4. MARKET FAILURE IS ONE SOURCE OF ANARCHY

How can we spend so much to provide such low rates of care and to suffer inferior health? Since all the other rich democracies cover all their people and spend much less, and since most also provide more care and enjoy better health outcomes, how can we explain the failure of the U.S. to finance medical security for all Americans? The explanation must be powerful. It must make sense of the decades of failure to win affordable medical security for all Americans.

The overarching explanation is that anarchy governs U.S. health care.

Anarchy means that no one in U.S. health care is accountable for anything that happens outside the building where they work.

Not for protecting Americans' access to needed care.

Not for containing costs by excising clinical and administrative waste, holding down prices, or curtailing theft.

Not for securing the right numbers of family doctors, other doctors, hospitals, dentists, or other caregivers in the right places.

Not for protecting and improving quality and appropriateness of care.

Anarchy means high cost, weak access, much inappropriate and low-quality care, and malconfiguration of doctors, hospitals, and other caregivers. It means that up to one-half of health spending is wasted.

Anarchy pervades U.S. health care. It results primarily from the absence of a functioning competitive free market and from the lack of effective government action.

Secondarily, it results from pursuing well-motivated but doomed efforts to shoehorn health care realities to fit theoretical requirements of a competitive free market. And from weak political support for effective and strategic public action.

The alternative to market and government failures is to devise self-regulating substitutes—such as budgeting for hospitals and trustworthy professionalism for doctors—for non-functioning markets and ineffective governments. These should rest on foundations of strategic public actions to cap spending and cost, cover all people, promote better caregiver configurations, and boost quality and appropriateness of medical care.

This chapter examines one of the two sources of anarchy, failure of the competitive free market in health care. Chapter 5 analyzes government ineffectiveness and incompetence, the second main source of anarchy. Chapters 7-17 take up the elements of the self-regulating substitutes for market and government failure.

Money, power, and professionalism shape each nation's health care by making four core choices. The first is how much of the nation's resources to devote to health care (and, therefore, not to housing, education and job training, food, infrastructure, environment, defense, vacations, and other forms of personal, corporate, or public consumption or investment).

The second is choosing the types of health care to provide, and at what prices and volumes.

The third is choosing who gets how much of what kinds of health care.

The fourth is choosing how to finance, organize, and deliver that care.

Three core consequences of market failure in health care

The consequences of market failure in health care are profound.

First, market failure means that profits in health care are not legitimate. Without a competitive free market to justify profits, profits don't signify efficiency, innovation, and delivering what people need and want. Comprehensive market failure—inability to come close to satisfying even 1 of the 7 requirements for free market competition—means that profits are not legitimate. Therefore, profit-seeking caregiving and insurance should be phased out.

Second, market failure in health care has imposed heavy burdens on governments. Governments have been politically, financially, pragmatically, and legally unable to shoulder those burdens. Market failure has led to pressure on governments to protect patients from loss of care and payers from having their money stolen. Often unwilling or unable to respond, governments sometimes deny that market failures are real or grave. When they do, their responses are usually inadequate. Governments have played the role of the worker with the wheelbarrow and shovel who tries to clean up after the circus parade. But the animals are numerous; the street is wide; and the blade of the shovel is very small.

Third, market failure plus government incompetence have meant that many Americans lack nearby caregivers who are available and able to address their medical needs. Caregivers are malconfigured. Primary care is in short supply—and getting shorter. Needed hospitals close. And no one is accountable for identifying the types and numbers of needed caregivers, or where they should be located.

A. Promises of market competition—the opiate of the managers

First, competitive free markets promise to make these four choices effortlessly and unthinkingly. Second, they promise efficiency—low cost, innovation, and satisfaction of consumer demand as expressed by purchasing power. Third, they promise to rely on an invisible hand, one that obviates all but minimal government regulation. These three promises spur many hopeful people to embrace market forces to improve health care delivery in the U.S. Many other people default to relying on markets because they are convinced that governments can't act competently in health care.

In markets, sellers of goods and services greedily pursue profits. Genuine markets transmogrify greedy profit-seeking to deliver on the three promises.

4. Market failure is one source of anarchy

In a competitive market, no seller is big enough to influence price of any good or service. Instead, the market sets the price of each good or service through the interaction of many small sellers and buyers. Sellers must therefore hold down their costs. Unless businesses selling goods and services hold down their costs, they will not earn profits since they can't boost profits by raising prices.

Innovation is a main means of cutting costs. It can take three main forms—substituting capital equipment for labor, inventing new methods of manufacturing, and re-organizing production processes. Innovative industries generally feature falling costs (and prices) and improvements in quality or effectiveness. The auto industry saw both, especially in the early decades of the 20th century. The price of a basic car in the U.S. fell by about 50 percent between 1900 and 2000, measured in real (inflation-adjusted) dollars. And in one decade, from 1990 to 2000, the price of a personal computer fell by about 40 percent even without adjusting either for inflation or for radically better performance.[1944]

Sellers in competitive free markets must offer what buyers wish to purchase. If not, sellers' goods and services remain unbought. In the Soviet Union during late 1950s and early 1960s, for example, inventories of clothing grew much faster than sales because potential buyers declined to purchase much of the clothing offered in stores.[1945]

Markets self-regulate. That is, they cut cost, innovate, and deliver what buyers seek without outside supervision. If one seller is inefficient, fails to innovate, or misjudges what buyers want, it is likely to go broke. If one seller somehow grows big enough to impose higher prices than the market would sustain, new competitors will enter the market and seek customers by charging prices lower than those of the big seller. The big seller is forced to cut prices to match those of the new competitors.

Competitive free markets relentlessly pursue efficiency to cut cost. This drives out waste. High levels of waste in U.S. health care (discussed in chapter 3) are—in part—symptoms of market failure. (Those high levels of waste are also symptoms of government incompetence, the topic of chapter 5.)

Although competitive free markets need little government intervention, some actions are required. Governments need to combat the tendency toward concentration by making entry easier and by anti-trust action when necessary. Governments should police markets to maintain standards of safety and prevent cheating or criminal behavior. Perhaps most important, governments intervene to redistribute purchasing power to promote fairer sharing of goods and services produced by markets.

That's because genuine competitive free markets are efficient but they tend to be inequitable. When competitive free markets allow buyers to use their purchasing power, they simply ratify the existing distribution of income. Buyers' choices and incomes determine who gets what. But since incomes are often markedly unequal, the result is unequal ability to buy what's needed or wanted.

This inequity can be remedied without undermining competitive market for goods and services. Deliberate government intervention can redistribute money to improve equity. Buyers can then purchase what they choose.

Markets are appealing, then, because their invisible hand exploits the widely-distributed hormonal greed of profit-seeking to deliver lower costs and prices, spur innovation, and produce what people wish to buy—all without government or insurance company regulation. Markets' unfairness can be redressed by redistributing income—buying power.

This appeal is so powerful that some well-intentioned health care reformers focus their energy on making markets work better. They sometimes try, for example, to boost competition by fighting mergers that aim to enhance hospitals' power to set higher prices.[1946]

And they applaud policies that raise patients' out-of-pocket (OOP) costs in hopes this will make sick people shop more carefully. That aims to turn patients into enlightened price-sensitive consumers who will wield battering rams to wreck or reform high-price and low-quality providers.[1947] Jenkins imagines that failure to tax health insurance premiums gives Americans "a giant regressive tax incentive to overconsume and to be insensitive to trade-offs between cost and benefits." [1948]

These putative reforms are all fantasies. They testify to the romantic power of the fiction of free market competition in health care. Sadly, they do little good and much harm because they can't overcome market failure. Much as focusing on SDLs saps energy from fixing health care (as discussed in chapter 2), trying to make markets work distracts attention from remedies that could actually build effective and affordable health care for all Americans.

Most U.S. economists embrace this romance. It is remarkable that so high a share of such smart and decent people do so. Economists' dominance of health policy research and health policy in the U.S. both reflects and helps to sustain belief in market forces. That dominance has helped powerfully to paralyze practical health reforms for decades. This paralytic macro-illness might be called "economitis."

Most health care owners and trustees embrace competition and its engine, profit-making. Owners and directors of for-profit hospitals and insurance companies tout competition and hire managers who do the same. Managers with MBA degrees were exposed to two years of competitive thinking in business schools. Many trustees of non-profit hospitals believe, with considerable justification, that they have had to focus on the bottom line and espouse the mantra of "no margin, no mission." [1949] [1950] [1951] So they hire the same sorts of managers.

I've called competition in health care the "opiate of the managers" because its intoxication relieves the pain and guilt—about care denial and putting profits before patients—that follow from embracing market behavior when no competitive market exists.[1952]

Clinging to competition

In health care, free market economists, hospital and insurance company owners and trustees, managers, politicians, and other romantic fantasists generally insist that six things are both desirable and feasible.

First, choice is a central value in markets, so patients should be free –or forced—to make financial choices among competing Medicare Advantage or ACA plans or Medicare Part D drug plans. Even though the plans they choose often have narrow networks of doctors and hospitals, which greatly constrains the much more important choice of actual caregivers. Similarly Medicare Part D drug plans compete by premiums, OOPs, covered meds, and administrative

requirements—which are so opaque that tiny shares of Americans actually find their way into the drug plan that best meets their needs.[1953]

Second, only competition can contain health care costs, so patients must be made price-sensitive when buying health care. This means high OOPs and weak insurance coverage. These magnify effects of income inequality by further limiting many patients' actual access to actual health care.

Third, choice and competition require that patients have accurate and relevant information about the price and quality of the medical services they might need. But data about price remain terrible and very few Americans even try to use them. Data about quality are even worse. Moreover, where to buy care—at what price and quality—is vastly less relevant than whether the patient actually needs it. Few of us have medical or nursing degrees.

Fourth, to persuade caregivers to lower their prices, they must be prevented from gaining market power through mergers or other techniques, and they must be incentivized financially to lower prices to gain volume, total revenue, and surpluses or profits. But in most places, caregiver concentration is high and growing.

But **fifth**, a health care world of multiple caregivers who compete by price and quality and face sharp financial incentives is a world of vast mistrust and complexity. High administrative costs result. Those addicted to choice and competition in health care insist that this is a price worth paying.

Sixth, all this is necessary because U.S. payers—insurance companies and governments—are neither competent or sufficiently politically motivated to contain health care costs. So competition is the only remaining cost control tool.

Despite decades of failure, affection for competition to hold down health care prices and costs remains high. In January of 2024, DHHS appointed its first "chief competition officer." She was supposed to work with the Federal Trade Commission and the Department of Justice's Anti-trust Division to boost competition to contain cost.[1954] It is hard to know whether this appointment was mainly symbolic and political—aiming to signal that Biden was in synch with Americans' trust in competition, or whether it was expected to have any practical effect. Steadily growing concentration and declining competition in health care make the former more likely.

As discussed shortly, none of the 7 requirements for competitive free markets are satisfied in health care today. Indeed, they cannot be satisfied. Insisting on market competition in health U.S. health care therefore leads to many abuses--high costs, very uneven access, malconfigured caregivers, and weak appropriateness and quality of care. Attempting to ameliorate and prevent abuses fills the bandwidths of federal and state governments. Those bandwidths have been pre-emptively narrowed by politicians' trust in health care competition, by caregivers' and insurers' distaste for government action, and by weak political pressure on government to make strategic decisions.

Weak political support for government action means that legislative responses to abuses are weak, half-hearted, indirect, and confusing. Subsequent regulations are necessarily long and legalistic and complex. Frequently litigated, they are typically ineffective, open to gaming by

affected parties. Political and financial pressures and judicial ham-stringing often lead to weak enforcement of many regulations. Other regulations are simply unenforceable.

Governments have lacked the political support, time, energy, knowledge, and attention to put their arms around health care problems, understand their causes, and legislate and implement the remedies that actually work fairly well in the world's other rich democracies. The government macro-disease could be called "regulitis." This chronic illness saps governments' energy. Governments do not learn to be more competent. Enervated and lacking in self-confidence, governments cede more responsibility to imaginary competitive free markets.

A few economists decry the lure of the market. Ginzberg long did so, noting that health care is "noncompetitive." [1955]

Rice is another. Writing with Vladeck, he urged that the power of sellers (caregivers) be acknowledged and addressed.[1956]

Glaser decried economists' powerful role in shaping U.S. policy.[1957] He contrasts it to their role in most other rich democracies, where they provide technical analyses such as estimating the benefits and costs of politicians' proposed reforms.

(As chapter 5 will discuss, the mirror-image faith that traditional government action can modulate markets' abuses in health care helps to sustain trust in market forces even though that faith is just as unrequited as faith in markets itself.)

Sadly, love of markets is sometimes exploited by cynical actors who assert that market competition justifies their own anti-competitive behavior. Some hospitals, insurers, drug makers, and others have marshaled free market competition arguments in hopes of neutralizing public legislative or regulatory action to curtail abuses stemming from their illegitimate and anti-competitive exploitation of their own market power. They tout their profits as evidence they are doing well by doing good. But without a functioning competitive free market, profits don't testify to efficiency, innovation, or satisfaction of consumer demand. They signal nothing but ability to garner profits. Absent such markets, profits might be evidence of efficiency or they might be the froth on the toxic waste stream that flows out of failed markets, propelled not by gravity or an invisible hand, but rather by greed and gaming.

Although market competition is powered by greed for profit, high profits are not durable in such markets. Small businesses constantly form and go broke. Economic life in a freely competitive market resembles personal security in Hobbes's state of nature. There, absent government's protections, life is "solitary, poor, nasty, brutish, and short."[1958]

In markets that actually are free and competitive, owners of small businesses work long hours and garner low profits. They constantly live with uncertainty. It is not surprising, therefore, that economic actors seeking securely durable profits work unceasingly to get bigger and gain leverage over prices—thereby thwarting free market competition—in order to protect themselves from bankruptcy. Nonetheless, highly profitable drug makers, medical device manufacturers, insurance companies, hospital chains, and others rely on self-sanctifying assertions that their virtuous conduct in a notionally competitive free market justifies their higher profits. These justifications constitute the main actual function of talk about markets in health care today.

This rhetoric serves as a vehicle for rationalizing more than unwarranted profits. It also rationalizes greed, selfishness, and manipulation. It supports obsessive attention to money in health care. An extreme assertion is that "profits are a vital—and completely moral—motivation for anyone engaged in productive activity."[1959]

Those who seek higher profits by scrambling for greater power and leverage in U.S. health care often find allies among many professional economists whose blood was infused with the competitive free market's virtues. A little like malaria—such that many economists feverishly see a mirage of competitive free markets in U.S. health care, not the reality of comprehensive market failure.

Monetization, financialization, incentives, and budgeting

Believers in competition use financial incentives to contain cost. Some suppose that good insurance coverage has fueled high U.S. health costs—even though other rich democracies' superior coverage is not associated with higher costs. Still, those who imagine a link between good coverage and high costs embrace high OOPs as a tool to control patients' imagined urge to use more health care.

Similarly, some suppose that paying fees to doctors who perform individual services and paying hospitals for each admission or ER visit have incentivized them to boost volumes of care. So capitation and "pay for value, not volume" are lauded as a way to reverse financial incentives.

In these and other ways, market thinking has rationalized what many justifiably call the monetization or financialization of health care.[1960]

One of the most remarkable things about U.S. health care is that so many doctors, dentists, other professionals, hospitals, nursing homes, and other institutions think about money so often, so intensely, and from so self-interested a viewpoint. The inability to contain costs by other means helps to explain the slide toward using money as a tool to slow cost growth. Intensification of financial thinking has not slowed health care cost increases. Instead, it has raised doctors' alienation and lowered appropriateness of patient care.

Many nations rely on capping total annual revenue for health care or on providing annual budgets for hospitals. The inevitable scarcity of money is visible to anyone who looks, and it becomes essential to spend it carefully—lest care's access or appropriateness suffer. Caregivers could reasonably be trusted to do this because few were profit-oriented or financially incentivized.

