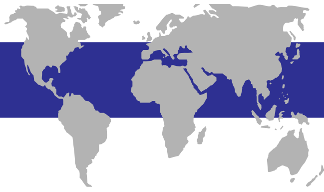

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W67

How The Cost-Plus System Evolved

The cost-plus system of health care finance is incompatible with competitive markets in which prices are determined by supply and demand. Cost-plus finance requires a regulated, institutionalized market in which normal competitive pressures are either outlawed or suppressed. This chapter briefly describes how the U.S. market for medical services evolved from a competitive to a regulated market, first for physicians' services, then for hospital services, and finally for health insurance.

The first building blocks of the cost-plus system were put into place by the political activities of physicians more than 100 years ago. Those activities, coordinated through the American Medical Association (AMA) and county medical societies, are called the actions of organized medicine, to distinguish them from the uncoordinated actions of individual physicians competing against one another in the marketplace. By the 1950s, organized medicine had achieved virtually all of its political goals: the creation of nonprofit institutions designed to control entry into the medical profession and to suppress competition for physicians' services; the creation of a nonprofit hospital sector, chiefly responsive to physicians; and the creation of a nonprofit health insurance sector that paid most medical bills with little scrutiny and few questions asked. That was Stage I in the evolution of the cost-plus system, and it survived for at least three decades.

During the 1980s, however, we entered Stage II, the cost-control stage. Physicians now are encountering harassment from third-party institutions and are increasingly torn between their obligations to patients and the demands of third-party payers. The irony is that the problems of today's physicians are attributable in part to the political actions of their counterparts more than a century ago. Today's health care system frustrates many people, who often search for someone or some group to blame. Physicians are all too often their targets. Throughout the past 150 years, though, most physicians have not been involved in politics. To the extent that they have had political preferences, most have favored free enterprise. The vast majority have been far more altruistic than the practitioners of other professions.

The historical facts recounted in this chapter will surprise most physicians as much as they surprise others. Those facts include the ways in which doctors' representatives pursued legislative goals and changed the institutional environment in which medicine is practiced. In doing so, the representatives of physicians had the same motives and many of the same objectives as the

representatives of other professions and trades. If there is a difference, it is only that special-interest politics proved more successful in medicine than in other fields. Today's doctors are not responsible for the political activities of doctors in the past. Indeed, physicians today are among the most tragic victims of cost-plus medicine. If they could, the majority would surely undo the harm done through the medical politics of the past.

Early History of Government Controls

In medical care, as in many other sectors of the American economy, a genuinely free market emerged not in 1776, but during the middle of the 19th century. Between 1830 and 1850, many of the medical licensing laws left over from the colonial period were repealed. Historian Ronald Hamowy has described the condition of the American medical profession at the close of the Civil War as follows:

> The profession was, throughout the country, unlicensed and anyone who had the inclination to set himself up as a physician could do so, the exigencies of the market alone determining who would prove successful in the field and who would not. Medical schools abounded, the great bulk of which were privately owned and operated, and the prospective student could gain admission to even the best of them without great difficulty. With free entry into the profession possible and education in medicine cheap and readily available, large numbers of men entered practice.

This experiment in free-market medical care was short-lived, however. The AMA was established in 1847 and quickly became the spokesman for the practitioners of orthodox medicine in the United States. Although the AMA often stressed the importance of raising the quality of care for patients and protecting uninformed consumers from "quacks" and "charlatans," its principal goal—like that of other trade associations—was to advance the financial well-being of its members. It pursued its objective by promoting the establishment of state medical licensing laws and the legal requirement that, to be licensed to practice, a physician must be a graduate of an AMA-approved medical school. Clearly, it sought to raise the incomes of existing practitioners. A report submitted by the committee on educational standards to the first AMA convention in 1847 was unusually candid:

> The very large number of physicians in the United States ... has frequently been the subject of remark. To relieve the diseases of something more than twenty millions of people, we have an army of doctors amounting by a recent computation to forty thousand, which allows one to about every five hundred inhabitants. And if we add to the 40,000 the long list of irregular practitioners who swarm like locusts in every part of the country, the proportion of patients will be still further reduced. No wonder, then, that the profession of medicine has measurably ceased to occupy the elevated position which once it did; *no wonder that the merest pittance in the way of remuneration is scantily doled out even to the most industrious in our ranks*—and no wonder that the intention, at one time correct and honest, will occasionally succumb to the cravings of hard necessity.

