Law, Economics and Society; Vol. 1, No. 1; 2025
ISSN 3066-9340 E-ISSN 3066-9359
https://doi.org/10.30560/les.v1n1p76

Healthcare – Where Law and Economics Fail Society – Needs the "Laboratory of Democracy"

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Received: February 4, 2025 Accepted: February 16, 2025 Online Published: February 19, 2025

Abstract

In the U. S., legal structures as well as economic systems fail to provide people in society with accessible and affordable life-saving medical care. Other government-run national healthcare systems called single payers experience similar medical inadequacies and dollar inefficiencies though not the legal issues of the U.S.

Systems theory identifies the government command economy with third-party payment structure as the root cause of healthcare over-spending, variable quality, slow service, and death-by-queue.

An effective solution for healthcare system failures derives from the root cause. To make healthcare affordable and accessibl: restore rule of law, remove third-party decision-making, and infuse free market forces. The U.S. could test this hypothesis if states became "laboratories of democracy."

Keywords: regulatory over-reach, insurance failure, BURRDEN, death-by-queue, Medicaid, third-party payment, command economy

1. Introduction

The U.S. healthcare system is failing the American people. Medical (health) care is both unaffordable and inaccessible. These failures can be directly attributed to legal irregularities and abrogation of economic principles of free market capitalism.

While this report focuses on the U.S., similar failures can be identified in nations with single payer healthcare systems.

This review describes how unaffordability and inaccessibility can be ascribed to a breakdown of rule of law and regulatory suppression of free market forces.

2. Ignoring the Law

Washington is contravening U.S. law three ways: constitutional, legislative, and functional.

The U.S. Constitution specifies where the federal government has "power" or authority and where it does not. Article I, Section 8 lists 18 specific areas where federal government should control. These include borrow & coin money; regulate commerce; post offices and roads; establish tribunals below Supreme Court; army; navy; declare war; and ten other powers.

The Tenth Amendment to the Constitution reads as follows. 'The powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people." Washington is prohibited from controlling any area of responsibility or authority not listed in Section 8. Healthcare was excluded from the Section 8 list. Federal control of the U.S. healthcare system is unconstitutional.

Washington ignores its own laws. Section 1801 of the Medicaid Act of 1965 is titled "Prohibition against any federal interference." It reads as follows. "Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person." (Public Law 89-97–July 30, 1965)

At present, Centers for Medicare and Medicaid Services (CMS) regulates eligibility standards, i.e., who can enroll; benefits, i.e., what medical care is provided; and what will be paid according to federal Allowable Reimbursement Schedules. The federal government thus controls all aspects of the Medicaid programs in 50 states and District of Columbia in direct contravention of its own law.

Government-run healthcare systems, both U.S. and single payer, are based on third-party payment where the third party – government or insurance company – collects healthcare dollars and authorizes payments according to federal guidelines. Payments for care, and therefore *delivery of care*, are decided by the third party. The third party, not the patient, decides what care the patient gets: what, when, by whom, and even if care is provided.

Third-party decision-making takes away patients' medical autonomy. Legally, a patient has sole agency regarding care he or she receives. Practically, the ultimate third-party payer, Washington, not the patient, makes medical decisions directly for 157 million Americans enrolled in Medicare, Medicaid, and Tricare, and indirectly for 147 million privately insured individuals as the insurance companies must abide by federal regulations.

Potentially, patients could exercise medical autonomy by paying for care out of pocket. In reality, prices for care are beyond the means of most people. Furthermore, the majority of physicians are employees of faculty practice plans, health plans, or insurance companies and cannot accept direct payment. They are bound by contract to third-party payments.

3. Fiscal Failure

U.S. healthcare is fiscal failure both for individual patients and nationally for 176 million taxpaying Americans.

The U.S. spent $4.9 trillion on its healthcare system in 2024, more than the entire GDP of Japan. This expenditure represented 17.9 percent of GDP. In 1960, the U.S. expended 5.6 percent of GDP in healthcare. As former President Obama described, the sharply upward U.S. healthcare spending curve is "unsustainable." According to its trustees, the Medicate Trust Fund will be insolvent by 2036 (Medicare Trustees Report (2024). If unchecked, healthcare spending will drive the whole country into bankruptcy.

The cost of care for individuals is equally grim. With insulin costing up to $1000 a vial, more than $2500 for an MRI, and heart surgery at six figures minimum, only professional athletes, Hollywood movie stars, and corporate CEOs can afford to pay for medical care out of pocket. Insurance premiums are equally unaffordable for the average family. Subsidies for insurance through the ACA simply transfer the exorbitant premium prices to taxpayers, especially future ones.

At first glance, this seems confusing. The U.S. is spending more than anyone else, viz., more than double what the United Kingdom is spending per capita, and yet, people can't afford care.