One peculiar aspect of monetization is the shape that budgeting has taken in U.S. health care. Early support for prepaid group practices and other HMOs rested heavily on their integration of financing with care delivery. A finite sum—a budget—was available to serve a defined group of people. Reformers who advocated ACOs, Medicare Advantage plans, and Medicaid managed care plans hoped that these mechanisms would oblige caregivers to serve patients well—but affordably.

Unfortunately, practice departed from theory. As implemented in the U.S., the budgeted HMOs and other entities have been increasingly operated for-profit. So they face financial incentives to withhold care from patients in order to boost profits or bonuses. This is corrupt and untrustworthy in the absence of free market competition and adequate safeguards for access

and appropriateness of care. Worse, the design of Medicare Advantage invites those operated for-profit to focus on boosting their revenue instead of caring for patients prudently. Thus, even the use of finite budgets to constrain U.S. cost growth and induce caregivers to serve patients prudently has—to a great degree—been hijacked.

Optimism. In the future, though, monetization of doctors' care and of organizations' budgets could be converted into a valuable foundation for better use of money to improve health care. This conversion requires at least two types of change.

The first is that doctors will need to think about how to spend money carefully to do as much as possible to boost patients' health with the dollars available. Their own financial well-being must be pushed into the background so they are liberated to put patients first. How to do that? By paying them well enough—and by paying them in ways—to liberate them to do what they trained to do—take care of patients.

The second type of change is making all organizations financially neutral. This means an end to for-profit delivery of health care. Instead, the finite budget must be spent each year to do as much clinical good as possible. The only reason to deny one type of care to one patient is to be able to serve another patient—one who'll benefit more from medical care. This change will capitalize on the gradually accumulating knowledge of how to spend money carefully but will channel it in a more valuable, fair, and affordable direction.

The absence of a competitive free market deprives profit-making of any legitimacy. Profits don't signal lower cost, efficiency, innovation, or satisfaction of consumer demand. They simply signal profits.

Market failure means that profit-seeking corrupts behavior, allocates resources badly, and justifies waste and denial of needed care.[1961] Profit-seeking justifies withholding needed care to low-paying or uninsured patients, and over-serving patients of high-paying insurance companies. It justifies over-providing types of care that are profitable and under-providing unprofitable care. It allows Steward and Prospect to tout profits won by despicable methods.

Profit-seeking wastes the most precious human resource in health care—the scarce time of doctors, nurses, and other caregivers. Paperwork wastes time, and—as discussed in chapter 3—mistrust between payers and caregivers is the main generator of paperwork.

Time is also wasted when a small but growing share of doctors pursue MBA degrees along with their MD or DO. Reporting on this trend, Liss portrays a doctor who planned on a career in rural primary care but instead ran a company to advise cardiologists.[1962] MBA programs generally teach ways to make profits. Absent a free market, doctors who pursue profit serve patients and the nation poorly. They have less of their own time to devote to learning medicine and practicing it proficiently—and they divert the time of other doctors toward seeking illegitimate profits.

B. Sadly, health care thoroughly violates each of the market's 7 requirements

Hospital chains, drug makers, insurance companies, and others compete for patients and profits in health care today, but they do not do so in anything close to a competitive free market. Consequently, current competition in health care can't deliver the low cost, innovation, and satisfaction of buyers' demands that truly competitive markets promise.

Clearly, free market competition is never either entirely present or absent. Competition is a continuum, not a dichotomy.

Suppose that we assign a value of 10 to a vigorously competitive free market in health care and a value of 0 to health care entirely lacking such a market. I'd then rate health U.S. health care a 1. The foundations—and, therefore, the benefits—of free market competition are missing in health care; their presence is imagined mainly by theoreticians or ideologues.

As Wainer writes, "Nowhere else in the world do so many health care dollars encounter so few mechanisms to limit profiteering."[1963]

Free market competition requires seven distinct things. All are largely absent from U.S. health care today. Indeed, they are unattainable in health care. The seven requirements and ways in which health care departs from them are summarized in Exhibit 4-1.

Many reforms seek to address one or more of the 7 areas where markets fail today. Most of governmental engagement with health problems aim to advance competition or modulate its ill effects. Both sets of remedies are doomed. The 7 requirements for competitive free markets are not remotely attainable in health care. Effective reforms must be built on very different foundations. Understanding reasons for market failure is essential to crafting those foundations.

Abandoning efforts to actually fix health care problems, many proposed health care reforms and have substituted indirect attacks on the various market failures instead. They imagine that creating a functioning and self-regulating free market will fix U.S. health care's vast problems. Because free market competition is unattainable in health care, this substitution is futile.

(This substitution parallels decisions by the Food and Drug Administration to approve new meds that have not actually been shown to be effective—or even safe. Rather, they might be effective because they induce some changes that are hypothesized to be beneficial. Those changes are called "surrogate endpoints." [1964] [1965] That's a pernicious example of Newspeak since these are not endpoints at all.

Worse, it sustains the flow of more money for business-as-usual into health care. And that permits the regime of rising costs, suppressing access, malconfiguring caregivers, and wasting one-half of our health care spending to stagger on for a few more years. It enables a financially obese boondoggle of galactic proportions.

4. Market failure is one source of anarchy

Exhibit 4 – 1

7 Requirements for Functioning Competitive Free Markets, and Reasons They Can't Be Satisfied in Health Care

The seven requirements for a free market	Why they can't be satisfied in health care
1. Many small buyers and sellers, so all parties are price takers, not price makers. The market makes the one price for each item. No one has power in the market to extract a higher or lower price.	In many regions, a few hospitals dominate delivery of acute care and obtain higher prices. Elsewhere, a few large private insurers or HMOs leverage lower prices. Medicare and Medicaid regulate the prices they pay. Payers pay very different prices for the same care.
2. No artificial restrictions on supply, demand, and price. Autonomous consumers decide how much to demand; producers decide how much to supply. Their interactions determine price. Consumers of care are sovereign—they independently decide how to spend their own money.	Very few patients are autonomous. Almost all are uninformed, worried, and inclined to listen to well-trained experts. Also, patients with insurance are not spending their own money, so they are not aware of the actual price or total cost of the care they get. In the past, hospitals and doctors established and controlled insurance companies expressly to assure themselves of regular revenue. Public payers set the prices they'll pay by law or regulation.
3. Easy entry and exit to and from the marketplace. If a caregiver gains a monopoly, which allows it to extract fat profits, those profits attract new caregivers, which bid down prices to free market levels.	Once some hospitals close or consolidate in a region, it is very costly or hard for new hospitals to open. Hospitals and other caregivers are highly concentrated in many regions. Also, drug makers have legal monopolies (patents) on new drugs.
4. Sovereign consumers have and use good information about price and quality to inform decisions of what care to buy. They know what they need and want. Sellers have good information about competitors' prices and quality.	Patients and families often have trouble finding valid information. And many people are worried when sick. Although caregivers—especially doctors—have much better access to information, even they often lack evidence on what care works and who needs it.
5. Constant suspicion—"let the buyer beware!" Don't trust anyone!	But patients are likelier to recover, other things equal, when they trust their doctor, nurse, or other caregiver. Also, mistrust engenders great administrative waste.
6. Price tracks cost closely, so buying something with a low price means buying from a low-cost producer. Price is a signal for cost. Buying low-price care rewards low-cost (efficient) caregivers.	Often, health care prices are not even close to cost of care. Some prices are much higher than cost, and others are much lower.
7. Sellers aim to maximize profit. Hospitals, doctors, and other caregivers seek high profits. Profits are legitimate because they are won via efficiency, innovation, and making what sovereign consumers wish to buy.	Many caregivers and insurers profit by generating high revenue, not through efficiency. Others cheat. And still others over-serve profitable patients or diagnoses. Many caregivers are big enough to extract high prices from private insurers. Many non-profit caregivers use higher revenues to finance costlier care.

1. Many small buyers and sellers mean the market sets 1 price for each item

A functioning competitive free market has so many small, separate, independent, and competing buyers and sellers that none are big enough to leverage prices up or down. This is a way of saying that the market itself makes the price. The market does so where supply meets demand. In this way, the market sets one price for each service. This price correlates with a particular volume.

In a competitive free market, the actions of lots of small buyers and sellers determine prices paid and quantities sold. The market makes one price for each type of good or service.

But health care, different private insurers, state Medicaid programs, and the federal Medicare program all pay different prices for the various individual medical services. Larger caregivers exert more power over payers—either by commanding more patients over private insurers, or by exerting more political pressure against Medicare and Medicaid. The existence of a wide range of prices for the same service manifests the failure of a competitive free market to operate.

When many different prices are paid for the same service, equity across patients falls. At the same time, the greater complexity associated with paying so many different prices elevates the costs of administering health care benefits.

Congress sets the prices Medicare will pay for various hospital, physician, hospice, and some other types of care. State legislatures set the prices that state Medicaid programs will pay for hospital, physician, dental, nursing home, prescription drug, and other types of care.

Private insurers, unable to regulate prices and legally prohibited from colluding, pay higher prices—and also a wider spread of prices. Bigger private insurance companies are often able to win lower prices for themselves. Mid-size and smaller insurers try to win lower prices for themselves by rewarding doctors or hospitals that agree to accept lower prices with “preferred” or “in-network” caregiver status. That means patients will pay less out-of-pocket when cared for by those doctors or hospitals. This is expected to boost volumes for those preferred caregivers. One result is an even greater spread of prices paid to doctors and hospitals.

Payer concentration. Insurance coverage through Medicare, Medicaid, or private insurance generates most of the revenue flowing into health care. In 2025, Medicare is paying 23 percent of the cost of personal health care services—those actually received by individual patients; Medicaid, 18 percent; and private health insurance 33 percent—for a total of 74 percent of all spending on care for individual patients.[1966] Other health insurers and other third party payers paid 13 percent. The remaining 12 percent was paid out-of-pocket.

This concentration of buying power grossly violates the many-small-buyers requirement for competitive free markets.

Governments use their regulatory power to set lower prices for themselves. Private insurance companies merge to pursue leverage over doctors and hospitals. One health insurer covered on-half or more of privately insured Americans in almost one-half of U.S. metropolitan statistical

areas (MSAs).[1967] For Medicare Advantage, fully 71 percent of MSAs were highly concentrated in 2022. And Medicaid managed care has seen increasing concentration, with a few large national companies crowding out smaller and local ones.[1968] [1969]

Three very different sets of prices. Different insurance companies pay very different prices for the same care at the same place. Medicare pays much lower prices than the insurance company averages, and most state Medicaid programs pay even less.

For doctors, a CBO study found that commercial insurers' prices were almost one-third above Medicare's in 2018.[1970] (Between 2013 and 2018, the insurers' prices rose twice as fast as Medicare's.) But Lopez and others' review of published studies found an excess of over two-fifths.[1971] Medicaid's prices paid doctors were almost one-third below Medicare's in 2019. They were about two-fifths lower for primary care, on average [1972] and less than one-half as high in 6 states.[1973]

For hospitals, Lopez and colleagues' review of 19 published studies found commercial insurers' prices for inpatient care to be 89 percent higher than those paid by Medicare. A 2017 report from the Medicaid and Chip Payment and Access Commission (MACPAC) found that Medicaid payments for inpatient care roughly averaged prices paid by Medicare—once states' supplementary payments were included. It noted very substantial differences across and within states, though. Prices paid for individual types of medical care varied within states.[1974]

Seeking to restrain spending, Medicare and Medicaid have steadily cut their reliance on price regulation. They have substituted capitation. Growing enrollments in Medicare Advantage and Medicaid managed care have done little or nothing to restrain spending. And they have not narrowed gaps in prices paid by commercial insurance, Medicare, and Medicaid.

Medicare Advantage covers over one-half of Medicare-insured patients. MA plans are run by insurance companies. When they negotiate prices with different doctor groups, they generally pay sums fairly close to the regulated prices set by Congress for traditional Medicare.[1975] They do the same when paying hospitals.[1976]

Medicaid managed care plans cover over three-quarters of Medicaid patients and account for over one-half of Medicaid spending. Almost all states capitate these plans and are permitted to choose approved methods by which the plans may pay caregivers. And they can mandate higher rates of payment for some services. Generally, though, Medicaid managed care has apparently done little or nothing to lift the low prices by which traditional Medicaid paid doctors and hospitals in most states.[1977] Interestingly, Medicaid managed care organizations denied prior approval for care 12.5 percent of the time, substantially higher than Medicare Advantage plans' 5.7 percent.[1978]

Wide price gaps. One price means one price. All payers pay the same price for the same item at any given place and time. But a wide range of prices characterizes U.S. medical care. This is a clear signal that nothing close to a competitive free market is in operation.

One of the most dramatic failures of prices to converge was reported by Hopkins and Ulick, who found that the private Medicare drug plans charged 2,200 different prices for a commonly-prescribed drug for prostate cancer. Price gaps were enormous, not merely inconsistent. They

varied four-fold across Michigan counties. Different PBMs, imagined by some to win lower prices, charged radically different sums for the meds examined.[1979]

Wang and colleagues found very wide ranges in prices—for the same services at the same hospitals—paid by different large insurance companies.[1980]

Morey and others studied variation in prices actually paid for three types of emergency room care. The middle of the three was deemed to require a moderate level of clinical decision-making. Private insurers paid a median price of $838. Cash payers paid $699. MA plans paid $367. And Medicaid managed care plans paid $273. The median private insurance price paid was just over three times the Medicaid managed care price.[1981]

Philips and Whaley found very considerable variations in prices paid to—both for their services and, even more, for their facility fees.[1982]

These gaps in price do more than signal a violation of the first requirement for a competitive free market. They also invite caregivers to discriminate among patients by price. Most caregivers will do what's right, medically and ethically. Some won't.

Hospitals and private insurers seek—and sometimes find—leverage over prices. Looking across various insurance companies, a Massachusetts state analysis found very wide differences in prices paid to various hospitals, even after controlling for patient acuity. Some hospitals were paid one-third, one-half, and even four-fifths above the statewide average, while others were paid three-quarters of the statewide average. [1983] Some of the larger merged systems were paid much higher prices.

In many regions, population density is too low to support more than one hospital and a few doctors. Little competition is possible there. Caregivers enjoy something close to geographic monopolies or oligopolies.

Elsewhere, both doctors, hospitals, and other caregivers (sellers) and employers or insurers or public programs (buyers) often merge or otherwise join together to exert leverage on price. In a number of metropolitan areas—such as Boston, New York, Pittsburgh, and parts of northern California, substantial shares of hospitals have merged in hopes of leveraging higher prices from private insurance companies. Promising to cut cost and boost quality, Boston's two biggest hospitals were allowed to merge in 1994 without even a public hearing. No actual evidence of lower cost or better quality has been adduced. A subsequent merger in the region promised—with a straight face—to improve competition.

Similarly, for-profit hospital chains like HCA often seek to buy enough hospitals in a region—such as Savannah, Nashville, Asheville, and parts of Florida and New Hampshire— to gain sufficient leverage to extract higher prices from private insurance companies.

Some hospitals' mergers have been horizontal—combining with nearby hospitals, while others have been vertical—buying doctors, nursing homes, home health agencies, hospices, ambulatory surgery centers, and even insurance companies. Cooper and colleagues found that hospitals' purchases of doctors' practices increased costs.[1984]

Godwin and others found that one or two systems fully controlled hospital inpatient care in almost one-half of U.S. metropolitan areas in 2022. In more than 4/5 of metro areas, one or two

systems controlled over ¾ of inpatient care.[1985] Mergers and closings were partly responsible. The result is little or no price competition.

Similarly, the Health Care Cost Institute reports that hospital care in 140 of 183 metropolitan areas was highly or very highly concentrated in 2021.[1986]

Hospitals seeking to merge promise lower cost and better quality for the public. Unsupported by evidence, both claims can be seen as smokescreens for self-interested private gains.

Even if mergers made hospitals more efficient, the cuts in their costs would not mean lower prices for payers or lower OOP payments for patients. Rather, any lower costs would fall straight to the merged entities' bottom lines. Higher margins would result.