It is ironic that most unorthodox ("irregular") practitioners at the time probably did more good—or less harm—to their patients than did the orthodox ones. A second irony is that the committee recommended standards so high that few of the convention's delegates could have met them. Indeed, one historian has concluded that "rigid enforcement of the AMA's preliminary standards would have closed down practically every medical school in the country and would have depleted the ranks of formally educated physicians in a few years."

Early Licensing Laws

Virtually every law designed to restrict the practice of medicine was enacted not on the crest of widespread public demand but because of intense pressure from the political representatives of physicians. Moreover, AMA-sponsored legislation invariably contained grandfather clauses that exempted existing practitioners. These laws did nothing to protect the public from quacks and charlatans already active. What they did was protect practitioners from the competitive pressures posed by potential new entrants into the medical profession.

At the first meeting of the AMA in 1847, the delegates not only endorsed collective fee-setting but unanimously endorsed a code that made adherence to established fee schedules a matter of medical ethics. Chapter II,

article 7, section 1, of the organization's original Code of Medical Ethics, read as follows: "Some general rules should be adopted by the faculty, in every town or district, relative to the *pecuniary acknowledgments* from their patients; and it should be deemed a point of honor to adhere to this rule with as much steadiness as varying circumstances will permit." In other words, the AMA endorsed the ideal of a medical cartel and made participation in it ethically mandatory. Over time, the AMA expanded the range of activities considered "unethical" to include (1) "solicitation of patients, either directly or indirectly," (2) " competition and underbidding," (3) "compensation ... inadequate to secure good medical service," (4) "interference with reasonable competition in a community," and (5) "impairment of 'free choice' of physicians."

AMA goals were also promoted by threats of license revocation. The most common causes for revocation, "dishonorable" or "unprofessional" conduct, were mainly euphemisms for what the AMA considered unfair competition. Of the 42 states that had revocation provisions in their medical practice acts in 1907, "incompetence" was grounds for revocation in only two of them.

In 1888, the *Journal of the American Medical Association* editorialized that "*Wholesome* competition is the life of trade; unrestricted competition may be the death of it." In 1898, the New York state medical fraternity proposed to prevent free vaccination and the administration of free diphtheria antitoxin on the grounds that it was "inimic to the best [financial] welfare of young medical men." The AMA's code of medical ethics condemned the practice of giving free care to affluent patients without compensation as "dishonorable" and "unprofessional" because it tended to injure other physicians financially.

In addition, organized medicine vigorously sought to eliminate competition from any unlicensed person who would treat the sick for compensation, regardless of the form of treatment and its effect on the patient. In most states, physicians were successful in broadening the definition of medical practice to include drugless and spiritual healers (for example, Christian Scientists, osteopaths, and chiropractors). At the urging of organized medicine, courts ruled that it was not a defense that patients knowingly accepted the mode of treatment offered, nor that patients may have benefited from the treatment.

In one case, the Nebraska Supreme Court ruled in 1894 that a Christian Science practitioner had violated the state's medical practice act by accepting compensation in return for treating solely by prayer those who called on him.

A similar decision was reached by the Ohio Supreme Court in 1905. In that case, the court ruled that Christian Science treatment in return for a fee constituted the practice of medicine, even though the cure was to come from God and not from the defendant.

