Health Insurance: The Problem, Not the Solution

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HEALTH INSURANCE: THE PROBLEM, NOT THE SOLUTION

Ryan Dwan*

I. INTRODUCTION

Developed countries across the world have been dealing with the issue of dramatically increasing costs of health care. This note will provide a background of health insurance industries in developed countries and how prices have been increasing universally. It will then discuss in more detail nationalized health care systems, single payer systems, and employer provided/private insurance systems. That section will relay the problems of each system by focusing primarily on the United Kingdom’s nationalized health care system, Canada’s single payer system, and the United States’ employer provided/private health insurance system.

This note will then examine the various factors contributing to these rising prices including the moral hazard concept,1 over administration, the disincentivizing of innovation, the problems with the pharmaceutical industry, inadequate government regulation, and a lack of market incentives. As a result of these symptoms of inefficient health insurance systems, providers can no longer operate like other competitive businesses. This note will further examine the problems associated with health insurance systems and offer a solution to a new hypothetical nation that has not yet set up its healthcare industry. The significant increases in the price of health care can be combatted with the implementation of market principles, primarily by almost entirely eliminating the health insurance industry alongside a few key regulations and programs.

II. HEALTH INSURANCE SYSTEMS IN DEVELOPED COUNTRIES: A BRIEF BACKGROUND

Developed country’s expenditure on health care per capita has increased dramatically in the past 50 years.2 In the United States, spending as a percentage of Gross Domestic Product ("GDP") has increased from 6% in 1970 to 17% in 2017.3 In that same time frame, comparable countries like Canada, France, the United Kingdom, Switzerland, Germany, and others have experienced a lower, but still alarming, increase from 5% to 11%.4 The United States spends over ten thousand dollars per capita on health care, while 16 other countries spend over four

* This note is dedicated to my mother, Maura Dwan, for her years of dedication to the healthcare industry and helping those who need it the most.
1 See Mark V. Pauly, The Economics of Moral Hazard: Comment, 58 THE AMERICAN ECONOMIC REVIEW 531, 535 (1968) (discussing how the principal idea behind the moral hazard concept as it relates to medical insurance is that by lowering the price paid by the consumer, usage is increased).
3 See id.
4 See id.
thousand dollars per capita per year. Why have the prices of health care and spending as a percentage of GDP increased at such a rate? The health insurance systems that countries in Europe and North America have adopted are inefficient and broken, each of them increasing the prevalence of the issues mentioned in the introduction and discussed in Part III.

A. Nationalized Health Care Systems

The United Kingdom transitioned to a nationalized health care system when they created the National Health Service (“NHS”) in 1948. The program was adopted with the goal of providing affordable care to all, regardless of their financial situation and ability to pay. The British government implemented this system with the purpose of financing and providing all of the care that the population required. As the then Labour Minister Dr. David Owen predicted, they were going to “finance everything, cure the nation and then spending would drop.” Unfortunately for them nationalized health care systems foster increases in the prevalence of the moral hazard concept, decreases in the quality of care, and increased difficulty to receive care as a result of doctor’s inability to meet the drastic increases in demand.

In the first year of the NHS’s operation the costs exceeded original estimates by 52 million pounds, “exceeding anything [its creators] had dreamt of.” Now that the provision of medical care was a government function in the United Kingdom, health care costs competed with all other government programs for funding. This promptly led to budget cuts for the NHS, and thus the “steady deterioration” of medical care quality in Britain. Doctors in the United Kingdom now had an average of over 3,000 patients, compared to 500 to 600 for doctors in the United States. By the late seventies it was rare for an NHS general practitioner to have any equipment other than stethoscopes and blood pressure meters, and most patients had to be sent to hospitals for even simple procedures. Wait times for non-emergency surgeries reached a length of years and “more than 700,000 English men, women, and children were on hospital waiting lists at any given time.”

In 1989, as it became apparent that the system was not working, the British government began its shift away from a total nationalized system towards increased competition in the market. To combat the growing problems in the industry, the NHS reversed

5 See id. (The other 16 countries are the United Kingdom, Finland, Australia, Iceland, Japan, Belgium, Canada, France, Denmark, Ireland, Austria, Netherlands, Sweden, Germany, Luxembourg, Norway, and Switzerland).
7 See id.
8 See id.
9 Id. at 3.
10 See id. at 1-3.
11 Id. at 3.
12 See id. (including spending for the military and pensions).
13 Id.
14 See id.
15 See id.
16 Id.
17 See id.
its policy of only treating patients in public hospitals and started using private hospitals. The NHS even struck a deal with HCA International, the United States’ largest health care provider, to treat approximately 10,000 patients at facilities in the United Kingdom. As the country transitioned away from a completely nationalized health system, the percentage of people in Britain spending money out-of-pocket on health care has increased by 40%.

The United Kingdom now employs a two-tiered health care system, which can be found in several European countries. The two-tiered system includes a government run public system that operates parallel to an industry in which individuals can purchase private care. However, this type of system still facilitates the issues discussed in Part III of this note, since it continues to maintain the problems associated with guaranteed health insurance provided and monitored by the government.