In Milwaukee, Advocate Aurora Health was sued in February 2024 for exercising its strong leverage as a must-have group to garner high prices. Insurers allegedly must have AAH in their network. One consequence has been AAH's ability to win payments for joint replacement surgery that are $21,000 (50 percent) higher than payments to a nearby alternative.[1987]

One recent case-control study of vertical mergers—between doctors and hospitals—found that patients were steered to merged entities, and that total spending rose.[1988]

The Department of Justice's Anti-trust Division and the Federal Trade Commission share responsibility for fighting anti-competitive mergers and other threats to competition stemming from bigness. Their actions in health care have generally been weak and transitory. One reason is that the standard for demonstrating that a combination restrains trade is so high that many mergers which rapidly enabled hospitals to extract much higher prices were never challenged. Also, when DoJ or FTC decides to act, courts often prove willing to tolerate high levels of concentration. DoJ and FTC officials occasionally warn of stronger enforcement efforts.[1989] These seem to have little effect.

A few outbursts of activity did stop hospital mergers in Rhode Island, Utah, and elsewhere, but these are exceptions. Sadly, though, preventing 2 Rhode Island hospitals from being acquired by stronger nearby systems may result in condemning the 2—financially weak after having been plundered by Prospect—to close. Organizations with motives and money to buy the hospitals were blocked for political and market-competition reasons. A financially weak organization was approved. This is not a recipe for success, nor is it one that recognizes the value of all 3 considerations of saving needed hospitals, enabling them to restore quality of their clinical services, and holding down total cost of hospital care.

Rhode Island Hospital fought off a purchase of the 2 by Mass General-Brigham. The state's attorney-general blocked Rhode Island Hospital from buying the 2. Late in 2023, he approved their purchase by a tiny Florida non-profit that had not previously run hospitals.[1990] But he needed to impose 85 conditions. By mid-2025, it had proven impossible to finalize the sale. The AG could not find an outside non-profit with demonstrated financial and managerial capacity, and experience, to buy and restore the hospitals. After Centurion proved unable to sell bonds required by one of the 85 conditions, the AG was obliged to relax it.[1991] Lawyers generally worship at the anti-trust altar of competition.

Lawyers' anti-trust suits are negative: they may fight mergers. But hardly ever does anyone fight positively and effectively to identify and to financially sustain needed hospitals and allow them to survive independently.

Unsurprisingly, Brot-Goldberg and colleagues found in the spring of 2024 that FTC enforcement of anti-trust laws against hospital mergers had been weak. The FTC moved against only 13 of 1,000 hospital mergers between 2002 and 2020. But, using the FTC's own screening tool, Brot-Goldberg and others found that about 200 of the mergers could have "been predicted to meaningfully lessen competition." [1992]

Mergers of hospitals located across different regions have also boosted prices. They have not been challenged on anti-trust grounds by either federal agency. Some individual states have done so but others have not.[1993] Late in 2023, BJC Health in St. Louis was allowed to merge with Saint Luke's in Kansas City. The resulting entity will operate 28 hospitals and garner some $10 billion in yearly revenue. Rather than promising efficiency, BJC's CEO trumpeted "'creating the region's premier destination to practice world-class medicine'"[1994] That might create new opportunities to boost prices.

Condon identified five cross-region mergers and acquisitions that have gone unchallenged.[1995] An exception has been the FTC's suit against U.S. Anesthesia Partners and its associated private equity firm. The FTC alleged that USAP sought to monopolize anesthesia in Texas and drive up prices. If further alleged that USAP fixed prices and worked illegally to keep out competitors.[1996] The American College of Emergency Physicians, once friendly toward private equity acquisitions, now opposes them.[1997]

Welsh Carson, the private equity firm that formed USAP, claimed that USAP's "commercial rates [increases] 'have not exceeded the rate of medical cost inflation for close to 10 years.'" [1998] That claim warrants scrutiny. Which measure of medical cost inflation was used? If it is the medical care component of the consumer price index, Welsh Carson's claim is not a reasonable one. That's because the CPI for medical care measures changes in charges—maximum prices, fantasy prices. These are far above—and rise far faster than—actual prices paid by commercial insurance companies. Or by other payers.

Abdelhadi and others tracked private equity acquisition of doctors' practices in ten specialties from 2012 to 2021 and, unsurprisingly, found substantial consolidation. Single companies owned 30 percent of doctors in 108 of 307 regions examined, and more than 50 percent in 50 regions. They called for "closer scrutiny by the Federal Trade Commission, state regulators, and policy makers." [1999] That call is likely to remain unanswered.

Newitt describes a bottom-up effort to preserve independent physician practices. Three groups of orthopedic surgeons in Durham, North Carolina, Indianapolis, and Seattle created a platform to support autonomous small and mid-size physician groups. It offers expert advice on negotiating with vendors, practice administration, and capital improvements. As other practices join the original three, they can share in the costs of supporting part-time CEOs, CFOs, and others.[2000]

In parallel, the Kaiser Family Foundation reports that insurance companies and other payers are very highly concentrated in most states. Fully 22 states have Hirschman-Herfindahl indices for insurers between 5,000 and 9,276, and another 24 states have HHIs between 2,500 and 5,000.[2001] An HHI above 2,500 is generally taken to indicate high concentration.

Recognizing the weakness and unsteadiness of the FTC and the DOJ's Anti-trust Division, Brown and Gudiksen have cataloged ways state and other entities could try to address consolidation.[2002] But the main problem with consolidation and resulting higher prices is not a

lack of tools. Rather, it is partly a lack of understanding of the breadth and depth of market failure. Some parties fatuously believe that "enough" competitors can be salvaged. And partly a lack of political pressure or will to confront powerful caregivers and payers.

Instead, politicians persistently posture. Competition champions clamor. And experts seize on signs of renewed vigor. Richman loudly applauds a "potential turning point in health care competition policy" when the Department of Health and Human Services issued a report on hospital consolidation.[2003] But it did so 5 days before Trump's 2nd inauguration.[2004] And there's almost nothing new in the report, which is mainly a compilation of replies to a DHHS request for information. Indeed, the report focuses on private equity, not combatting consolidation and advancing competition in health care.

In August of 2025, Trump revoked Biden's 2021 executive order number 14036, which promoted competition in health care and other sectors.[2005] An assistant AG in the DoJ's Antitrust Division became a strong contender in the competition psychobabble context by asserting that ceasing to push competition and oppose mergers amounted to "'empowering the American people in the free markets.'" [2006]

As noted elsewhere, particularly in chapter 12, state-level actors lack even baseline assessments of which hospitals are needed to protect the health of the people, let alone how many competing caregivers or payers are sufficient to revive "enough" competition.

That latter matter is very simple. The more competitors, the more market competition.

Finding ways to rescue or restore a level of competition deemed sufficient is a false challenge. That train has left the station. The real challenge is to find a workable substitute vehicle.

Price gaps and equity of care. The persistence of wide price variations gravely violates the one-price rule of competitive free markets. States set prices for Medicaid patients who are not enrolled in Medicaid managed care plans. Prices paid for those who are enrolled in those capitated plans are seldom higher. These are usually the lowest widely-paid prices. Some Medicaid patients may receive lower levels of care as a result.[2007] Privately- insured patients, whose care generates higher prices to hospitals, are more likely to suffer over-service—receive more care than needed—than are other patients.[2008] This waste is avoidable.

When different payers' patients' care is paid for at different prices, the clinical decisions by caregivers who seek to maximize revenue or surplus/profit will be distorted.

Everyone who thinks seriously about U.S. health care is aware of this problem, but its effects on under- or over-service are far from the center of financial and policy reforms. Movement to a single price for each individual medical service is barred by well-grounded expectations of political opposition. Most states are unwilling to pay more for Medicaid patients. Hospitals worry that, were they paid single prices, they might suffer a net drop in revenue. But single prices' value in advancing financial and clinical neutrality in caregivers' decisions would substantially improve appropriateness and equity of care. (They would also aid in designing fair and adequate prospectively-set fixed budgets for hospitals.)

In failed markets, prices for each individual service do not converge. Unfair and inappropriate care result. And, as will be discussed shortly, market failure also means that some services'

prices are well above cost while others are below cost. This distorts patterns of care toward profitable services.

Late in 2023, UnitedHealth Group was sued by three California hospitals on anti-trust grounds. When the hospitals employed doctors formerly affiliated with Optum, a UnitedHealth subsidiary, Optum allegedly made it hard for patients to follow their doctors. And UnitedHealth allegedly refused to renew contracts with those hospitals for commercially-insured and MA patients.[2009]

This allegedly illegal coordination by two arms of a vertically integrated corporation resembles the allegations that some insurance companies comply only on paper with the ACA's requirement that they devote at least 85 percent of their premium revenue to paying for health care. Some may avoid actual compliance by paying artificially inflated prices for meds to affiliated PBMs. This makes their health care expenses look higher than they really are.[2010]

Shoehorning: weak efforts to combat mergers

Those who hope to rely on competition in health care attempt to shoehorn health care realities to fit requirements of market theories. This chapter discusses three main types of shoehorning: combatting mergers and other consolidations to prevent further erosion of small competing caregivers and insurers; pushing patients to act like sovereign consumers; and complementary efforts to provide information that would enable notionally motivated notional consumers to shop by price and quality.

At most times—between short bursts of aggressive enforcement [2011]— federal and state anti-trust efforts have been weak and ineffective in deterring large system from forming or in breaking them up after they gain market power.[2012] One reason is that large regional or national hospital systems wield considerable political influence.

A second is that mergers are sometimes sold as ways to cut cost or boost quality. In reality, if mergers did actually cut any cost—a claim they tout but rarely even try to substantiate—any savings would fall straight to the hospitals' bottom lines. They would not result in cuts in premiums. When Boston's Massachusetts General Hospital sought to merge with Brigham and Women's Hospital, the two institutions variously predicted that they'd save $200 million yearly, $150 million in 3 years, $160 million in 4 years—or that they'd actually saved hundreds of millions of dollars. No such claims have ever been substantiated. (When I asked a nationally-known reporter whether she asked for evidence to support a claim of large savings by the CEO of the merged organization, she replied that he seemed so sure of the assertion and therefore didn't think it necessary to ask for evidence.)

Instead, the result has been a massive rise in prices extracted from Blue Cross and other private insurers. In 2021, for example, private insurers paid Massachusetts General Hospital prices that were 37 percent above the statewide average.[2013]

The merged New York-Presbyterian Hospital has, as intended, become a must-have hospital able to leverage highly favorable prices and other contractual provisions.[2014] In 2024, a union complained that NYP prevented it from steering members to less expensive hospitals. NYP's high prices and alleged anti-steering efforts led the Justice Department to investigate NYP for actions in restraint of trade.[2015]

Third, some mergers are approved by regulators to allow a strong hospital to rescue a needed but financially weak hospital.[2016] Some see this anti-competitive response as the only way to prevent the needed hospital from closing. But that manifests three failures. Payers, collectively, don't know which hospitals are needed to protect the health of their communities. Payers also don't know how much money is required to sustain needed hospitals when they are operated efficiently. And payers are not accountable, individually or collectively, for assuring that needed hospitals generate required revenue.

Larger insurers sometimes leverage lower prices for themselves. Insurers merge in hopes of countering or mitigating hospitals' own leverage. Insurers and other payers also try to form narrow networks of hospitals and doctors in hopes of extracting lower prices from them in exchange for higher volumes of patients.

More often, caregivers have been effective in gaining leverage over payers. Most mergers have not been challenged by federal or state anti-trust regulators. Payers remain more fragmented than caregivers, their potential collective power largely unrealized.[2017]

Remarkably, both hospitals and insurers insist that their own mergers are desirable, while the other side's mergers boost cost or undermine quality.[2018] [2019] [2020] [2021]

2. No artificial (non-market) restrictions on supply, demand, or price

In a competitive free market, autonomous patients (consumers) would act independently to decide what care they want and need, and from whom they would buy it—using their own money.

In a competitive free market, autonomous caregivers (suppliers)—doctors, hospitals, dentists, nursing homes, drug makers, and others—would decide what care they would like to give. No one would restrict their numbers, types, or locations.

The interactions of these many autonomous caregivers and patients would decide prices of various types of care and volumes of each type actually given to patients. The intersection of the demand and supply curves would indicate price of each unit of care and volume given.

In real-world health care, though, artificial restrictions on health care demand and supply are not merely exceptions; they are overwhelmingly the norm.

First, buyers of health care are not independent-minded, informed consumers. Rather, they are patients who depend heavily on doctors to advise or decide how to diagnose or treat medical problems.

Many restrictions affect the configuration of caregivers and the prices they charge. Patients suffer a variety of restrictions, also. Most of these are inherent aspects of medical care, not artificial or arbitrary restrictions. Buying health care differs enormously from buying food, clothing, bicycles, home repairs, and other ordinary goods or services.

The most noteworthy difference is that patients are patients, not the sovereign consumers imagined by free market theory. Calling them "consumers" does not change that. Patients are often worried or anxious. They usually have little accurate information about the nature of their

medical problem, how to treat it, where it should be treated, at what price, and by which physicians. Much information can be found on-line, but it is very hard for ordinary humans to separate the electronic wheat from the chaff—to learn one's diagnosis, the best of possible treatments, actual prices to be paid out-of-pocket by patients, quality of care of different hospitals and doctors, and the rest. Information that is available on-line is confusing, incomplete, and often contradictory. Understandably, patients rarely use such information.

Most patients, instead, trust their physicians greatly—or would like to do so—and rely heavily on their advice. Most patients believe doctors will generally act in patients' interest even though doctors' decisions about how much care or what types of care may be distorted by financial incentives.[2022] Patients often feel a powerful need to trust doctors because they are worried, and because they find it so hard to locate or understand information relevant to diagnosis and treatment.

This is one reason patients are not the sovereign, independent health care consumers posited by free market theory. Often worried and rarely well-informed, patients rely on doctors' advice.

This has several consequences. One is the risk of supplier-induced demand. Here, some doctors may persuade patients to accept diagnostic and therapeutic interventions like labs, imaging, biopsies, meds, and surgeries that might have low or no clinical value—and might even be harmful.

A second is that patients, unable to decide what care they need, judge caregiver quality, or to weigh benefits against costs, may suppose that higher prices signal better quality—and that more care is better than less care. When paid by the doctor visit, hospital admission, or other unit of care, caregivers face little pressure to compete by price, and are financially incentivized to boost volumes of services.

These combine to engender two things. One is competition by quality of care or—absent much objective evidence about quality—a better reputation. The other is a push to raise the ceiling on care—the best care that can be given to and afforded for some patients. That means less attention to raising the floor—the worst care that some patients receive, or that those patients suffer from non-receipt of needed care.[2023]

This all means higher cost and reduced equity of access to care.

Second, insurance coverage means that patients' own money is usually a small percentage of prices actually paid. Indeed, public and private health insurance programs were created to make it more affordable for patients to obtain needed care.

Only about one-tenth of Americans—those without health insurance—rely entirely on their own savings, income, credit cards, or charity to pay for medical care.

In passing, it is worth noting that the word "consumer" was invisible in discussions of medical care until it was written into the 1966 and 1975 federal health planning laws.[2024] That legislation divided the world into "consumers" and "providers" and sought to give the former majorities on health planning boards. Before then, words like "patients" were used to describe recipients of medical care. Few fantasized that patients were able, willing, or competent to become informed consumers. And doctors and nurses were called doctors and nurses, not providers—a term that

is hated in some quarters.[2025] Infiltration of words like consumer and provider are symptoms of the widespread fantasy that a functioning competitive market exists in health care.

Support from Medicare, Medicaid, and private insurance companies means that most patients are not spending their own money for medical care, most of the time. Patients' out-of-pocket (OOP) payments have fallen substantially over the past 60 years, the period for which good data are available. As shown in Exhibit 4 - 2, patients paid over one-half of the cost of health care services in 1960 but only one-eighth in 2020. OOP shares for hospital care were particularly low in 2020. Not shown, shares for dental care and long-term care were generally substantially higher.

Exhibit 4 - 2

Out-of-pocket Shares of Spending on Health Care Services, 1960 - 2020

	1960	**1980**	**2000**	**2020**
Personal health care total	55%	26%	17%	12%
Hospital care	20%	5%	3%	3%
Physician and clinical laboratories	59%	30%	11%	7%
Retail prescription drugs	96%	72%	28%	13%

Source: Office of the Actuary, Center for Medicare and Medicaid Services, "Actual and Projected National Health Expenditures, 1960-2033," https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected.