The explanation is dollar inefficiency: too much money is paying for activities in healthcare that produce no care for patients. This is spending on BURRDEN – Bureaucracy, Unnecessary Rules and Regulations, Directives, Enforcement, and Noncompliance activities like oversight, analysis, and reporting. One 1999 study, 25 years before the expense of the ACA was added ($1.76 trillion), estimated the U.S. expended 31 percent of GDP on BURRDEN (Woolhandler, Campbell, Himmelstein, 1999). A 2019 report put the figure at more than 50 percent [4] (Waldman, 2019). Using the more recent estimate applied to 2024 data, $2.45 trillion U.S. taxpayer dollars were wasted on BURRDEN.

To put U.S. dollar inefficiency in perspective, the federal government denied Americans an amount of money for medical care equal to the entire GDP of Italy ($2.45 trillion).

4. The Healthcare Market

In all government-rum healthcare systems, whether U.S. or single payer, the market is atypical. It has three parties, not the usual two.

In the typical free market, the two parties who transact directly are buyer and seller. Buyer is also consumer as well as payer. Because the buyer expends personal funds, he or she has a powerful incentive to economize. Buyer won't spend hard-earned dollars if prices are too high.

The second party is a seller who competes with other sellers based on price and quality to garner dollars from buyer/payer. Sellers who have high prices, poor quality, or slow service soon find themselves with no buyers and out of business. The combined effect of these two free market forces – buyers' need to economize and inter-seller competition – produces the best goods and services available to the most people at the lowest prices.

Healthcare is a centrally controlled market also known as a command economy. The central controller is the third-party payer that makes all financial and medical decisions. By its regulatory authority, Washington is the ultimate

third-party decision maker since private insurers must follow federal regulations. Buyer is consumer but not payer. Therefore, buyer has no incentive to economize. Sellers do not compete for buyers' dollars. They compete for contracts with health plans, or the government based on price. Insurers' cost basis and therefore their premiums are constantly driven upward by the expense of ever-expanding BURRDEN, which also drives up providers' expenses.

The result in U.S. healthcare is the same as occurs in every other centrally controlled economy like the now-defunct U.S.S.R. or present-day Venezuela: poor quality, slow service, and excessive spending (Tomasetti, 2024; Depersio, 2024).

Third-party decision-making disconnects buyer from seller and thereby suppresses free market forces that normally keep prices low and quality high.

5. Effects on Society

The combination of regulatory over-reach and a command economy in healthcare has profound deleterious effects on society, on We the People or We the Patients.

There is the false promise and disappointed public expectation that coverage equals care (Waldman, 2017). Most Americans believe that by having health insurance, whether private or government-supported, they will get the medical care they need when they need it. Data shows this is not happening.

Maximum wait times to see a primary physician have increased to a medically unconscionable 132 days (Merritt Hawkins, 2017; AMN Healthcare, 2024). Medicaid acceptance rates are declining. Nationally, one third of physicians do not accept new Medicaid patients. In Texas, the acceptance rate is less than 50 percent of doctors (TMA, 2016).

As more individuals have government health insurance, access to care decreases. This "seesaw effect" is due to three inverse relationships (Figure 1) (Waldman, 2023a; Waldman, 2024). As the number of government-insured patients goes up, more money goes to insurance companies leaving less for providers. This reduces patients' access to care. Insurance profits rise when care for patients is delayed, deferred, or denied. As more individuals have government insurance, more money is spent on BURRDEN and less money is available for care.

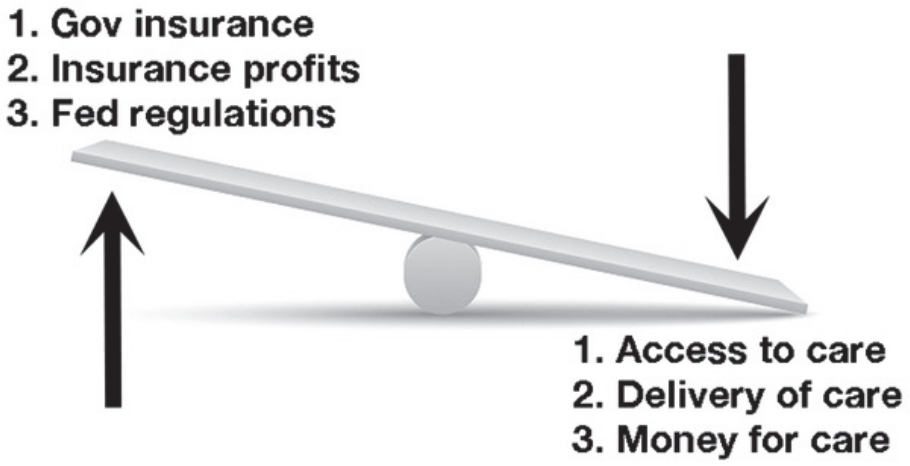

Figure 1. The Healthcare Seesaw

The seesaw is due to federal regulatory over-reach and third-party payment; failures of rule of law; and dollar inefficiency.