**B. Single Payer Systems**

Another common health care program found across the developed world is the single payer system. Single payer systems encounter many of the same problems that nationalized health care systems experience. The illusion of “free” health care dramatically increases the demand for medical care, incentivizes providers to increase the administration of care, disincentivizes hospital innovation, and gives health care providers no incentive to cut costs. Additionally, countries have had trouble relying solely on their single payer systems to provide care to its people. For example, Canada needs to use the United States’ market as a “safety valve.” Canada has introduced and implemented programs to start sending a number of their cancer patients to the United States for treatment. Between Canadian patients and the Canadian government, more than $1 billion is spent per year on medical care in the United States. Countries with socialized medicine are also able to “reap the benefits of new drugs without sharing the burden of their development.” Drug companies must now focus on countries freer markets to recoup their expenditures from the costly process of drug development. The drug development process is expensive for drug companies, as only one in

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22 See id.
23 See id.
24 See Wollstein, supra note 6, at 3.
25 See id. at 3-4.
26 See GOODMAN, *TWENTY MYTHS ABOUT SINGLE-PAYER*, supra note 20, at 8.
27 Id. at 7.
28 See id.
29 See id.
30 Goodman, supra note 18, at 17.
31 See id.
five drugs tested ever reach the public and the cost of bringing a new drug into the market averages about $900 million.32 Countries with socialized medicine are then able to access those that are successful after. This begs the question: what would happen to Canada and other country’s single payer systems if freer markets no longer existed and they no longer had such safety valves?

C. Employer Provided and Private Insurance Systems

The third health care system found in developed countries is the system currently being implemented in the United States, which includes a mixture of employer provided health insurance, privately purchased insurance, and publicly provided insurance.33 Opponents of allowing the free market to govern the health care industry often point to the United States as an example of the free market’s failure to properly regulate the industry.34 However, the United States does not have a free market approach to healthcare and has not had one for a long time, more specifically since World War II.35 In 1942, the wartime economy threatened the United States’ dollar with potentially dangerous inflation.36 In order to control this threat, the United States government drastically limited employer’s ability to increase their worker’s wages.37 As a result, businesses could no longer compete for prospective employees by offering higher pay.38 Thus, in order to hire preferred candidates, employers started establishing and increasing their employee insurance programs.39 Naturally, the prevalence of employer sponsored health insurance programs drastically increased as a result.40 During the 1940s “the number of persons enrolled in private health plans increased from 20.6 million to 142.3 million.”41

Furthermore, in 1954 the Internal Revenue Service decided that contributions to employee health insurance plans would not be considered taxable as income.42 These two actions by the United States government unnaturally shifted the country’s health care system to one largely relying on employer-provided care. By the year 2000, 66.8% of nonelderly individuals were covered by employer-sponsored insurance plans.43 As a result, out-of-pocket

32 See id. at 16.
33 See Wollstein, supra note 6, at 4-6.
34 See id. at 4.
35 See id.
37 See id.
38 See id.
39 See id.
40 See id.
41 Id.
42 See id.
spending by consumers as a percentage of expenditure in the health care industry dropped from 48% in 1960 to 15% in 2000.44

This shift to an employer provided insurance system has had profound negative effects on the individual, as it has undermined the growth of worker's take home wages.45 While it is true that pay increases have proportionally gone to the top ten percent of earners, this does not tell the full story.46 Since the year 2000 real wages for the top ten percent of earners has increased by 15.7%, while wages have only increased by 3% for workers in the bottom tenth and 4.3% for workers in the bottom quarter.47 However, "corporate greed" is not the lone factor contributing to wage stagnation and there is little agreement on the actual cause.48

One theory states that the culprit is the rising costs of benefits, specifically employer-provided health insurance.49 The Pew Research Center recently released data about the employment-cost index of businesses in the United States.50 This index compares the compensation of employees by the percentages paid towards their wages/salaries and their total costs of benefits provided by the employer.51 Since 2001, the total benefit costs of civilian workers has increased by an inflation-adjusted 22.5%.52 In that same time period, wage and salary have only increased by an inflation-adjusted 5.3%.53 As the price of health care has increased, so has the total cost of benefits paid per employee.54 These health insurance premium increases for employers have forced a larger and larger percentage of potential take home pay for workers with employer provided health insurance to be redirected in order to account for these rising costs.55 As a result, worker's wages have been relatively stagnant for the last half century.56 The average hourly earnings of non-management private-sector workers in July, 2018 were calculated to be $22.65.57 The average hourly rate was measured to be $4.03 in January of 1973.58 Adjusted for inflation, that $4.03 in 1973 had the purchasing power of $23.68 today, $1.03 more than the current hourly average.59

The health care system in the United States has shifted away from a free market approach to an unnatural insurance driven one. This has fostered an environment where, like the other health insurance systems of the world, the following problems are able to thrive.

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44 See Blumenthal, supra note 36, at 83-4.
47 See id.
48 Id.
49 See id.
50 See id. (defining the employment-cost index as a "measure of the change in price of labor, defined as compensation per employee hour worked").
51 See id. (Total benefits include "overtime payments, paid leave, insurance premiums, retirement contributions and other benefits").
52 See id.
53 See id.
54 See Sawyer, supra note 2; see also Desilver, supra note 46.
55 See COUNCIL OF ECONOMIC, supra note 45.
56 See Desilver, supra note 46.
57 See id.
58 See id.
59 See id.
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III. PROBLEMS ASSOCIATED WITH HEALTH INSURANCE

The aforementioned health care systems create environments that cause a number of the same problems to arise.

A. Moral Hazard

The moral hazard problem exists in all three of the aforementioned health care systems. The principal idea behind the moral hazard concept as it relates to medical insurance is that by lowering the price paid by the consumer, usage is increased. The Oregon Health Insurance Experiment supports this concept. The state of Oregon collected a pool of low-income individuals in the state who did not have health insurance. Oregon then randomly gave half of this pool insurance through the Medicaid program, and left the other half without insurance. After a period of two years, the state analyzed the financial hardship, utilization of health care, and overall health of the two groups of subjects.

The study found that having insurance through Medicaid reduced financial strain on individuals and increased total usage of care, but observed no statistically significant effect on the physical health of the participants. However, the study did show that the mental health of those not selected to gain insurance was adversely effected. The rates of depression for those who gained insurance dropped by 9.2 percentage points, most likely as a result of less worry associated with needing to pay for potential future care. This is supported by the fact that those with insurance had a 25 percent higher rate of reporting themselves to be in "good or excellent" health compared to their counterparts, despite no material difference in health.

