

# Medical neoliberalism and the decline in U.S. healthcare quality

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**Abstract:** U.S. medical neoliberalism has led to the expansion of the private sector within the healthcare industry and restructured healthcare delivery into a commodity to be purchased rather than a natural born right. The privatized aspects of the healthcare industry, namely pharmaceutical industry, medical device manufacturers and the health insurance industry, are siphoning off healthcare dollars which could be used by hospital systems for patient care. This has led to decreased access to primary care and poorer health among the U.S. population. Public health metrics which traditionally have been used to measure positive strides in healthcare quality have been on the decline for several years now.

**Keywords:** Medical neoliberalism; healthcare quality; healthcare industry; healthcare delivery; healthcare access

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## Introduction

At first glance, the term “neoliberalism” may come across as partisan terminology. Rest assured, neoliberalism does not reside exclusively with any particular political affiliation. Rather, neoliberalism can be defined as a form of liberalism with a focus on free market capitalism. In practice, this translates into an expansion of the private sector into the public aspects of our daily lives. Neoliberalism has been associated with increased globalization, outsourcing of jobs into markets which are less costly to employers and deregulation of industry.

Neoliberalism has had an important role to play in U.S. healthcare. Namely, it has restructured healthcare delivery into a commodity to be purchased rather than natural born right. It prioritizes consumer choice over equity and access to care. In addition, it places the burden of that choice in the hands of the consumer. Consumers can make the right decision for their health. Or they can make the wrong decision for their health. And if the healthcare they received does not meet standard of care, they can sue for malpractice in an attempt to recoup money for services that were improperly rendered (1). This is analogous to how you might return a defective product to Walmart.

In this piece, I will attempt to link neoliberal practices to a decline in U.S. healthcare quality. It is my desire to

convey that neoliberalism is incompatible with public health and the delivery of quality care. Specific questions for you, the reader, to keep in mind are:

- (I) What measurable quantitative aspects demonstrate the state of decline in the U.S. healthcare system?
- (II) What aspects of U.S. healthcare delivery have been most impacted by privatization?
- (III) How have healthcare systems compensated for a declining share of healthcare dollars within the industry?

## Materials and methods

This review was compiled from pre-existing contemporary research, government data and news reports in order to showcase the state of the U.S. healthcare industry. Pre-existing studies utilized in this review have been featured previously in predominant medical journals and nationally circulated news publications. This review is based on studies and reports published on the trends in healthcare quality in the USA over the past 10 years from about 2010 to current day.

## Compliance with ethical standards

The author wishes to declare that he has no conflict of

interest while reporting this piece. This is not a research study, therefore no experiments involving human participants and/or animals was conducted. No informed consent was required due to lack of human participants.

## Results

### *U.S. healthcare access and quality*

Based on 2018 analysis by the Commonwealth Fund, the United States spends the most money on healthcare among all industrialized nations (nearly 17.8% of its gross domestic product). Yet it lags behind all of those countries in terms of access, equity, quality, efficiency and healthy lives (2).

Based on 2019 Census data, since the federal government took steps to weaken the Affordable Care Act and toughen Medicaid requirements (explained in detail later), the number of insured Americans is at a low. 27.5 million people (8.5% of the population) did not have healthcare coverage, an increase from 25.6 million people (7.9% of the population) the previous year. Also, the portion with government insurance (Medicaid and Medicare) fell by half a percentage point while the percentage with private insurance remained unchanged (3).

Despite the number of uninsured people in the country, around 90% of the country does indeed have healthcare coverage. Yet, despite having healthcare coverage, their out-of-pocket costs continue to be on the rise. This population can be deemed “underinsured.” Another report by the Commonwealth Fund found a 50% rise in underinsured Americans between 2010 (29 million) and 2018 (44 million) (4). Rising out-of-pocket costs are forcing underinsured Americans to resort to raising money on crowdfunding websites, such as GoFundMe, in order to cope with their medical bills. In addition to this, private organizations have begun capitalizing on the culture of overwhelming medical expenses. For example, Groupon has begun advertising deals for medical services; because Groupon offers transparency in pricing and values that are significantly lower than the alternatives, consumers find this option to be significantly more attractive (5). One of the principles of free market capitalism is that gaps and inefficiencies in the market will be addressed through innovative means. However, there’s an argument to be made that those gaps and inefficiencies shouldn’t exist in the first place.

With such poor access to healthcare in the United States, it should come to no surprise that public health metrics

historically used to purport advancements in U.S. health are now on the decline. For example, CDC data shows that life expectancy has declined over the past several years. Life expectancy decreased from 78.9 to 78.7 years between 2014 and 2015, remained unchanged between 2015 and 2016 and decreased again to 78.6 years between 2016 and 2017. This trend was driven largely by drug overdose (particularly fentanyl-derivatives and opiates) and suicide (6). In fact, the U.S. suicide rate is the highest it has been since World War II and the highest increases have been among American Indian and Alaska Native ethnic groups (7).

In addition to this, the historical declines seen with cardiovascular mortality have begun to slow down and plateau over the past several years. A 2016 article in JAMA cardiology cataloged cardiovascular disease mortality rates from 2000–2014. They observed a flattening of age-adjusted mortality rates from 2011–2014. And these rates were consistent across all cardiovascular diseases (including coronary artery, cerebrovascular and peripheral vascular diseases) in all ethnic groups (8).

