

BOOK REVIEW

BIG MED: MEGAPROVIDERS AND THE HIGH COST OF HEALTH CARE IN AMERICA

DAVID DRANOVE AND LAWTON R. BURNS
CHICAGO: UNIVERSITY OF CHICAGO PRESS, 2021, 335 PP.

DALE STEINREICH*

David Dranove is an economist and Walter McNerney Distinguished Professor of Health Industry Management at the Kellogg School of Management at Northwestern University. Lawton R. Burns is a sociologist and James Joo-Jin Kim Professor of Health Care Management at The Wharton School at the University of Pennsylvania. Their joint effort, *Big Med: Megaproviders and the High Cost of Health Care in America*, purports to offer special insights into the pathologies of the American health-care system *via* an interdisciplinary approach (vii).¹

The good begins with the subtitle: *Megaproviders and the High Cost of Health Care in America*. Thankfully, Dranove and Burns (D&B hereafter) and the University of Chicago Press are treating health care as two separate words and eschewing the fashionable

* Dale Steinreich (dsteinreich@drury.edu) is an instructor of economics at Drury University.

¹ Page numbers refer to the hardcover version of the book.



but awkward “healthcare.” Megaproviders (integrated delivery networks [IDNs], more on them below) are certainly a factor behind the high and rising costs of health care in the U.S. However, IDNs are certainly not the only factor behind high and rising health care costs, and health care costs were certainly high and rising before IDNs became more and more prevalent in the U.S. since the early 1990s. Do these two very basic facts become lost on our esteemed and highly credentialed authors as we move from the title to the end of the epilogue of their book? We shall see.

I. FROM HOSPITALS TO INTEGRATED DELIVERY NETWORKS (1811–2017)

The following is a summary of the complex evolution of hospitals in the U.S. from 1811 to 2017, broken into five parts.

A. Hospitals (1811–1960)

The hospital story in the U.S. begins in the early nineteenth century with the founding of Massachusetts General Hospital in 1811. More than a half-century later, New York Presbyterian was founded in 1868 and Presbyterian Hospital was founded in 1893 (not 1883, as D&B claim) to become no less than the flagship facility of today’s massive University of Pittsburgh Medical Center (UPMC).

As D&B aver, American hospitals in the nineteenth century were institutions where the sick were isolated from the rest of society or the injured or infected had their limbs removed. Hospitals only slowly evolved from dungeons of death and dismemberment to oases of life-saving treatments after the steady arrival of many innovations: the first and increasing use of nitrous oxide and ether as anesthetics (1844–46), the first use of vaccines for cholera, anthrax, rabies, typhoid fever, and plague (1879–97), the development of ABO blood typing and the first successful blood transfusion (1901–07), the use of insulin for the treatment of diabetes (1922), the first blood bank [at Cook County Hospital in Chicago] (1937), the use of penicillin from first dose to a production level of 650 billion units per month (1942–45), the first cardiac pacemaker (1952), and the first kidney transplant (1954).

In 1950, approximately 5,000 community hospitals were receiving the largest portion of U.S. health care spending (D&B, p. 13). That same year, the public-assistance amendments to the Social Security Act of 1935 created a federal program providing matching funds to states that paid for health care services for welfare recipients. This limited program was a precursor to the Kerr-Mills Act of 1960's Medical Assistance to the Aged (MAA) program, which provided federal funds to states that paid for health care services for the elderly poor (Moore and Smith, p. 45). Kerr Mills also provided funding for the building of new hospitals and new wings on existing hospitals. Hospital spending was further subsidized by the insurance industry and government with few limits such that, adjusted for inflation, it increased by 2.6 percent from 1950 to 1980 (D&B, p. 13).

B. Hospitals and Their Economic Enemies (1960–93)

The second era in hospital history is punctuated by hospitals fighting five major nemeses: health-maintenance organizations (HMOs), price and supply controls, outpatient surgery centers, selective contracting, and the Health Security Act of 1993.

Health-Maintenance Organizations (HMOs). HMOs offered care that was prepaid and provided by staff working in teams. There was also an emphasis on illness prevention in some of them, hence the name health maintenance organizations. By 1950, they had mostly caught on in the west coast states of California and Washington. Despite this limited success, hospitals and doctors saw them as serious threats to their incomes and profits and thus swung into action, lobbying state legislatures to forbid HMOs from advertising in any medium. HMO physicians came under severe persecution: many saw local medical societies revoke or deny them membership while hospitals cancelled or denied them admitting privileges. Nevertheless, the industry slowly grew with the help of the HMO Act of 1973 and several regulatory and court victories.

Headwinds returned to the industry in the 1990s after it implemented a number of measures to control costs, against which many enrollees fiercely rebelled. For a time, the industry became notorious in popular culture, even on top-rated television sitcoms,

for stiffing patients of adequate care and prematurely discharging enrollees right after major surgeries.² Physicians and hospitals used this notoriety as a launching pad to successfully lobby for more regulations on HMOs (e.g., any-willing-provider and freedom-of-choice restrictions).

Price and Supply Controls. While now obvious in hindsight, the back-and-forth fight between governments and the health care sector over the level and rate of health care spending came after the passage of the Medicare and Medicaid programs in 1965. Medicare overnight became the top buyer of health services in the nation while Medicaid became one of the largest components of each state's budget. With federal and state government budgets experiencing immediate stress and hospitals being a prime factor behind spending (more than a third by 1970), governments targeted them (D&B, p. 19). In 1971, the state of New York implemented fixed payments per day (Murray and Berenson, p. ix). Seven other states, Medicare, and private insurers copied the program. Hospitals responded by increasing the number of days per stay, i.e., patients stayed longer.

The next system of price controls was Medicare's prospective payment system (PPS) of 1983, which provided fixed payments per hospital admission plus adjustments for diagnoses (470 options known as diagnosis-related groups [DRGs]) and treatment. Not long after PPS was introduced, state Medicaid and private insurers jumped on board. PPS drove down Medicare and hospital spending until hospitals gamed it with upcoding (moving patients to higher-paying diagnostic categories) and unbundling (moving diagnostic procedures to outpatient centers and releasing not-fully-recovered patients to skilled-nursing centers or home-care programs). This allowed hospitals to earn not only standard DRG fees, but outpatient, skilled-nursing, and-or home-care fees.

