

## GOVERNMENT CAN BE HAZARDOUS TO YOUR HEALTH

by M. Stanton Evans

*M. Stanton Evans prepared this presentation as part of the most recent Center for Constructive Alternatives seminar, which examined national health care.*

*Mr. Evans graduated cum laude from Yale University and did graduate work in economics at New York University under Ludwig von Mises. He was the editor of the Indianapolis News from 1960 to 1974.*

*A nationally syndicated newspaper columnist and speaker, Mr. Evans also is a regular contributor to Human Events and Private Practice. He now makes two radio commentary broadcasts each week for CBS Spectrum, having appeared regularly for three years on the television Spectrum series. He has been the national chairman of the American Conservative Union since 1971.*

The secret of winning a debate is to define the grounds on which it is conducted. Liberals in Washington and in the various state assemblies have long been conscious of this simple precept, and as a result have been winning debates—and legislative roll calls—from time out of mind. Non-liberals seem to have trouble grasping it, and in consequence find themselves repeatedly debating *which* projected liberal remedy must be applied to “problems” obligingly formulated for them by their opponents.

A textbook example of this procedure may be discovered in recent discussions of the so-called health care crisis in America. Among others, Senator Edward Kennedy, organized labor, and various elements in the media have argued that private medical care is a shame and disgrace that should be corrected by some kind of Federal health care scheme. The Republican administration, the American Medical Association, and a variety of Republican legislators have hopped directly into this rhetorical bear trap, saying yes, there is a health care crisis, but *our* solutions are infinitely preferable to Senator Kennedy’s. The major point at issue—the alleged defects of the private system and the need for Federal action—is thus conceded at the outset and further government intrusion all but assured.

This result becomes the more ironic when we reflect that the “health care crisis” cried up by Kennedy and confessed by the Republicans is almost totally devoid of factual content. The truth of the matter is that the quality of health care in our country has been getting better and better, that the

benefits of such care have been made increasingly available to ever larger numbers of people, and that most of the asserted shortages and deficiencies complained of are imaginary in nature. Equally important, it develops that where our health care problems are real and not illusory, they are demonstrably the result of government intervention.

In his major speech on this question in the summer of 1970, Senator Kennedy alleged that health care services in our country were progressively deteriorating and that decent care was not available to most Americans. “In spite of the broad agreement that our population has a right to health care,” he asserted, “the evidence is overwhelming that this right cannot be adequately exercised by most of our people. . . . If we are to avoid the collapse of our health services and the disastrous consequences that would ensue for tens of millions of our citizens, we must take action. . . the cost is increasing, but the quality is declining.”<sup>1</sup>\*

A glance at the relevant statistics will show this picture to be completely erroneous. The quality of medical care in the United States has in fact improved continuously across the decades, conquering such once-dreaded diseases as polio, tuberculosis, and typhoid fever. Because of these achievements, average life expectancies have increased dramatically—from

\*The Kennedy health plan, as originally introduced, was a comprehensive program, compulsory on all Americans, providing for unlimited payment for physician services and most kinds of hospital care. It would have eliminated private health insurance plans. First-year cost of the program, as estimated by the Department of Health, Education, and Welfare, would have been \$77 billion.

49 years in 1900 to more than 70 years today. Among the more impoverished members of our society, particularly Negroes, the average life expectancy is lower than that for the population at large—64.6 for blacks as opposed to 71.3 for whites. But the gap has narrowed, and in the later years of life, when medical care is a crucial factor, there is virtually no difference at all. (At age 65 the average white American male can expect another 13 years of life; the average black American male another 12.7 years.)<sup>2</sup>

Among the major allegations against the present system is the “doctor shortage.” In fact, the ratio of physicians to general population is better in the United States than in the major European nations to which we are so frequently and unfavorably compared. And it is continually improving—from one physician for every 712 Americans in 1960 to one for every 600 in 1972. (In France the 1972 ratio was one physician for every 750 people, in Britain one for every 1,150.) There are problems of physician availability in America created by the proliferation of government medical programs (28,000 MD’s in government service), but the fact remains that physicians and health care personnel have been produced in impressive quantities.<sup>3</sup>

Concerning the complaint that there is a “maldistribution” of medical services, the 1967 comment of the presidential Commission on Health Manpower is to the point: “. . . physical distance from available care is not a major barrier for either urban or rural residents. Even in rural areas, hospital facilities of 25 beds or more are within a 25-mile distance of all but 2 percent of the population, and only one-tenth of 1 percent have to travel more than 50 miles.” (Marvin Edwards, *Hazardous to Your Health*, Arlington House, 1972, pp. 104-5.)

