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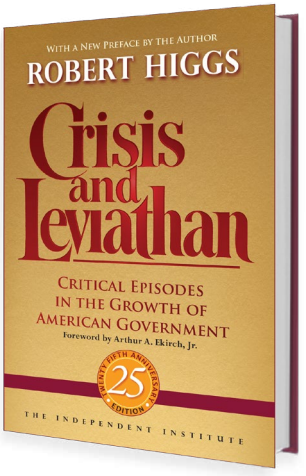

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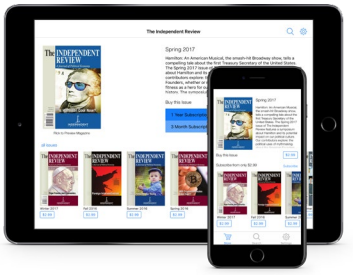

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CONTROVERSY

If the "Business Model" of Medicine Is Sick, What's the Diagnosis, and What's the Cure?

BY ROBERT L. OHSFELDT

In his thoughtful essay "The Business Model of Medicine: Modern Health Care's Awkward Flirtation with the Marketplace" in this issue, Dr. James P. Whalen highlights several shortcomings of the U.S. health care system. In his criticism, he is hardly alone. Indeed, the production of tomes cataloging the system's numerous ills has become something of a growth industry. Recent examples include *As Sick as It Gets* (Mueller 2001) and *Oxymorons: The Myth of a U.S. Health Care System* (Kleinke 2001). Authoritative international bodies such as the World Health Organization (WHO) and the Organization for Economic Cooperation and Development (OECD) have issued less-than-favorable assessments of the U.S. health care system (Docteur, Suppanz, and Woo 2003). Even in more sympathetic assessments, such as *From Marcus Welby to Managed Care: The Economic Evolution of American Health Care* (Dranove 2000) and *The Corporate Practice of Medicine: Competition and Innovation in Health Care* (Robinson 1999), the authors find that the system has ample room for improvement.

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Many of the specific points Whalen raises relate to three common themes in the literature: the U.S. health care system is too expensive, produces mediocre health outcomes, and provides inadequate and inequitable access to care for the population. In some respects, Whalen's concerns about the "business model" of health care echo those voiced almost twenty years ago by Dr. Arnold Relman, then editor of the *New England Journal of Medicine,* in an exchange of letters with Princeton health economist Uwe Reinhardt (Relman and Reinhardt 1986). However, Whalen's principal concern is that the profit-seeking motive among entrepreneurial providers of prescription drugs, devices, or procedures drives them to devote excessive resources to promotional activity directed toward both consumers and physicians. Further, he concludes that this promotion often leads patients and their physicians to select inappropriate, excessively expensive, and even potentially dangerous treatments.

In this essay, I place Whalen's concerns in the context of the three general themes common in critiques of the U.S. system, and then I comment on the apparent negative effects of promotional activities and on his proposed solution.

Too Expensive?

Although definitional complexities abound in any cross-national comparisons of "health" spending, let us take it as a given that per capita spending on health care is greater in the United States than in any other OECD country. Let us also take it as a given that per capita gross domestic product (GDP) is greater in the United States than in any other OECD country (excluding tiny Luxemburg). In these circumstances, we would expect the higher GDP to translate into higher health care spending because health care is a "normal" good. However, in a simple linear regression of health spending per capita on GDP per capita in 1999 across OECD countries, Docteur, Suppanz, and Woo (2003) find that the United States is an "outlier," with actual health spending per capita exceeding "expected" spending by more than 30 percent.

A rationalization of this finding might rest on econometric nitpicking—using the same OECD data in a semilog rather than in a linear model reduces the prediction error for the United States to less than 1 percent (my estimate using SAS Version 8.0). Or a more fundamental explanation might relate to differences in the availability of discretionary health care services across countries: residents of other OECD countries might spend more on health care if their governments allowed them to do so. Perhaps the critics are wrong, and Americans really don't spend "too much" on health care after all.

Let us assume, however, that the critics are correct. Another potential explanation for "excess" spending in the United States pertains to differences in the prices of inputs used to produce health care. The popular press has directed considerable attention to the higher prices of certain brand-name prescription drugs in the United States than in Canada. The usual interpretation is that U.S. prescription-drug prices are "too high," but, as one might have suspected, the popular press has focused on

drugs with the largest price differentials. After adjusting for purchasing-power parity, some drug prices (for the most part, generic-drug prices) are in fact lower in the United States than in Canada. Whether drug prices "on average" are higher or lower depends on the choice of consumption weights used to define the average—a classic index-number problem (Berndt 2000).