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Some hospitals and doctors have been accused of preying on patients by forcing them to pay very high prices for care when they lack protections of either regulated Medicare and Medicaid prices or prices negotiated with private insurance companies. Uninsured patients have no effective protections so doctors and hospitals often charge them their highest prices even though most uninsured patients have low incomes and assets.

Also, insured patients who stray out of their insurance company's preferred network of caregivers may be charged remarkably high prices. This problem has received growing attention in the past decade owing to high-visibility press reports of outrageously high surprise bills imposed on patients who thought they were in network—or who faced medical emergencies and could not safely obtain in-network care. State legislation and then the federal No Surprises Act of 2020 sought to address parts of this problem.

Third, supplies and capacities and spatial distributions of physicians and hospitals have been constricted, restricted, and diverted by many artificial non-market influences. Artificial restrictions and influences on the configuration of doctors have been prolonged and thorough. (The word "configuration" refers to the numbers, types, and locations of caregivers.) In the years after the Second World War, U.S. physician groups appear to have worked to hold down numbers of seats in medical schools and also federal subsidies for training doctors.[2026] [2027]

Even today, after the additions of many new medical and osteopathic schools—along with the growth in yearly class size of existing ones—the U.S. has only about three-quarters as many physicians per 1,000 people as the typical rich democracy.[2028] It is third from the bottom across rich democracies in doctors per 1,000.

Just as important, teaching hospitals have exercised very considerable power over the types of physicians trained in their residency programs. Unsurprisingly, individual teaching hospitals have sought the types of residency slots they deemed most useful to support care delivered ***in those hospitals***. They have not, generally, considered the ***nation's subsequent need for physicians***.[2029] This is one part of the explanation for the relatively low share of primary care physicians in the U.S.

Early Blue Shield plans insurance plans—controlled by state medical societies—covered surgeons' and other procedure-performing specialists' care for many years before they covered primary care. Their coverage decisions had the effect of substantially boosting incomes of surgeons and others who performed procedures. This has helped to make careers in primary care less attractive, markedly and dangerously distorting the configuration of physician care (please refer to chapter 11).

Hospitals tend to compete more by perceived quality of care and scope of services than by price. One reason is that most hospitals are non-profit (57 percent) or public (18 percent), with only 25 percent for-profit.[2030] Another is that the physicians and medical schools associated with the teaching hospitals that increasingly dominate care in metropolitan areas are more devoted to pushing back frontiers of medical knowledge than to pursuing profits.

Mergers, purchases, and other consolidations of hospitals have markedly cut price competition in many regions. In cities, the disproportionate closing of lower-cost community hospitals and of hospitals in Black neighborhoods have reduced competition and access to care (see chapter 12). Public policies supported hospital closings out of a belief this would cut cost of care. But the resulting combination of the loss of less expensive hospitals and greater ability of surviving hospitals to leverage higher prices appear to have made those policies counter-productive.

For drug makers, patent protection—unaccompanied by meaningful public price regulation or negotiation—has allowed drug makers to impose on Americans the world's highest prices for meds.

Attempts to shoehorn realities to fit market theories: pushing patients to act like sovereign consumers

Pushing patients to act as carefully-shopping price-conscious consumers is impelled partly to shoehorn the health care reality of dependent patients to fit the theoretical requirements of a free market. The main element of that push is to cut health insurance coverage and boost out-of-pocket payments. This is supposed to induce patients to shop by price and quality. And to support better consumer choices, data on prices—and quality—are to be made available.

As often happens, this theory is advanced by people with an agenda. Here, it is hoped, sovereign consumers' careful shopping will slow the growth in prices and volumes of care—slowing health care spending increases. This amounts to asking the weakest, least

knowledgeable, and least-well-organized party—individual humans who are ill or injured—to hold down health care costs.

This is rare in rich democracies for two reasons. It restricts access to needed care and does so in grossly unfair ways, as discussed in chapter 7. And it doesn't work to contain costs, as discussed in chapter 8.

If this is unfair and doesn't work, why push it? First, because it can serve as a substitute for effective action to slow growth in health care costs. Second, because of its theoretical and political appeal to people with affection for free market remedies for health care problems. And third, because of its practical value as a smokescreen for a massive federal subsidy to higher-income Americans.

This problem is discussed shortly. It is taken up separately in the 4th section of this chapter, under the heading of market failure owing to lack of good information about price and quality.

The HSA boondoggle. Some see high OOPs as a way to offset the notional "moral hazard" of good insurance coverage—to deter people from reckless behaviors that damage health or to recklessly use unnecessary or marginally valuable health care simply because it is free when obtained.

High OOPs are a form of under-insurance that particularly oppresses people with low incomes or ongoing health problems that require sustained care.

One reason is that fixed-dollar OOPs are a much bigger share of the incomes—or savings—of lower-income Americans. A $30 co-payment to see a doctor is a lot of money for a low-income person but not a lot for higher-income person. It is true that OOPs overall have fallen as a share of health care spending. But, wrote Altman, that's the wrong denominator. The right one, he asserted, is income, which has not kept pace with health care costs.[2031] Moreover, the average masks the heavy burden of OOPs on lower-income Americans who need and use lots of health care. Rose and colleagues found that OOP costs to cancer patients were $600 to $700 monthly.[2032]

The second reason is that, remarkably, federal policy has allowed higher-income people to financially immunize themselves against the need to worry about OOPs.

Worries about moral hazard—and hopes that consumerism will combat it—have served to grease a substantial transfer of wealth to higher-income Americans. Health Savings Accounts (HSAs) have been touted by market ideologues. Americans with high-deductible health insurance are eligible to contribute to HSAs. In 2025, the minimum deductible required to qualify for an HAS was $3,300 yearly for family coverage.

Families may put up to $8,550 into their HSA in 2025. This is before-tax income.

Higher-income Americans are more likely to afford to set aside these before-tax dollars in health savings accounts, and use that money to pay OOPs. Unsurprisingly, lower-income Americans use HSAs at much lower rates. In 2017, only 4 percent of HSA contributions was made by households with incomes below $50,000 and 77 percent was made by households with incomes above $100,000.[2033]

At the end of 2023 assets in 37 million HSA accounts totaled $123 billion.[2034] That sum rose to $155 billion by January 2025.

All this money is triple-tax-free. Money contributed is not subject to federal income taxation. Interest, dividends, and capital gains inside HSA accounts are not taxed. Money withdrawn for health-related purposes is not taxed. Additionally, the high-deductible health insurance policies that qualify Americans to contribute to HSAs have lower premiums.

Moreover, tax-deductibility is more valuable to higher-income Americans—those facing higher rates of federal income taxation.

Thus, Bush's 2003 combination of high-deductible health plans and health savings accounts meant a big, new federally-subsidized income and tax shelter for higher-income Americans.

Trump's 2025 budget reconciliation bill further boosted HSAs' value to those who can afford them. HSA dollars could be used to pay gym memberships. Americans with contracts for direct primary care could use their HSAs to pay up to $1,800 yearly. HSA contribution limits would be raised for some people. And those over age 65 who are enrolled in Medicare Part A only would be allowed to pay into HSAs.

These provisions would boost federal subsidies to people with HSAs by a total of $44 billion between 2025 and 2035.[2035] That would be roughly a 20 percent increase in these subsidies to wealthy Americans—a rise from about $200 billion to $244 billion in the next decade.[2036]

The power of high OOPs to deter lower- and middle-income Americans from seeking health care is magnified by the high shares of income they pay for food and housing. Those high shares plus high OOPs have meant greater delays in seeking health care.[2037]

Similarly, Americans suffering chronic illness and disabilities need more health care and, when they use it, they face higher OOPs. These Americans have lower incomes to pay those higher OOPs. Park and Stimpson found that disabled people covered by Medicare have substantially higher OOPs and must devote higher shares of their incomes to pay them.[2038] Under-insurance is worsened by weak financing of long-term home care and other services, as discussed in chapter 13.[2039] [2040]

Moral hazard mythology. Free market economists worry that many or most patients have been unable or unwilling to act as sovereign consumers. They further worry that good insurance coverage could make patients reckless—both about their personal behavior, thereby damaging their health, and about their use of medical care, thereby boosting costs. Good insurance is thought to mean moral hazard, and that undermines a foundation of competitive markets.[2041]

Insurance companies that cover ships or cars or homes worry about a "moral hazard" problem. This is when an insured party is better off financially when their ship sinks, car crashes, or home is wrecked by a tornado.

But health insurance works differently. Patients are never better off financially when they use more health care. People do use more health services when they pay less OOP, but this is hardly surprising.

4. Market failure is one source of anarchy

As mentioned in chapter 1, the U.S. stands out in the share of politicians, backed by influential economists, who assert that high OOPs are good for us because people facing higher OOPs use less health care. They combat "moral hazard," the belief that patients will line up for unnecessary medical care if it is well-insured. Gladwell is right to assert that the focus on moral hazard rests on a myth.[2042]

Many who endorse OOPs rely on the findings of the RAND Health Insurance Experiment. But they are probably wrong to do so. The HIE's three main findings were that, indeed, people paying more OOP used less care, that high OOPs lead patients to proportionately cut use of highly effective and ineffective care, and that overall health was not affected—but that the sickest and poorest patients, and those with serious illnesses—fared better with free care.[2043] [2044] [2045]

The first finding is unsurprising.

The second reveals OOPs to be a blunt tool to drive down the cost of health care or to drive up its efficiency and effectiveness.

The third finding reveals the unequal effects of OOPs on rich and poor.

Indeed, proponents of OOPs have very rarely sought to inflict them equitably. A $30 co-pay for a doctor visit will not deter a high-income person. Those who would rely on OOPs to discourage unnecessary care and save money should have advocated equal-pain OOPs—setting OOPs that rise as a proportion of income as income goes up. But that approach is vanishingly rare.

In 2025, the Cleveland Clinic began requiring patients to pay OOPs up-front for non-emergency care. The Clinic had some $17 billion in accumulated net assets at the time but claimed that its 1.7 percent operating margin compelled it to require up-front payments. This policy would have particularly harmed patients with chronic illnesses, disabilities, or low-incomes. That's because these patients would need care more frequently and would have less money to pay the required OOPs.[2046] In the face of bad publicity and pressure from city politicians, the Clinic withdrew the new policy just two weeks later.[2047]

The U.S. tolerates the imposition of much higher OOPs than most nations. Only Switzerland surpasses us.

Why is this? Because U.S. politicians have been unwilling to hold down health care costs and because insurance companies lack effective tools to do so, some businesspeople and many free market economists have placed heavy bets on patients to contain costs.

Since ordinary patients are certainly the weakest, least-informed, and least-well-organized group in health care, it is perhaps remarkable that politicians, businesspeople, and economists have chosen to draft them as cost control warriors. Weak and unorganized, ordinary patients can exert little practical leverage to hold down costs. This makes it politically possible to impose on them but impossible for them to make a positive difference.

Why patients, then? The moral hazard fantasy? The consumer sovereignty imagined by some? The lack of alternatives and the need to seem to try something to hold down cost—especially something that fits with market thinking. To justify shifting costs from employer-paid premiums to worker-paid OOPs? Or the desire to shift the burden of financing from premiums

to OOPs in hopes that most workers will be glad for lower premiums while few workers (especially those who are acutely or chronically ill or those who are disabled) will pay the higher OOPs?

If consumers are to serve as the front-line soldiers in the cost control war—or as kami-kaze pilots, they need to be plagued with high OOPs. This is partly an ideological position held by free market believers, and partly a desperate position held by those who perceive inadequate restraints on U.S. health care costs.

Those who seek to shoehorn health care to better fit requirements of competitive markets have therefore proposed cutting insurance coverage by boosting OOPs in hopes that patients would be motivated to shop for medical care by price and quality.

(The word "quality" refers to technical proficiency with which a service is given. It is distinguished from "appropriateness," which refers to whether a service is actually needed—likely to be useful in diagnosing a problem or effective in mitigating its harm.)

This section discusses motives and methods of pushing patients to act like sovereign consumers. Section 4 of this chapter takes up efforts to enable notionally motivated sovereign consumers to shop for medical care by price and quality.

Free market ideologues, aiming to make health care work like a market, have urged cutting the adequacy of insurance coverage in hopes of motivating patients to shop more carefully by price and quality.[2048] They therefore favor higher OOPs—making insurance less adequate.[2049] Employers and private insurance companies, possessing few effective tools to cut their own obligations to pay for care, have raised these OOPs—dollar per visit co-payments, co-insurance percentages of a bill to be paid OOP, deductibles that must be paid yearly before insurance covers most services, and annual OOP maxima for individuals or families. Low-income patients and those with chronic illnesses will be more likely to cut back on needed care.

It is manifestly reckless to cut insurance coverage and boost OOPs, without first choosing to believe that careful shopping by consumers will safely save money; second, without assuring that clearly understandable data on price, quality, and need for care are available; and, third, that patients are willing and able to use those data. Failure to build and test these foundations is policy malpractice—holding out a happy theory of sovereign consumers without evidence that it is real.

This pattern repeats in capitating HMOs, MA plans, and ACOs—and then spurring them to compete by cost and quality—in the absence of robust, simple, and hard-to-cheat methods of adjusting for risk. Each is a sort of bait-and-switch—enticing politicians and experts with happy theories that are not supported by reality.[2050]

Sick Americans understandably need—and should use—more medical care, and they are also more likely to be poor. Therefore, by reducing insurance coverage, higher OOPs hit sick people and poor people harder. Higher OOPs are taxes on being sick or injured and using care. They are highly regressive. This means that a given dollar OOP cost is necessarily a greater percentage of the income of someone making, say, $40,000 yearly than of the income of someone making $160,000 yearly.

In theory, OOPs could be calibrated to income or to health, but this has proven politically and practically difficult. Wharam and Rosenthal point to opportunities for doing this.[2051] Crafting

more equitable caps on OOPs might make their sustained use more fair, but they remain an ineffective tool to contain cost because they focus on patient behavior, not that of payers.

In the real world, over one-third of individual health insurance plans' caps on out-of-pocket spending exceeded the standard that took effect nationally in 2024. In some 15 states, average OOPs exceeded even the Affordable Care Act's weak standards.[2052]

OOPs mutate as they proliferate. Facility fees are one example. When hospitals buy doctors' practices, they often add facility fees to each visit. (This is prohibited for new purchases of practices, but doctors' offices bought before 2015 are grandparented.) Hospitals justify these fees by asserting they are legitimate allocations, to visit to a doctor, of hospitals' fixed costs—like finance, billing, and general administration. The share of facility fees covered by third parties is not known; payer coverage varies.[2053] When not covered, these function as added OOPs. These are heavy financial burdens on low-income or chronically ill citizens.

Patients charged for communicating with doctors via EHR patient portals like MyChart are similarly burdened. Hopkins, BJC, Cleveland Clinic, Vanderbilt, UCSF, and Mayo are among rising numbers of hospitals imposing MyChart fees for many communications. Hospitals and doctors say they impose these charges only when communications require doctors to spend substantial time to investigate or decide about diagnosis or treatment, or when coordination of services is necessary.[2054] [2055] [2056] [2057] [2058]

Holmgren and colleagues reviewed an all payer claims data base and concluded that "health system interest in the e-visit billing has evolved from a short-term pandemic necessity to a potential long-term source of revenue." [2059] In practice, it is difficult to separate billing for substantial electronic clinical encounters from short questions and short replies.

In one sense, these portal payments are fair if they help compensate doctors for their time. In another sense, they are unfair when not covered by insurance, so they—like all other OOPs—disproportionately hit low-income or chronically ill patients. Imposing these charges for diagnosis, treatment, and coordination of care would not have been possible a decade ago. And most doctors would not have thought to levy them—since these services were implicitly covered by the fees doctors collected for office visits or other care for which they were paid.

