of medical goods, and services and prices were reasonable. However, after the advent of these programs, third-party spending on routine medical services increased, and out-of-pocket spending fell dramatically. To match the coverage of these government programs, especially Medicare, the private-insurance market took a reactionary turn for the worse, which was encouraged by earlier legislation that allowed health insurance to be purchased with pretax dollars

from an employer. The move to third-party payment was further accelerated by passage of the HMO Act of 1973 (http://www.law.cornell.edu/uscode/html/uscode42/usc_sup_01_42_10_6A_20_XI.html) .

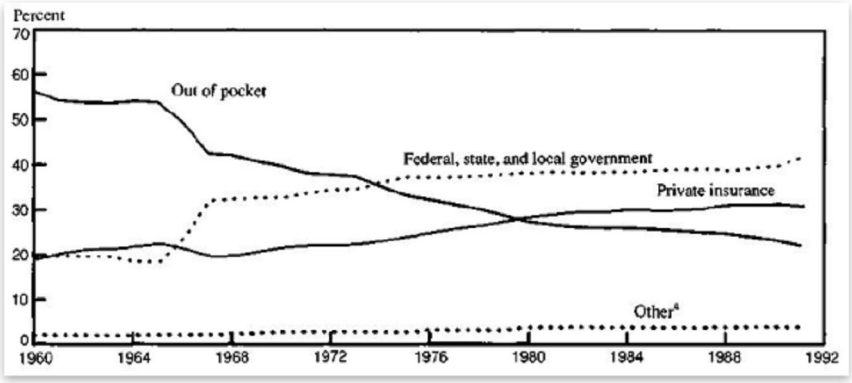


Figure 1. Sources of personal health expenditures

The act gave HMOs greater access to the employer-based market, providing for the rapid expansion of managed care. Finally, as Thomas DiLorenzo has pointed out (http://mises.org/daily/3793) ,

> Layers of regulation plague every aspect of medical care and health insurance in America ... each state imposes dozens of regulatory mandates on health insurers, requiring them to include coverage of everything from massage therapy to hair implants.

A colleague of mine, who practiced before and after this dramatic shift occurred, and whom I will not name due to his academic affiliation, neatly summarized how third-party payment for routine medical services has led us to the current situation we are in with regard to healthcare costs. He wrote to me:

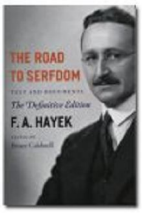
> I have lived through those times when the patient and the doctor each had a sense of responsibility regarding the patient's health. There was, in effect, a "contract" between the two that resided in the awareness that the doctor was the expert and would do the best he/she could for the patient and the patient, in return would pay for those services. There were no guarantees but an expectation of ethical behavior by both parties. Healthcare costs were reasonable and in those instances where payment was beyond the reach of a patient's resources, arrangements could be, and were usually made.
>
> The system worked and worked well. Enter third party pay and it all went to hell in a hand-basket because it now became possible to charge whatever the system would bear.

Because of this change, medications, tests, and procedures that in many cases provide only marginal benefits are now widely used despite the fact that they may cost much more than the procedures they were intended to replace.

In a real market, many of these "breakthroughs" would simply not be viable. But because the test of viability in America's government-managed healthcare system is not consumer sovereignty, we have a situation where Medicare, Medicaid, and

politicized private-insurance companies pay hundreds of dollars a month more for a drug that decreases total event rates by a few percentage points compared to whatever that drug replaced or was intended to augment.

The following is an example of a real and very popular drug that I use on a routine basis that I will call drug X. Drug X works by inhibiting blood clot formation (when a blood clot forms in a vessel in the heart, one can have a heart attack). Drug X and drug Y work together by acting on different substrates of the clot-formation process to ultimately effect the same outcome — stopping clots from forming. Drug X costs on average $141.82 per month. Drug Y costs a couple of dollars per month over the counter at your local drug store. What does the data tell us about the two?