Those with new insurance realized an increase in the following: (1) visits to the emergency department by 40 percent; (2) visits to their doctor (or primary care physician) by 50 percent; (3) cholesterol monitoring sessions by 50 percent; (4) likely of getting mammograms by 100 percent; and the likelihood of being admitted to the hospital by 30 percent. Despite the rise in health-related visits and testing, the study found no significant changes in physical health, which included blood pressure, cholesterol, glycated hemoglobin, or 10-year cardiovascular risk. These findings support the proposition that individuals who possess health insurance often consume health care not out of necessity, but because it is available to them at what appears to be a lower price.

In many cases the moral hazard concept occurs knowingly and purposefully by the individual. For example, most European countries use their courts to determine the insurance

60 See Pauly, supra note 1, at 535.
62 See id.
63 See id.
64 See id.
65 See id.
66 See id.
67 See id.
68 See id.
69 Id.
70 See id.
compensation payouts for people who have suffered personal injuries. In cases of fatal injury (with the exception of Italy), the injured party’s income is the primary determinative factor in calculating the compensation. While in cases of serious injury “it is the cost of medical care and rehabilitation as well as current and future supervised care that have a central impact upon the amount of damage claims determined.” However, this personal injury insurance system is being abused by people trying to take advantage of the insurance when they do not truly need it. One parliamentary committee study in Ireland found that 20% of all insurance claims had been fraudulent. Similarly, during an investigation into whiplash insurance claims, the Irish Times found that 90% of whiplash patients stopped attending treatment once the compensation was paid.

Studies conducted by Insurance Europe and the Association of British Insurers (ABI) have found that in 2011 the United Kingdom discovered 138,814 fraudulent insurance claims, while it is estimated that £1.9 billion of fraud is undetected each year. According to the ABI, on average, insurance fraud adds £50 to the bill of every single policy holder in the country per year.

B. Over Administration

Over administration is primarily an issue encountered in the single payer and private insurance systems. Similar to consumers’ moral hazard of consuming more health care simply because it’s available to them, providers often over administer care because insurance is there to pay for it. As one general surgeon put it in an interview with Atul Gawande, “the way to practice medicine has changed completely. Before it was about how to do a good job. Now it is about ‘how much will you benefit?’” This is shown by a 2003 Dartmouth study that found

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72 See id.
73 Id.
75 See id.
76 See id.
77 See INSURANCE EUROPE, THE IMPACT OF INSURANCE FRAUD 2 (2013), https://www.insuranceeurope.eu/sites/default/files/attachments/The%20impact%20of%20insurance%20fraud.pdf (“Insurance Europe is the European insurance and reinsurance federation. Through its 34 member bodies — the national insurance associations — Insurance Europe represents all types of insurance and reinsurance undertakings, eg pan-European companies, monoliners, mutuals and SMEs”).
78 See id. at 9.
79 See id. (A study conducted by the German insurance association GDV estimated that the cost of fraud in Germany exceeds €4 billion per year and Sweden even discovered a criminal network that had staged at least 214 fake traffic accidents for insurance compensation).
80 See Atul Gawande is a surgeon and public-health researcher, and became a staff writer at The New Yorker in 1998.
that patients in higher cost regions received more care that was more expensive, but not more of the care that they needed.82

Another factor that contributes to over administration in the health care industry is the practice of self-referral.83 The severity of this problem is shown in a study conducted by Jean Mitchell concerning the frequency of testing ordered by urologists who owned their own laboratories compared to those who did not.84 Her study found that in 2005 self-referring urologists billed the patient’s insurance, in this case Medicare, for 93 percent more surgical pathology jars compared to the rest of urologists.85 Additionally, it found that, on average over the course of the study, that the self-referring urologists billed the patient’s insurance for 4.3 more jars per procedure.86 Knowing that the patient’s insurance plans would pay regardless, these urologists ordered unnecessary tests and billed for more each time in an effort to increase their profits.

C. Disincentivizing Innovation

The disincentivizing of innovation is a problem associated with the nationalized health care system and single payer systems. Socialized medicine systems lower provider’s ability to profit off of patients and lead to less innovation and updates in the system.87 From 1987 to 1993 Canada spent less money on improving hospitals than Washington D.C. alone.88 Around that same time, there were less magnetic resonance image (“MRI”) machines in Canada than there were in Washington State.89 A lower number of available machines coupled with demand for their use lengthens the amount of time it takes to get the procedure done.90 In Canada the average wait time to get an appointment for an MRI through the public health plan is 12 to 18 months.91 Consequently, consumers in the United States have more favorable access to modern health care technology compared to Canada and the United Kingdom.92 Additionally, the decreased availability of machines coupled with a demand for tests will increase the price per procedure. In the United States out-of-pocket cash payments for an MRI

82 See id. ("They found that patients in higher-spending regions received sixty per cent more care than elsewhere. They got more frequent tests and procedures, more visits with specialists, and more frequent admission to hospitals. Yet they did no better than other patients, whether this was measured in terms of survival, their ability to function, or satisfaction with the care they received.").
83 See Jean M. Mitchell, Urologists’ Self-Referral For Pathology Of Biopsy Specimens Linked To Increased Use And Lower Prostate Cancer Detection, 31 HEALTH AFFAIRS 741, 741 (2012) ("The term self-referral describes arrangements in which a physician refers a patient to a health care facility in which the physician has a financial interest.").
84 See id.
85 See id. at 745.
86 See id.
87 See Wollstein, supra note 6, at 3.
88 See id.
89 See id.
91 See id.
92 See Goodman, supra note 18, at 5.
cost around $342 for a procedure without contrast, and $450 for one with contrast.93 In Canada, an out-of-pocket cash payment for an MRI on average would cost $870, about double the price in the United States.94 Similar problems also exist in the United Kingdom. For example, Great Britain only has enough kidney dialysis machines to provide 82 percent of the procedures that are demanded by its people.95 The United Kingdom also has a shortage of MRI and CT machines, which are both critical to a variety of diagnosis processes.96