The perfect storm of a doctor shortage, medically dangerous wait times, and trillions diverted from care to pay BURRDEN results in death by queue (Medford-David et al, 2024). Americans are dying while waiting in line – a queue – for care that doesn't come in time to save them (Waldman, 2023b; Waldman, 2023c).

6. Other Nations

Single payer nations with government-run healthcare like the United Kingdom (U.K.) and Spain share the U.S. inaccessibility problem but not the legal ones. The Spanish Constitution of 1978, in contrast to the U.S. Constitution, specifically assigns responsibility for healthcare to the federal government (Spanish Constitution, 1978). In Great Britain, the High Court has ruled that the government's National Health Service (NHS) can over-ride the medical decisions of a guardian [17] or even a patient (Waldman, 2018).

Single payer nations have accessibility and quality concerns similar to the U.S. These problems may be exacerbated in single payers because their primary method to limit spending is to ration care, both limiting money for facilities like operating rooms, burn units, and expensive drugs as well as underpaying physicians. The NHS also over-burdening doctors with too many assigned patients.

The combination of inadequate facilities, too many patients per doctor, and low wages has created a crisis in the NHS with a "mass exodus" of physicians out-migrating to practice in other countries (Gregory, 2023). The doctor shortage is not only hard on current patients but ominous for future patients. With the loss of senior, experienced clinical physicians, who will teacher and mentor future doctors?

During the 2018 flu season, NHS hospitals had to cancel more than 50,000 elective surgeries due to insufficient staff and bed shortages (Donnelly, 2018). In September 2024, nearly eight million Britons, 11.7 percent of the entire population, were on queue (in line waiting) for needed medical care (Rudy, 2024).

Quality of care patients receive with government-run healthcare both in U.S. and other nations is variable and sometimes substandard. In the U.S. along with death-by-queue previously noted, Americans no longer believe they have the best care in the world or sometimes even good care (Brennan, 2024). In the NHS, two separate Blue-Ribbon Panels were constituted to evaluate unacceptable outcomes in government-run medical facilities (Bristol Royal Infirmary Inquiry Report, 2001; Gosport Independent Panel Report, 2018; Moffitt, 2019). Both reports substantiated the claims of poor quality. Sweeping changes were recommended in the NHS. Individual physicians were fired. No major changes were implemented in the NHS.

7. Point-Counterpoint

This article contrasts the *existing* government-run, command economy approach to a *theoretical* free market model. Healthcare in the U.S. is not a free market – it is a government-controlled system. Functionally, U.S. healthcare is single payer system.

Since there are no national healthcare systems that are free markets, there are no outcomes data to compare with command economy, government-run healthcare. Based on evidence, it is clear that current systems are failing patients. Government-run healthcare consistently fails to provide timely, quality medical care. The U.S. has the additional problems of abrogating rule of law and excessive, "unsustainable" (Obama, 2009) spending.

8. Conclusion

Government-run healthcare systems whether in the U.S. or other large, industrialized nations are failing people who depend on them. What Washington has done to healthcare over the past 60 years are what systems thinkers call "fixes that fail or backfire" (Kim, n.d.).

It is time for a new approach. Systems theory can point the way. A possible *cure* for healthcare follows from identification of the root causes of system dysfunction: legal and economic.

Restore rule of law to healthcare in the U.S. This requires the federal government to withdraw its "power" over healthcare. Following Medicaid law would stop federal "interference" and would return control of state Medicaid programs to the states. Medical autonomy can be restored when patients, not third parties, are making their own medical decisions. Operationally, this last recommendation is primarily economic rather than strictly legal.

Return control of healthcare spending to patients. Employers should fully compensate employees rather than giving an average of $25,968 of employees' earnings to insurance companies as "employer-supported benefits" (Ginn & Waldman, 2024). 157 million Americans could put those funds into new, unlimited CSAs (Care Spending Accounts) and shop for both care and insurance. Such infusion of free market forces would drive down prices and improve service access along with quality.

With states' control of Medicaid and the free market balancing supply with demand, the bulk of federal healthcare regulations become unnecessary and can be repealed. The savings to taxpayers from such regulatory relief would be substantial, certainly hundreds of billions, possibly trillions. Just the cost of ACA regulatory infrastructure was between $716 billion and $1.76 trillion (Amadeo, 2017; Kliff, 2012).

The U.S. does not need to adopt this free market approach for the whole nation. They could perform a scientific experiment using the states as "laboratories of democracy," per Supreme Court Justice Louis Brandeis' suggestion in 1935 (New York Ice Co. v. Liebermann, 1932).

Allow the states to design and implement their own healthcare systems in the large, populous states. For instance, Texas with 30 million residents (more populous than Australia) could implement a free-market system such as Empower patients (Ginn & Waldman, 2024). California with 40 million people (more than Canada) could adopt single payer (Waldman & Ginn, 2017). After several years, compare the results. Such a socio-economic-medical experiment could be illuminating, even therapeutic.

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