As with rate restrictions, supply restrictions also began in the state of New York, but seven years earlier under the Metcalf-McCloskey Act of 1964. This law protected New York hospitals from new

² In the very successful NBC comedy series *Frasier*, there is a scene in the 1996 episode "It's Hard to Say Goodbye If You Won't Leave," in which Frasier Crane's date asks him how his friend (who underwent a serious operation that day) is faring. Frasier answers that the hospital plans to send him home the next day. Horrified, the date asks, "After a heart transplant?" Frasier answers, "Well . . . he's with an HMO."

competitors unless the new competitor could convince a planning board (staffed by appointees of state politicians) that there was a “need” for its services. If persuaded of a need, the board would then award the new industry entrant a certificate of need (CON) and construction of new facilities could begin. A decade later, the National Health Planning and Resources Development Act of 1974 became U.S. law, incentivizing the creation of CON programs in all states. Today, CON programs are required in 35 states.

A very common but mistaken line of thought is that businesses automatically oppose just about any regulation of their industries. One among myriad counter-examples: hospitals and Blues insurers love CON programs because they block new competitors from entering their industries and drive out smaller incumbent competitors. Thus, large hospitals survived rate setting and CON while many smaller urban and rural hospitals drowned in insolvency and closed. In the two decades since the passage of Metcalf-McCloskey, it was no accident that the list of largest hospitals in the U.S. had changed very little. Few other industries enjoyed similar stasis.

Outpatient Surgery Centers. Until the early 1970s, surgery usually entailed a stay of at least a few days in a hospital. Outpatient surgery was an innovation where quick, minimally invasive surgeries (e.g., tonsillectomies and hernia repairs) were undertaken that allowed a patient to be discharged the same day or early the next. The first independent facility was SurgiCenter, founded in Phoenix, Arizona in 1970. Patients liked ambulatory surgical centers (ASCs) because they were smaller, quicker, and easier to check in and out of than hospitals. Public and private payers liked their lower charges. By 1980, a decade after SurgiCenter was founded, about 200 ASCs were operating in the U.S. and by 1988, more than 1,000 (D&B, pp. 25–26).

ASCs, of course, posed a serious threat to hospitals’ inpatient surgery services. Hospitals fought back in two ways. First, they opened their own ASCs connected to their main campuses. Second, while these new facilities were contiguous to the main hospital, many were built with separate entrances to mimic the convenience of independent centers. Exclusive was their perceived dimension of extra safety: if something went wrong or there were complications, the patient could be taken next door to the main hospital with no

delay. This was the carrot dangled to patients, which was effective. The stick was wielded against insurers: all outpatient surgeries must be done at our hospital or we will not do any business with you. For hospitals with good reputations, these were serious threats. After many insurers caved to these demands, independent ASCs sued hospitals, contending that hospitals were abusing their market power to hinder local competition. Hospitals argued that their markets were not local, and courts bizarrely and continually agreed with them, dismissing the lawsuits.

Selective Contracting. Despite large insurers being five to seven times larger than the largest hospitals in terms of revenue, insurers had little power over hospitals and physicians. Before the 1980s, insurers rotely paid all bills with nary an objection. Patients had few if any co-payments and few if any obstacles to continually patronizing the costliest physicians and facilities. Only enrollees in stingy HMOs faced narrow provider networks. D&B report (27–28) that in this environment, “every provider, even small community hospitals and solo physicians, could price like a monopolist.”

Selective contracting in the 1980s changed this: in response to states no longer requiring insurers to reimburse all licensed providers, insurers formed preferred-provider organizations (PPOs). PPOs arranged networks of providers, and if enrollees sought care outside their network, they paid high costs, thus providers had a strong incentive to be a network member. In return, insurers demanded and usually received significant discounts for letting providers into their networks. Policyholders won big with lower-cost coverage but little or no change in access. D&B report that PPO enrollment skyrocketed from close to zero in 1983 to approximately 28 million by 1987 (p. 28).

C. Hospitals Become Integrated Delivery Networks (IDNs) (1993–98)

The early years of the 1990s were a watershed. The hospital industry, especially after selective contracting, felt that it had lost the upper hand in its relationship with insurers. If it were ever to return to its position of relative dominance it held in the past, it would have to pull one more economic rabbit out of the health-care hat. More and

more the answer seemed to lie in vertical integration, meaning that hospitals merged with physician practices, insurance plans, or both.

The year 1992 saw the election of Bill Clinton. First Lady Hillary Clinton and her health-care advisor Ira Magaziner led the crafting of the Health Security Act, "Act" being a misnomer because the bill never passed Congress. The plan consisted of three main components: the establishment of regional state health alliances, the creation of insurance plans by local insurance firms and providers, and prices for services that would be set by the alliances. As D&B state, "[w]hile the Clinton Plan died on arrival in Congress in the spring of 1994, it nevertheless frightened providers into a variety of integration efforts" (34).

The starting gates having been flung open, the horses bolted forth. Within just a few years, hospitals turned into massive health systems or, in the parlance of industry consultants and executives, integrated delivery networks (IDNs). There was horizontal integration where hospitals bought or merged with other hospitals, vertical integration where hospitals bought physician practices and the physicians became hospital employees, and vertical integration where hospitals created their own health insurance plans. By one estimate, while only 16 percent of hospitals were part of an IDN in 1994, 50 percent were part of an IDN by 1998 (D&B, p. 42). So effective was the threat of the Clinton Health Security Act in driving consolidation that, while from 1980 to 1993 about 300 hospitals merged, in 1994 alone there were over 600 mergers. Then from 1995 to 1998 there were over 500 mergers per year. After this, the merger craze lost steam (D&B, pp. 42–43).

D. Integration Fizzles (1998–2000)

After the fog cleared in the wake of the integration bacchanal came the mundane task of providing health-care services. Three case studies show how, in the eternal hunt for the economies-of-scale unicorn, costs soared and revenues nosedived.

The Allegheny Health Education and Research Foundation (AHERF). AHERF began as Allegheny General Hospital (AGH) in Pittsburgh, Pennsylvania. AGH operated in the shadow of its much larger and more prestigious rival, the University of Pennsylvania

Medical Center (UPMC). To change this, in 1986 AGH hired a sky-is-the-limit ambitious executive named Sherif Abdelhak as its new CEO. Abdelhak saw hyper-integration as the avenue to toppling UPMC from its throne and taking its place as the Grand Poobah of Pittsburgh. A year later AHERF purchased the Medical College of Pennsylvania (MCP) in Philadelphia. Four years later (in 1991) it purchased the United Hospital system. In 1993, it bought the financially sinking Hahnemann Medical College in Philadelphia.