D. The Pharmaceutical Industry

Many of the problems associated with the global phenomena of drastically increasing health care costs can be attributed to the pharmaceutical industry.

i. Expansion of the Definition of Health Care

The industry’s principle flaw is how the industry itself operates. As David Goldhill97 points out in his book, “the health care industry has responded to our willingness to pay for anything labeled ‘health care’ by continuously expanding the definition of health care.”98

Goldhill offers the history of erectile dysfunction as an example of this problem.99 In the 1990s Pfizer, one of the world’s premier pharmaceutical companies, attempted to develop a new drug to treat angina.100 The drug, patented as Sildenafil in 1996, did not successfully treat angina, but it did demonstrate an ability to induce erections.101 As a result, Pfizer released the drug with the new name Viagra in 1998 as a treatment for what they called erectile dysfunction.102 As of 2013 Viagra and its competitors had profited approximately $35 billion in sales for drugs treating erectile dysfunction.103 This point is not meant to disparage Viagra and its competitors, but is erectile dysfunction really necessary medical care to be covered by

94 See MRI Scans, supra note 90.
95 See Goodman, supra note 20, at 29.
96 See id.
97 See DAVID GOLDFILL, CATASTROPHIC CARE: HOW AMERICAN HEALTH CARE KILLED MY FATHER – AND HOW WE CAN FIX IT 371 (Alfred A. Knopf, 2013) ("David Goldhill is president and chief executive officer of GSN, which operates a U.S. cable television network seen in more than 75 million homes and is one of the world’s largest digital games companies. He is a member of the board of directors of The Leapfrog Group, an employer-sponsored organization dedicated to hospital safety and transparency. Goldhill graduated from Harvard University with a BA in history and holds an MA in history from New York University").
98 Id. at 96-7.
99 See id. at 98.
100 See id.; see also Mayo Clinic Staff, Angina, MAYO CLINIC (Jan. 18, 2018), https://www.mayoclinic.org/diseases-conditions/angina/symptoms-causes/syc-20369373 (defining angina as a type of chest pain caused by reduced blood flow to the heart).
101 See GOLDFILL, supra note 97, at 98.
102 See id.
103 See id.
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insurance alongside insulin and chemotherapy? Men had been experiencing erectile dysfunction for thousands of years with no threat to their physical well-being.104

Goldhill points out that traditionally “people get sick and medicine provides a cure,” but now that concept frequently operates in the opposite.105 In society today “much of the innovation in health care is now about the simultaneous search for new treatments and new conditions that require these treatments,” meaning that many pharmaceutical companies now look for new conditions just as often as they seek to find new treatments for existing ones.106

This expansion of what constitutes healthcare has also spread beyond pharmaceuticals to other sectors of the industry and facilitated questions like “is cosmetic surgery healthcare?”107 This question has made necessary the distinction between cosmetic surgery and reconstructive surgery.108 Cosmetic surgery changes the aesthetic of the body without altering function, while reconstructive surgery’s purpose is to improve the function of the body.109 Most countries with a universal healthcare system, like Canada, Japan, and the Netherlands, only cover these reconstructive procedures when there are health concerns.110 Individuals would need to go to the private sector in order to get cosmetic work done, either by paying themselves or through private health insurance.111 Why would cosmetic surgery even be covered by private insurance instead of being paid for by private payment or a loan? The entire purpose of insurance is to protect the policy holder from unforeseen medical expenses, not an unnecessary procedure they are choosing to undergo.

ii. Drug Company Marketing

(1) To consumers: Direct-to-consumer-advertising (“DTCA”) in the pharmaceutical industry refers to the practice of pharmaceutical companies “communicat[ing] information about their medicines...directly to the general public.”112 In practice, DTCA is detrimental to a healthy society. Most countries have gotten it right and have either banned or greatly restricted DTCA: according to the Advertising Regulations 1994 in the United Kingdom advertising non-prescription drugs is permitted while advertising for prescription only drugs is prohibited; Germany’s Law on Advertising in the Field of Healthcare bans the advertising of drugs “where the disease has only one treatment option available on the market;” advertising is allowed in France only for non-prescription drugs whose purchase would not be reimbursed by their social

104 See ANGUS McLAREN, IMPOTENCE: A CULTURAL HISTORY 18 (The University of Chicago Press, 2007) (discussing how attempts to fix impotence date back as far as the ancient Greeks and Romans).
105 GOLDHILL, supra note 97, at 98.
106 Id.
107 Id. at 118-19.
109 See id.
111 See Clinic Staff, supra note 108; see also Daley & Gubb, supra note 110, at 3.
program; and in Spain advertising is only permitted for medicine that treats minor symptoms.\textsuperscript{113} The United States and New Zealand are the only two countries that still allow DTCA of prescription drugs.\textsuperscript{114} As of 2012 in the United States drug companies were spending over $3 billion per year on marketing to consumers and in 2007 "tens of millions of dollars" were being spent in New Zealand.\textsuperscript{115} These advertising funds are used to brand the pharmaceutical company’s drugs and raise awareness of the aforementioned conditions they want to treat.\textsuperscript{116} These advertisements are proven to work, as a UCLA medical center study found that every $1,000 spent on advertising generates approximately 24 new prescriptions.\textsuperscript{117}

(2) To providers: Pharmaceutical companies also market their drugs to providers of care. Although paying providers directly to prescribe specific drugs is illegal (also referred to as kickbacks), drug companies are still allowed to pay physicians for speaking at an event or consulting for the company.\textsuperscript{118} It is also not illegal for drug companies to pay for physician’s travel costs and meals.\textsuperscript{119} The Physician Payments Sunshine Act provision of the Affordable Care Act requires that drug and device companies report all of these payments they have made to doctors.\textsuperscript{120} Despite the forced transparency, this loophole has proven to be effective for drug companies as a study conducted by CNN and the Harvard School of Public Health found that doctors who received money from pharmaceutical companies were more likely to write a prescription.\textsuperscript{121} "Among doctors in the top 25th percentile of opioid prescribers by volume, 72% received payments . . . [of] those in the top fifth percentile, 84% received payments . . . [and of] those in the top 10th of 1% -- 95% received payments."\textsuperscript{122} In 2015, a JAMA study found that 48% of all doctors in the United States had received payment from the drug or

\textsuperscript{113} Id.