Still, let us assume that drug prices "on average" really are higher in the United States than in Canada. Other inputs used to produce health care services also have higher prices in the United States than in Canada. For example, U.S. physicians, nurses, and other skilled hospital-based employees earn more than their Canadian counterparts, after adjustments for purchasing-power parity (Fuchs and Hahn 1990; Redelmeier and Fuchs 1993; Bell et al. 1999). The difference is particularly striking for U.S. physicians, who earn up to 80 percent more than Canadian physicians.

Simply cutting the earnings of physicians and other skilled health-sector workers in the United States to Canadian levels would (in a static model) eliminate a substantial portion of the alleged 30 percent "excess" in health care expenditures. But are U.S. physicians' incomes really "too high"? Except possibly in some subspecialties, the return on investment in medical education resembles the rates of return on education in other professional occupations, such as law and business (Nicholson 2002; Weeks and Wallace 2002). The health sector must compete with other sectors for labor, so it is doubtful that U.S. physicians' incomes could be reduced substantially without adversely affecting the supply of physician services (except possibly in certain subspecialties).

Mediocre Outcomes?

If Americans spend the most on health care, we might reasonably expect the U.S. system to produce health outcomes superior to those of health systems spending less. However, the "usual metrics"—for example, healthy (quality-adjusted) life expectancy at birth, or the child mortality rate—do not reveal such superiority (see table 1). Clearly, in a nation as wealthy as the United States, the abnormally high child mortality rate, especially among blacks, is tragic. Characteristics of the health system affect child mortality by affecting the care that children and pregnant women receive, but a complex combination of other social, economic, and cultural conditions, through some elusive causal pathways, also contributes to this tragedy. These other conditions lie beyond the purview of the health care system. Therefore, child mortality may not be very "sensitive" to differences in health system characteristics and hence may not be especially informative about system performance.

The abnormally low estimated life expectancy at birth in the United States obviously is affected by the abnormally high child mortality rate, but death rates among adolescents and youths also can have a dramatic impact on estimated life expectancy at birth. Therefore, some specific cultural aspects of American society outside the purview of the health care system contribute to the "underperformance" of that sys-

Table 1: Comparison of General Health Metrics, United States and Selected Developed Countries, 2001

	Child Mortality (Age 5)*	Healthy Life Expectancy (Birth)*	Healthy Life Expectancy (Age 60)*
United States	9 (7)	66 (69)	15 (17)
White	7 (6)	67 (69)†	15 (17)†
Black	16 (13)	61 (65)†	14 (16)†
Australia	7 (5)	70 (73)	16 (19)
Canada	6 (5)	68 (71)	15 (18)
Denmark	6 (5)	69 (71)	16 (17)
France	5 (4)	69 (74)	16 (19)
Germany	5 (4)	68 (72)	15 (18)
Italy	6 (5)	69 (73)	16 (18)
Japan	5 (4)	71 (76)	17 (21)
Sweden	4 (3)	70 (73)	17 (19)
Switzerland	6 (5)	71 (74)	17 (20)
United Kingdom	7 (6)	68 (71)	15 (17)

*Male (female). †Imputed using ratio of race-specific to overall life expectancy in years.
Sources: WHO: U.S. Vital Statistics (race-specific data).

tem as measured by life expectancy at birth. Two examples are deaths associated with motor vehicle accidents and homicides.

According to WHO data, the U.S. death rate from motor vehicle accidents is approximately three times higher than the rate in Sweden or the United Kingdom, and one and one-half to two times higher than the rate in Australia, Canada, Denmark, Germany, and Japan. In the United States, unintentional injury (accidents) was the fifth-leading cause of death in the year 2000 overall, but it was the leading cause of death among individuals between the ages of one and thirty-four, the second-most common cause among individuals age thirty-five to forty-four, and the third-most common cause among individuals forty-five to fifty-four (Anderson 2002). In contrast, among individuals age sixty-five and over, unintentional injury was the ninth-leading cause of death. The unusually high rates of death from unintentional injury among young Americans reduces the estimated life expectancy at birth for the United States, but they do not necessarily signal a deficiency in the U.S. health care system.