It is not clear whether the doctors who devote time to communicating via MyChart actually benefit from the portal fees imposed by the larger systems where they work. The various systems' policies probably differ. What is clear is that the fees are regressive and are therefore much more likely to deter lower-income people from communicating via portals. Since it is often very hard to reach doctors by other means, and since wait times for appointments can stretch to weeks or months, lower-income people are less likely to seek or get timely answers to their questions.

Those theory-driven people who push higher OOPs to turn patients into health care consumers suffer from stunted empathy. They imagine most people can afford the co-payments, co-insurance, high annual out-of-pocket maxima, and other burdens devised to force them to make notionally rational consumer choices about how much medical care they want and need, and where to buy it.

Hyman and associates suppose that higher OOPs will induce patients to shop for lower prices and higher quality.[2060]

But Sinaiko and Sommers reply that evidence doesn't support this supposition. Americans rarely shop for health care by price and quality; very few use price transparency tools.[2061]

People rarely know, in advance, what services they are likely to receive. The tools themselves are typically hard to use. And they rarely contain accurate data relevant to patients—their own OOP burdens.

Nonetheless, the transparent romance lingers. Kona and Stovicek describe state attempts to make prices more transparent.[2062] Massachusetts, which created a price comparison web site in 2018, found that it was not being used because it was not very useful. Visits averaged fewer than 10 daily. But an editorial criticizing the existing web site naively embraced improvements rather than abandonment.[2063]

Trump pushed price transparency during his first term. Claxton and colleagues described what they politely called "challenges" in obtaining useful data.[2064] A group calling itself Patient Rights Advocate urged reliance on transparent price data but reported low levels of hospital compliance. Those levels peaked in mid-2023 and fell substantially by the fall of 2024.[2065]

A month after his second inauguration, Trump signed an executive order calling for stronger enforcement of the transparency requirements he ordered late in his first term.[2066] [2067] Muhlestein offers 14 steps to improve price transparency.[2068]

This is absurd. One intrinsic barrier to providing Americans with good information about their out-of-pocket burdens is that health insurance plans are so complicated and varied. Co-insurance is a percentage of actual price that patients must pay OOP. But numerous prices for the same unit of care mean widely varying co-insurance burdens. Uncertainty about which caregivers are actually in-network, combined with different OOP annual maximum payments, further complicate learning prices patients must pay.

A second intrinsic barrier is that OOP burdens associated with an episode of care in a doctor's office, an ER, an ambulatory surgery center, or a hospital inpatient bed will depend on the services provided or the diagnosis at discharge. Both are difficult to learn in advance—at the time a patient is notionally shopping by price and quality.

A third intrinsic barrier is that, even if accurate and relevant data on prices to be paid OOP could somehow be provided in a form that actual humans were able and willing to use, the data on quality are generally very bad. How, then, are patients to be able to weigh the quality of care they might get at different prices?

Recognizing that a) providing relevant and up-to-date price data is nearly impossible, b) that it is costly, c) that very few people try to use those data, d) that shopping by price in dangerous in the absence of balancing evidence about quality, and e) that few patients know what care they need, a health care board in one state is considering sending a formal letter to the legislature repudiating the effort and asking that its financing cease. This board would thereby fill the role of the child in Andersen's story of the Emperor's New Clothes.[2069]

Confrontation, paternalism, or cooperative communication. The effort to boost consumer sovereignty in health care flies in the face of the inevitable imbalance of education, experience, and knowledge between patients and doctors. One million Americans work as physicians; 339 million do not.

Well-intentioned patients' rights advocates sometimes call this inevitable imbalance "medical paternalism." They often seek to empower patients. Devices they pursue include requiring patients to sign informed consent forms before surgery (though not before taking meds) and also shared decision-making.

The choice here is between adversarial confrontation and cooperative communication. Some who are antagonistic toward doctors favor confrontation and mistrust. They may provide political support and rhetorical ammunition to reinforce advocates of higher OOPs to make patients weigh whether care is worth its OOP cost.

Converting patients into consumers entails consumer sovereignty and heightened mistrust and confrontation between doctor and patient. This is very different from a patient-doctor alliance that features shared decision-making and clear two-way communication. Then, patients would describe what they hope for and physicians would provide information that patients seek about diagnosis and treatment options.

Urging greater attention to patient rights, advocates call for limits on doctors' freedom of action. These calls are often well-justified, as when physicians urge or give aggressive treatment when patients do not want or need it.

As mentioned earlier, Paradis wrote with fury about the explicitly unwanted—but repeated provision of— surgical and radiological over-treatment his hospitalized father suffered for late-stage pancreatic cancer. His father had sought only palliative care. Neither Paradis (a physician) nor his brother (a lawyer) succeeded in forcing their father's doctors to cease aggressive but futile treatments.[2070]

Sometimes, patients are pushed to make decisions too quickly.[2071]

Cooperative decision-making is a promising way to neutralize excessive care. Arterburn and colleagues found that providing decision aids and information to patients who might be candidates for hip or knee implants led to much lower rates of surgery.[2072]

But shared decision-making is difficult. It takes skill, time, patience, and energy. Some physicians and patients embrace it but others struggle with it. Braddock and colleagues describe some of the challenges.[2073] Marvel and others raise related concerns.[2074]

Empowering and informing patients—and engaging physicians—in shared decision-making will improve care, lower cost, and make care more equitable. It will be a strong foundation for spending our vast dollars more carefully. And for reconciling both doctors and patients to the finite limits of those dollars and, therefore, to the need to make trade-offs. As discussed in subsequent chapters, finite budgets for care plus financial neutrality for caregivers greatly strengthen the foundations of trust and equity that can support shared decision-making. Those foundations are stronger still when they rest on trusting, durable relations between patients and their primary caregivers.

All this is very different from strengthening patients to confront doctors.

In practice, the theory-driven cries for data about price and quality, and for boosting OOPs, manifest the failure of competitive free markets to contain health care costs, They also reflect

employers' and insurers' desires to shift costs of health care from employers' group insurance premiums to individual sick or injured employees and dependents. Sometimes, they are an emotional push to blame people who were imagined to have gotten sick or injured through bad behavior.

This approach is one of many smokescreen cost controls. These do nothing useful to combat causes of high U.S. costs but do cloud ability to perceive either those causes or remedies that might actually work.

Proponents of higher OOPs very rarely propose that OOPs rise in proportion to discretionary income—so all Americans would feel equal pressure to make rational medical care choices.

Supposing that citizens or patients can act effectively as consumers can threaten equity. In 2006, West Virginia obtained a federal waiver allowing it to impose behavioral burdens on Medicaid patients. They included signing an agreement to take meds, keep appointments, and avoid unnecessary ER visits. Violating the agreement could entail loss of some benefits or entire eligibility.

But a patient with cognitive or emotional difficulties—or low income or transportation problems—could have considerable difficulty adhering to the agreement. Then-director of CMS Mark McClellan lauded the waiver because "'Medicaid enrollees in West Virginia will now become part of an emerging trend in health care that empowers patients to make educated consumer-driven decisions related to their own treatments.'" [2075] His assertion might be viewed as a product of ideologically-generated blinders, stunted empathy, or simple policy malpractice.

3. Easy entry and exit

This third requirement for competitive free markets means that new doctors, dentists, nurses, hospitals, home health agencies, nursing homes, and other caregivers must be able to freely establish themselves and deliver care. It also means that caregivers must be allowed to depart from health care if they go broke or simply choose to cease serving patients.

Free entry is the more important requirement. It meant that if any group acquired a monopoly or an oligopoly—became so big and dominant that it could force buyers to pay prices higher than those justified by free market competition and thereby earn unjustifiable profits—a new group could enter the market. The new group would undercut those high prices, bringing them down. It would thereby gradually extinguish undeserved monopoly/oligopoly profits.

In health care, barriers to entry of new doctors, hospitals, other caregivers, and insurers are common and long-standing.

Physicians. Freedom of entry into the medical profession has varied over time. After the 1830s, Jacksonian democratic deregulatory free market principles had allowed something close to free entry of doctors into the profession—subject to minor requirements—in many states. (In recent years, some free market economists have suggested a return to this—that doctors be allowed to declare themselves doctors—without being subject to education or training

requirements states now require. Patients would choose doctors by reputation and education.[2076])

Today, it is harder to become a doctor in the U.S. than in other rich democracies. Our ratio of doctors per 1,000 people is third-lowest across rich democracies, ahead only of Japan and South Korea. When U.S. doctors' high administrative burdens are factored in, it seems likely that our nation is at the bottom in net available physician clinical time per 1,000 citizens.

At the same time, U.S. physicians' yearly incomes and accumulated wealth are either highest or second-highest across rich democracies. Within the U.S., it is noteworthy that Mississippi, the state with the lowest ratio of doctors to people, is also the state whose doctors' average incomes are highest.

Low supply and high incomes/wealth testify to high barriers to entering the profession.

Erecting those barriers began with the Flexner Report of 2010, three-quarters of a century after they were lowered in the Jackson era. That report highlighted great deficiencies in training U.S. doctors. It led states gradually to require four years of medical school plus a year of internship before they'd license new physicians.[2077] Medical schools, in turn, required degrees from four-year colleges. That meant nine years of education and training post-high school, a substantial barrier to entry into the profession. Fewer than one-tenth of American youth had even high school diplomas in 1910.[2078]

Entry into surgical and medical specialties faced even higher barriers, since many residencies were unpaid until after the Second World War. Teaching hospitals instead offered room and board.

In the years after the Second World War, growing numbers of teaching hospitals sought more and more residents to deliver low-cost services to patients. With the supply of U.S. medical school graduates lagging behind teaching hospitals' demands for residents, Congress was persuaded to allow greater numbers of visas for graduates of non-U.S. medical schools to enter the country. Currently, almost one-quarter of U.S. physicians attended medical school outside the U.S. or Canada.

Even so, U.S. physician supply remains tightly constrained. And worse, when U.S. doctors' high administrative burdens are factored in, it seems probable that our nation is at the bottom across rich democracies in net available physician clinical time per 1,000 citizens.

No entity or cluster of entities is accountable for learning need for physicians, for building adequate training capacity, or for ensuring that needed physicians earn incomes commensurate to sustaining the right numbers and types of doctors in the right places.

As discussed in chapter 11, reasons for the shortage of U.S. doctors include lack of accountability for identifying numbers of needed doctors, disagreement about appropriate numbers, duration and cost of training, and population growth and aging that outpace the addition of seats in schools of medicine and osteopathy.

Hospitals. Until the 1940s, cities or counties, philanthropists, community groups, and individual doctors could build hospitals inexpensively. Before the era of specialized hospital architecture and building and life-safety codes, low capital and other start-up costs made for low entry

barriers. One Chicago hospital called itself the city's narrowest hospital since it was established in a town house. Nantucket's Cottage Hospital in Massachusetts was so named because it was opened in three adjacent small homes. Low capital costs helped enable the rapid growth of hospitals—from about 180 in 1880 to over 4,000 by 1909.

Urbanization, industrialization, and fear of infectious diseases encouraged growth of hospital care. Spread of scientific nursing, anesthesia for surgery, improvement of surgical techniques during the Civil War, antiseptic surgery, and then the x-ray machine all made hospitals safer sites of care. Industrialization also made for accumulation of wealth in some hands. Portions of that wealth were devoted philanthropically to financing hospital construction.

After the Second World War, the federal Hill-Burton program contributed one-third of the capital cost of building new hospitals in under-bedded regions. It also paid to rehab or expand existing hospitals. By the 1960s, after the growth of private health insurance and the passage of Medicare and Medicaid, the great majority of hospital patients were insured. Hospitals' resulting credit-worthiness enabled them to sell bonds at low interest rates. Interest costs were lowered further after most hospitals were allowed by federal and state law to sell bonds whose interest payments were not subject to taxation.

Despite tougher building and life-safety codes, hospital construction costs remained low through the 1960s, with one Baltimore hospital relocating to a suburb at a cost of only $14,000 per bed. By contrast, new and replacement hospitals in 2022 had reached $2 million per bed and more in some cities. This is owing to a combination of rising construction costs, a switch to single-bed rooms (in pursuit of greater privacy and reduced risk of infection), more space and equipment in operating rooms and elsewhere, and higher levels of amenities.

Today, high construction cost is one of the barriers to entry of new hospitals. Additionally, many states have enacted certificate of need (CoN) laws that require licenses for building new hospitals or expanding or rehabilitating existing ones. First passed in 1964 in New York State, these laws stemmed from a belief that hospitals were adding beds and equipment unnecessarily, raising both capacity and cost—cost of construction and greater operating cost to serve more patients. Roemer's Law—that a bed built was a bed filled—gained credence. CoN laws explicitly reflected a belief that any resulting inter-hospital competition actually ended up increasing costs. It was expected that higher volumes of care would offset any price restraints resulting from greater competition. It was increasingly suspected that hospitals rarely competed by price, but rather by scope of services, perceived quality, or amenities.

Another barrier to entry of new hospitals has been the success of existing hospitals in buying many doctors' practices. In 2016, for example, hospitals owned fully 43.5 percent of primary care practices, up from 27.7 percent in 2010.[2079] Parallel trends have prevailed for specialist physicians.

The consolidation of hospitals through a combination of purchases, mergers, and closings has reinforced many hospitals' leverage over private insurance companies. This varies greatly from region to region, though. Massachusetts hospitals have leveraged the nation's highest excess prices from private insurance companies. In 2018, Massachusetts acute care hospitals extracted private insurance prices that were almost quadruple Medicare's national average price (294 percent higher). One reason is that the state has gone from 140 independent hospitals in 1960, the year President Kennedy was elected, to fewer than 60 today. In 2018, five systems in the state controlled three-quarters of hospitals' net assets (accumulated wealth) and garnered over two-thirds of hospital surpluses.[2080]

Multi-state for-profit hospital corporations seek leverage by buying a substantial share of hospitals in a region.[2081] They also offer incentives to boost admissions. Consolidation means that profit-seeking for-profit hospitals can raise prices. This makes it unnecessary for them to undertake the more difficult job of cutting or containing cost.

Despite the concentration, high prices, and costs of hospital care in the U.S., it is often unattractive to build new hospitals to compete with existing ones. First, In many parts of the United States, population density is too low to allow more than one hospital to operate. Second, in many other places, small numbers of hospitals have won so great a share of patients—and doctors—that it is very hard for new hospitals to enter the area to compete for patients. Third, cost of building a new hospital is very high. Fourth, certificate of need regulatory barriers can be substantial. Fifth, non-profit hospitals often use the extra revenue they derive from their power over insurers to improve the breadth, depth, or quality of care they can give. These work to improve their reputations, not their profits. Sixth, high shares of hospitals' revenue come from Medicare and Medicaid. These payers pay regulated prices. MA and Medicaid managed care plans pay prices that are adjacent to the regulated prices. That's an added impediment to price competition.

In combination, these factors make for high barriers to entry of new, competing hospitals.

4. Sovereign consumers have good information about price and quality

Good information informs the decisions of sellers and buyers in competitive free markets. Sellers know the prices other producers charge for their goods and services, and also the quality of those products. Independent buyers have their own solid information about price and quality of what is on sale. Knowing their own minds, they can choose how to spend their inevitably finite money to maximize value received.

Imagining that notional consumers could shop by price and quality in order to contain costs and reward good caregivers asks the weakest and least knowledgeable actors to make the most important health care choices. This signals an abdication of responsibility by those who could actually act effectively to contain cost and boost appropriateness and quality of health care.

Choice is trumpeted as good. But the average Medicare patient was able to choose among 43 different Medicare Advantage plans during the fall 2023 open enrollment period.[2082] Is it possible to understand the options and make careful choices among so many plans?

No.

Choice—and decisions that are often driven by lower premiums—also leaves many patients in narrow networks of doctors and hospitals, often severing long-standing ties with caregivers. And it saddles patients with high OOPs and surprise bills when they wander out-of-network.

Shoehorning patients to act like consumers impels futile efforts to provide usable price and quality data

Chernew and Mintz seem to believe that Americans place an extraordinarily high value on the right to exercise choice of health insurance company.[2083] Though they assert the primacy of choice, they adduce only one shallow citation in support—the opinions—not a consensus—or some members of *Health Affairs'* Council on Health Care Spending and Value.[2084] Chernew and Mintz wrote that Americans so value choice that they must accept or embrace reliance on market mechanisms to enable choice in coverage. Unfortunately, these mechanisms are administratively expensive and also fail to contain health care costs.