Since 1965 the number of doctors in America has increased three times as fast as population growth, the number of auxiliary medical personnel almost four times as fast. As of 1970, there were some 323,000 physicians in the United States and an enormous army of four million health workers all told. Also in 1970 the nation had about 7,000 hospitals containing 1.6 million beds, and these institutions employed more than 2.5 million people. (In 1960 the corresponding figure was about 1.5 million employees.) These data compare to an average daily patient population in American hospitals of about 1.3 million people in 1970—which means almost two employees per patient.<sup>4</sup>

“. . . The entire year,” notes Harry Schwartz of the *New York Times*, “there were almost 32 million hospital admissions. Between 1960 and 1970 the number of persons in the United States rose only about 13 percent but the number of hospital admissions jumped by almost 27 percent. . . . In 1970, these data suggest there were 20 million or more patient-doctor contacts and about two million people spent at least one night in a hospital. In the United States in the 1970s medical care is available to the great bulk of the population; it is not limited to a small clique of the rich and powerful.” (*The Case for American Medicine*, McKay, 1972, p. 10.)

Private health care insurance has been one of the major growth industries in America. Long before

adoption of Federal health care programs the vast majority of Americans carried such insurance. In 1940, 12 million Americans were covered by medical policies; by 1959 some 127 million people, about 72 percent of the civilian population, had some form of health insurance. By 1972 the number had reached 182 million—roughly 90 percent of the American population. These figures do not suggest that coverage has been denied to most Americans or that they are too dumb to apply for it. Yet despite these facts the Federal planners insist on investing universal schemes of subsidy and compulsion to cover people already covered.<sup>5</sup>

Arguments for Federal health care make much of statistics for infant mortality—usually played off against the corresponding figures for Sweden and other Scandinavian countries and used as a reproach against the American system. Since these statistics are kept on totally different bases in other countries (the Swedish practice of not requiring a report of birth until five years after the event providing one notable example) such comparisons are completely invalid—and have been so designated by the World Health Organization, which compiles them.



Infant mortality statistics do, however, provide a convenient test of Senator Kennedy’s charge of progressive deterioration in medical care—which they refute *in toto*. The figures for America show that in 1950, 29.2 babies out of every 1,000 died within the first year of life; by 1970, this figure had been reduced to fewer than 20 per 1,000—a drop of 33 percent. The record is one of obvious improvement, not progressive breakdown.<sup>6</sup>

On the total record, indeed, it seems the Federal health care proponents would be a little wary of invoking foreign comparisons—particularly with Sweden. The availability of medical services is a much greater problem in Scandinavia and Europe than it is in America. Author Allan Brownfeld reported in 1970 that “there is hardly a single hospital in Sweden where there are not long waiting lists for all kinds of hospital care. It is estimated that in Stockholm alone there are more than 4,000 persons

waiting to enter hospitals, 1,800 for surgery. In some cases, waiting periods for minor operations may be more than half a year.”<sup>7</sup> The reason for the crowding is that, under Swedish health insurance, people tend to use their “free” care to the fullest.

As noted by the *New York Times*, Swedish medicine is plagued with numerous other problems, including rising costs that have pushed the tax burden to stratospheric levels. An average Swedish family with about \$12,000 in annual income pays 55 percent of that in tax, compared to less than 30 percent for an American family similarly situated. Since Sweden converted from a system of voluntary health insurance to government-provided coverage, medical costs have gone through the roof. Within 12 years costs increased ninefold—from \$305 million in 1960 to \$2.77 billion in 1972.<sup>8</sup>

This expansion is readily understandable. Since doctors have no incentives to control costs, patients come to hospitals for the most minor or imaginary ills and hospital stays are protracted. Private practice of medicine on an outpatient basis has been discouraged, although steps are afoot to alter this. In addition, the Swedish system has discouraged entry into medicine by new physicians, and it is noteworthy that the doctor-patient ratio is considerably lower than in the much more populous United States. In America there are 172 doctors for every 100,000 of population—in Sweden approximately 135.