Although homicide is a much less common cause of death than unintentional injury in the United States, the difference between the U.S. homicide rate and that observed in other developed nations is astonishing. According to WHO data, the U.S. homicide rate is ten to twelve times greater than the rates in Japan and the United Kingdom, eight times greater than the rates in France and Germany, and five to six times greater than the rates in Australia, Canada, Denmark, Italy, and Sweden. These differences are even more dramatic if race-specific rates are examined. In 1998, among non-Hispanic whites, the homicide rate (per 100,000 population) was 3.2, whereas the rate was 26.1 for non-Hispanic blacks and 9.9 for Hispanics (Keppel, Pearcy, and Wagener 2002). Indeed, homicide was the *leading* cause of death among black males age fifteen to thirty-four in 2000 (Anderson 2002). Obviously, this tremendous waste of human life is a critical problem in American society, but whatever the causes of this carnage—poverty, racism, a "culture of violence"—the U.S. health care system per se has little effect on it.

Most deaths from unintentional injury or homicide occur before the age of sixty. Thus, cross-national comparisons of healthy life expectancy at age sixty are relatively unaffected by differential death rates from unintentional injury and homicide. Using healthy life expectancy at age sixty as a performance metric (table 1), the apparent "underperformance" of the U.S. system is muted substantially, especially for black males. Of course, part of the improvement may reflect the universal health care insurance for Americans age sixty-five and over in the form of Medicare. To the extent that economic or racial disparities in access to care contribute to the low values of the usual population health metrics in the United States, this impact would be less pronounced among those age sixty-five and over.

When more specific performance metrics that are (at least potentially) more sensitive to health-system differences are used, in many cases the United States does indeed appear to outperform other, less expensive health systems. Table 2 reports five-year age-adjusted survival rates for several types of cancers. In all cases, the survival rate for the U.S. overall exceeds that for European nations. Within the United States, survival rates for whites are higher than those for blacks. Presumably this difference reflects, at least in part, race differences in average socioeconomic status and access to health care. Even so, survival rates among black Americans tend to be on a par with the overall survival rates in European nations.

As always, it is important to avoid placing too much weight on such cross-national comparisons. Differences in case definitions or other aspects of measurement may yield misleading results. Indeed, awareness of such complexities is the point of this discussion.

Inadequate and Inequitable Access?

Researchers have devoted considerable effort to the analysis of various aspects of "the uninsured" in the United States. People without health insurance tend to use fewer

Table 2: Five-Year Age-Adjusted Cancer Survival Rates, United States and Selected European Countries.

	Breast (Female)	Cervical (Female)	Colon (Male)	Lung (Male)	Prostate (Male)	Thyroid (Female)
United States[1]	82.8	69.0	61.7	12.0	81.2	95.9
White	83.9	71.8	62.5	12.0	82.7	95.7
Black	69.2	55.6	52.6	12.0	69.2	93.0
England[2]	66.7	62.6	41.0	7.0	44.3	74.4
Denmark	70.6	64.2	39.2	5.6	41.0	71.7
France	80.3	64.1	51.8	11.5	61.7	81.0
Germany	71.7	64.1	49.6	8.7	67.6	77.0
Italy	76.7	64.0	46.9	8.6	47.4	77.0
Sweden	80.6	68.0	51.8	8.8	64.7	83.7
Switzerland	79.6	67.2	52.3	10.3	71.4	78.0

[1] *Source:* Ries et al. 2003 (years of diagnosis 1986–88).
[2] *Source:* Berrino et al. 1999 (years of diagnosis 1985–89).

and different types of health care services than those with insurance, resulting in either no care (especially for preventive care) or lower-quality care. Depending on who is counting, when, and which data they use, at any given time approximately 30 to 40 million Americans have no health insurance (Fronstin 2001). Some one-third of this total consists of those who are "chronically" uninsured, whereas the remaining two-thirds are in a transitional "spell" without insurance, with a median spell duration of less than six months (McBride 1997; Copeland 1998). Most of these spells result from loss of health insurance after a change in jobs or from loss of Medicaid eligibility because of changes in household income.

Many of the chronically uninsured are self-employed or employed by companies with only a few employees. Some small employers might be willing to provide "bare bones" health insurance coverage for catastrophic illness among their employees, but few do so. One reason is that state insurance regulations often mandate coverage for numerous types of services—a "bare bones" policy is not permitted (Sloan and Conover 1998; Jensen and Morrisey 1999). Some workers, however, simply prefer to take their chances in order to receive as cash compensation what might have been spent on benefits.