By 1901, all states and territories except Alaska and Oklahoma had medical examining boards. Of the 51 jurisdictions, 30 required candidates for a license to undergo an examination and to present a diploma in medicine; seven required either an examination or a diploma; and two made the M.D. degree a prerequisite for the practice of medicine. Although the number of physicians continued to increase, the number per 100,000 people fell from 163 in 1880 to 157 by the turn of the century.

Nonetheless, in 1901 the *Journal of the American Medical Association* continued to complain about overcrowded conditions in the medical professions. Hamowy explains why: Licensing laws mandating an examination were clearly not sufficiently restrictive to severely limit the numbers of new physicians entering the profession, even when these laws also required a diploma in medicine. The answer was to lie in statutes which both required a diploma and, in addition, empowered the state examining boards to exclude graduates of "sub-standard" colleges from consideration for licensure.

The Flexner Report

In 1906, the AMA's Council on Medical Education inspected the existing medical schools and found the training acceptable in less than half of them. These findings were never published, however. Arthur Bevan, head of the Council on Medical Education, explained why: "If we could obtain the publication and approval of our work by the Carnegie Foundation for the Advancement of Teaching, it would assist materially in securing the results we are attempting to bring about."

The AMA's efforts were successful. In 1910, the foundation commissioned Abraham Flexner to perform what amounted to a repeat of the AMA's inspection and grading of medical schools. Flexner had absolutely no qualifications for the task. He was not a physician, scientist, or medical educator. He had an undergraduate degree in the arts and was the owner and operator of a for-profit preparatory school in Louisville, Kentucky.

Flexner evaluated existing medical schools by conducting a grand inspection tour. Sometimes he evaluated an entire school in one afternoon. He measured the schools by comparing each to the medical school at Johns Hopkins. He was accompanied on the tour by the secretary of the AMA's Council on Medical Education, N. P. Colwell, who provided him with the results of the AMA's previous labors. Flexner apparently accepted a good bit of assistance from the AMA and spent many hours at its Chicago headquarters preparing his report.

Control of Medical Schools

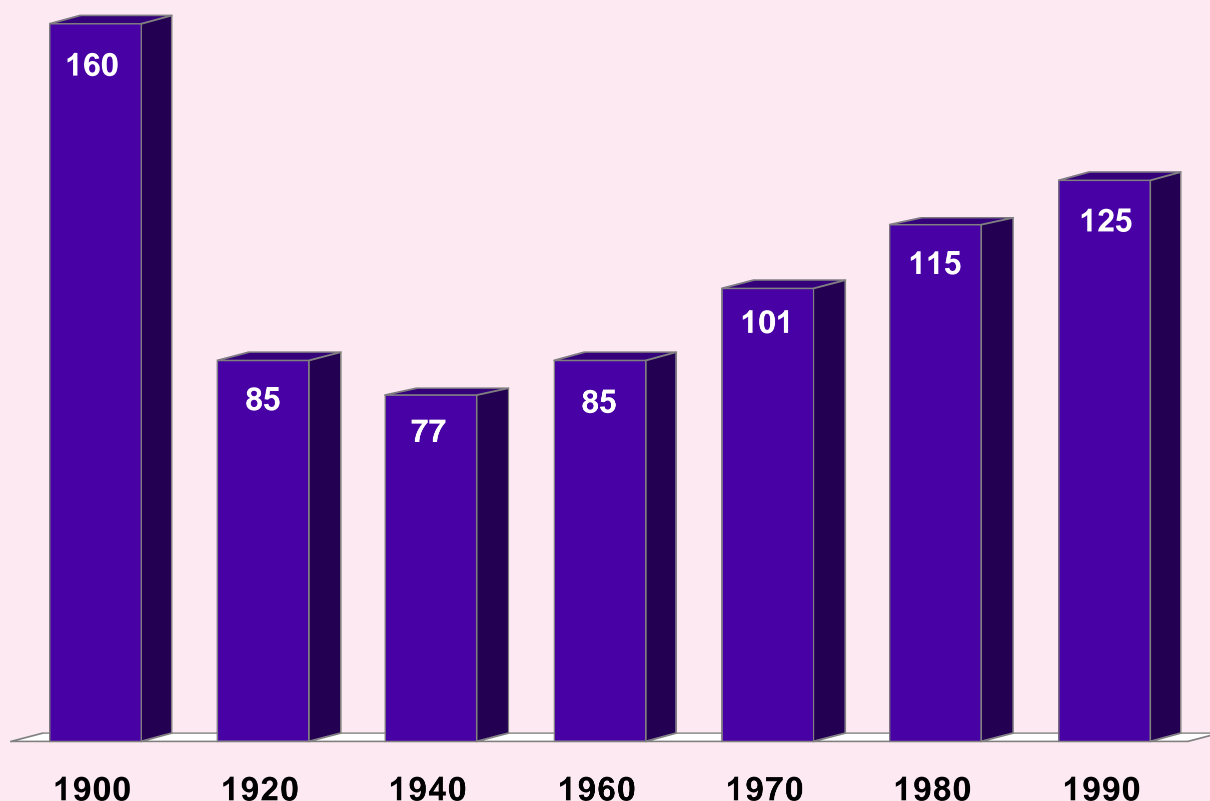
The Flexner report had an enormous impact on the future of medical education in the United States. Indeed, as Reuben Kessel has written, "If impact on public policy is the criterion of importance, the Flexner report must be regarded as one of the most important reports ever written." It convinced legislators that only graduates of first class (Class A) medical schools ought to be licensed, and they delegated the classification of institutions—explicitly or implicitly—to the AMA. In time, every state established standards of acceptability for obtaining a license to practice medicine. These standards, set either by statute or by state medical examining boards, provided that the boards consider only the graduates of schools approved by the AMA and/or the American Association of Medical Colleges, whose lists were identical.