Remarkably, they do not seem to acknowledge that the right to choose an insurance plan cancels the arguably much more important rights to enjoy free choice of caregivers or to sustain durable and trusting relations with doctors, other clinicians, and hospital services. As shown in chapter 1, unstable relations between payers (private insurance companies, MA plans, and Medicaid managed care plans) and caregivers mean that failed negotiations can force patients to switch doctors.

Moreover, when they have the chance to choose plans, few citizens do so. Ochieng and colleagues found that about 7 in 10 Medicare beneficiaries did not even compare plans during the 2021 open enrollment window.[2085]

Keckley thinks that most consumers are not "'prepared to make judgments about treatment alternatives based on evidence….We have lulled consumers to be dependent on physicians.'"[2086] Is this remarkable? Is it different in other rich democracies?

As shown in chapter 3's section on clinical waste and in chapter 16, it can be hard for doctors, much of the time, to make good judgments about treatment alternatives based on evidence. And doctors have actually attended medical or osteopathic school, unlike other Americans.

Even though most patients have not been able or willing to act like sovereign consumers, advocates of shoehorning health care realities to fit market theories have persistently tried to provide valid, relevant, and usable information on price of care. These efforts have failed. Although these advocates also trumpet the importance of data on quality of care, available data are even less useful than those on prices paid.

Some observers note that U.S. health care coverage and rules for OOPs are the most complicated in the world. Navigating this maze is hard, time-consuming, frustrating, and expensive.[2087] Levitt and Altman conclude that U.S. health care's complexity is the "enemy of access and affordability."[2088]

Market theorists recognize that good information would be essential to enabling notional consumers to act effectively in a competitive free market, if one existed in health care—and if those consumers were motivated to use the information. Many recognize that their efforts to push patients to act like consumers would seem hypocritical, cynical, or delusional in the absence of these data. Some may even believe that the information would somehow create sovereign consumers. But those data, while necessary to making consumers sovereign, are far from sufficient to do so.

4. Market failure is one source of anarchy

In the real world of health care, the data on price are terrible and the data on quality are worse. They are not improving meaningfully.

Worse still is that even good data would be used by few patients. Worst of all, even if good data on price and quality could somehow be made available, and even if 104 percent of all patients used those data, the patients would still not be sovereign and competent consumers.

That's because good, usable, and used data on price and quality fail to provide what sovereign consumers would most need: knowledge of what care is appropriate, effective, and needed to diagnose and treat their medical problems.

American patients find it hard to use even basic information about proposed care to make informed decisions to consent to treatment. Lin and colleagues have found that disclosure forms are inconsistent in information provided. Worse, "most forms were also written with complex language." On average, they were written at an 11th grade reading level,[2089] well above the AMA's recommended level of 6th grade English.[2090]

Over the past two decades, a substantial data collection industry has sprung up, one that purports to make information on price and quality available to patients. Initially spurred by state action,[2091] it has been reinforced by Trump-era federal legislation requiring hospitals and insurers to post detailed price data.[2092] [2093] Despite happy headlines like "Proposed rule would make hospital prices even more transparent," [2094] they are not one bit transparent to ordinary humans. Stronger transparency regulations and strongly regulatory enforcement will not help.

Thomas and colleagues compared hospitals' posted on-line prices for notionally shoppable services like routine vaginal deliveries or brain MRIs with those provided by hospitals by telephone. The two sets of prices varied considerably.[2095] Moreover, patients who actually try to shop by price care about their own net (post-insurance) cost—their out-of-pocket cost. It is a waste of time to post "prices" which might actually be list prices (fantasy charges).

Ordinary humans find it very difficult to make single yearly choices of insurance plans in the U.S. Chandra's attempt to clarify choice reveals this powerfully.[2096] It is vastly harder to make repeated attempts to learn OOP prices to be paid for each individual service.

In December 2023, the Biden Administration announced new efforts to boost "transparency" of MA plans.[2097] It purported to do so by requesting information "from the public on how best to enhance MA data capabilities…." This rests on some reformers' hope that better information will inform consumers, who will then somehow generate pressure for MA plans to act with greater efficiency, effectiveness, or decency.

This vacuous activity may have been sparked by an April 2023 Kaiser Family Foundation report complaining that Medicare beneficiaries and policy makers lacked adequate data on plan performance.[2098]

Indeed, over one-third of Americans enrolled in ACA marketplace plans found it "somewhat or very difficult to find a plan that meets their needs."[2099] It is worth asking whether too many MBAs, economists, and lawyers are running around loose in U.S. health care, dreaming up ideologically-driven arrangements that exist in no other rich democracy. Arrangements that insult actual humans. Those people may be sacrificing U.S. health care on an altar of fantasy.

4. Market failure is one source of anarchy

Market proponents create the world's most complicated methods of covering people and of attempting to contain spending on medical care. They then bemoan most humans' inability to act like consumers. For people on Medicare, deciding between traditional Medicare and MA plans is one choice; picking a MA plan is a second. The federal State Health Insurance Assistance Program (SHIP) is supposed to offering counseling. But Garrido and Dorneo identify imbalances in SHIP availability. Elders with lower incomes and less education were less likely to live near a SHIP site. Reasonably, Garrido and Dorneo recommend SHIP expansion or alternative ways to help elders navigate their choices.[2100]

Still, it is probably much more reasonable and useful to begin by recognizing that no other nation asks potential patients to choose among indecipherable options, that no other nation pretends that informed consumer choice is possible, or that it is an effective way to bring down costs or boost quality.

Alternatives therefore merit consideration. One is to standardize three or so sets of MA options so elders might choose meaningfully among them. A second is to end MA entirely—for reasons discussed in chapter 8—and rely instead on simpler, more effective, and more trustworthy methods of containing costs and protecting Americans' health.

But today, the push for consumerism in health care persists.[2101] Why? One reason, some write, is that lack of price transparency makes it hard for employers to buy coverage responsibly. And that employers need to do so to discharge their fiduciary responsibility to workers.[2102]

The grounds for this assertion seem very shaky. How could employers use data on prices of individual services to help workers? Employers' focus should be buying the best available coverage and quality for the lowest possible price. One of the main impediments to doing so is ongoing failures by insurers' and both federal and state governments to standardize a few types of alternative insurance policies, covered benefits, OOPs, and the rest.

Why the failure to standardize? Possibly, because standardizing a few policies would simplify choice, which would worry smaller insurance companies: they'd fear being crowded out by a few large competitors.

It may be that high OOPs might not really be intended—by many—as a spur to more careful shopping to contain spending on health care. Some parties' real aim might not be to make health care fit a requirement of free competitive markets. Rather, the high OOPs might be desired simply to suppress many Americans' use of health care and to thereby constrain costs.

In this view, the data on price and quality might be sought not to support actual consumerism to contain cost but rather to rationalize rationing according to ability to pay—leading lower-income patients in particular to cut back on use of health care. OOPs are the most regressive method of raising money to pay for health care since they fall most heavily on lower-income Americans, especially those with costly-to-treat acute or chronic illnesses.

Consumerism proponents may recognize that they have painted themselves into a policy and financial corner. If they were to acknowledge the futility of obtaining price and quality data humans can use, they would be obliged to consider various alternative ways to contain cost—ways that might be effective and equitable—ways that are in effect in the world's other industrial democracies.

A focus on consumerism as a path to making markets work to contain cost can serve to crowd out methods of cost containment that could actually work. Those caregivers and insurers who actually seek more money to finance business-as-usual in health care could strongly support continued reliance on cost controls that don't control costs.

The view of patients as consumers extends beyond price and quality data. It is manifested in a provision of the 2016 21st Century Cares Act that, in April 2012, required that patients receive lab, imaging, and other diagnostic results as soon as they become available. Many see this as empowering patients and giving them better information to inform questions for caregivers and to investigate ways to diagnose and treat their medical problems.[2103] Others worry that patients can be upset or confused by viewing medical information that's unfiltered by professional judgment, context, or personal support.[2104]

Bad price data

Data on prices have been and will almost certainly remain essentially useless for several reasons. First, hospitals, other caregivers, and insurers often fail to comply with requirements to post information.[2105]

Second, the information is often out-of-date.

Third, after decades of demands for price data, the information available is, simply, often junk. Thomas and colleagues compared hospitals' own posted on-line prices with hospitals' own prices provided by telephone. Very substantial shares of hospitals exhibited price differences of greater than 50 percent for the same service—at the same hospital.[2106]

Fourth, the price data are often irrelevant—as when they pertain to charges (list prices) or even total average prices actually negotiated between an insurer and a hospital or doctor.

If patients are to shop by price, the price that matters is the money they must expend OOP. But those actual OOP payments are hard to learn in advance. That's partly because services to be provided are often not known in advance, and each service has its own OOP payment. Also, different plans offered by the same insurance company entail very different OOP obligations. A final complication is that actual OOPs are contingent on satisfying yearly OOP maximum outlays.[2107]

Patients are much less willing to shop by price in emergencies or when need for care is urgent.

Medicare Part D offers one dramatic example of the intentional failure to make available good information about price and quality, and to use available information. That's because, as discussed in chapter 15, and as summarized shortly, spending on medications is the most predictable type of health care spending.

The lack of such information is endemic throughout health care. Prices paid by public payers like Medicare and Medicaid are highly visible to both sellers and buyers—caregivers and patients. But more and more care for patients covered by these programs is actually paid for by private entities like Medicare Advantage plans and Medicaid managed care plans. Many prices paid by these plans are considered trade secrets.

The same is true for prices negotiated by private insurers with hospitals, doctors, drug makers, and others. Indeed, the same insurance company might pay a doctor different prices for different groups of patients covered through different employer-sponsored plans.

Privately insured patients—about one-half of all Americans—have little information about total prices actually paid for their care. They have almost as little information about the out-of-pocket costs of their care—the prices they will actually end up paying. One reason is that both doctors and hospitals and other caregivers—and the patients' own insurance plans—rarely know which services a patient will receive until care is actually given.

A second reason is that most patients face complicated out-of-pocket requirements. These include annual deductibles; fixed-dollar co-payments per visit or per prescription for some care but co-insurance percentages on other visits or prescriptions; and annual out-of-pocket maximum payments. The deductibles and out-of-pocket maximum payments are calculated separately for individuals and families, separately for in-network and out-of-network care, and—increasingly—separately for meds and for all other care.

Four other complications are worth mentioning. Insurers' directories of participating or in-network doctors can be inaccurate, deceiving patients into believing that they will pay low out-of-pocket prices, only to learn that the doctor was out-of-network, exposing them to much higher burdens.[2108] Moreover, patients who see different doctors or are cared for at different hospitals often face different fixed-dollar co-payments or co-insurance percentages. Further, patients might suppose that an ACA provision means they could certain screening or preventive care without making any out-of-pocket payments, but bills are triggered if the screening leads to treatment.[2109] Also, insurers may refuse to pay claims. In 2020, fully 18 percent of claims submitted by patients covered through healthcare.gov were denied by insurers.[2110] Finally, if patients did somehow have good data on price, they might worry that low-price caregivers might be poorly trained or incautious—unless patients also had good data on quality of individual caregivers.

Patients who decide to run the gauntlet of these complexities and act like conscientious shoppers still encounter difficulties learning doctors', hospitals', or drug makers' list prices, negotiated actual prices set by contract between caregivers and insurance companies, insurance companies' payments, and net out-of-pocket costs patients and families must shoulder.

Decades of effort to make accurate and relevant price data available in usable forms have yielded negligible results. Still, the efforts continue. New federal legislation has sought to oblige both hospitals and insurers to post detailed prices in 2021 and 2022.[2111] So far, compliance is spotty. Fierce, hopeful, but radically unrealistic advocates like Fisher continue to push price posting as a painless panacea.[2112] *Axios* covered another Fisher report in the fall of 2024, this one lamenting a drop in the share of hospitals complying with federal price transparency regulations.[2113] Rarely has something so meaningless received so much regular attention. Employer groups fight to keep unusable, useless, and unused price data available.[2114] They are either optimistic or anxious to deflect pressure to take effective action to cut health care costs.

After so many years of fruitless effort, all this now appears a dramatically cynical exercise in pretending to make available relevant data,[2115] but—at best—would provide information that no more than one or two percent of Americans might be able and willing to use.[2116] "Doing the

same thing over and over and expecting different results" is said by some to be Einstein's definition of insanity.

More generally, most people simply are unable or unwilling to pay attention to the complex information requirements demanded by free market fanatics. Two-thirds of workers eligible for health insurance and other employee benefits spend a half-hour or less reviewing information during yearly open enrollment periods.[2117] And that information could include very consequential matters like which doctors and hospitals are in various insurers' narrow networks.

Interestingly, when physicians used real-time benefit tools (RTBTs) to learn patients' estimated OOPs for meds, the doctors prescribed different meds one-seventh of the time when the patient would save $5 or more. So it might be useful to give relevant financial data to professionals who are likely to be competent and willing to marshal information about price and value to help their patients.[2118] Alternatively, in a real health world, doctors would marshal budgets to care for patients as well and as economically as possible with the dollars available.

In sum, it is wrong to argue that patients should try to shop by price for the great bulk of needed and costly health care. Possible exceptions include specific services like MRIs. These are closest to standardized consumer goods or services.

Medicare's drug benefit—designed to confuse patients and impair rational choice

The difficulty patients face in finding the Medicare Part D prescription drug plan that best covers the meds they need at the lowest total cost highlights how hard it is to obtain good information. Only about 10 percent of patients are enrolled in the Part D plan that offers them the lowest across available plans.[2119] [2120] Cost includes both premiums and OOPs.

Even though Part D was designed to allow and require lots of decisions by citizens, this was a cynical smokescreen. Part D was designed—intentionally—to make it hard for patients to choose the plan that was best for them.

What purpose could that serve? Knowing that drug costs are the most predictable costs in health care, many experts long believed that free-standing competing drug plans were doomed to underwriting melt-downs. This happens when patients are able to find the best deals for themselves. People needing lots of costly drugs opt for the plan that best covers them. Premiums rise commensurately. Those for whom the higher premiums are a bad deal drop out, leaving only the costliest patients paying the highest premiums.[2121] [2122]

Indeed, some experts predicted that only elders with high out-of-pocket drug costs would even buy stand-alone prescription drug coverage.[2123] [2124]

Since insurance is possible only when risks are unpredictable—so purchase of insurance is widespread and premiums can be kept relatively low—Part D's designers intentionally made it hard for patients to find the best plan for themselves. This is why each plan has its own formulary of covered meds, its own step therapy requirements, its own schedules of deductibles and co-payments and co-insurance, its own cluster of participating pharmacies, and its own premiums. These variations make it hard for patients to choose rationally. This is the main reason Congress did not establish a single, standard set of OOPs and benefits.

All this was shamelessly marketed to the public as a reliance on inter-plan free market competition to hold down costs.[2125]

Worse quality data

As hard as it is to obtain good price data, accurate information on quality of different hospitals, doctors, nursing homes, dentists, or meds is much more difficult to compile. The same is true for the quality/efficacy/safety of alternative methods of diagnosing or treating a problem, or of alternative meds to ameliorate or cure it.

Consider Leapfrog, one of the main purveyors of letter grade ratings of hospital safety. One study found "there was negligible difference in mortality or complication rates among hospitals receiving A, B, or C grades." These were about 94 percent of hospitals examined. The remaining 6 percent of hospitals graded D or F did have "slightly higher 30-day mortality."[2126]

Consider also the star ratings assigned to MA plans. The star ratings are putatively designed to guide citizens toward higher-quality plans. The information on quality is notionally part of the theory of competition in health care. It also rationalizes some $12.8 billion in bonus payments to 4- and 5-star rated plans in 2023.[2127] Although the star ratings exist, they seem to be devoid of practical meaning. One study found they are "uncorrelated with plan mortality effects."[2128]

Berenson and colleagues have concluded that decades of efforts to measure clinical processes and outcomes, and patient experience, "may have actually compromised care delivery—at a high cost."[2129]

Since the U.S. has some 5,000 hospitals but about 200 times as many doctors, it is not surprising that data on physicians' quality are even more meager. Bond and colleagues found that scores on Medicare's Merit-based Incentive Payment System (MIPS) for doctors were inconsistently associated with process and outcomes measures. They concluded that "the MIPS program may be ineffective at measuring and incentivizing quality improvements among US physicians."[2130] If Medicare can't measure doctors' quality in useful ways, how can patients be expected to evaluate those doctors?