A similar story has been written in England, where the crush of national health insurance has brought a marked deterioration of medical services. Medical writer Marvin Edwards notes that more than 40 percent of the hospitals in England are 100 years old or more, and most of the others are more than 80 years old. Between 1948, when socialized medicine was instituted, and 1962, there were no new hospitals built. Only three were built between 1962 and 1970.

There is a tremendous overcrowding of British hospitals, and only 30 percent of them, according to a committee of British physicians, have adequate emergency facilities. These problems are accentuated by the fact that length of confinement in British hospitals is considerably greater than in America—a usage encouraged, again, by the availability of so-called free medical care. Government figures in August 1966 disclosed that more than 100,000 elderly and chronically ill Britons were on waiting lists to get into hospitals. The situation prevailing in the United States seems almost idyllic by comparison.

Wherein, therefore, lies the American crisis? The answer appears to consist of one factor only—the rising cost of health care services. As President Nixon put it in his 1974 health care message: “The overall cost of health care has . . . risen by more than 20 percent in the last two and a half years, so that more and more Americans face staggering bills when they receive medical help today.”<sup>9</sup> And this, we may grant, is indeed a problem. But what is the source of it? The answer, as in so many other species of national distress, is that the Federal government itself is directly responsible for the evil complained of.

It is rather plain that over the long pull the medical price index has been moving in synchronization with prices generally—in response to the inflation that has ravaged our economy. This inflation, of course, is itself the work of the Federal government through its continued expansion of the money supply. Like the more general effort to scapegoat private industry for inflation, the outcry over medical prices is a case of the Federal culprit crying “thief.”

It is noteworthy that elements in our medical system have experienced slower price hikes than have numerous nonmedical items. Department of Labor statistics as of 1970 showed medical costs in the previous two years had risen less than meat, poultry, and fish, home ownership, transportation, and so on. Between August 1971 and August 1972, the medical price index rose only 2.2 percent, less than the general cost of living. And between 1965 and 1970, physicians’ fees rose less than the average hourly compensation in the private economy. So in some particulars the price of medical care was moving upward in less vertiginous fashion than other elements of the economy.

Yet it would be foolish to deny there has been, on the whole, a continuous and often precipitate hike in medical costs—most notably hospital room rates, which approximately tripled in the decade of the 1960s. In general, both doctors’ fees and hospital costs were increasing more rapidly in the early 1970s than they had in the early 1960s, and these factors have frequently been cited by proponents of further Federal intervention. So it is here, apparently, that we find the bedrock proof of privately generated crisis.

Yet in point of fact this hike in medical costs above and beyond the general inflation is *also* the consequence of Federal intervention in the medical marketplace—through the Medicare and Medicaid subsidy programs enacted in 1965 to provide medical care to the aged and the indigent. As a result of these programs, millions of extra dollars have been poured into the medical system, putting enormous pressure on facilities and boosting prices skyward—results that could have been predicted by anyone who had bothered beforehand to weigh the relevant economic factors.

Indeed, in viewing this procedure, one may plausibly reverse the usual complaint and contend the problem with American medicine, to the extent there is one, is that for many people it is much too cheap. If that statement seems outrageous in view of rising outlays for health and hospitals, it is because the people who incur the bills are often different from the people who pay them. This is, in fact, the essence of the problem. When people using medical facilities see the service as being “free” or extremely inexpensive, rising frequency of use will push the total cost up through the roof.

Consider what would happen, for example, if people were told they had a right to “free” gasoline, food, automobile repairs, clothing, airline tickets, or anything else, with the bills for whatever they consumed to be forwarded to someone else for payment. The crush of demand would be unmanageable, and

the "someone else" who had to pick up the tab would be headed for the poorhouse. This is in essence what has been happening in the matter of subsidized health care.