With so many acquisitions made in so little time, clearly Abdelhak and his executive team were not able to adequately analyze their additions to AHERF. AHERF's newly acquired hospitals were suffering losses and had high levels of debt, its endowments at both newly acquired medical schools were barren, and it overpaid for the physician practices it needed to feed patients to its new hospitals. These economic albatrosses were serious enough, but then came the national trend toward outpatient surgery which left AHERF with lower revenue from fewer inpatients. With 14 hospitals, two medical schools, 30,000 employees (including more than 500 doctors), and 750,000 insurance enrollees, AHERF declared bankruptcy in July 1998 owing \$1.3 billion in debt. It was the largest health care nonprofit bankruptcy in U.S. history.

Detroit Medical Center (DMC). The year before Sherif Abdelhak was appointed CEO of AHERF—1985--Detroit Medical Center (DMC) was created from Grace Hospital, Harper University Hospital, Children's Hospital of Michigan, Hutzel Women's Hospital, and Detroit Receiving Hospital. DMC, like AHERF, suffered blows to its profitability from fewer inpatients and declining reimbursements from managed-care insurers and Medicare. While those national trends were stressful enough, local factors such as the economic decline of Detroit, powerful unions, and large proportions of Medicaid and Medicare patients further distressed DMC's financial health. As if the aforementioned factors were not ominous enough, in 1997 DMC acquired nineteen outpatient clinics that were nowhere near as promising as they first appeared to be. After two consecutive years of losing over \$50 million per year and seeing its debt sink to "junk" status, DMC shed 2,000 jobs (20 percent of its staff) in early 1999.

Allina. During the debate over the Clinton Health Security Act, few systems seemed to be in better position to adapt to its anticipated

managed-care revolution than Minneapolis, Minnesota's Allina. With 19 hospitals, 400 doctors, and an insurer (Medica) with one million enrollees, it seemed to be a *fait accompli* that Allina would achieve its dreams of becoming the Kaiser of the American Midwest. Unlike Kaiser, though, its road was very rocky. First, patients began rebelling at restriction of choice. Minnesotans, unlike docile Californians, rejected being assigned particular doctors and facilities. About 70 percent of the members of Medica's HMO plan sought and received care at non-Allina facilities, which made it impossible to effectively control costs (D&B, pp. 60–61). While Allina could have strictly cracked down on out-of-network care, a large and rapid exodus of employers and enrollees could have put it in worse shape. Secondly, Allina struggled to get its doctor, hospital, and insurance divisions working from the same organizational playbook, especially its newer doctors who were cool to the firm's goals. Finally, Minnesota's progressive state government began demanding that Allina divest from Medica because Allina was overcharging Medica members to compensate for its own profligate spending and inefficiencies. With no insurance division, Allina's plans to be the Kaiser of the American Midwest were dashed, probably forever.

E. IDNs Today

By the year 2000, not only had the integration of doctors, hospitals, and insurance firms failed to achieve synchronous operations, economies of scale, and global capitation, it had missed all of those marks spectacularly. In the aftermath, while some IDNs shed their insurance arms and doctors who refused to get on board organizational game plans, just about all IDNs kept all of their acquired hospitals. Horizontal integration, if not vertical, had been profitable for them and still is to this day, even if it has not been good for patients, insurers, and insurance consumers as costs continue to soar and quality of care is consistently mixed at best.

The following revealing table (D&B, p. 2) shows how large IDNs, which are essentially local health firms, have grown in comparison to some of the largest, best performing, and most renowned international business firms. The surprises include that The University of Pittsburgh Medical Center (UPMC), again, a local firm, has a revenue equal to Whole Foods, a grocery retailer with more than 500

locations in three countries. Sutter Health in Northern California has a revenue stream comparable to the international automaker Tesla. Northwell Clinic of just Long Island, has revenue comparable to the worldwide software firm Adobe Systems. And while it certainly is reasonable to expect that Cleveland Clinic should be able to generate more revenue than the Cleveland Cavaliers professional basketball team, it is shocking that in reality its actual revenue is comparable to the entire National Basketball Association (NBA) league.

Table I. The Nation's Largest Megaproviders, as of 2017

System	Location	Revenue	Comparable
UPMC	Western Pennsylvania	\$16b	Whole Foods
Partners	Eastern Massachusetts	\$13.4b	Gucci
Sutter	Northern California	\$12b	Tesla
Northwell Health	Long Island	\$9b	Adobe Systems
Cleveland Clinic	Northeast Ohio	\$8.4b	National Basketball Association (NBA)
Intermountain	Mountain states	\$7.6b	Jet Blue
Advocate Health	Northern Illinois	\$6.2b	Spotify
NY Presbyterian	New York City	\$5.6b	Regeneron
Sentara Health	Southeast Virginia	\$5.3b	Yahoo!
Baylor, Scott, and White	Dallas, Texas	\$4.8b	Chipotle
Total		\$88.8b	Boeing Hyundai Motor IBM Johnson & Johnson

II. HISTORY, CAUSALITY, AND INTEGRATION

D&B's history of the industrial organization of the U.S.-hospital industry from 1993 forward is unquestionably second to none. A sweeping and thorough account of recent history, though, in no way necessarily evinces a sound etiology of industry dysfunction. The following is a synopsis of the classical free-market study of the industrial organization of U.S. health care as developed by (in chronological order) Kessel (1958), Hamowy (1979), Friedman (1982), Goodman and Musgrave (1992), and Wolinsky and Brune (1994). After the synopsis will be a concluding section of this review juxtaposing D&B's version of events with the classical free-market perspective noting the differences and implications.

A. Free Markets to AMA-AHA Cartel (1830–1910)

The free-market era in American medicine did not begin in the United States in 1776 with the Revolution. From about 1830 to 1850, licensing laws and regulations enacted during the colonial period and early America were generally repealed or ignored. This recalcitrance was, at least in part, the result of an increasing acceptance of eclecticism and homeopathy against the mainstream medicine (allopathy) of the day that included bloodletting and high-dose injections of metal and metalloidal compounds containing mercury or antimony (Hamowy 1979, p. 73).