(http://mises.org/store/Road-to-Serfdom-The-P252.aspx)

Multiple studies have been performed to answer the question: Does drug X improve cardiovascular outcomes compared to drug Y alone after a patient has had a major cardiovascular event or a stroke? The answer, unequivocally, is *yes*. By how much? The answer is *a few percentage points,* give or take.[2] (#note2) Does it eliminate the risk all together? The answer, unequivocally, is *no*. It should also be noted that drug X in addition to drug Y confers a minor increase in the risk of having a major bleeding event. So the question is: How many people, in the appropriate clinical setting, knowing this information, would buy drug X for $140 per month? Probably not nearly as many who take it now for nothing or for a small copay. Leaving aside the issue of brand names and patents, under conditions of market competition, do you think the company who makes drug X would lower the price to entice more buyers? If they did not lower the price, or simply could not lower the price due to production costs, I would venture to guess that drug X would not be marketable outside of a small niche of patients.

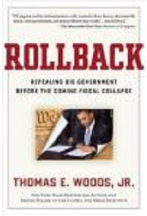
Now ask yourself, is the doctor who recommends drug X the bad guy? Of course not: drug X does provide a benefit beyond drug Y itself, and furthermore, if he didn't offer it and the patient had a heart attack (which could happen despite being on drug X) the doctor could be at risk of losing his medical license. After all, drug X is part of the standard of care. Is the patient the bad guy? Of course not: if you were offered the chance to take a drug that had a defined benefit and wouldn't cost you that much, you'd be silly to reject it. Is the pharmaceutical company the bad guy? No, they have a responsibility to their shareholders to make a profit, so they should sell their product at the highest price possible.

So who's to blame? The answer: a system that has been developed by government intervention to interfere with consumer sovereignty and make every individual pay for every other individual's medical expenses so that the individual consuming the care does not bear the full price at the point of utilization. We should not conclude from this example that the run-up in healthcare costs is solely due to increased spending on pharmaceuticals, for this situation applies to everything from doctor visits to laboratory tests to diagnostic studies to minimally invasive and full surgical procedures. Very simply stated, consumers now use many medical services that they would simply reject if they had to pay for them out of pocket — and truthfully, in most cases, they would be none the worse off for rejecting them.

The RAND Health Insurance Experiment (http://www.rand.org/health/projects/hie.html) was a prospective social experiment (and to this date, the only social experiment) in which health insurance with different levels of benefit coverage was randomly assigned to individuals, and subsequent health outcomes were compared

across experimental groups. The results showed that while spending increased as benefit coverage increased, health status and health outcomes did not improve. There was very little evidence to demonstrate that having a high level of benefit coverage improved population health on average.[3] (#note3) The RAND Health Insurance Experiment debunks the idea that patients are not capable of being prudent consumers of medical goods and services.

So what does all this tell us about solving the current problem with healthcare costs? I think the answer is relatively straightforward: if we returned purchasing power to patients — in effect, restored consumer sovereignty — healthcare spending would decline dramatically and prices for medical goods and services would reflect the true value to consumers in a competitive market.



(http://mises.org/store/Rollback-P10449.aspx)

Under free-market conditions, would there be a role for health insurance? The answer is clearly *yes,* but health insurance would much more closely resemble the rational/catastrophic model that developed spontaneously before the onset of serious government intervention into the healthcare industry. Can we get back to that model? *Yes,* in theory, but it would require that we abolish all government insurance programs, deregulate the system at the federal, state, and local levels, and get rid of all the existing tax deductions, exemptions, and subsidies for the purchase of health insurance.

The main objection to restoring consumer sovereignty as I have described is the progressive appeal to *social justice*. Paul Krugman tried to make the case for this in a recent editorial entitled "Patients Are Not Consumers" (http://www.nytimes.com/2011/04/22/opinion/22krugman.html) in the *New York Times*. Krugman's logically flawed and contradictory arguments can be boiled down as follows:

1. Healthcare is a right and the doctor-patient relationship is sacred; therefore, patients should not be viewed as consumers.

2. Doctors and patients cannot be trusted; therefore, a third party must intercede in the decisions made between the patient and his or her doctor, because somehow, without any personal knowledge or previous interaction whatsoever, the third party knows what the patient needs better than the other two connected parties (doctor and patient).

(If you think these two points are contradictory, you are not alone.) Krugman writes,

> Here's my question: How did it become normal, or for that matter even acceptable, to refer to medical patients as "consumers"? The relationship between patient and doctor used to be considered something special, almost sacred. Now politicians and supposed reformers talk about the act of receiving care as if it were no different from a commercial transaction, like buying a car — and their only complaint is that it isn't commercial enough.
>
> What has gone wrong with us?