Ultimately, the Flexner report led to the large-scale closing of medical schools that failed to meet AMA standards. By exercising its power to certify, the AMA caused an almost continuous reduction in the number of medical schools in the United States over the next four decades. [See Figure I.] As a consequence, the number of medical students dropped dramatically. As Figure II shows, following the release of the Flexner report the ratio of doctors to population fell steadily for two decades. To see how effective the AMA's policies were, consider that doctors in 1963 had far more to offer patients than at the turn of the century and were in far greater demand. But the number of doctors per 100,000 people in 1963 —146 — was precisely what it had been in the year that Flexner had written his report.

The impact of the Flexner report may be unique in U.S. regulatory history. Kessel explains why:

FIGURE I

Number of Medical Schools in the United States,1900 to 1990*



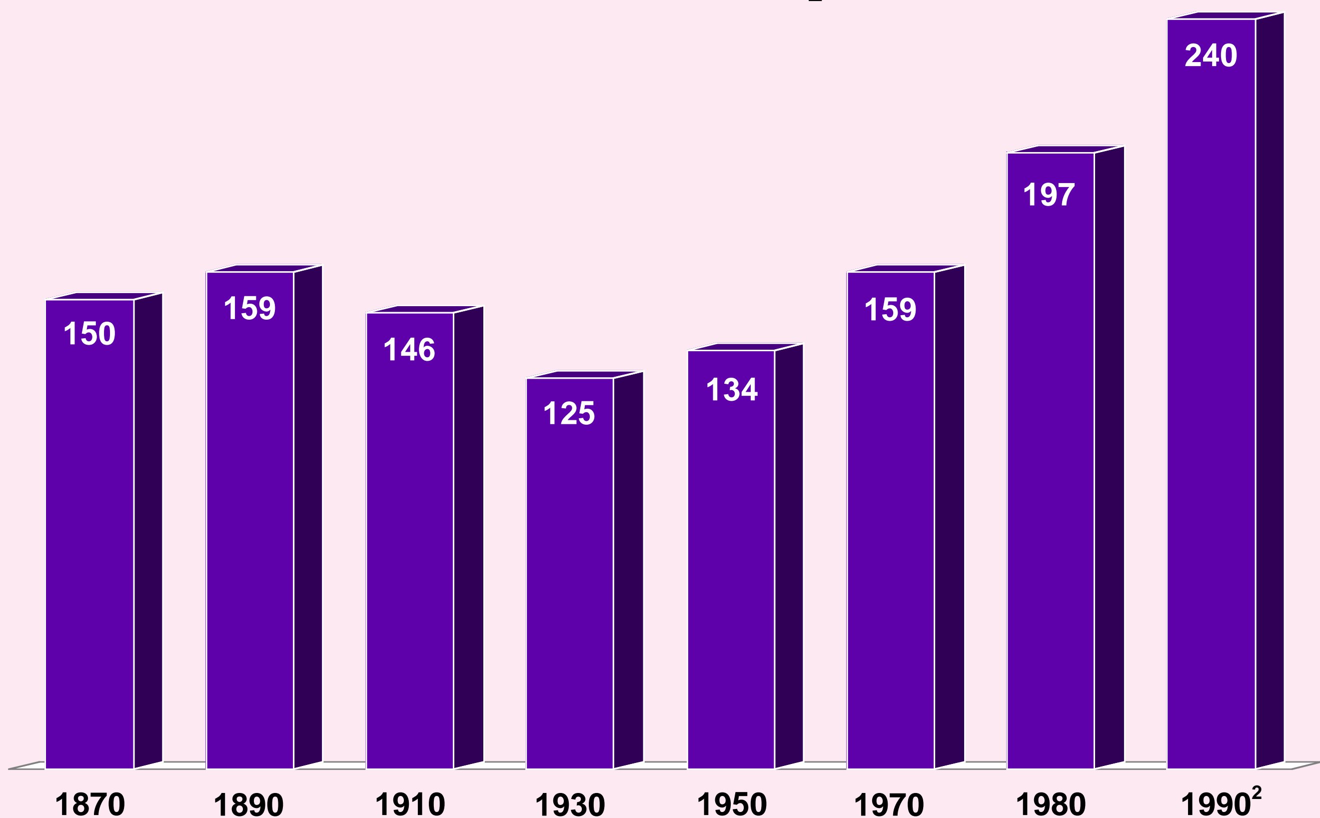
Sources: For 1900-52, U.S. Bureau of the Census, *Historical Statistics of the United States, Colonial Time to 1970*, Bicentennial Edition, Part 2 (Washington, 1975), Series B 275-90, pp. 75-76; for 1960, U.S. Department of Health and Human Services, *Health, United States, 1989* (Washington, 1990); and for 1970-90, Undergraduate Medical Education: Annual Issue on Medical Education, *Journal of the American Medical Association, various years.*