Individuals who lose health insurance because of job change have the option to purchase an extension to "bridge" the spell under the Consolidated Omnibus Budget Reconciliation Act (COBRA) and the Health Insurance Portability and Accountability Act (HIPAA), but the purchase of optional extensions is rare (Berger et al. 1999), in part because individuals have to purchase an extension for the insurance plan they had while employed—they can't switch to a cheaper "bare bones" policy. Many states have attempted to reduce spells without insurance for means-tested public insurance programs (Medicaid) by defining a minimum eligibility duration of twelve months or more, but the cost for state governments often is substantial (Short 2000).

The "uninsured issue" is moot in developed countries other than the United States in large part owing to the presence of some form of universal health care or health insurance coverage. Individuals in these countries cannot choose to be uninsured. Researchers have devoted a fair amount of effort to the study of "queues" for health care services in these systems and of the impact of queues on the process of care and on health outcomes. Lengthy (at least by U.S. standards) queues are ubiquitous for many types of services in health systems with universal health care. For example, the mean waiting time for a magnetic resonance imaging (MRI) of the head in Canada in 1997 was 150 days, compared to 3 days in the United States (Bell et al. 1999).

Although the impact of these long waiting times can be catastrophic for individual patients, providing "equally limited access for all" (instead of highly unequal access as in the United States) generally is assumed to be a key contributor to the superior population health measures for non–U.S. health systems. There is something of a consensus that improving access to care for the currently uninsured is an important area for reform in the U.S. system, but no consensus about how to improve access.

Profit Seeking: Wasteful and Harmful?

Do profit-seeking producers of drugs, devices, or procedures devote excessive resources to (often) deceptive promotional activities for their products, resulting in inappropriate use of services or products that increase costs and reduce quality? Dr. Whalen cites several specific examples where this appears to be the case. My intent is not to dispute these assertions, but to offer an alternative interpretation of their implications.

To begin, consider direct-to-consumer (DTC) advertisements for prescription drugs. A recent study funded by health insurers and cited by Whalen (NICHM 2001) notes that DTC advertising in the United States for prescription drugs amounted to 2.5 percent of total U.S. advertising expenditures for all consumer products in the year 2000. The three most heavily advertised prescription drugs in 2000 were Vioxx ($161 million, 10.6 percent of sales), Prilosec ($108 million, 2.6 percent of sales), and Claritan ($100 million, 4.9 percent of sales). To put these fig-

ures in context, the report also lists U.S. advertising expenditures for several consumer products, including Budweiser ($146 million, 3.2 percent of sales), Dell Computers ($160 million, 0.9 percent of sales), and Pepsi ($125 million, 8.9 percent of sales). (Data for U.S. sales computed by author from information in company annual reports.) However, spending for Zithromax, the drug ranked fiftieth in DTC spending in the report, was $9.8 million (0.7 percent of sales). Clearly, DTC spending as a percentage of sales is small for most of the hundreds of brand-name prescription drugs available in the United States with annual sales in excess of $100 million.

Another concern is that DTC advertisements for prescription drugs are misleading in that they overstate the benefits or minimize the risks of using the drug. The Food and Drug Administration (FDA) regulates DTC advertising for prescription drugs, using more stringent requirements for scientific evidence and for "fair balance" between stated benefits and stated risks than the Federal Trade Commission, which regulates advertising for nonprescription "over-the-counter" (OTC) products. Most of the "misleading" advertisements the FDA has identified involve judgments about the quality of scientific evidence for a benefit claim or the adequacy of fair balance, not about unambiguously false claims. Moreover, even if a DTC ad for a prescription drug is misleading to consumers, they cannot act on that misinformation and purchase the product without a physician's approval. This "learned intermediary" provides protection to consumers beyond that provided for OTC drugs.

Suppose a misleading DTC drug ad induces a patient to approach a physician to request a prescription for the drug. Does that event have a negative impact on physician-patient interactions? In a recent FDA-conducted survey of 459 physicians (Aikin 2003), 41 percent believed DTC ads had a "somewhat" or "very" positive impact on physician-patient interactions, 28 percent were neutral, and only 5 percent believed the ads had a "very" negative impact. Approximately 17 percent reported that they felt "somewhat" or "very" pressured by their patients to prescribe an advertised drug, and some 18 percent indicated that DTC ads had been "a problem" in their interactions with patients. The specific problem for physicians in most cases was that they had to spend time explaining why drug X "is not right for you" (to paraphrase the ubiquitous closing qualifying line in television ads for prescription drugs). Some commentators might suggest to these physicians that spending time talking to patients is part of their job. Time is money, however, and physicians could see another patient or go home a little earlier if this expenditure of two or three minutes were avoided.