Eclectics emphasized plant remedies, bed rest, and steam baths, while homeopaths emphasized a different set of medicines in small doses (letting the body heal itself as much as possible), improved diet and hygiene, and stress reduction. The worst results these treatments produced were allergic reactions or no improvement in health. Hence it is not surprising they began to be preferred over the ghastly bleeding and metal injections of allopathy, which further sickened, injured, or killed a comparatively large number of patients (Hamowy 1979, pp. 73–74).

Medical education was plentiful and inexpensive, and entry into the most acclaimed schools was not exceedingly difficult. Most schools were privately owned and because licenses to practice were not required or enforced, anyone could establish a practice. However, this does not mean that consumers flocked to any new medical practice that suddenly appeared in their towns. While homeopathy, eclecticism, or doing nothing may not have restored the health of all of their adherents, the results of allopathy's bloodletting, cutting, and metal injections were frequently worse than many of the diseases they were supposed to treat. This is why it took time for caregivers of any stripe to win trust in the cities and towns of nineteenth century America.

By 1860, there were more than 55,000 physicians practicing in the United States, one of the highest per capita numbers of doctors in the world, about 175 per 100,000 (Hamowy 1979, p. 73). By 1870, approximately 62,000 physicians were in practice in the United States, of which roughly 5,300 were homeopathic and about 2,700 eclectic (Hamowy 1979, p. 74).

Even though it consisted of only about 13 percent of the physician labor market, competition from eclectics and homeopaths reduced the incomes of allopaths such that allopaths began organizing to lobby state governments to not only severely restrict (if not outright ban) eclectics, homeopaths, and the schools that trained them, but also significantly reduce the number of allopaths in practice to dramatically increase allopaths' incomes and prestige. No other national organization led this effort with more fervor and effectiveness than the American Medical Association (AMA).³

B. The American Medical Association (AMA)

The American Medical Association (AMA) had been formed in 1847 by Nathan Smith Davis, who had been working at the Medical Society of New York on occupational licensing and education. While the pretense of early allopathic campaigns was always the support of more rigorous standards for greater safety or more effective treatments for patients, the reality was barriers to entry in the labor market. Hence it was no surprise that in 1870, Davis worked successfully to ban female and black physicians from becoming members of the AMA (Link 1992).

The AMA formed its Council on Medical Education (CME) in 1904 to restrict medical education. However, AMA's conflict of interest was too obvious. This is where Abraham Flexner and the Carnegie Foundation entered the picture. Flexner's older brother Simon Flexner was the director of the Rockefeller Institute for Medical Research (RIMR). Simon recommended Abraham for an open position at Carnegie to lead a study of U.S. medical schools. Abraham's acceptance of the role was the perfect special-interest symbiosis. Carnegie's desire was to advance secularism in higher education and it saw the AMA's agenda as helping achieve that goal. RIMR's benefactors were allied with allopathic drug companies and opposed for-profit schools that were independent

³ The markedly different perspective represented by sociologist Paul Starr (1982) is that eclectics and homeopaths committed career suicide by joining allopaths in the campaign to reestablish occupational licensing. Starr does not see Flexner as decisive in killing medical schools. Compare to economist Kessel (1958): "If impact on public policy is the criterion of importance, the Flexner report must be regarded as one of the most important reports ever written."

of big business and state-influenced foundations. Last of all, AMA acquired an objective-appearing front in Carnegie (Rockwell 1994).

Not only was Abraham Flexner not a physician of any sort, he was not even a widely known authority on education, never mind medical education, as he had never even seen the inside of a medical school before joining Carnegie. His report was already effectively written, since it was essentially AMA's unpublished 1906 report on U.S. medical schools. Furthermore, Flexner was accompanied on his tour by Nathan Porter Colwell, secretary of AMA's CME to ensure that the report would arrive at all of AMA's desired conclusions. Flexner then spent time at AMA's Chicago headquarters preparing what small portion of the final product was his actual work (Goodman and Musgrave 1992, pp. 143–44).

Regardless of these scandalous circumstances, state medical boards and legislatures used the report as a basis for closing a large number of medical schools. Around the time of Flexner, there was a high of 166 medical schools (Rockwell 1994); by the 1940s there were just 77—a 54 percent reduction (Goodman and Musgrave, p. 145). Most small rural schools were closed, and only two African-American schools were allowed to remain open (Beck 2004). By 1963, despite advances in technology and a large growth in demand, one effect of the report was to keep the number of doctors per 100,000 people in the United States—146—at the same level it was at in 1910 (Goodman and Musgrave 1992, p. 145). Of the approximately 375,000 physicians in practice in 1977, only about 6,300 or 1.7 percent were African American (Goodman and Musgrave 1992, p. 147).

As labor supply saw a severe drop, incomes significantly rose. Wolinsky and Brune (1994) report that doctors were firmly in the lower middle class around the time of AMA's founding with an average income of about \$600 per year (p. 45). Average incomes rose to about \$1,000 around 1900 (p. 45). After Flexner, incomes began to soar such that a 1928 AMA study found that average annual incomes had reached a whopping (for the time) \$6,354 (p. 45). Even during the Great Depression, physicians earned average incomes of about four times that of average workers (pp. 45–46). A 2009 survey put family practice doctors (on the low end of the physician-income range) at a median income of \$197,655 and

spinal surgeons (at the high end) at a median income of \$641,728 (American Medical Group Association 2009). These figures, which would be significantly higher today, are mind boggling to ordinary Americans, even in good economic times. In addition, the cyclical unemployment that displaces workers from jobs in almost all other industries during recessions or depressions became just about nonexistent for physicians after Flexner.

C. AMA's War on For-Profit Hospitals

It would not make sense to restrict physicians without restricting hospitals. For-profit hospitals were the first to go, and where they were not outright prohibited, they faced a number of burdens that nonprofit hospitals escaped such as income and property taxes (Goodman and Musgrave 1992, p. 157). Nonprofits received generous government subsidies, tax-deductible contributions, and local planning agencies working in their favor to keep for-profit competitors out of the community or prevent them from expanding (Goodman and Musgrave 1992, p. 157). This systematic discrimination against for-profit hospitals took its toll: at the time of Flexner, almost 60 percent of all US hospitals were for-profit institutions. By 1968, only 11 percent were for-profit institutions, with about an 8 percent share of hospital admissions (Goodman and Musgrave 1992, p. 156).