\textsuperscript{115} Ana Swanson, \textit{Big pharmaceutical companies are spending far more on marketing than research}, \textsc{The Washington Post} (Feb. 11, 2015), https://www.washingtonpost.com/news/wonk/wp/2015/02/11/big-pharmaceutical-companies-are-spending-far-more-on-marketing-than-research/; Les Toop & Dee Mangin, \textit{Industry funded patient information and the slippery slope to New Zealand}, 335 \textsc{BMJ} 694, 694 (2007).

\textsuperscript{116} See \textsc{Goldhill}, supra note 97, at 107.


\textsuperscript{118} See \textsc{Industry payments to doctors: Opioids are the tip of the iceberg}, \textsc{Low Institute} (Mar. 21, 2018), https://lowinstitute.org/news/industry-payments-doctors-opioids-just-tip-iceberg/ [hereinafter \textsc{Industry Payments}].

\textsuperscript{119} See id.

\textsuperscript{120} See id.


\textsuperscript{122} Id. ("On average, doctors whose opioid prescription volume ranked among the top 5% nationally received twice as much money from the opioid manufacturers, compared with doctors whose prescription volume was in the median. Doctors in the top 1% of opioid prescribers received on average four times as much money as the typical doctor. Doctors in the top 10th of 1%, on average, received nine times more money than the typical doctor.").
medical industry.\textsuperscript{123} In the year 2018 alone, disclosed payments of around $12 billion to over 1 million doctors from 2,191 companies were recorded.\textsuperscript{124}

\begin{enumerate}
\item \textbf{Overuse}
\end{enumerate}

Both the expansion of the definition of health care and issues with drug company advertising have contributed to the growing rate of prescription and subsequent overuse of pharmaceuticals. David Goldhill points out that these conditions in the pharmaceutical industry have led to drug companies focusing more on what he calls “me-too” drugs rather than new treatments.\textsuperscript{125} This paired with health insurance creates a dangerous combination because of how the transaction has been interfered with. In a traditional business setting a business would need to convince the consumer that the benefits of their product are worth the cost.\textsuperscript{126} However, when a comprehensive health insurance plan is involved the cost is pushed off to a third party.\textsuperscript{127} Hence providers need only assure that the consumer will benefit, with no regard for the cost.\textsuperscript{128}

This phenomenon is also seen in the realm of chronic conditions.\textsuperscript{129} Chronic conditions, such as cancer, often require a combination of various treatments.\textsuperscript{130} However, conditions like heart disease as a result of high cholesterol are different. While high cholesterol was traditionally treated with lifestyle changes in a person’s exercise habits and diet, it can now be treated with a daily statin pill covered by insurance.\textsuperscript{131} This greatly skews the treatment process, as David Goldhill points out, other citizens would be unwilling to “subsidize more fish and vegetables in my grocery cart” but insurance systems require them to “share the cost of my pharmaceutical alternative.”\textsuperscript{132} When presented with the option of taking on the daunting task of healthy living and taking a pill daily at what appears to be at a low or no cost, it is human nature to take the easy route.\textsuperscript{133}

The over prescription of drugs by doctors is a major problem. One survey of 5,000 members of the American College of Physicians found that more than a quarter of them admitted to prescribing medication that likely won’t have any benefits to the patient.\textsuperscript{134} Twenty-

\begin{itemize}
\item \textsuperscript{123} See \textit{id}.
\item \textsuperscript{125} GOLDFILL, supra note 97, at 105 (When he says “me-too” drugs Goldhill is referring to drug company’s practice of creating drugs and airing advertisements meant to alert consumers of conditions they did not know they had until they hear all of the symptoms listed).
\item \textsuperscript{126} See \textit{id}. at 106.
\item \textsuperscript{127} See \textit{id}.
\item \textsuperscript{128} See \textit{id}.
\item \textsuperscript{129} See \textit{id}. at 100 (offering a general definition of chronic conditions as “long lasting, noncontagious, and resistant to cure,” with chronic diseases including hay fever, arthritis, diabetes, heart disease, and cancer).
\item \textsuperscript{130} See Cancer Treatment, NATIONAL CANCER INSTITUTE, https://www.cancer.gov/about-cancer/treatment (last visited Nov. 20, 2019).
\item \textsuperscript{131} See GOLDFILL, supra note 97, at 103.
\item \textsuperscript{132} Id.
\item \textsuperscript{133} See \textit{Humans are hard-wired to follow the path of least resistance}, UCL NEWS (Feb. 21, 2017), https://www.ucl.ac.uk/news/2017/feb/humans-are-hard-wired-follow-path-least-resistance.
\end{itemize}
seven percent of doctors said that they had prescribed antibiotics to patients "even when it was likely the treatment wouldn’t be effective." Keep in mind that these are only the doctors that are admitting to writing unnecessary prescriptions, it is probable that the problem exists on a much larger scale. Prescriptions are also being written by doctors even without a proper clinical diagnosis. In 2007 Health Affairs found that the proportion of psychiatrist visits in which antidepressants were prescribed to the patient without any note of an actual psychiatric diagnosis had reached 72.7%.

