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In a recent article for *Tikkun*, Dr. Arnold Relman argued that the versions of health care reform currently proposed by "progressives" all primarily involve financing health care and expanding coverage to the uninsured rather than addressing the way current models of service delivery make it so expensive. Editing out all the pro forma tut-tutting of "private markets," the substance that's left is considerable:

> What are those inflationary forces? . . . [M]ost important among them are the incentives in the payment and organization of medical care that cause physicians, hospitals and other medical care facilities to focus at least as much on income and profit as on meeting the needs of patients. . . . The incentives in such a system reward and stimulate the delivery of more services. That is why medical expenditures in the U.S. are so much higher than in any other country, and are rising more rapidly. . . . Physicians, who supply the services, control most of the decisions to use medical resources. . . .

> The economic incentives in the medical market are attracting the great majority of physicians into specialty practice, and these incentives, combined with the continued introduction of new and more expensive technology, are a major factor in causing inflation of medical expenditures. Physicians and ambulatory care and diagnostic facilities are largely paid on a piecework basis for each item of service provided.

As a health care worker, I have personally witnessed this kind of mutual log-rolling between specialists and the never-ending addition of tests to the bill without any explanation to the patient. The patient simply lies in bed and watches an endless parade of unknown doctors poking their heads in the door for a microsecond, along with an endless series of lab techs drawing body fluids for one test after another that's "been ordered," with no further explanation. The post-discharge avalanche of bills includes duns from two or three dozen doctors, most of whom the patient couldn't pick out of a police lineup. It's the same kind of quid pro quo that takes place in academia, with professors assigning each other's (extremely expensive and copyrighted) texts and systematically citing each other's works in order to game their stats in the Social Sciences Citation Index. (I was also a grad assistant once.) You might also consider *Dilbert* creator Scott Adams's account of what happens when you pay programmers for the number of bugs they fix.

One solution to this particular problem is to have a one-to-one relationship between the patient and a general practitioner on retainer. That's how the old "lodge practice" worked. (See David Beito's "Lodge Doctors and the Poor," *The Freeman*, May 1994).

But that's illegal, you know. In New York City, John Muney recently introduced an updated version of lodge practice: the

AMG Medical Group, which for a monthly premium of $79 and a flat office fee of $10 per visit provides a wide range of services (limited to what its own practitioners can perform in-house). But because AMG is a fixed-rate plan and doesn't charge more for "unplanned procedures," the New York Department of Insurance considers it an unlicensed insurance policy. Muney may agree, unwillingly, to a settlement arranged by his lawyer in which he charges more for unplanned procedures like treatment for a sudden ear infection. So the State is forcing a modern-day lodge practitioner to charge more, thereby keeping the medical and insurance cartels happy—all in the name of "protecting the public." How's that for irony?

Regarding expensive machinery, I wonder how much of the cost is embedded rent on patents or regulatorily mandated overhead. I'll bet if you removed all the legal barriers that prevent a bunch of open-source hardware hackers from reverse-engineering a homebrew version of it, you could get an MRI machine with a twentyfold reduction in cost. I know that's the case in an area I'm more familiar with: micromanufacturing technology. For example, the RepRap—a homebrew, open-source 3-D printer—costs roughly $500 in materials to make, compared to tens of thousands for proprietary commercial versions.

More generally, the system is racked by artificial scarcity, as editor Sheldon Richman observed in an interview a few months back. For example, licensing systems limit the number of practitioners and arbitrarily impose levels of educational overhead beyond the requirements of the procedures actually being performed.

Libertarians sometimes—and rightly—use "grocery insurance" as an analogy to explain medical price inflation: If there were such a thing as grocery insurance, with low deductibles, to provide third-party payments at the checkout register, people would be buying a lot more rib-eye and porterhouse steaks and a lot less hamburger.

The problem is we've got a regulatory system that outlaws hamburger and compels you to buy porterhouse if you're going to buy anything at all. It's a multiple-tier finance system with one tier of service. Dental hygienists can't set up independent teeth-cleaning practices in most states, and nurse-practitioners are required to operate under a physician's "supervision" (when he's out golfing). No matter how simple and straightforward the procedure, you can't hire someone who's adequately trained just to perform the service you need; you've got to pay amortization on a full med school education and residency.

Drug patents have the same effect, increasing the cost per pill by up to 2,000 percent. They also have a perverse effect on drug development, diverting R&D money primarily into developing "me, too" drugs that tweak the formulas of drugs whose patents are about to expire just enough to allow repatenting. Drug-company propaganda about high R&D costs, as a justification for patents to recoup capital outlays, is highly misleading. A major part of the basic research for identifying therapeutic pathways is done in small biotech startups, or at taxpayer expense in university laboratories, and then bought up by big drug companies. The main expense of the drug companies is the FDA-imposed testing regimen—and most of that is not to test the version actually marketed, but to secure patent lockdown on other possible variants of the marketed version. In other words, gaming the patent system grossly inflates R&D spending.

The prescription medicine system, along with state licensing of pharmacists and Drug Enforcement Administration licensing of pharmacies, is another severe restraint on competition. At the local natural-foods cooperative I can buy foods in bulk, at a generic commodity price; even organic flour, sugar, and other items are usually cheaper than the name-brand conventional equivalent at the supermarket. Such food cooperatives have their origins in the food-buying clubs of the 1970s,

The clinic would use generic medicines (of course, since that's all that would exist in a free market). Since local juries or arbitration bodies would likely take a much more commonsense view of the standards for reasonable care, there would be far less pressure for expensive CYA testing and far lower malpractice premiums.

Basic care could be financed by monthly membership dues, with additional catastrophic-care insurance (cheap and with a high deductible) available to those who wanted it. The monthly dues might be as cheap as or even cheaper than Dr. Muney's. It would be a no-frills, bare-bones system, true enough—but to the 40 million or so people who are currently uninsured, it would be a pretty damned good deal.