It is usually possible to learn whether a physician has paid a claim for malpractice, but even this information is sometimes self-reported and not verified. Frequently successful patient malpractice suits might signify poor care, but these are not helpful in ranking most physicians by technical quality of care.

Nonetheless, the search continues for better data on quality of care and for ways to induce patients to use them. One manifest reason is large, persisting differences in quality of care. Alley and colleagues found very different statin adherence by patients of 809 Ohio cardiologists. Grouping patients by adherence rates for different doctors, 73 percent of the patients in the top decile were taking their statin regularly, but only 39 percent of patients in the bottom decile.[2131]

The authors urge employers to find good data and get their workers and dependents to use them. That's a useful posture for consultants to take. But do many employers really want to get even more involved in employees' health care? Employers and their insurance companies would like to contain health spending. But can they be effective in doing so? Or are they and their consultants wandering down a path that's rewarding only (or mainly) to the insurance

companies and the various expert advisors? Higher OOPs, narrow networks, and trying to steer patients to ostensibly higher-quality care may keep employers hoping that they and their insurance companies can hold down spending. But for how long?

It's useful to ask whether the Ohio data reflect the quality of the doctors' care, the characteristics of patients served by different doctors (their income, insurance coverage, personalities, trust in medical care, and other factors), or some combination of the two? To what degree would better quality require educating doctors and their clinical colleagues on ways to persuade patients to take prescribed drugs? And to what degree would it require lower OOPs for meds, educating patients on the safety and efficacy of meds, and other patient-facing efforts?

Information on individual doctors is both rare and hard to interpret. New York State published cardiac surgery data on individual hospitals and surgeons. Several hospitals suffering high severity-adjusted death rates reorganized their services and showed marked improvement. But some doctors with lower quality ratings asserted they are better surgeons so, naturally, harder cases are referred to them. One complaint about this reporting approach was that some hospitals and doctors up-coded the severity of their patients' illnesses. Another was that some hospitals and doctors ceased operating on high-risk patients to hold down their reported death rates.[2132]

Lacking good data on quality, some patients might rely on reputation or even on prices—reckoning that better doctors or hospitals can charge higher prices. Abelson, though, reports on Pennsylvania data showing high payments aren't correlated with higher quality. She cites Lee at Pacific Business Group on Health, who said "'For most consumers, the fact that there is no correlation between quality and cost is one of the dirty secrets of medicine.'" [2133]

Even though it is hard to obtain good data on quality and persuade patients to use them, differences in quality across doctors are probably enormous. Chapter 16 will consider how to improve technical quality and appropriateness of physicians' services.

And, as also discussed in chapter 16, technical quality of care is different from appropriateness of care. As patients, we need both. But most efforts to measure quality pertain to competence or skill in performing a given task, not whether the care given coincided with the care needed to diagnose and treat the patient.

Since the data are so weak, why are they trumpeted?

The confluence of weak data on cost to patients and weaker data on quality of patient care makes it hard for even the most conscientious of patients to successfully shop by price and quality.

Current data on price and quality constitute a huge Potemkin village of meaningless numbers created to convince hopeful or gullible people that evidence to guide health care choices has been—or will somehow, some day, be created.

This is a fool's game. Some propagandists trick only others but some trick themselves, also.

This smokescreen is part of the gassy camouflage created by several types of believers. Some deeply believe that a competitive free market exists in health care or that it can be created. Others believe that competitive free markets are the only tool to contain cost, so that even a badly functioning market is better than any of the alternatives. Even if access to care for lower-income or chronically ill patients is disproportionately suppressed by OOPs. Others hope that higher OOPs for sick people will lower the premiums they must pay for their employees' health insurance. Still others wish to use market rhetoric to sustain rich financial harvests for some caregivers or payers.

A strong example of the last is the marketing of Medicare Advantage plans are marketed to Americans. In mid-2023, CMS reported "a steep rise in beneficiary complaints related to the marketing of Medicare Advantage and Part D plans." The National Association of Insurance Commissioners raised similar concerns. A Kaiser Family Foundation-sponsored study found high levels of TV advertising, with ads focusing on low costs and extra benefits and few mentioning quality.[2134] Much of the information provided fails to enhance citizens' capacity to make informed choices.

Those who declare they want to empower health care "consumers" with information about price, quality, or what care is needed in order to strengthen market forces in U.S. health care are actually telling sick or low-income Americans to go play in traffic.

Or worse. They are drafting Americans to serve as kami-kaze pilots in a cost control war. They seek to oblige the weakest and least-informed party—Americans who are ill or injured—to figure out what care they need and then shop for it by price and quality. It is noteworthy that only one Japanese admiral or general was numbered among the thousands who flew kami-kaze airplanes.

Why rely on the weakest and least informed of us to contain health care costs? That's a policy worthy of Marxist ideologues.

As discussed in chapters 8 and 9, other rich democracies craft effective methods of containing cost while financially protecting all citizens. These rely, to varying degrees, on capping spending politically, making visible the trade-offs between higher health care spending and other good things, and relying on doctors, hospitals, and other caregivers to spend money cautiously.

What data are needed and who should use them?

Spending inevitably scarce health care dollars to win the best outcomes and the greatest medical security for all Americans requires good evidence. Evidence on how to diagnose and treat the illnesses and accidents that plague us. It also requires caregivers who use that evidence.

That requires clinical knowledge—of how to diagnose and treat different illnesses and injuries.

4. Market failure is one source of anarchy

Even more important, suppose—against all the evidence—that accurate and trustworthy information on price and quality actually became available to patients. We'd still need to understand how to process it—how to make sense of it. Unfortunately, most Americans report confusion about the meaning of basic insurance terms like co-payment, co-insurance, or deductible.[2135]

But suppose we could process, summarize, and make sense of good data on price and quality. We still would not know whether we actually needed a given service—whether it was appropriate for us. If not, buying it at any price or quality is entirely a waste of money.

Patients would still not become informed shoppers because only a tiny share would have useful information on the most important factor: what medical care is actually needed (appropriate and effective) to diagnose and treat an illness or injury.

Only about one million Americans are working as doctors and four million as nurses. They are much better equipped than the rest of us to know or learn enough to make informed judgments about the care they need. Even they need much better information about how to diagnose and treat us. And about how to weed out the dangerous, futile, or ineffective care whose provision wastes money.

Even physicians often find it hard to know what to do. And they've actually graduated from medical or osteopathic school and completed residencies. (Please refer to chapter 4's discussion of clinical waste in U.S. health care, and also to chapter 16 on quality and appropriateness of care.)

Doctors are overwhelmingly the decision-makers. They diagnose and treat patients. Few competent and autonomous consumers of medical care inhabit the real world. They are disproportionately doctors, nurses, and people related to them, or educated professionals who are motivated and—sometimes—competent to identify valid, accurate information on-line that's relevant to diagnosing or treating their illness or injury. Most humans have little choice but to trust their doctor.

And trust is absolutely not a requirement of well-functioning competitive free markets. The opposite is true. This is taken up as the fifth requirement for effective markets.

Name that hospital or insurance company!

How can patients choose meaningfully if the names of payers and caregivers keep changing? A few examples.

Almost all of the various Blue Cross plans were called Blue Cross plans. They were originally all non-profit. Then, starting in California, some converted to for-profit status. The original BC names for the various state and local plans were retained. Did patients know they were now covered by a for-profit? A company called Anthem Blue Cross was formed as the holding company for those for-profit BC plans. Until it merged with WellPoint in 2004. Then, it became WellPoint. Until 2014, when it became Anthem again. The combined entity renamed itself as Elevance in 2022. But its Medicare and Medicaid products are under the WellPoint umbrella.

In 2019, Dignity Health, the nation's largest non-profit system, was formed by the merger of Catholic Health Initiatives and Dignity Health. In 1986, two groups of Mercy Hospitals merged into Catholic Health West, which re-named itself as Dignity Health in 2012. Catholic Health Initiatives was formed in 1996 by merging three groups of Catholic hospitals—Catholic Health Corporation, Franciscan Health System, and Sisters of Charity Health System.

In 2013, Catholic Health East and Trinity Health combined as Trinity Health. Catholic Health East was formed in 1992 by combining the Franciscan Sisters of Allegany Health System, Eastern Mercy Health System, and the Sisters of Providence Health System. Trinity Health was created in 2000 by merging the Congregation of the Sisters of the Holy Cross and the Sisters of Mercy of the Americas.

5. Constant mistrust or suspicion

"Caveat emptor," or "buyer beware" is caution enjoined on all market participants. Don't trust anyone. Double-check and confirm. This requirement for a competitive free market is not at all satisfied in U.S. health care.

Mistrust makes no sense at all in a world of medical care where patients depend overwhelmingly on doctors' judgments. As the U.K.'s General Medical Council states, "Patients must be able to trust doctors with their lives and health."[2136]

Since doctors are fiduciaries, they must behave in trustworthy ways. Fiduciary duties include those of care, competence, good faith and fair dealing, loyalty, and avoiding conflicts of interest.[2137] This includes offering needed care and refraining from offering unneeded care that boosts income.

Does a patient's trust in a doctor correlate with better health outcomes? In one meta-analysis, trust correlated moderately with a patient's assessment of their own outcome, but not with objective measures of outcome.[2138] A different meta-analysis examined the connection between patient experience—including a number of trust-related measures—and clinical safety and effectiveness. It found consistent positive associations across many types of patients, settings, diseases, and outcome measures.[2139]

Does anyone actually believe that mistrust between patients and doctors makes for better U.S. health care? People who mistrust their doctor will worry more. Worrying is not good for our health. And people who mistrust are likelier to seek second or third opinions, boosting cost of care.

6. Price tracks cost closely

This is the most technical requirement for free market competition. In such a market, prices of goods or services are set in close relation to the costs of producing them. Things that cost more have higher prices. Market prices send signals to buyers. When buyers opt for lower prices (holding quality constant), they reward more efficient suppliers. Suppliers that set excessive prices owing to inefficiency or greed are punished: fewer people buy what they offer.

In health care, though, price and cost are often far apart. Some prices are far above cost while others are far below cost. This means that patients or payers that try to buy by price do not actually reward efficient producers of health services or goods.

One reason is that caregivers often find it difficult to learn the costs of various services they give. A hospital stay, in particular, is usually very complicated. Types and volumes of individual services can be hard to track accurately, and their costs can be hard to measure.[2140]

Wood described an exception—a successful efforts at one specialized eye and ear hospital to learn costs of various types of care and then align prices with those costs.[2141] Some third party payers cooperated in implementing this pricing method. Wood acknowledged that this activity might be easier at a specialized hospital, one treating relatively few diagnoses, but he believed that acute general hospitals could also succeed. That does not seem to have happened.

Prices vary radically across payers and over time. Different payers pay very different prices for the same care. Most state Medicaid programs pay less than Medicare does for hospital care and much less for physician care. And Medicare pays much less than do most private insurance companies.

In recent decades, hospitals rapidly accelerated the rate of rise in the list prices they posted for various services. In 1998, the ratio of hospital charges—their list or sticker prices— to their costs was 1.3. This means their charges averaged 30 percent above their costs. That ratio rose to 2.9 in 2008 and to 3.8 in 2018—boosting charges to nearly quadruple actual costs of care.[2142] Charges—posted prices—have become increasingly remote from actual costs of care.

Uneven profitability of services can distort care patterns. In a competitive free market, prices of services with high costs should be higher than prices of services with low costs. Over time, generally, all care would converge toward equal profitability. So caregivers' clinical decisions would not be distorted by differential profitability. This simply does not hold in health care. This market failure helps to magnify clinical waste.

Ambulatory surgery centers are highly profitable in part because their prices are high relative to their costs. Their proponents attribute this to greater efficiency. But they may profit also by skimming profitable types of high-acuity care like total joint replacements away from inpatient settings.[2143] The services are highly profitable in part because payment rates by Medicare (for example) were originally set at high levels in the early days of providing them. Over time, techniques of care improve and costs fall, but prices remain sticky at their high original levels. ASCs also benefit by enlisting surgeons and anesthesiologists as owners. This makes those doctors more likely to refer profitable patients.

ASCs also serve lower shares of low-paying Medicaid patients. The persisting differences in prices paid by various payers for the same care violates the market's price-tracks-cost requirement. A strong example is Tenet's United Surgical Partners International. A Tenet executive said USPI was not worried about possible Medicaid cuts in early in the second Trump administration because "the Medicaid exposure is de minimus…." [2144]

More broadly, statewide data from Pennsylvania consistently showed that ASCs were about five times as profitable as acute care hospitals, and also that ASCs' share of Medicaid patients was substantially below hospitals'.[2145]

4. Market failure is one source of anarchy

Back in 2005, Ginsburg and Grossman carefully described ways in which newer types of care have been made excessively profitable to hospitals.[2146] This distorted patterns of care by leading to high use of high-priced care. Medicare DRG payments for innovative care have been set initially to be close to actual initial costs of delivery of care. But, over time, costs fall but DRG prices remain stuck at high levels. Ginsburg and Grossman therefore called for re-setting prices in proportion to actual costs. Objectively, though, this is a very difficult job. And organizations that profit by serving profitable patients fight to keep their prices high.

As early as 1981, Roe described a similar problem with physician payments under usual, customary, and reasonable fee-for-service price-setting. He noted that innovative surgery—like much heart surgery—initially took a great deal of time and cost a great deal of money. They required expensive support staff and services. Fees for heart surgeons were set accordingly. Over time, though, surgical methods improved. Less time and fewer support workers were required. Actual costs of care fell. But surgeons' fees did not fall. Just like DRG prices for innovative types of hospital care, the doctors' fees were stuck at their high initial levels.[2147]

Financial incentives can be corrosive. If care is very well-paid, physicians can come to believe that more and more patients might benefit from it.

Medicare's switch to paying doctors by a formulaic resource-based relative value scale (RBRVS) was an attempt to bring payments in line with costs. But weaknesses in method, discussed in chapter 9, limited the value of this intended reform.

7. Sellers aim to maximize profit and profits reward efficiency and satisfaction of sovereign consumers' demands

Thorough violation of all of the six previous requirements of a functioning competitive free market mean that the invisible hand is palsied in health care. It fails to convert greed into low-cost, innovation, and provision of what people want to buy. Pursuit of profit in giving health care is therefore unworthy of applause.

Moreover, a large share of caregivers are legally non-profit organizations, so the lure of garnering a surplus is typically modulated. In combination, the illegitimacy of making profit via caregiving and the modulated profit-seeking behaviors of many hospitals and a high share of nursing homes mean that this seventh requirement of competitive free markets is not remotely satisfied.

In a competitive free market, producers' pursuit of profit drives cost-cutting, innovation, and satisfaction of consumer demand. Competitive free markets do legitimate profits: they transmogrify greed from an undesirable motive to one that animates pursuit of good things. Profit then signals "doing good by doing well."

Absence of a competitive free market means that any profits or surpluses that caregivers garner are not legitimate. Profits are often amassed by corrupt behavior, as documented in the section on theft in chapter 3. This means it will be productive and desirable to eliminate profit-making in giving health care (see chapter 9).

4. Market failure is one source of anarchy

→ Interestingly, the lack of investment in cost-reducing technologies is one of the strongest pieces of evidence that a functioning free market is absent in health care. Cost-cutting is the main path to profit in sectors of an economy where free markets prevail. In health care, though, investments tend to seek enhanced quality—pushing the ceiling upward—the best that health care can do for some—not lowering cost to raise the floor below which we don't let any Americans fall.

Although free markets rely on the motivation to pursue profit, genuine free market competition works to erase substantial profits. That's because new competitors enter any arena where high profits are being earned, learn to operate efficiently, boost supply, and compete on price. This combination squeezes out the profits of those producers who'd been earning them.