E. Inadequate Government Regulation

Too much government regulation, and more specifically inadequate regulation, inflates the costs of health care. One particular investigation into Scripps Memorial Hospital found that the hospital has to answer to 39 governmental bodies and 7 nongovernmental bodies. They had to file a number of often complicated reports that needed to be filled out by a trained professional. Additionally, in the United States, medical special interests have been lobbying politicians to implement legislation that reduces competition in the field.

This process began in 1910 when the American Medical Association ("AMA") lobbied state governments to tighten their restrictions on medical licensing and to allow the state AMA offices to reduce medical school class sizes and to oversee the merging or closing of "nearly half of medical schools." The United States restricted the supply of providers and competition in the market again in 1972 when the Nixon Administration started requiring federal "certificate-of-need" for the construction of any new medical facilities. By the 1980s the United States "was restricting the supply of physicians, hospitals, insurance and pharmaceuticals, while subsidizing demand." An environment that limits the availability of providers while simultaneously incentivizing consumers to consume more will obviously increase prices unnaturally.

Hospitals also spend a large portion of their revenue on protection against malpractice. European countries handle this issue more efficiently, as they afford more protections for their medical providers from less serious malpractice claims. However, in the United States, it is estimated that malpractice costs and protections account for between 2% and 10% of the total cost of health care in the United States. These high administrative costs

135 See id.
137 See id.
139 See id.
141 Id. (The State governments have subsidized the medical education of the number of doctors the AMA recommends since this time).
142 Id.
143 Id.
144 See Goodman, supra note 138.
145 See id.
are passed on to the consumer, through higher prices, by the medical providers to compensate for the burden imposed on them.146

The implementation of poor regulations of the insurance industry has created unnecessary expenditures. The impact of these unnecessary insurance company expenditures is seen in the private insurance system. Insurance companies and medical providers spend a nonsensical amount of money interacting with one another.147 In the year 2006, American physicians spent an average of $82,975 interacting with their patient’s insurance providers.148 The total administrative costs of the healthcare system in the United States is estimated to be near $294.3 billion.149 Another study estimates that 14% of medical practice’s revenue goes towards the process of managing claims.150

F. Lack of Market Incentives

i. Lack of Incentive to Decrease Prices

A lack of incentive to decrease prices is prevalent in all three of the aforementioned health care systems. As a result of insurance and third-party payments being so prevalent in the health care industry, providers no longer compete based on price.151 As a result of consumers knowing that they have health insurance to cover some or all of their costs, they almost never compare prices of multiple providers before making their decision and rarely even consider price in their decision-making process. Medical care providers know this, so they have no incentive to compete with other providers on price. This is depicted perfectly in an article published in the Los Angeles Times about the varying costs of health care.152 First the article discusses the experience of Jo Ann Snyder, a woman who needed to have a CT scan done of her abdomen and pelvis after she had colon surgery.153 Ms. Snyder had health insurance so she had the CT scan done.154 The hospital charged her $6,707 for the procedure, her insurance partially covered it so her out of pocket expense was $2,336.155 Had Ms. Snyder not used her insurance to cover the scan at that particular hospital, the total bill would have been only $1,054.156

While conducting research for the article, the Los Angeles Times called local hospitals with the goal of finding the most cost effective option.157 A CT scan was available at

148 See id.
149 See id. at 1447.
151 See Goodman, supra note 138.
153 See id.
154 See id.
155 See id.
156 See id.
157 See id.
a cash price of $250.158 Health care providers are aware that most consumers have health insurance, that they will almost entirely disregard price in their decision making process, and that they will still be compensated even if they charge excessively high prices.

The article goes on to provide another example. One patient needed to have routine bloodwork done and was charged $782 dollars with her insurance plan.159 She could have gotten that same procedure done for $95 dollars if she did not use her insurance and paid in cash.160

ii. Incentive to Increase Prices

The incentive for providers to increase prices exists in the private insurance system and the single payer system. Consumers almost always do not take price into account when choosing where to get medical care from, and providers know this. John Goodman, the president of the National Center for Policy Analysis in Dallas,161 points out that when providers do not compete on price, they compete through amenities and ambience.162 Hospitals are looking more and more like hotels, with increasingly expensive amenities to offer prospective patients. However, these exuberant expenditures on lavish amenities need to be accounted for in the budget. This contributes to higher costs for the providers, which are once again passed on to the consumer through higher prices.163 Insurance systems foster an environment in which medical providers compete based on their ambience and amenities instead of on price, which in turn further drives the prices for medical care higher.

Doctors are also incentivized to increase their costs when it comes to deciding which drugs to prescribe or use during procedures.164 Since the doctors know that insurance will pay for the procedure and price is disregarded for the most part, they will often choose to use more expensive drugs to increase the costs they can charge.165 For example, doctors in the dialysis business have been found to intentionally choose more expensive drugs for their procedures even though there are far less expensive drugs available that do the exact same thing.166 These doctors do not have to answer for their arbitrarily increased prices because they do not have to compete based on prices in excessive insurance driven systems.

IV. HOW TO FIX THE BROKEN SYSTEMS

The principal problem in the debate between socialized medicine and the free market is the proper balancing technique. Universal health care systems have no profit incentive for innovation or price controls while free markets would rather treat over the long term, charging along the way. Thus, some sort of balance, no matter how small, must be found between these

158 See id.
159 See id.
160 See id.
161 See Goodman, supra note 18, at 1.
162 See Goodman, supra note 138.
163 See id.
165 See id.
166 See id.
two systems. In this section, I will offer a system to a hypothetical new country (Country X) that has not yet set up its health care system. The goal of this solution will be to create a system that decreases the amount of money spent on health care and maximizes the availability and quality of the care itself, with no need for medical tourism elsewhere.