If DTC ads and other promotional activities by pharmaceutical companies induce physicians to make decisions contrary to their patients' best interests, why not just ban these activities? (After all, DTC ads for prescription drugs are banned in most developed nations.) The U.S. Constitution, however, protects freedom of speech, even commercial speech (to a degree). The current *Central Hudson v. Public Service Commission of New York* (1980) criteria for the extent of permissible government

restrictions relate to the following considerations: (1) Is the expression protected (that is, "pure" speech)? (2) Is the asserted government interest in regulation substantial? (3) Does the regulation directly advance the government interest? (4) Is the regulation more extensive than necessary to advance the governmental interest? Permissible restrictions must satisfy the first and fourth conditions in the negative and the middle two conditions in the affirmative. Although the government can (and does) regulate the content of DTC ads and physician "details," it would be difficult to regulate their quantity or to ban them altogether.

For the sake of argument, suppose that promotional activities, either targeted directly at physicians or indirectly through their patients, have a profound effect on the way physicians provide medical care to their patients. Does this situation often harm patients, or does it merely waste their (or their insurer's) money? Following up on Whalen's point about the advertising costs of Cox-2 inhibitors (Vioxx, Celebrex), we might also conclude that many patients with pain from osteoarthritis would achieve similar pain relief by using generic OTC drugs such as ibuprofen, available for a few dollars per month, rather than paying $75 to $110 per month for Vioxx or Celebrex (retail prices from Drugstore.com, April 30, 2003).

In an ideal world, a physician would endeavor to compare the incremental costs and incremental benefits of alternative treatments, using lower-cost generic drugs whenever the incremental cost of a brand-name drug exceeded its incremental benefits. In other words, a physician would help solve what Dranove (2000) labels the patient's "shopping problem." But physicians are not compensated according to how well they solve the patient's shopping problem. In a fee-for-service practice, they are paid to "do things," such as receive patient visits. Even in salaried practices, doctors have productivity quotas to satisfy. The physician needs no more time to write a prescription for Vioxx than to tell a patient how much OTC ibuprofen to use. Indeed, writing the prescription may take less time. The patient is expected to achieve similar pain relief in either case. That one means to pain relief costs much more than the other is not the physician's "problem."

One way to make it the physician's problem is to devise mechanisms of compensation that provide financial rewards to physicians who do a good job of solving the patient's shopping problem, but that task is easier said than done. Capitation (a fixed payment per patient per period of time) provides an incentive to use cheaper means to produce similar outcomes, but it also can provide an incentive to use cheaper means to achieve inferior outcomes. To avoid the latter, undesirable result requires a robustly competitive market for capitation contracts, a situation in which the physicians who choose to produce poor care will be at risk of losing contracts. This outcome in turn requires reliable mechanisms to measure and credible means of communicating information about the quality of care provided. The development of independent third-party provider "scorecards" represents a movement in this direction.

Another specific example Whalen cites for the adverse effects of the "business model" is the proliferation of neonatal intensive care units (NICUs). As he notes, the

literature suggests that NICUs with a higher volume of patients tend to have better health outcomes than NICUs with a lower volume. Whalen posits that the proliferation of NICUs occurs because they are "cash cows" and confer an element of prestige on the hospital that would not be attained otherwise. By analogy to "natural" monopolies, he suggests that an obvious solution is regulation of NICU capacity and prices.

In fact, most states *do* regulate NICU capacity and other aspects of hospital capacity through "certificate of need" (CON) programs. However, in a recent review of the literature on CON programs, Conover and Sloan conclude, "Unlike many areas of research in health policy, research into CON effects on acute care costs provides a rather clear answer. CON has not succeeded in cost containment" (1998, 476–77). Indeed, the bulk of the literature indicates that CON programs increase cost (Antel, Ohsfeldt, and Becker 1995).

A CON program may improve quality (but not reduce costs) for some specific types of services by increasing patient volumes—for example, for coronary artery bypass graft surgery (Vaughan-Sarrazin et al. 2002). However, even if CON can improve quality, it is an unacceptably blunt instrument in a sector as innovative and dynamic as health care. A fundamental problem with CON is that it awards a property right—a monopoly franchise—to the recipient in perpetuity. The resulting rent-seeking behavior is as predictable as it is pervasive. CON ossifies market structure and stifles innovation. If the state indeed "needs" to impose a regulatory limit on the number of NICUs, a system of contestable franchises would be at least an improvement over CON. Another superior alternative would be periodic licensure (and relicensure) of NICUs based on volume and other quality-assurance considerations.