Eliminating most for-profit hospitals and medical schools made sense for AMA and organized medicine since they were controlled by owners or shareholders who had the incentive to control costs in order to maximize profits. Cost-explosive nonprofits were free to pursue the political goals that organized medicine favored, especially excessively long and costly educations which served as another barrier of entry to the profession.⁴

D. The Rise of Health "Insurance"

In the early 1900s, many prepaid health plans were created for rail, timber, and mine workers in Oregon and Washington to help

⁴ Especially amusing in this regard was an article by two Dartmouth physicians (Weeks and Wallace 2004) arguing for maintaining restricted entry *because of high costs*.

offset the inherent risks of those industries. Within the relatively free-market, for-profit insurance system of the time, claims were closely monitored by adjusters. Fees, procedures, and exceptionally long hospital stays were tracked and subject to challenge. A group of physicians in Oregon that resented this type of close oversight created a plan where procedures were reimbursed and fees paid with few questions asked (Goodman and Musgrave 1992, p. 159). Plans with similar structures began dominating markets in other locations where they secured government-provided advantages over their rivals. By 1939, these loose cost-containment plans began to be marketed under the Blue Shield name. That same year, Blue Cross was endorsed by the American Hospital Association (AHA). Already in existence for ten years, Blue Cross had begun as a hospital insurance plan for Dallas school teachers that allowed them to pay for up to three weeks of hospital care with low monthly payments.

As the Blues gained market share, organized medicine waged an intense war on non-Blues plans.⁵ Goodman (1980), Kessel (1958), and Rayack (1967) provide case studies of physicians losing hospital privileges and even their licenses for accepting non-Blues plans. The Blues also gained government-supplied advantages not available to non-Blues plans. In many states, the Blues paid no or lower premium taxes and sometimes no real-estate taxes. They also were not required to maintain minimum benefit/premium ratios and could have no or lower required reserves. With these government-supplied advantages, the Blues steadily came to dominate the industry. By 1950, Blue Cross held 49 percent of the hospital-insurance market, while Blue Shield held 52 percent of the market for standard medical insurance (Goodman and Musgrave 1992, p. 160). The two firms merged in 1982 to form Blue Cross Blue Shield (BCBS) and today, according to the company itself, about one of every three Americans is a BCBS enrollee (BCBS.com).

Blues-created “insurance” had at least four properties that made it very different from ordinary, actuarially sound insurance (Goodman 1993, pp. 684–85):

- **Coverage of routine services.** The practice of paying for routine or trivial services such as checkups and flu shots converted

⁵ See Goodman and Musgrave, p. 159.

actual insurance to prepaid consumption that encourages over-consumption of medical goods and services, which puts upward pressure on costs.

- **Cost-plus reimbursement.** Insurers pay not a sum of prices for services rendered to patients but artificial “charges” or “reimbursements” that bear no necessary relationship to the actual market costs of the goods and services consumed.

- **“Pay-as-we-go” financing.** Unlike genuine catastrophic hospital insurance that placed premiums in growing reserves to pay claims, the Blues collected premiums that only covered expected costs over the following year. If a large group of enrollees became ill over several years, the premiums of all enrollees were raised to cover the increase in reimbursements that had to be made.

- **Premiums based on “community rating.”** The word “community” meant that every person in a specific geographic area regardless of age, habits, occupation, race, or sex was charged the same insurance premium. For example, elderly enrollees can consume up to four times the medical reimbursements that teens consume, but under community rating both groups of enrollees pay the same premium. Low-risk enrollees subsidize high-risk enrollees.

This only leaves the mystery of how health insurance became attached to employment. The answer is found two decades before Medicare and Medicaid: wage and price controls that the federal government implemented during World War II prevented large employers from competing for labor based on wage rates, so they competed based on benefits. One of the most effective benefits for luring superior employees to large employers was generous health-insurance benefits. The decision by the federal government to allow large-employer benefits to be obtained tax-free while effectively taxing plans purchased by small businesses and the self-employed created a system where medical insurance became not only perversely tied to the size of a worker’s employer but to employment itself. The premiums charged for many self-employed customers and small businesses became unaffordable.

E. Health-Maintenance Organizations (HMOs)

Health-maintenance organizations (HMOs) were prepaid practices that began mainly on the U.S. West Coast in the early 1900s.

Western Clinic in Tacoma (1910) and Ross-Loos Medical Group in Los Angeles (1929) were among the earliest. Kaiser Permanente began with a clientele of shipyard workers during World War II. When the war ended, it had hospitals and physicians but no more shipyard-worker clientele, so it started marketing to the wider public and by the 1970s had more than 3 million enrollees in five states (Dranove 2008, p. 61).

Still, HMOs had limited appeal. By 1970, Kaiser was the only major HMO in the United States, with most of its enrollees forced to join through their labor unions (Holleran 1999). The Health Maintenance Organization Act of 1973 made federal grants and loans available to HMOs, removed certain state restrictions if HMOs became federally certified, and required employers with 25 or more employees who offered standard health insurance benefits to offer federally approved HMO plans.

F. The Patient Protection and Affordable Care Act (PPACA/ACA)

The Patient Protection and Affordable Care Act (PPACA/ACA) of 2010 was signed into law by Barack Obama on March 23, 2010. Among many provisions, the act includes expanded Medicaid eligibility, a prohibition of denials of coverage for preexisting conditions, and an individual mandate to purchase federally approved health insurance or pay a fine. The individual mandate still exists but the penalty for noncompliance was removed in late 2017.⁶

⁶ While this ends the classical free-market account of the industrial organization of U.S. health care, an ideal updated history would begin with a merger of the classical Kessel (1958) *et al.* account with D&B's 1993 to 2017 history of IDNs. What would be left on the cutting-room floor is D&B's non-sequitur etiology and their solutions based on it. The next addition would be a detailed history of the industrial organization of the pharmaceutical industry, which still has not been incorporated into the classical free-market account.