A. Government Contracts for Certain Treatments with Catastrophic Coverage System

First, it is important to recognize that the free market alone would not be able to effectively govern the entirety of the health care industry. A completely free market would encounter issues dealing with life-threatening, chronic, or preexisting conditions. However, Country X could mitigate these issues by implementing a system that protects those who cannot afford care while also utilizing market principles. A government contract system would meet these goals. Systems like this already exist, especially in the United States.167 When a government needs a job to be completed by a private business, they will release a Statement of Work detailing their expectations for the potential job.168 Private businesses then submit a competitive bid in the hopes of being chosen for being able to provide the best quality in comparison to their given price.169 Providers would submit competing bids in response to Statements of Work issued by the government detailing the potential care or procedure. Generally, government agencies expect the business to make a 15% profit from the job, which could be used or lowered in Country X’s case.170

This system would be tied into a sort of “universal catastrophic coverage” (“UCC”), the concept of which has been offered as a partial solution for some time.171 UCC programs are usually laid out as a plan to protect all people from the possibility of financial ruin as a result of costly medical expenditure that are absolutely necessary and they have no choice but to receive.172 To maximize the effectiveness of the model and its impact on low-income citizens Country X would incorporate three factors, a low-income threshold, a deductible, and preventive care.

The UCC contract-bidding system’s primary purpose in Country X is to prevent or limit the financial burden that a catastrophic diagnosis can impose on people. Thus, the system must principally protect low-income individuals and families. In order to do so, Country X must determine a federal poverty level (“FPL”) each year. The FPL concept was introduced to the United States in the 1950s.173 In that era health care expenditure was significantly lower than it is today, so a buffer should be applied to account for this.174 Accordingly, any citizen of Country X that is at or below 130% of the FPL would not have a deductible under the plan. For those that are over the 130% mark, their deductible will be 15% of their eligible income; the amount  

168 See id.
169 See id.
170 See id.
172 See id.
173 See id.
174 See id.
their income exceeds the 130% mark. For example, in 2019 the United States FPL was $12,490 for individuals and $30,170 for a family of five.¹⁷⁵ The 130% mark would be $16,237 for the individual and $39,221 for the family of five. So, if the individual and the family both made a total income of $50,000, the individual’s deductible would be $5,064.45 and the family of five’s would be $1,616.85. The deductible for a family of four with a total income of $5 million would be $744,978.75. This would ensure that those who can afford to pay these higher prices would pay and those who struggle would not have to bear the entire, or possibly any, cost.

This system would also incorporate a portion for preventive care because of some procedure’s effectiveness at catching dangerous conditions early on. However, not all preventive care procedures are cost effective, or even medically effective.¹⁷⁶ In order to solve this problem, Country X would create an organization similar to the United States’ Advisory Committee on Immunization Practices (“ACIP”).¹⁷⁷ ACIP gives the vaccinations they analyze a letter grade.¹⁷⁸ The organization for Country X would also give letter grades to types of preventive care after weighing the effectiveness and cost effectiveness of the service. This organization would also issue a recommended frequency of testing for different categories of the population like age and other factors that could increase or decrease the likelihood that an individual would have a condition. Citizens of Country X would have the option of paying for additional preventive care services on their own. However, they could count some preventive care services against their deductible. Citizens could use their deductible for services rated either an A or B by the organization, as often as the organization recommends, and as long as they fit into frequency according to age range given by the organization.

B. No Insurance System for the Rest of the Market

As David Goldhill discusses in his book, one explanation of why prices of health care treatment continue to increase is how the general population views the industry.¹⁷⁹ He points out that the population “seem[s] to accept what we pay as an inevitability, as something somehow generated outside the business decisions that drive health care.”¹⁸⁰ Most people think of health care “costs” rather than “prices,” as if they are inelastic expenditures that are set in stone.¹⁸¹ This is because health care systems across the world have consistently been, and continue to be, manipulated by government involvement. The problem of dramatically increasing prices can be combated by pairing free market principles governing the health care industry with a few specific regulations of the industry.

Though there is no health care system in the world that fully adopts free market principles for the industry, the best and closest example would be the Singaporean system. Singapore is a relatively young country, gaining their independence from Great Britain in

¹⁷⁷ See id. (ACIP examines vaccinations and recommends whether or not they should be taken. If they are recommended, the vaccination must be covered in full by both public and private insurance).
¹⁷⁸ See id. at 2034.
¹⁷⁹ See GOLDHILL, supra note 97, at 22.
¹⁸⁰ Id.
¹⁸¹ Id.
1965.\textsuperscript{182} After becoming independent, they quickly modeled their health care system after Great Britain with services offered at health clinics free of charge.\textsuperscript{183} However, Singapore's founding father, Lee Kuan Yew realized that "[t]he ideal of free medical services collided against the reality of human behavior."\textsuperscript{184} Singapore quickly shifted to a system in which patients had to pay per visit to the clinic in order to remind the public that health care was not free, and that they must be responsible for their health and payments.\textsuperscript{185} Ultimately, the government fully restructured the system in order to allow public and private hospitals to operate with more autonomy and compete with one another for patients.\textsuperscript{186} Increased choices for consumers countered the rising prices.\textsuperscript{187} Now, Singapore has the lowest percentage of GDP spending on health care of all the high-income countries in the world at only 3.5 percent.\textsuperscript{188} They achieved this feat by increasing personal expenditure by consumers in the healthcare industry.