Such regulation, however, may not be needed at all. California is one of several states that repealed CON regulation after federal funding of state health-planning activities was eliminated early in the Reagan administration. A recent study tracked entry and exit for providers of coronary artery bypass grafts in California from 1984 to 1994 (Chernew, Gowrisankaran, and Fendrick 2002). At the beginning of this period, the principal factor driving entry was a healthy return on investment, resulting from generous payment from Medicare and other payers (with the exception of managed-care organizations and Medicaid). By the end of the period, declining Medicare payments and increasing price competition for contracts with other payers caused the return on investment to decline substantially. If indeed NICUs are "cash cows" for hospitals, maybe the solution is more competition, not less.

Payers also have made note of the relationship between volume and outcomes. The Leapfrog Group for Patient Safety, founded by the Business Roundtable with support from the Robert Wood Johnson Foundation, has developed a set of guidelines for large employers as purchasers of health care services (see http://www.leapfroggroup.org/index.html). Among other things, these guidelines encourage payers to develop selective contracts with hospitals identified as producing a sufficient volume of specific procedures to ensure adequate quality. Indeed, one of the services identified is "high-risk" delivery; hospitals with an average daily census of at least fifteen newborns in their NICU are recommended.

Both the robust price competition observed in California and the quality competition envisioned by the Leapfrog Group rely on the ability of payers to engage in selective contracting with providers. However, at least thirteen states have enacted "any willing provider" laws for hospitals (Ohsfeldt et al. 1998). These laws prohibit selective contracting for some types of insurers and thus, at least in theory, limit payers' ability to negotiate lower prices or to exclude "low-quality" providers from provider panels. In *Kentucky Association of Health Plans v. Miller* (2003), the U.S. Supreme Court rejected an attempt by payers to use ERISA to challenge the laws. This decision may encourage more states to enact such laws.

Concluding Comments

In recent years, it has become popular to speak of the "failure" of managed care in the United States. Dranove concludes, however, that had the growth of managed care during the 1990s not occurred, total health spending might have been $300 billion higher than the actual spending in the year 2000—or, some $2,000 more per privately insured individual (2000, 162). These savings were achieved because of a high degree of competition among plans that required managed-care organizations to become more efficient to survive.

The success of managed care in the 1990s, however, also sowed the seeds of its "failure," and the cost-containment effects of managed care have begun to wane in recent years. One factor has been diminished competition—plans (and providers) found it easier to merge with their competitors rather than to continue to compete with them—but government regulation has played a prominent role as well. Many individuals who had entered managed care in the 1990s to enjoy the lower costs of managed-care plans chaffed at the restrictions imposed by managed care in order to achieve lower costs. "Reform" legislation for managed care ensued. These new regulations inhibited the formation or maintenance of tightly organized provider panels and sought to restore the unfettered access to care characteristic of the "blank-check" era of health insurance. The quixotic quest for a "free lunch" never ends.

Whalen does not paint a very flattering portrait of entrepreneurial "purveyors of products" (to borrow Relman's phrase) in health care. Physicians' traditional disdain for "for-profit" medicine, however, is more that a little ironic. As Clark Havighurst has noted, "American medicine has fought valiantly to defend its right to entrepreneurship in health care, and it has fought just as valiantly to deny almost everyone else that right" (qtd. in Relman and Reinhardt 1986, 16). It would be easy, though inaccurate, to pigeonhole Dr. Whalen as one of the legion of physicians who pine for the blank-check era when they were the only for-profit (or for-net-practice-income) providers allowed. Whalen's essay, however, does not provide an especially flattering portrait of physicians either: he thinks "purveyors of products" easily manipulate them into making uninformed or even foolish choices on behalf of their patients, at little or no profit to themselves.

If entrepreneurship is indeed a "force for evil" in the health care system, what Whalen believes should be done to perform an exorcism remains unclear. One hint is his allusion to public-utility regulation, but the empirical record on that front is not

encouraging. As summarized by Robinson, "Rather than control monopoly, regulation creates monopoly; rather than promote the public interest, regulation rewards private interests; rather than encourage operating efficiency, regulation condones managerial slack; rather than reduce prices, regulation raises costs" (1999, 31–32).

More government regulation is not part of the solution—it's part of the problem. Increasing competition is not part of the problem—it's part of the solution.

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