III. *METHODENSTREIT* OVER HEALTH CARE⁷

A. Was All Well Before IDNs?

Clearly both accounts (first, Kessel 1958; Hamowy 1979; Friedman 1982; Goodman and Musgrave 1992; and Wolinsky and Brune 1994; and second, D&B) are not commensurate in ability to explain the changes in prices, costs, output, and affordability of health care over time. The first question that D&B's account elicits is, "If U.S. health care had few problems before IDNs (driven by the Clinton Health Security Act) appeared in the early 1990s, what spurred the creation of the Clinton Health Security Act?" Puzzling is D&B's account of the 1991 rise of Pennsylvania U.S. Senate candidate Harris Wofford and 1992 presidential candidates Bob Kerrey and Paul Tsongas. All three candidates proposed significantly changing the health-care system in terms of improving affordability, access, or both. Instead of explaining why so many politicians made health care a campaign issue in 1991 and 1992 before the IDN wave came about, D&B just drop the three names on the way to introducing Bill and Hillary Clinton and the Clinton Health Security Act. The obvious answer to the question of why health care was a major campaign issue in the political races of 1991 and 1992 is the American public's widespread dissatisfaction with the pre-IDN U.S. health-care system. D&B seem oblivious of it and focus instead on the high and runaway costs, limited access, and mixed quality of only the post-IDN sector.

B. AMA and the Artificial Scarcity of Physicians

The second area of blissful ignorance appears to be the AMA-driven artificial scarcity of not only allopathic physicians and

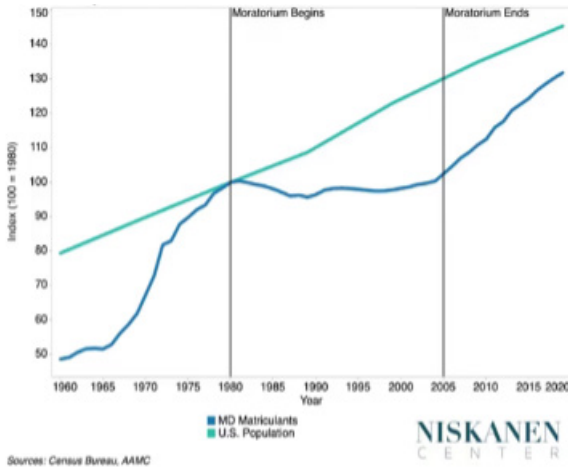
⁷ The "method struggle" in health care that is actually occurring is over how to best treat the sector's economic malfunctions: high and volatile costs, costly access, exorbitant insurance premiums and high deductibles, pricey and too-tightly-controlled prescription drugs. The mainstream health economics and policy approach is to ignore the supply and demand factors that led to each of these problems and propose new interventions to reverse them. A second approach is to examine the state of the industry before these malfunctions arose, analyze what led to each one of them over time, and then base reform on the resulting facts and knowledge. D&B clearly endorse a version of the mainstream approach. This review argues for the second approach.

their competitors, but hospitals and medical services. Then there was organized medicine's transformation of genuine insurance into an economically unsound doppelganger plagued by soaring costs and unaffordable premiums. It was these phenomena that led to early 1990s demands by the American public for health care reform that led to the Health Security Act, which in turn spurred the IDN wave of 1993 to 1998. D&B focus on the failures of vertical integration in IDNs but (with the exception of the doctor-hospital war on HMOs) mostly ignore the pathologies of the special-interest integration in the pre-IDN, AMA-AHA-twin-cartel industry.

Clearly D&B are not persuaded that there is an artificial scarcity of human capital in U.S. health care. They write that after the passage of Medicare and Medicaid, "[s]upply rose to meet the dramatic increase in demand . . . medical school enrollments swelled by 40 percent in the 1970s . . . in 1966, the United States had about 300,000 physicians. By 1980 there were over 460,000" (p. 19). Besides not even being consistent proportions for the same interval of time (300,000 to 460,000 for 1966–80 is a 53.3-percent increase, which is significantly higher than 40 percent for 1970–80), these numbers are misleading outside of any comparison to the growth rate of the U.S. population.

In fact, the period from 1965 to 1980 is such an anomaly precisely because it is the only interval of time in the last 60 years at the end of which (year 1980) the growth rate of M.D. graduates was roughly equal to that of the growth rate of the U.S. population (see the time-series graph below from Thompson 2022). Census and AAMC data then show it plummeting and not beginning to rise again until 2005. Who found this disturbing? No less than a staff writer at the thoroughly mainstream progressive *Atlantic* magazine. In the February 14, 2022 issue, Derek Thompson notes that the U.S. "has the longest, most expensive medical education system in the developed world, and among the lowest number of physicians per capita." One logjam area is deliberate federal underfunding of residency positions through Medicare, which serves as another clever barrier to entry to the labor market.

Figure I. US Population and MD School Matriculants, Indexed to 1980



To their credit, D&B provide their audience a glimpse of the special-interest conflict in American medicine in their account of the doctor-hospital war on HMOs. What is missing is how organized physician interests drove all efforts toward artificial scarcity and cartel profits: first in labor supply and hospitals, then insurance and pharmaceuticals.

Although offering the first-known program of prepaid care, the first true HMO was not Western Clinic in Tacoma, Washington founded in 1910, but the Ross-Loos Medical Group founded in 1929 by physicians Donald Ross and H. Clifford Loos. While Ross-Loos offered a prepaid medical plan to employees of the Los Angeles Department of Water and Power that covered physician and hospital services, also included, *contra* mainstream allopathic medicine, was an emphasis on health maintenance and disease prevention. The emphasis on health maintenance and illness prevention was unique and ran directly against the grain of mainstream allopathic medicine, which emphasized high-profit pharmaceutical and surgical treatments. For this transgression, Ross and Loos were kicked out of their local medical society (Fox and Kongstvedt, p. 3).

Organized medicine also played hardball against Michael Shadid, who founded Community Hospital in Elk City, Oklahoma in 1931. For offering a managed-care plan, not only was he expelled from his county medical society and fought vigorously by the Oklahoma Medical Association and AMA, he was also threatened with revocation of his medical license.

C. Kaiser: Miracle or Mirage of Managed Care?

In mainstream health policy circles, Kaiser is the unquestioned poster child for allegedly doing adroitly since 1945 what so few others have: put physicians, hospitals, and insurance under one roof. D&B seem to agree with this perspective in terms of its operations in California, however, they readily acknowledge the problems the firm encountered when it left its California Oz in the 1990s and attempted to transplant its alleged west coast success to seven locations in the eastern U.S. Unlike Coca-Cola and KFC, so far was its recipe from a universal hit that by 1998, the crest of the 1990s IDN wave, Kaiser only held on to three of its new eastern U.S. locations that are still to this day anything but runaway successes. However, the same could be said for its performance in the past decade or more in California: only mainstream health policy analysts have yet to get the memorandum. D&B admit that Kaiser's regional market share was stuck at only 30 percent "for decades" (p. 35). What they do not discuss is an even more ominous report from 2012 (Varney) showing that Kaiser had fallen out of its position as cost leader. In fact, the massive California Public Employees' Retirement System (CalPERS) had been accepting premiums from Blue Shield that were lower than those offered by Kaiser, a transaction unimaginable before then.