I take this to be Krugman's variant of the social-justice argument — because healthcare is a right and the doctor-patient relationship is sacred, patients have a right to whatever they and their doctor agree to; they should not be forced to pick and choose.[4] (#note4) Of course, healthcare is not a natural right, as natural rights

define what somebody else, including the government, cannot do to you. They do not oblige anyone to act on your behalf, and they do not oblige you to act on the behalf of anyone else, except to respect the fact that others have the same rights as you. If a right to healthcare were recognized, it would necessarily enslave each of us to everybody else's healthcare needs. But Krugman does not really believe healthcare is a right, as the next part of his argument reveals. He writes:

> About that advisory board: We have to do something about healthcare costs, which means that we have to find a way to start saying *no*. In particular, given continuing medical innovation, we can't maintain a system in which Medicare essentially pays for anything a doctor recommends. And that's especially true when that blank-check approach is combined with a system that gives doctors and hospitals — who aren't saints — a strong financial incentive to engage in excessive care. …
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> [T]he point is that choices must be made; one way or another, government spending on healthcare must be limited.

As the above passage makes clear, to Krugman and progressives like him, healthcare is not really a right, and the doctor-patient relationship is not really all that special. Instead, healthcare is a privilege to be granted at the prerogative of the ruling class. Progressives do not reject the idea of consumer sovereignty because it is economically or ethically flawed, but rather because the act of being a consumer requires that an individual's natural rights be fully protected. The recognition of such rights represents a check on arbitrary power, and as such it is the enemy of the state and ruling elites like Krugman, who have an insatiable lust for power and control over the rest of us.

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Notes

[1] (#ref1) Carlstrom C. "The Government's Role in the Health Care Industry: Past, Present, and Future." (http://www.clevelandfed.org/research/commentary/1994/0601.pdf)

[2] (#ref2) It is often stated that, in the appropriate clinical setting, drug X, in addition to drug Y, decreases the risk of having a cardiovascular event by 10–20 percent, whereas I have stated it is only a few percentage points. Both statements are true. The larger risk reduction refers to "relative risk" and the smaller risk reduction refers to "absolute risk." Let's say the risk of having an event is 4 percent and taking a drug lowers it to 3 percent. Under this condition, the drug would confer a relative risk reduction of 25 percent and an absolute risk reduction of 1 percent. Obviously, the former sounds much more impressive than the latter. Therefore, when discussing risk reduction I prefer to speak in terms of absolute risk, which makes more sense from a consumer perspective.

[3] (#ref3) Newhouse, J. *Insurance Experiment Group. Free for All? Lessons from the RAND Health Insurance Experiment* (http://books.google.com/books?id=SVUJ4W9Lk5IC) . Cambridge: Harvard University Press, 1993.

[4] (#ref4) I have no doubt that the majority of "thought leaders" in the field of

health policy would disagree with the assertions made in this paper — namely, *that denial of consumer sovereignty by government intervention is responsible for uncontrollable medical costs* — but this only mirrors the majority of mainstream economists who have ignored the Austrian School for so long and at the nation's peril. They will say that the problem of consumer sovereignty and medical costs can be minimized because other nations with extensively government-run healthcare systems pay less for healthcare than the United States. And while it is true that other nations spend less per individual, it only reflects the fact that they have been, up to this point, stricter with rationing and price controls. However, it must be noted that these other countries are *also* experiencing medical costs that are spiraling out of control, and the same argument I have presented in this paper can be applied to each of them.

Hagist and Kotlikoff studied the growth in healthcare spending for ten developed countries over the time period 1970–2002 and found that, "Government health care expenditures have grown much more rapidly than the economy in all developed countries. Between 1970 and 2002 these expenditures per capita grew at almost twice the rate of gross domestic product (GDP) per capita in 10 countries studied: Australia, Austria, Canada, Germany, Japan, Norway, Spain, Sweden, the United Kingdom and the United States." (http://www.ncpa.org/pdfs/st286.pdf)

Where consumer sovereignty is violated by government intervention results will be worse, not better, than the conditions government wished to improve — medical goods and services are no exception.