The fact is that the free market pricing system is the only rational method of apportioning demanded resources. Among other benefits, that mechanism enables us to sort out demand intensities—providing service where it is seriously required but discouraging frivolous or excessive use. If airline tickets were free, you might fly to San Francisco or New York every weekend. If you had to pay your own way, you would be a bit more cautious in your traveling. Where price considerations are obscured, demand and resulting costs will skyrocket.

This pattern has been repeatedly shown in studies of health insurance programs, and has become especially acute in the decade since the Federal government got into the health care business. Our medical economy has steadily shifted away from direct payment by the patient to third-party systems in which someone else picks up the tab. The result has been skyrocketing use of services and facilities.



Between 1965 and 1971, for example, direct payment for medical care increased only from \$18.9 to \$24.2 billion. Third-party payment, however, leaped up from \$22 billion to approximately \$50 billion—with government outlays almost tripling from \$10.8 to \$28.5 billion. As recently as 1965, more than half our medical outlays were for direct payment; by the early 1970s the proportion was down to slightly more than a third.<sup>10</sup>

As that sequence suggests, the decisive factor was the arrival of Medicare and Medicaid, entitling millions of people to medical care at someone else's expense. An enormous surge of monetary demand was unleashed, crowding in on doctors' time and health facilities. The double effect was to saddle taxpayers with a staggering bill (up to \$25 billion annually) and to push up prices as demand outstripped supply. Between 1960 and 1965, the physician component of the Consumer Price Index rose by about 3 percent annually—but between 1966 and 1970 it

rose by an average of 7 percent. The unit cost of hospital care increased more rapidly still: In the early 1960s it was rising by about 6 percent a year. Since the advent of Medicare and Medicaid, it has gone up by an eye-popping 13 to 14 percent annually.<sup>11\*</sup>

Economist Herbert Klarman suggests, in this connection, two principal explanations of our rising medical costs:

Medicare increased the flow of funds to hospitals. Along with other forms of health insurance or prepayment, Medicare also perpetuates a dual set of prices—a gross price received by the provider and a much lower net price paid by the consumer out of pocket at the time of illness. The dual price distorts reality for the consumer and encourages the provider to enhance and elaborate the quality of care, even at a higher cost.

The other explanation, which I tend to stress, focuses on cost reimbursement, which was widely adopted under Medicare (and Medicaid). Under this method of payment a hospital is paid a daily rate related to its own cost of operation. The hospital administrator can no longer deny requests for higher wages or more supplies on the ground that money is lacking; to get money, he need only spend more.<sup>12</sup>

It is precisely in the latter category that the most phenomenal increases in medical prices have been occurring. Hospital rates that stood at roughly \$45 a day in 1965 had shot up to an estimated \$115 a day in 1973, with further increases on the way. By far the vast majority of these expenditures—roughly 70 percent—have gone to pay the wages of hospital personnel, as wages pushed steadily higher by employe demands have connected up with public funds. (Ironically enough, the very union leaders who have helped to organize these demands are in the forefront of complaining about the excessive costs of hospital care.)

All these trends have been evident in the rocky course of the Medicaid program, which has provoked a deluge of medical claims and placed a number of states under severe financial stress. In California, the "Medi-Cal" program wound up in 1970 with 2.5 million people on the rolls and annual costs of \$1.2 billion. Per capita medical costs in California were driven up to \$517 a year, compared to \$312 per capita for the rest of the nation. A similar story was written in New York, Texas, and numerous other states. In Indiana, a supposedly "minimal" Medicaid program that was to have cost some \$300,000 a year soared in cost to \$115 million in fiscal 1975.<sup>13</sup>

Nationally, Medicaid costs increased from \$1.3 billion in 1967 to \$5.5 billion in January 1970—

\*Other data on the medical trend of the 1960s are also instructive. For one thing, while the population of America increased by only 13 percent, the number of hospital admissions went up by 27 percent. For another, low-income Americans received more hospital care and physicians' services per capita than did those in high and middle income brackets. In the latter 1960s, the poor averaged 114.5 hospital admissions per 1,000 of population and 4.6 physician visits per capita. The corresponding figures for middle income Americans were 95.4 and 4.0.

in keeping with a similar explosion of costs for Medicare. Robert J. Myers, former chief actuary of the Social Security administration, observes that cost overruns for Medicare during the first three years of operation amounted to \$11 billion—41 percent above the original estimates.<sup>14</sup> For the hospital insurance portion of the program, costs were approximately double the original estimates. These results, of course, are in complete conformity with the experience of other nations that have adopted government “health insurance” programs.