D. Prospects for Improving Competition Among and Management of IDNs

In chapter 10, D&B offer suggestions for increasing competition in the hospital industry and in chapter 11 offer suggestions for reforming how IDNs are managed. While the authors have unquestionably produced a coherent chronicle of the development of the U.S. hospital industry from 1993 to today, they have not identified

the ultimate causes of high and uncontrolled costs of American health care services. Given that they appear to have mistaken a symptom of long-running market distortion and dysfunction—IDNs—for a cause, there is little point in refuting each and every one of their proposals for increasing competition and improving firm management in the industry.

However, we should make observations about two: reconceptualizing competition on the basis of value chains and utilizing the U.S. Department of Justice and Federal Trade Commission to pursue antitrust actions against firms allegedly engaged in anti-competitive activity. D&B (p. 229) want to redefine competition in the age of the IDN:

While we have seen how megaproviders abuse their market power, we have also seen many of them do things in terms of information systems and provider incentives that markets are hard-pressed to copy. We believe that the integration experiment deserves to continue. We also believe that we can curb many of the worst megaprovider abuses through selected, albeit limited, reforms to antitrust law. This will require us to rethink what it means to have competitive health care markets. As we will explain, thinking of competition in traditional terms—competition among hospitals, competition among doctors, competition among insurers—fails to address the real benefits of competition. What matters for value creation is whether we have competition among health care value chains. We should allow megaproviders to play an important—if circumscribed—role in such competition.

It is hard to decide what, if anything, to take seriously in this one-of-many incoherent passages in an overall incoherent book. How do the authors know that IDNs outshine markets in terms of information systems and provider incentives? Where on Earth did they see this play out? How is competition redefined in terms of value chains? It is not clear (p. 232):

When two firms have different visions for organizing the value chain, the market often reveals which vision is clearer. For decades, General Motors believed in vertical integration. Japanese and European carmakers took a different approach, preferring to work with networks of semiautonomous and independent parts suppliers. We know how that competition played out. Chrysler tried the Japanese approach in the US, but still lagged behind GM and Ford (maybe best practices in Japan are not best practices here). Likewise, Advocate Health is more

integrated than Edward-Elmhurst Health, a two-hospital system in Chicago's western suburbs. When patients choose between one system or the other, they are also choosing among competing visions of how to organize the value chain. It is this competition that we seek to preserve.

Forget the apples-to-stones comparison between the much more competitive automobile industry and ultra-state-protected health-care cartels. When it comes to Advocate vs. Edward-Elmhurst, there are hardly only two value chains in these two "competing" systems. For example, if each system has eight hip-and-knee-replacement orthopedic surgeons (with no overlap where a surgeon performs surgery in both systems), then there are no fewer than 16 total value chains in the two systems combined, not two as the authors assert.⁸

Second, the authors embrace changes to both antitrust law and antitrust actions (a euphemism for central planning) as a way to fine-tune the organization of the industry. This after undermining the argument for such actions every bit as effectively, if not more, than any Austrian economist. In the book's preface the authors admit that "the two of us have been among a handful of academics to testify in hospital antitrust cases, where courts have blocked several problematic horizontal and vertical mergers. Yet systems continue to grow" (viii). They begin their first chapter on antitrust (chapter 4) with a quote from, of all people, the libertarian political philosopher Isabel Paterson (giving her last name the typical misspelling with two ts) stating that, "As freak legislation, the antitrust laws stand alone. Nobody knows what it is they forbid." And then there is this gem (pp. 228–29):

Some of our academic colleagues think that the proper way to deal with megaproviders is to break them up, or to make blanket prohibitions against them by changing the standard presumption of anticompetitive harm in antitrust law. It is foolish to rely on antitrust laws, even if we reform them. The agencies are understaffed. Megaproviders enjoy too

⁸ Different orthopedic surgeons prescribe different pre- and post-operation protocols, use artificial ball joints made by the particular manufacturer they favor, follow five-year to lifetime rules on requiring patients to consume antibiotics one hour before teeth cleanings to prevent joint infections. Unless two physicians perform surgery in exactly the same way and follow the exact same pre- and post-operation protocols, then they constitute different value chains.

much local support. And besides, haven't past antitrust efforts been rather toothless?

But then they can't quite give up the ghost (p. 229):

There is something to be said for throwing the bums out. If power is the problem, then why take half measures?

The problem with antitrust is that the argument for a long time has certainly not been about power *per se*, but *which* power, as Paterson believed. (It is unfortunate that the authors quoted her without apparently even bothering to read and/or understand her.) First there is the dual-political-party cartel, the Democratic and Republican parties that control about 99 percent of elective party offices in the U.S. and have openly colluded over decades to cement their dominance over potential competitors *via* ballot access laws, front-loaded primaries, proportional allocation of party delegates (which favors establishment candidates and makes a comeback against an opponent with a lead difficult), and blatant barriers to entry such as superdelegates and massive multi-state contests such as Super Tuesday and Super Tuesday 2, where outsider candidates usually have little chance of winning. Despite all of these aforementioned actions being illegal under The Sherman Antitrust Act of 1890, there is little if any chance that the vertically integrated U.S. Department of Justice will bring suit against the two-party duopoly that supplies it with labor.

Then there is health care. In chapter four, D&B amazingly fret about the merger between Evanston Hospital and Highland Park Hospital that created the Evanston Northwestern Healthcare (ENH) system. Although the Federal Trade Commission (FTC) won on the district and appellate court levels and thus could have forbidden the merger, it allowed it to proceed with the merging firms each being required to negotiate separately with insurers, with reimbursement rates permitted to remain confidential. ENH has since added one additional hospital (p. 101). And yet there is no stated concern not only from D&B but most antitrust proponents about a century of flagrantly anticompetitive activities by AMA or Blue Cross and Blue Shield. The latter were amazingly allowed to merge into one company in 1982.