High profits persist only in the absence of a competitive free market. Durable profiting, indeed, is one more signal of the absence of a competitive market.

For-profit hospital chains, insurance companies, drug makers, and others claim that their high profits are outward signs of inner virtues of efficiency, innovation, and satisfaction of consumer demand. In the absence of a functioning competitive free market, they mean no such things.

Without such a market, profit signals only greed. It does not connote cost cutting, innovation, or satisfaction of consumer demand. Those who would self-sanctify their profits in a health care world where the seven requirements for competitive free markets are systematically violated turn Adam Smith on his head and pound him into the ground.

Without a free market, profits are illegitimate in health care. Without a free market, the increased insertion of more and more financial incentives by some economists and free market fantasists is just as illegitimate.

One of the most common and pernicious incentives is the proliferation of patient deductibles, co-insurance, co-payments, and out-of-pocket maximum payments that are imagined to convert sick, injured, disabled, and frightened patients into vibrant and empowered consumers.

A second is to offer financial incentives to doctors of hospitals in the form of "gain-sharing" in accountable care organizations. These incentives are expected to induce doctors to spend money more carefully in hopes of garnering some of the savings. "Value-based payments" bribe caregivers to cut costs and, ostensibly, boost quality. Exposing caregivers to more financial incentives induces them to pay more exquisitely detailed attention to their own revenue and less to spending finite health dollars to do as much as possible to deliver needed health care.

A third is to offer insurers and other parties fixed-payment contracts to serve lower-income Medicaid patients in hopes that the prospects of pocketing unspent money will induce the contractors to boost efficiency and effectiveness of medical services. Under-service is the more likely response to these under-financed contracts.

A fourth is to allow Medicare Advantage plans to make their members look sicker and more disabled than they really are. Revenue goes up but costs do not. Cost to Medicare rises.

Ending for-profit caregiving and insurance is desirable, feasible, and affordable

4. Market failure is one source of anarchy

Health care's failure to satisfy the 7 requirements of free market competition means that profit-seeking doesn't yield the benefits promised by markets. Innovation, cost-cutting, and satisfaction of sovereign consumer demand are all weak. Since greed in health care doesn't motivate good behavior, and since it breeds waste and theft, it should probably be pushed out.

Is that humanly possible? That seems to be the case in the world's other rich democracies. Professional and institutional caregivers appear to act as fiduciaries, relying on evidence of what care works and which patients need it to serve patients within budgets.

It is feasible to choose and train doctors to act altruistically. As mentioned in chapter 1, Casalino and colleagues found that patients of doctors who'd been identified as altruistic had three-fifths the chance of a potentially preventable hospital admission, two-thirds the chance of a potentially preventable ER visit, and 9 percent lower health care spending.[2148] Both professionals and organizations would accept stewardship of the nation's vast but finite clinical and financial resources.

Is that affordable? Suppose that for-profit hospitals and insurers were deemed undesirable owing to the absence of competitive free market to legitimate their profits. They might be taken under eminent domain law, provided that stockholders were fairly compensated. Fair market value is the typical standard [2149] but adjustments might be considered.[2150]

If owners of stock in the three largest for-profit hospital chains were given 20-year bonds paying 5 percent interest in compensation for their shares, the yearly nation-wide cost would be $4.25 billion. The 5 percent return would be a 1 percentage point premium over the mid-2023 interest rate paid on 20-year U.S. Treasury bills. At the end of 20 years, the principal sum would be paid, awarding today's stock-holders $85 billion in interest plus $85 billion in principal, for a total of $170 billion over 20 years.

The cost of compensating stockholders in the seven largest for-profit health insurance companies would be much greater—about 10 times greater. Shareholders' value is $852 billion in mid-2023, taken at the mean of the highest and lowest price of each stock over the past 52 weeks. On the same terms as those for for-profit hospitals' owners, shareholders in for-profit insurers would be paid $42.6 billion yearly for 20 years, for a total of $852 billion, plus payment of principal after 20 years, for a total of $1.7 trillion.

Interestingly, almost three-fifths of the total shareholder value is in UnitedHealthcare. Compensating UnitedHealthcare stockholders would do much more than address for-profit ownership of health insurance. It would cover Optum, which controls one of the nation's three large pharmacy benefits managers and employs or is aligned with some 70,000 doctors and also owns home health and other caregivers. There is good reason to believe that United's stock price is artificially inflated by undeserved revenue and profit on MA—money stolen by exaggerating the cost of treating United's MA patients. A lower stock price means lower cost of buying out stockholders' equity.

If compensating owners of for-profit caregivers were deemed financially feasible, the question of its practical feasibility arises. For-profit caregivers rarely exist simply in isolation. For-profit hospitals are often vertically integrated with physicians, home health agencies, ambulatory surgery centers, and other caregivers. For-profit payers often have risk contracts with Medicare, Medicaid, or private employers. For-profit PBMs are intertwined with most aspects of pharmaceutical coverage, formularies, and attempted cost control. And for-profit physician

groups or ASCs often have partnership or other contractual relations with non-profit hospitals.[2151]

A second option would be to leave for-profit owners in place but to reform how they act by substantially re-shaping the legal, regulatory, financial, and care delivery environments in which they operate. This option is worth considering for at least two reasons. It would obviate financial compensation to stockholders. And it would recognize the need to address the very common bad behavior of nominally non-profit caregivers and insurers.

Rooke-Ley and colleagues have summarized abuses by MA plans. They decry prior authorization delays and claims denials, other barriers to care, administrative waste, and clinician demoralization. To fix these systemic problems, though, they propose creating a MA Administrative Contractor to conduct prior authorization and claims adjudication. The contractor's work would rely on Medicare's coverage rules, paralleling the contractors that pay claims for traditional Medicare patients.[2152]

If this proposal succeeds in improving MA patients' access to care, would it obviate MA plans entirely? Why, though, would we expect it to succeed? Plans could find ways to game or bribe the new contractors, for example. MA plans have for decades politically manipulated the payment rules under which they operate. What would impair their political power and allow imposition of the MA Administrative Contractors?

Eliminating for-profit MA plans would be substantially more effective than adding an administrative layer or shifting one from MA plans to the new contractors.

After considering this option, it should probably be rejected. It is complicated. It is attended by political and legal difficulties. Even a seemingly simple step, such as requiring disclosure of private equity ownership of caregivers, has stalled in Congress.[2153] And the bad behavior of both for-profit and non-profit caregivers can and should be addressed in more straightforward ways.

Non-profits often behave badly

Perhaps surprisingly, this is even true in a health care world where many parties—such as non-profit hospitals—claim to disdain profits and don't seem to aggressively pursue them. As shown in Exhibit 4-3, non-profit hospitals were 57 percent of all institutions but had higher shares of beds and gave even higher shares of inpatient admissions, outpatient visits, and births. They incurred three-quarters of all hospital expenses.

Exhibit 4-3

Hospitals, Beds, Care, Workers, and Expenses by Control, 2018 [2154]

	Hospitals	Beds	Admissions	OP visits	Births	Workers	Expenses
Control							
Non-profit	57%	68%	72%	76%	74%	73%	75%
For-profit	25%	18%	16%	8%	14%	11%	11%
State + local gov't.	19%	14%	12%	16%	13%	15%	14%
TOTAL	100%	100%	100%	100%	100%	100%	100%

Source: American Hospital Association, *2020 Hospital Statistics,* Chicago: AHA, 2020, Table 1.

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Most hospitals—like most universities—operate not-for-profit. This means that any surpluses (excesses of revenues over costs) belong to the organization, not to any individual owners.

Many non-profit hospitals are devoted to serving local communities. Many compete fiercely. But not ordinarily by price. Instead, they seek to build their reputations by delivering cutting-edge medical care in newer buildings with the latest equipment and the glossiest amenities. Some are indistinguishable in appearance from luxury hotels.[2155]

Some non-profits, even those originating in religious orders, appear to espouse market-oriented rhetoric and elements of profit-oriented behavior. CommonSpirit's CEO announced in March 2024 that the system would focus on the "strongest markets." It was doing so in the face of $1.4 billion in losses in the previous fiscal year.[2156] Decades earlier, successive issues of the *Health PAC Bulletin* described ways in which for-profit hospitals' behaviors were pushing non-profits to imitate them if they wished to survive.

A pattern of non-profit behavior prominently identified by Vladeck decades ago is the tendency to spend more money than they garner.[2157] They over-invest in buildings and equipment that multiply things they can do. These investments boost costs. And Vladeck cites Parkinson in noting that institutions like the League of Nations or the U.N. began to decline around the time they built costly new palaces.[2158]

In recent years, even as they have continued to construct palaces and increase the scope of their services, many large non-profit regional clusters of hospital have also chosen to accumulate billions of dollars of assets. Twenty prominent examples located in 13 states are reported in Exhibit 4-4. Large multi-state non-profit or for-profit chains like Hospital Corporation of America or CommonSpirit are not included.

Exhibit 4-4

20 Prominent Non-profit Regional Teaching Hospital Clusters' Net Assets, 2019-2021

Hospital/system	State	Date	Total Net Assets ($B)
Mass General Brigham	Mass.	30 Sept 21	$16.2
Mayo Clinic	Minn.	31 Dec 20	$12.4
U. of Pittsburgh Medical Center	Penn.	31 Dec 21	$11.3
Indiana University Health	Indiana	31 Dec 21	$10.3
Cleveland Clinic	Ohio	31 Dec 19	$9.8
Sutter Health	California	31 Dec 20	$9.4
Northwestern Memorial	Illinois	30 Sept 20	$9.1
New York + Presbyterian	New York	31 Dec 20	$9.1
Inova Health Systems	Virginia	31 Dec 20	$8.1
Methodist Hospitals	Texas	31 Dec 20	$8.0
Northwell Health	New York	31 Dec 21	$6.8
Baylor Scott + White	Texas	30 June 19	$6.7

Boston Children's	Mass.	30 Sept 20	$6.5
Sentara Health Care	Virginia	31 Dec 20	$6.5
BJC Health Care	Missouri	31 Dec 20	$6.2
Hosp of Univ of Pennsylvania	Penn.	30 June 20	$5.8
Johns Hopkins Health System	Maryland	30 June 20	$3.8
NYU Langone	New York	31 Aug 20	$3.4
Henry Ford Health System	Michigan	31 Dec 20	$3.0
Beaumont Health	Michigan	31 Dec 20	$3.3
TOTAL – 20	13 states	Dec 20	$155.7

Sources: Audited financial reports and IRS 990 forms

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These are variously justified as essential buffers against economic downturns, means to finance investments in new buildings or equipment or programs, or sources of subsidies for unprofitable patients or services. What is remarkable is how rapidly these net assets have grown in the past two decades. They testify to major teaching hospitals' ability to extract higher prices from private insurance companies. Sources of that ability include successive mergers with some formerly competing hospitals, purchases of other hospitals closings of still others, and ability to attract philanthropic donations.

Some teaching hospitals have claimed that fear of the Clintons' health insurance proposals of the mid-1990s drove them to seek leverage over insurers. Costly teaching hospitals worried that the Clintons' reliance on competing health maintenance organizations to contain cost induce those HMOs to send as many patients as possible to lower-cost community hospitals, squeezing teaching hospitals' prices, volumes of patients, and total revenues.

That said, growing for-profit sections in health care—insurance companies, drug makers and pharmacy chains, hospital chains, ambulatory surgery centers, nursing homes, and others—do powerfully pursue profits. Most know that absence of a competitive free market means their profits can't be anointed by Adam Smith's oil, so they sell snake oil instead. Ignoring that absence, they claim their profits are well-deserved because markets mean you can only do well by doing good.

Sadly, these are profits without honor.

The rhetoric of competitive markets and their actual absence combine to invite parasites and predators to enter the world of health care delivery and insurance to financially pillage and plunder sanctimoniously but remorselessly under the false flag of profit.[2159] Dayen's assessment of Scully illustrates this pattern.[2160] So does a concise history of actions by UnitedHealth Group.[2161] So do the cannibalizing of formerly non-profit hospitals by Steward, Prospect, and others.

CEO income. CEOs, trustees, and directors rationalize high and rising hospital and insurance company CEO pay by claiming it is needed to attract the best people to undertake this difficult work. The work is not easy—partly because U.S. health care financing and delivery are so complicated, and partly because absence of a coherent peace treaty among public and private payers, doctors, hospitals, patients, and politicians oblige the various parties to spar with one another constantly.

4. Market failure is one source of anarchy

High CEO pay in health care has become a lightning rod for political discontent. Some newspapers have featured regular annual summaries of non-profit hospital CEO salaries in their region. High and rising pay is seen to manifest the high costs and inequality thought to permeate health care itself. In the city of Los Angeles, citizens will vote in 2024 on a referendum sponsored by a health care union that would cap hospital CEO pay at $450,000. [2162]

The Lown Institute has prepared detailed comparisons of CEO pay with average pay of workers. Across hospitals, the degree of inequality varies markedly, with larger teaching hospitals showing the highest average ratio at 14:1.[2163]

And between 2005 and 2015, the gap between CEO pay and that of physicians and nurses has grown. At 22 major medical centers, CPI inflation-adjusted CEO compensation rose by 93 percent. It rose by 26 percent for orthopedic surgeons, 15 percent for pediatricians, and 3 percent for RNs. The average CEO's income rose from 1.5 times the average orthopedic surgeon in 2005 to 2.2 times as much in 2015. For pediatricians, the ratio rose from 7:1 to 12:1. And for RNs, it rose from 23:1 to 44:1. The last figure signifies that hospitals value the contribution of a CEO at 44 times that of an RN.[2164]

In Massachusetts, non-profit hospital CEOs enjoyed substantial double-digit pay rises between 2020 and 2021, with the highest-paid CEO receiving $5.4 million in total compensation in 2021.[2165]

Multi-million-dollar incomes for hospital and insurance company CEOs make citizens, voters, patients, and politicians angry. Those incomes are not justified by legitimate free market competition. They signal greed and power.

By contrast, the highest paid hospital CEO in Ontario made $C647, 000 in 2022, or $US497, 000 at an average 2022 exchange rate of 0.7688 U.S. dollar per Canadian dollar.[2166] Starkman reports very wide gaps between pay for many US and Canadian CEOs at comparable hospitals.[2167]

The average UK hospital CEO's total compensation was £185,000 in 2022, or $US228,000 at an average 2022 exchange rate of 0.8115 pounds per dollar.[2168]

Hospital trustees and directors insist that paying more attracts and retains better CEOs. But CEOs' accomplishments are hard to measure. Perhaps, trustees and CEOs imagine they have hired good CEOs because they pay them so much. Indeed, one authority has urged eliminating CEO bonuses or stock options immediately because, he asserts, any organization's performance rests on the work of many people over many years or decades.[2169]

The failure of U.S. health care to satisfy any of the seven requirements for genuine free market competition means that the benefits of such a self-regulating market are unavailable. Those benefits include low cost, innovation, and delivery of the medical care patients seek.

No competitive market is available to convert greedy profit-seeking into these three benefits.

4. Market failure is one source of anarchy

Garnering profits via care delivery is therefore illegitimate. So, for reasons discussed in chapter 9, profit-seeking by caregivers should be outlawed. They should be converted to non-profit ownership. Stockholders' equity should be bought out.

At the same time, non-profits can't be given a free pass. The litany of their bad behaviors—inside and outside health care [2170]— obliges all of us to strenuously demand efficiency, careful decisions about what care to give and to whom to give it, and honesty from non-profit caregivers.

No competitive market is available to guide decisions about the overall numbers, types, locations of and hospitals, doctors, dentists, and other caregivers. Only effective public action can configure caregivers correctly—the right types, in the right locations, with reasonable capacity.

Anarchy in U.S. health care results in part from the failure of the competitive free market. And in part from the inability and unwillingness of governments to compensate for that failure by putting their arms around health care and making strategic decisions to cover all people, contain cost, configure caregivers in relation to need, and boost quality and appropriateness of care. Chapter 5 now describes the failures of governments, analyzes causes of failures, and identifies ways to do better.

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