As ever, a government-sponsored problem calls for a government-sponsored solution, and legislators concerned about the rising cost of Medicare and Medicaid decided to pile another intervention on top of those already noted. In an effort to get the situation under some kind of control, Congress in 1972 passed a little-noticed amendment establishing so-called Professional Standards Review Organizations to determine the propriety of doctors’ fees and the treatments being prescribed.

Through the device of PSROs, functionaries at the Department of Health, Education, and Welfare are able to sit in judgment on physicians; they are also able to examine medical records in doctors’ offices. While the asserted purpose is to find out if doctors are making proper charges under Medicare and Medicaid, it is noteworthy that the right to snoop in medical files extends to private patients as well.

Since the regional review boards involved in the program are staffed chiefly with doctors, PSRO has been advertised as a way of letting the medical profession police itself. Close examination of the law, however, makes it plain that the real policing is to be done by the Secretary of HEW and his subordinates. The law repeatedly states that PSRO procedures shall be conducted “in accordance with the regulations of the secretary. . . .” Under this direction, the network of PSROs is to establish national norms of treatment of illnesses that are or “may be” paid for by Federal programs.

The law says “each PSRO shall apply professionally developed norms of care, diagnosis and treatment” for specific ills and also maintain computerized profiles of individual physicians to see that they are behaving properly. If not, sanctions may be imposed, up to and including fines of \$5,000. The offending physician would also be subjected to orchestrated professional opprobrium under the provisions of the law. Thus does one act of government intervention beget another, and another.

Similar lessons may be gleaned from another crucial aspect of American health care—the production and marketing of beneficial drugs. The long-term record of the American drug industry is phenomenally good; the production of such beneficial substances as sulfa drugs, penicillin, and the Salk vaccine has contributed enormously to the conquest of disease and improvement of life expectancies. Yet in recent years these advances have slowed perceptibly, as a direct result of Federal interference.

The principal villain in this scenario is a set of drug law amendments passed by Congress in 1962.

In response to drug scares of that epoch, our legislators decreed that no new drug could be licensed for sale until it had been proved “safe and effective” by laborious procedures. Before that time, the standard had been “safe,” which is hard enough to determine by itself. But “safe and effective” has proved to be a formula for bureaucratic seventh heaven.

To establish compliance with these criteria, the Food and Drug Administration (FDA) has taken to pawing through thousands of pages of data covering tests and re-tests of proposed new drugs. The nature of the change may be judged from the fact that in 1948 one well-known pharmaceutical company (Parke & Davis) had to submit 73 pages of evidence to secure the licensing of a drug. In 1968, this same company had to submit 72,200 pages of data, transported by truck, in an effort to have an anesthetic licensed.<sup>15</sup>

As a result of this drawn-out procedure, it takes an inordinate amount of time for a new drug to be cleared, and the number of beneficial drugs arriving on the market has been reduced accordingly. Prior to 1962 it took about six months for a new drug application to be processed. A decade later the time lag was 27.5 months. More ominous still is the sharp decline in the total number of “new chemical entities” coming on the market. Prior to 1962, it was 41.5 a year; by 1970 it had dropped to 16.1.<sup>16</sup>

In the five years 1957 through 1961, before the new drug law amendments took effect, a total of 261 new drug entities were produced in America; in the ten years 1962 through 1971, the total was 167. In 1961 America was the world leader in production of new drugs, with a total of 31, compared to nine in France. Over the next eight years, the United States introduced only 35 new drugs all told, while France produced a total of 156.