Other countries can make similar progress by eliminating government and private insurance for all treatment except for life-threatening, chronic, and preexisting conditions. In a sense, markets like this already exist around the world, in the form of "medical tourism."\textsuperscript{189} Medical tourism is "travel with the express purpose of obtaining health services abroad."\textsuperscript{190} One of the only times that the health care industry operates as a competitive market is when a foreigner is seeking medical care. Hospitals are forced to actually compete with one another on price in these circumstances, often resulting in transparent prices near the marginal cost of the care itself.\textsuperscript{191} When insurance is removed, the system would adapt to fit a consumer driven model. There would be an increase in the prevalence and importance of online marketplaces that already exist.\textsuperscript{192} One particular example of these services operates in the United States and connects doctors to patients who have filled out medical questionnaires, uploaded their medical records, and have requested the procedure they need.\textsuperscript{193} Doctors then submit competitive bids to perform the treatment.\textsuperscript{194} These types of services have been shown to be effective even before a switch to a completely competitive system has been made.\textsuperscript{195} For example, in 2011 the service MediBid facilitated 50 knee replacements at an average price of $12,000.\textsuperscript{196} That is almost one third of what insurance companies paid doctors on average.\textsuperscript{197} Country X should implement

\textsuperscript{183} See id. at 7.
\textsuperscript{184} Id.
\textsuperscript{185} See id.
\textsuperscript{186} See id.
\textsuperscript{187} See id.
\textsuperscript{189} Goodman, supra note 138.
\textsuperscript{190} Annette B. Ramirez de Arellano, Patients without Borders: The Emergence of Medical Tourism, 37 INT'L J. OF HEALTH SERVICES 193, 193 (2007).
\textsuperscript{191} See Goodman, supra note 138.
\textsuperscript{193} See id.
\textsuperscript{194} See id.
\textsuperscript{195} See id.
\textsuperscript{196} See id.
\textsuperscript{197} See id.
laws that follow these principles while also lowering the barriers for entry to providers. An increase in the number of providers competing with one another alongside market principles would stimulate the reduction of prices and increase quality.

Such a system may seem daunting at first. One could reasonably argue that a person would be fine paying out of pocket for medicine and small procedures, but once they need a more significant expensive one, like the aforementioned knee replacement, they would be in trouble. However, it is important to note that these individuals would be saving a substantial amount of money that could be used for these procedures. People in countries with private insurance would be saving the money that would otherwise be paid towards premiums, while those in countries with a socialized health care system would save money on significantly decreased taxes. Individuals are not using health care more often than they are, so the money that they would otherwise lose through taxes and premiums can be saved and used when they do need to undergo serious treatments.

C. No Direct to Consumer Advertising for Drugs or Treatment

As previously mentioned, DTCA advertising is pharmaceutical companies “communicat[ing] information about their medicines...directly to the general public.” This practice is extremely harmful to a society’s culture surrounding health care. A Health Affairs study conducted in the United States, one of the few countries that allows full DTCA, found that 86% of all consumers had seen or heard a direct-to-consumer-advertisement in the last year. This caused about 35% of all of the respondents to ask about an advertised drug during a visit with their physician. Additionally, “[n]early two-fifths of patients having a DTCA visit talked about a prescription drug, about one in five discussed a new concern, and about one-third talked about a possible change in treatment for an ongoing condition.”

These advertisements did achieve their intended goal, as “[n]early three-quarters of respondents with a DTCA visit received a drug prescription” and “43 percent of DTCA visits resulted in a prescription for the advertised drug.” However, the study found that no health effects varied significantly, whether the patient had switched to an advertised drug or a different one. Also, “no clinically notable differences” were noted between patients with new or existing diagnoses. As Dr. Matthew Hollon points out, “Since ‘almost every drug product has some advantage for some patient,’ it is anecdotally true that any information the industry provides about a product has some benefit for someone.”

198 Pharmaceutical direct-to-consumer advertising in Europe, supra note 111.
200 See id.
201 Id. at 86-7.
202 Id. at 89.
203 See id. at 91.
204 Id.
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This shows the actual effect of DTCA, to artificially create consumer demand and undermine the physician-patient relationship.\textsuperscript{206} Patients should instead feel that something is wrong and meet with their physician, who then analyzes their condition and decide what the appropriate treatment should be.\textsuperscript{207} This leads to over-prescription by some physicians, as the particular study that Hollon discusses found that “patient demand was the most commonly cited motivation for prescribing the target drugs.”\textsuperscript{208} Thus, Country X should implement laws that would prohibit all DTCA, as it fosters an undesirable culture in health care and promotes unnecessary expenditure and treatment.

D. No Payments of Any Kind to Doctors from Drug Companies

Country X should also prohibit certain parts of marketing to providers by drug companies. Kickbacks, or paying providers directly to prescribe desired drugs, should be made illegal. However, Country X should also make it illegal for drug companies to make payments of any kind to any practicing doctor. In some countries it is not currently illegal for drug companies to pay physicians to speak at events, to consult, or even to pay for physician’s meals and travel costs.\textsuperscript{209} As previously mentioned, of “doctors in the top 25th percentile of opioid prescribers by volume, 72% received payments . . . [of] those in the top fifth percentile, 84% received payments . . . [and of] those in the top 10th of 1% -- 95% received payments.”\textsuperscript{210} Payments made by drug companies to physicians have been shown to increase dangerous and unnecessary prescriptions in the name of profit.\textsuperscript{211} In order to prevent this disastrous situation from occurring, Country X should outlaw any payments made by drug companies to any doctor.

V. CONCLUSION

Health care costs are increasing around the world as a result of the excessive role insurance has in the industry. Whether it be provided by the government, an employer, or a private insurance company, too much insurance is driving the price of health care up. This growing problem can be fixed by eliminating the health care industry for the treatment of conditions that are not life-threatening, chronic, or preexisting. Market principles must be applied to the remaining health care industry and providers must be forced to compete with one another based on price. Doing so would lower the price of treatment in the health care industry without sacrificing quality and access. Adopting a free market approach with a few effective government regulations and programs would achieve these goals.

\textsuperscript{206} See id. at 384.
\textsuperscript{207} See id.
\textsuperscript{208} Id. at 383.
\textsuperscript{209} See Industry Payments, supra note 118.
\textsuperscript{210} Kessler, Cohen & Grise, supra note 121.
\textsuperscript{211} See id.