* The numbers given are for academic sessions ending in specified years. Beginning in 1954, the totals included Puerto Rico; beginning in 1960, the totals include osteopathic medical schools.

The delegation by the state legislature to the AMA of the power to regulate the medical industry in the public interest is on a par with giving the American Iron and Steel Institute the power to determine the output of steel. This delegation of power by the states to the AMA, which was actively sought and solicited, placed this organization in a

FIGURE II

Number of Physicians in the United States Per 100,000People 1870 to 1990[1]



Sources: For 1870-1970, U.S. Bureau of the Census, *Historical Statistics of the United States, Colonial Times to 1970*, Bicentennial Edition, Part 2 (Washington, 1975), Series B 275-90, pp. 75-76; and for 1980-90, U.S. Department of Health and Human Services, *Health, United States, 1989* (Washington, 1990), Table 85.

[1] Figures may include physicians not in active medical practice. Beginning in 1960, totals include osteopaths.

[2] Projected total.

position of having to serve two masters who in part have conflicting interests. On the one hand, the AMA was given the task of providing an adequate supply of properly qualified doctors. On the other, the decision with respect to what is adequate training and an adequate number of doctors affects the pocketbooks of those who do the regulat-

ing as well as their closest business and personal associates. It is this power that has been given to the AMA that is the cornerstone of the monopoly power that has been imputed by economists to organized medicine.