Kropotkin and E. P. Thompson. But far more important than reforming finance is reforming the way delivery of service is organized.

Consider the libertarian alternatives that might exist. A neighborhood cooperative clinic might keep a doctor of family medicine or a nurse practitioner on retainer, along the lines of the lodge-practice system. The doctor might have his med school debt and his malpractice premiums assumed by the clinic in return for accepting a reasonable upper middle-class salary.

As an alternative to arbitrarily inflated educational mandates, on the other hand, there might be many competing tiers of professional training depending on the patient's needs and ability to pay. There might be a free-market equivalent of the Chinese "barefoot doctors." Such practitioners might attend school for a year and learn enough to identify and treat common infectious diseases, simple traumas, and so on. For example, the "barefoot doctor" at the neighborhood cooperative clinic might listen to your chest, do a sputum culture, and give you a round of Zithro for your pneumonia; he might stitch up a laceration or set a simple fracture. His training would include recognizing cases that were clearly beyond his competence and calling in a doctor for backup when necessary. He might provide most services at the cooperative clinic, with several clinics keeping a common M.D. on retainer for more serious cases. He would be certified by a professional association or guild of his choice, chosen from among competing guilds based on its market reputation for enforcing high standards. (That's how competing kosher certification bodies work today, without any government-defined standards). Such voluntary licensing bodies, unlike state licensing boards, would face competition—and hence, unlike state boards, would have a strong market incentive to police their memberships in order to maintain a reputation for quality.

which applied the principle of bulk purchasing. The pharmaceutical licensing system obviously prohibits such bulk purchasing (unless you can get a licensed pharmacist to cooperate).

I work with a nurse from a farming background who frequently buys veterinary-grade drugs to treat her family for common illnesses without paying either Big Pharma's markup or the price of an office visit. Veterinary supply catalogs are also quite popular in the homesteading and survivalist movements, as I understand. Two years ago I had a bad case of poison ivy and made an expensive office visit to get a prescription for prednisone. The next year the poison ivy came back; I'd been weeding the same area on the edge of my garden and had exactly the same symptoms as before. But the doctor's office refused to give me a new prescription without my first coming in for an office visit, at full price—for my own safety, of course. So I ordered prednisone from a foreign online pharmacy and got enough of the drug for half a dozen bouts of poison ivy—all for less money than that office visit would have cost me.

Of course people who resort to these kinds of measures are putting themselves at serious risk of harassment from law enforcement. But until 1914, as Sheldon Richman pointed out ("The Right to Self-Treatment," *Freedom Daily*, January 1995), "adult citizens could enter a pharmacy and buy any drug they wished, from headache powders to opium."

The main impetus to creating the licensing systems on which artificial scarcity depends came from the medical profession early in the twentieth century. As described by Richman:

> Accreditation of medical schools regulated how many doctors would graduate each year. Licensing similarly metered the number of practitioners and prohibited competitors, such as nurses and paramedics, from performing services they were

> perfectly capable of performing. Finally, prescription laws guaranteed that people would have to see a doctor to obtain medicines they had previously been able to get on their own.

The medical licensing cartels were also the primary force behind the move to shut down lodge practice, mentioned above.

In the case of all these forms of artificial scarcity, the government creates a "honey pot" by making some forms of practice artificially lucrative. It's only natural, under those circumstances, that health care business models gravitate to where the money is.

Health care is a classic example of what Ivan Illich, in *Tools for Conviviality*, called a "radical monopoly." State-sponsored crowding out makes other, cheaper (but often more appropriate) forms of treatment less usable, and renders cheaper (but adequate) treatments artificially scarce. Artificially centralized, high-tech, and skill-intensive ways of doing things make it harder for ordinary people to translate their skills and knowledge into use-value. The State's regulations put an artificial floor beneath overhead cost, so that there's a markup of several hundred percent to do anything; decent, comfortable poverty becomes impossible.

A good analogy is subsidies to freeways and urban sprawl, which make our feet less usable and raise living expenses by enforcing artificial dependence on cars. Local building codes primarily reflect the influence of building contractors, so competition from low-cost unconventional techniques (T-slot and other modular designs, vernacular materials like bales and papercrete, and so on) is artificially locked out of the market. Charles Johnson described the way governments erect barriers to people meeting their own needs and make comfortable subsistence artificially costly, in the specific case of homelessness, in "Scratching By: How the Government Creates Poverty as We Know It" (*The Freeman*, December 2007).

The major proposals for health care "reform" that went before Congress would do little or nothing to address the institutional sources of high cost. As Jesse Walker argued at Reason.com, a 100 percent single-payer system, far from being a "radical" solution,

> would still accept the institutional premises of the present medical system. Consider the typical American health care transaction. On one side of the exchange you'll have one of an artificially limited number of providers, many of them concentrated in those enormous, faceless institutions called hospitals. On the other side, making the purchase, is not a patient but one of those enormous, faceless institutions called insurers. The insurers, some of which are actual arms of the government and some of which merely owe their customers to the government's tax incentives and shape their coverage to fit the government's mandates, are expected to pay all or a share of even routine medical expenses. The result is higher costs, less competition, less transparency, and, in general, a system where the consumer gets about as much autonomy and respect as the stethoscope. Radical reform would restore power to the patient. Instead, the issue on the table is whether the behemoths we answer to will be purely public or public-private partnerships. ["Obama is No Radical," September 30, 2009]

I'm a strong advocate of cooperative models of health care finance, like the Ithaca Health Alliance (created by the same people, including Paul Glover, who created the Ithaca Hours local currency system), or the friendly societies and mutuals of the nineteenth century described by writers like Pyotr