What these figures suggest but cannot tell us explicitly is the number of Americans who are suffering in pain, or dying, because drugs that could have saved them are not being marketed in their country. We do know that dimethyl sulfoxide (DMSO), an effective painkiller developed in the United States and used around the globe, has been arbitrarily banned from use in America. We also know, on the testimony of Dr. John Laragh of Columbia University, that the FDA held up the marketing of diazoxide—“a lifesaving drug for patients with serious high blood pressure”—for ten years of “clinical trial and administrative debate.”<sup>17</sup>

Indeed, it is altogether possible that Americans could become a “have not” people in their access to medication—with the fruits of chemical and technological improvement created here exported to others but denied us. *Medical Economics* observes that three-quarters of the new drugs being developed by American pharmaceutical firms are going exclusively to people in other lands and are barred from use in America.<sup>18</sup>

In a similar vein, seven new asthma medications have been introduced in Europe in the past decade, but only two of these have made it to the United States. Forty-seven new medications to treat heart and circulatory problems came on the world market

between 1967 and 1971, but only six were made available in this country. Five new drugs for the treatment of hypertension have recently appeared in Europe, but no new general-purpose hypertension medicine emerged in America between 1963 and 1972.

It is noteworthy that penicillin, if discovered today, probably could not pass the relevant tests of the bureaucracy. After all, the drug does cause unfavorable reactions in some people, and it is less effective in certain cases than in others—considerations that could flunk it on FDA's "safe and effective" meter. Yet penicillin has saved thousands of people from pain and death, and only a fanatic or perhaps a bureaucrat would contend that humanity would be better off without it.

The point of these reflections is that we can't know for sure how many penicillins are nowadays being blocked from the market or interminably delayed by the procedures of the FDA. We know simply that an enormous number of beneficial drugs have been denied to Americans by the self-same Federal government that is supposedly bending every effort to upgrade the quality of their health care.

We confront, in sum, a round-robin of government-generated answers to government-created problems—answers that are, or very shortly will become, considerable problems in themselves. Where private medicine has been allowed to do its work, the American record has been one of steady and often miraculous improvement; where evils in the system are complained of, we may almost invariably trace them back to one or another species of intervention. The indicated answer is not to get the government further into medicine, but to get it out—as rapidly as possible.

<sup>1</sup>Senator Edward M. Kennedy, "National Health Insurance and Health Security," reprint from *Congressional Record*, August 27, 1970.

<sup>2</sup>Marvin H. Edwards, *Hazardous to Your Health* (Arlington House, 1972), pp. 40-44.

<sup>3</sup>*Ibid.*, pp. 92, 103.

<sup>4</sup>Harry Schwartz, *The Case for American Medicine* (McKay 1972), pp. 9-10.

<sup>5</sup>*Source Book on Health Insurance Data*, Health Insurance Institute, 1973-74 edition, pp. 18-19; Rita R. Campbell and W. Glenn Campbell, *Voluntary Health Insurance in the United States* (American Enterprise Association, 1960), p. 1.

<sup>6</sup>Schwartz, *op. cit.*, p. 40.

<sup>7</sup>*Indianapolis News*, November 3, 1970.

<sup>8</sup>*The New York Times*, December 24, 1973.

<sup>9</sup>Message to Congress, February 6, 1974; text in *Congressional Quarterly*, Feb. 9, 1974, p. 254.

<sup>10</sup>Schwartz, *op. cit.*, p. 116.

<sup>11</sup>Herbert E. Klarman, "Major Public Initiatives in Health Care," *The Public Interest*, Winter 1974, pp. 109, 112.

<sup>12</sup>*Ibid.*, p. 110.

<sup>13</sup>Edwards, *op. cit.*, p. 240, and *Indianapolis News*, January 16, 1974.

<sup>14</sup>Edwards, *op. cit.*, p. 250.

<sup>15</sup>Walter S. Ross, "The Medicine We Need — But Can't Have," *Reader's Digest*, October 1973.

<sup>16</sup>Milton Friedman, "Frustrating Drug Advancement," *Newsweek*, January 8, 1973.

<sup>17</sup>*Medical Economics*, August 6, 1973.

<sup>18</sup>*Ibid.*

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