Effects on Medical Practice

The most important consequence of the control of medical education by organized medicine, then, was that physicians acquired the power to reduce the supply of medical services and increase their incomes. But there were other effects. One was a shortage of minority physicians. Of the 375,000 physicians in the United States in 1977, only 1.7 percent were black. Moreover, 83 percent of the black physicians were trained at two predominantly black medical schools, Howard and Meharry. Prior to 1910, there had been more black medical schools, and blacks and other minorities had found it relatively easy to enter the profession. Following the Flexner report, most black medical schools were closed, and black would-be physicians confronted rationing schemes at those medical schools that did remain open. Discrimination against other minorities, such as Jews, and against women, became rampant.

Because the decisionmakers on medical school admissions boards could not, or would not, discriminate on the basis of price, they discriminated on other grounds. As Lee Benham has explained, "It should not surprise us that the successful members of the subsequent queue looked remarkably similar to those making the admissions decisions." No doubt many of those decisionmakers reflected the views of Flexner himself. Flexner wrote that "a well-taught negro sanitarian will be immensely useful; an essentially untrained negro wearing an M.D. degree is dangerous" and "the practice of the negro doctor will be limited to his own race."

Other effects of the Flexner report were that medical education became increasingly lengthy and costly, and its subject matter became increasingly unrelated to the conditions of medical practice. The fact that only nonprofit medical schools could become "approved" probably contributed to the nonmarket-oriented attitude of many medical schools and their willingness to cooperate with the goals of organized medicine.

Several writers have observed that the AMA's changing positions on the proper standards for medical education correlated far more closely with the financial pressures faced by practicing physicians than with any clearly defined goals of medical training. For example, Philip Kissam has written that:

> The AMA's Council on Medical Education has been able to reduce the number of new physicians entering the profession by increasing the standards for accreditation of medical schools, thereby driving some schools out of business, discouraging new schools from opening, and reducing the size of others [yet the] quality standards imposed for physician licensure have never been carefully correlated with definitions of acceptable medical performance. Most significantly, major "improvements" in standards for accredited medical schools generally have been imposed at times when physicians' incomes were relatively depressed and have been accompanied by open expressions of concern by leaders of organized medicine about the "over-crowded" medical profession.

Economic Effects of the Licensing of Physicians

After surveying the development of licensing laws in various professions, economist Thomas Moore concluded that "licensing raises the cost of entry which, in turn, benefits practitioners already in the occupation at the time of licensing." Because that is the principal effect of licensing, Moore concluded that it is also the principal purpose.

Traditionally, a medical license was an unlimited license to perform medical services. A physician, once licensed, could theoretically perform any kind of surgery—including open-heart and brain surgery—without any special training as a surgeon. Further, most state licensing laws granted a lifetime tenure to the licensee. Although most states required periodic license renewal, renewal was generally a clerical procedure requiring little more than the signature of the physician and the payment of a nominal fee. Until recently, few states required physicians to show evidence of having updated their knowledge as a condition for maintaining a license.

Not only were physicians not required to keep abreast of the state of medical science in their specialty but, in some states, a physician could continue to practice even if mentally ill. A 1967 survey found that only one state, Arizona, required that a candidate for a medical license be "physically and mentally able safely to engage in the practice of medicine." Some statutes did establish mental illness or mental incompetence as grounds for suspension or revocation of a license, if the extent of the illness rendered the physician "unsafe or unreliable as a practitioner." But other states provided for license revocation or suspension only if the physician entered a mental hospital.