D&B highlight the vertical integration and conflicts of interest in large cities in the 1950s between hospitals and the Blues. On the corporate boards of Blues plans sat hospital executives, and to make the potential conflicts of interest even less subtle, the national headquarters of both the Blue Cross Association (BCA) and American Hospital Association (AHA) sat in the same building in Chicago, Illinois: 840 North Lake Shore Drive. Here was a vertical integration of service provision and its financing that gave physicians and hospitals “a near stranglehold on the health economy” (p. 14). If antitrust actions in health care had even a shred of credibility, how did they ignore this arrangement? The question does not seem to remotely occur to the authors.

Not only are the American Medical Association or AMA acronym mentioned only 12 times in the entire book (not including the chapter notes or index), the organization is treated as if it were a credible authority, rather than flagrant violator, of the spirit, if not letter, of antitrust law (p. 242):

This sounds more complicated than it is. The FTC has for decades been engaged in similar reviews of joint physician pricing initiatives, and has ramped up activity since passage of the Affordable Care Act and the creation of Medicare ACOs. Most physicians understand the concepts of market shares and efficiencies. The Advocacy Division of the American Medical Association does a good job informing physicians about these issues, and even provides limited antitrust advice to its members. We are not advocating anything new here; we are merely applying existing practices to a new purpose.

E. Kenneth, What Is the Frequency?

And then there are some serious head-scratching statements about markets.

Page 18:

Before 1960, government largely stayed out of health care markets.

A stunning statement, given all the state actions in the wake of the Flexner Report (1910) and the establishment of Blue Shield, and later, Blue Cross.

Page 237:

As much as we hate to admit it, there are limits to what we can accomplish through unfettered markets. We are even tempted to revive certificate of need (CON), despite its many shortcomings.

Unfettered markets? The current IDN-dominated sector? That is indefensible, especially given that it is their own theory that proposed intervention (in the form of the Clinton Health Security Act) drove the initial IDN wave in the early 1990s. There are myriad contradictions and confusions littered throughout the book, which is part of the reason it is such a difficult book to read and follow. The experienced reader begins to wonder, is it me or them?

IV. CONCLUSION

While D&B implicitly promised that their book would provide special insight into the pathologies of health care because they were taking an interdisciplinary approach, that assurance could not be more unfulfilled. Chapters 1–6 (at most) form a worthy contribution to the history of the evolution of the American hospital from 1811 to today, with the chronicling of the IDN era from 1993 to the present day particularly seminal.

But, as previously stated at the beginning of Section II of this review, this in no way necessarily forms an accurate etiology of the health care industry's dysfunction. Thus, again, megaproviders are another symptom rather than a root cause of industrial malfunction. In that sense, *Big Med* is another all-too-typical contemporary analysis in health economics and policy. What is *a priori* ruled out is true market allocation of goods and services. New interventions and *de facto* central planning are the only acceptable solutions. Further, if D&B are the "good guy" free marketeers, who needs interventionists and their state-monopoly Medicare for All? As Francis Jeffrey (1814) famously wrote about William Wordsworth in the *Edinburgh Review*, "This will never do."

REFERENCES

- American Medical Group Association (AMGA). 2009. Physician Salary Survey. Alexandria: AMGA.
- Blue Cross Blue Shield. *Blue Cross Blue Shield*. 2022. www.bcbs.com.
- Beck, Andrew H. 2004. "The Flexner Report and the Standardization of American Medical Education." *Journal of the American Medical Association* 291, no. 17: 2139–40.
- Dranove, David. 2008. *Code Red: An Economist Explains How to Revive the Healthcare System without Destroying It*. Princeton: Princeton University Press.
- Fox, Peter D. and Peter R. Kongstvedt. 2020. *Health Insurance and Managed Care: What They Are and How They Work*, 5th ed. Burlington: Jones and Bartlett.
- Friedman, Milton. 1982. *Capitalism and Freedom*, 2nd ed. Chicago: University of Chicago Press.
- Goodman, John C. 1980. *The Regulation of Medical Care: Is the Price Too High?* Washington, D.C.: Cato Institute.
- _____. 1993. "Health Insurance." *The Fortune Encyclopedia of Economics*. New York: Warner Books.
- Goodman, John C., and Gerald L. Musgrave. 1992. *Patient Power: Solving America's Health Care Crisis*. Washington, D.C.: Cato Institute.
- Hamowy, Ronald. 1979. "The Early Development of Medical Licensing Laws in the United States, 1875–1900." *Journal of Libertarian Studies* 3, no. 1: 73–119.
- Holleran, Scott. 1999. "The History of HMOs." *Arizona Republic*, Nov. 1.
- Jeffrey, Francis. 1814. "The Excursion; Being a Portion of the Recluse, a Poem." *Edinburgh Review*, no. 47.
- Kessel, Reuben A. 1958. "Price Discrimination in Medicine." *Journal of Law and Economics* 1, no. 1: 20–53.
- Link, Eugene Perry. 1992. *The Social Ideas of American Physicians (1776–1976): Studies of the Humanitarian Tradition in American Medicine*. Plainsboro: Associated University Presses.

- Moore, Judith D. and David G. Smith. 2005. "Legislating Medicaid: Considering Medicaid and Its Origins," *Health Care Financing Review* 27: 45–52.
- Murray, Robert and Robert A. Berenson. 2015. *Hospital Rate Setting Revisited: Dumb Price Fixing or a Smart Solution to Provider Pricing Power and Delivery Reform?* Washington, D.C.: Urban Institute.
- Rayack, Elton. *Professional Power and American Medicine: The Economics of the American Medical Association*. Cleveland: World Publishing.
- Rockwell, Llewellyn H. Jr. 1994. "Medical Control, Medical Corruption," *Chronicles*, June.
- Starr, Paul. 1982. *The Social Transformation of American Medicine*. New York: Basic Books.
- Thompson, Derek. 2022. "Why America Has So Few Doctors." *The Atlantic*, February 14.
- Varney, Sarah. 2012. "Why Isn't Kaiser Less Expensive?" *KQED*, 10 May.
- Weeks, William and Amy Wallace. 2004. "Weakness in Numbers." *Barron's*, June 14.
- Wolinsky, Howard and Tom Brune. 1994. *The Serpent on the Staff: The Unhealthy Politics of the American Medical Association*. New York: Tarcher Putnam.