In the 15 states that listed malpractice among the specific grounds for licensing discipline, the standard was usually "gross malpractice," "gross neglect," "gross carelessness," or "gross incompetence." The practical effect of these provisions, as one study concluded, was that the "disciplinary criteria are ... analogous to less stringent criminal standards of gross malpractice, which are usually included in state penal statutes." It would appear that Kessel's 1970 observation that "once a doctor wins a license to practice, it is almost never revoked unless he is convicted of law-breaking" was not an exaggeration.

Restrictions on Nurses and Other Paramedical Personnel

Although medical practice statutes did little to protect the public from incompetent doctors, they did a great deal to discourage competent nonphysicians, such as nurses, paramedics, and physicians' assistants. Numerous studies in the 1970s established that nonphysicians can safely perform many routine medical acts. They include physical examinations, diagnosis and treatment of common illnesses, minor surgery, and decisions to continue or modify prescribed treatment for convalescing or chronically ill patients. Studies also showed that when trained nonphysicians were used innovatively under the direction of physicians, the costs of medical treatment could be substantially reduced.

But standing between the patients and safely administered, lower cost medical treatment were numerous state laws. A 1975 survey found that, for the country as a whole, many—or perhaps most—routine medical procedures

could be carried out only by licensed physicians. Moreover, in those states that allowed delegation of medical acts, the nonphysicians usually had licensing laws of their own and lobbied to keep other qualified nonphysicians from legally performing those same acts. Although many states liberalized their medical practice statutes during the 1970s, many of their unjustifiable restrictions exist even today.

Restrictions on Advertising

Professional licensing of physicians was also used to protect physicians from competition with each other. The AMA not only made adherence to a fee schedule an issue of professional ethics, but also pronounced advertising to be unethical and unprofessional. In 1961, the licensing laws of 40 states defined advertising as unprofessional conduct, and thus grounds for license suspension or revocation. However, only advertising that benefited an individual physician was "unprofessional." Advertising that benefited the medical community as a whole was a different matter. Kessel has explained the distinction:

> The advertisement of medical services is approved by the medical profession if and only if such advertisements redound to the interest of the medical profession as a whole. Advertisements in this class are, for example, announcements of the availability for sale of Blue Cross-type medical plans. These plans allow their subscribers the choice of any licensed practitioner .... On the other hand, advertisements that primarily redound to the interest of a particular group, for example, advertisements by a closed panel medical group, are .... resorted to only by "unethical" doctors .... [A]dvertising in this class constitutes competitive behavior and leads to price cutting. It tends to pit one doctor or one group of doctors against the profession as a whole with respect to shares of the medical care market.

Organized medicine used its state-created powers to punish deviant advertising behavior on numerous occasions. Here are some examples from the 1970s: In Minnesota, a gynecologist was warned against making radio and newspaper announcements of his one-week drive to encourage women to

obtain pap smears by offering discount prices; in Santa Clara, California, the county medical society prohibited clinic doctors who specialized in preventive industrial medicine from seeking new corporate clients; and in St. Louis, the local medical association forced the director of Washington University's sterilization and pregnancy termination clinic to apologize for mailing a brochure describing the center's facilities, even though the brochure was mailed to local physicians.

The attitude of the AMA toward advertising and price competition was paralleled by that of the associations of related health practitioners. The code of ethics of the American Dental Association, for example, stated:

> It is unethical for a dentist to give lectures or demonstrations before lay groups on a particular technique (such as hypnosis) that he employs in his office.
>
> It is unethical for specialists to furnish so-called patient education pamphlets to general practitioners for distribution to patients where pamphlets, in effect, stress unduly the superiority of the procedures used by specialists. Publication of such so-called patient education material has the effect of soliciting patients.

As another illustration, consider the rules and regulations of the Michigan Optometric Association in 1969. Eligibility for membership in the association was based on a point system and initial membership required 65 points. Constraints on advertising or disseminating information accounted for 70 out of the 100 possible points.

Virtually all of the restrictive practices described above either have been declared illegal by the federal courts or are almost certainly destined to become illegal. Yet the attitudes shaped and molded by the restrictive practices remain pervasive.