### *U.S. hospital system performance*

Based on the aforementioned data, there is no question that the quality of U.S. healthcare is on the decline. One would assume that healthcare systems were minting money from the cost of their services alone. However, this is not the case. According to a 2018 Navigant study which analyzed both for-profit and nonprofit networks, two-thirds of 104 U.S. health systems saw a decline in operating margins between 2015 and 2017. This amounted to an overall 44% reduction and a \$6 billion loss. For-profit operating margins declined by 39% over the same timespan (from 4.15% to 2.56%). Nonprofit systems reported margin drops of 34% (9). In addition to this, a 2017 Chartis group and iVantage study predicted 41% of rural hospitals will face negative operating margins. At the time of the study, 80 rural hospitals had been closed down between 2010 and 2017 (10).

These numbers can be attributed to declines in revenue caused by:

- (I) Higher rates of uninsured patients and health-insurer-payer mixes, which relied heavily on public payers with lower reimbursement rates. This occurrence was exaggerated in states that chose not to opt into the Medicaid expansion provided for under the Affordable Care Act;
- (II) Lower availability of employer-sponsored health coverage;

- (III) Tighter payer-negotiated rates;
- (IV) Shortage of primary care physicians. Based on 2019 data published by the AAMC, there will be a projected physician shortage between 46,900 and 121,900 physicians by 2032. Additionally, the major factor driving increased demand for physicians will continue to be an aging population and greater prevalence of chronic medical conditions (11). And;
- (V) Worse population health disparities.

Decreased revenues are not a phenomenon exclusive to rural areas. Many urban hospitals are affected as well. Using New York State as an example, though total hospital revenue in 2019 increased by \$14 billion (23% higher than the national average) these gains went towards only about one-quarter of the state's hospitals. 44% of New York State hospitals lost money in 2016. This phenomenon can be attributed to the patient population's desire to be treated in academic medical centers and large regional hospitals. This phenomenon is a product of medical consumerism. Patients do their research and wish to be treated at sites that have better and more consistent patient outcomes. However, as a result, many safety-net hospitals in the state are operating with negative margins and are struggling to stay afloat, despite having the majority of the state's inpatient admissions (12).

Based on the aforementioned data, many hospital systems in the country are in financially precarious situations. But how is their performance? Based on a 2019 Leapfrog analysis, their performance in terms of patient safety isn't faring much better. Out of more than 2,600 hospitals graded, 32% earned an "A", 26% earned a "B", 36% earned a "C", 6% earned a "D" and less than 1% earned an "F". Analysis concluded that patients at "D" and "F" hospitals faced a 92% greater risk of avoidable death. Patients at "C" hospitals faced an 88% greater risk of avoidable death and patients at "B" hospitals faced a 35% greater risk of avoidable death (13).

### *U.S. pharmaceutical industry*

So where does neoliberalism come into play? Medical neoliberalism has resulted in the expansion of the privatized aspects of the healthcare industry: biotechnology (pharmaceutical companies and medical device manufacturers) and private health insurance. These privatized aspects of medicine are siphoning off healthcare dollars which could be used by hospital systems to treat patients.

Prescription drug prices in the United States continue to rise. Average total drug spending per hospital admission increased 18.5% between 2015 and 2017. Outpatient drug spending per admission increased 28% while inpatient drug spending per admission increased 9.6% during the same period (14). In addition, The Office of Actuary at the Center for Medicare and Medicaid Services (CMS) has forecasted accelerated drug spending increases, ramping up to nearly 6.1% growth by 2020 (15). Rising drug prices are a significant source of high patient out-of-pocket-costs.

Why has there been minimal attempt to curb drug prices? Governments around the world are able to negotiate with drug companies and influence drug pricing. However, the United States government negotiated away its ability to do so when passing Medicare part D legislation. Congress' decision to abdicate its ability to regulate drug prices can be directly linked to the financial influence of the pharmaceutical industry on politics. Annual political donations by the pharmaceutical industry have traditionally hovered around the \$30 million range. However, these numbers have continued to rise. Political donations were particularly high during the 2012 and 2016 election cycles (amounting annually to \$51.3 million and \$63.8 million, respectively). 2018 political donations by the pharmaceutical industry amounted to \$43.7 million (16). Because of the influence of money in U.S. politics, drug companies have retained the ability to independently set their own prices.

U.S. patent law guarantees drug manufacturers exclusivity to the sales rights of their drugs for a longer period than other countries. U.S. drug patents are good for around 20 years from the time that they are issued (17). This guarantees that drug manufacturers will hold a monopoly over drug sales for that period of time. And with drug monopolies comes monopoly pricing (explained later).

The biotechnology industry is unique in the sense that it carries an immense burden in terms of research, development and clinical trial costs. These combined costs amount to hundreds of millions of dollars, if not billions of dollars. However, researchers at Memorial Sloan Kettering found that the cumulative revenue from the top 20 best-selling drugs in the United States more than enough covered the cost of R&D conducted by the 15 companies that make those drugs. Total costs of all the R&D amounts to around \$80 billion a year. Yet the revenue from the top 20 drugs alone nets the pharmaceutical industry nearly \$120 billion (18). The biotechnology industry has high risks and high rewards. However, R&D is not the driving determinant of drug prices. The key determinants are:

- (I) The value of the drug in treating a condition;
- (II) The prevalence and severity of the condition (which creates the demand);
- (III) Whether the drug is a short-term curative or long-term maintenance medication; and
- (IV) The driving motivations of the drug company. If it is more interested in providing a service to humanity, it will price its drugs reasonably. If it is more interested in profits, then it will price-gouge the patients.

### *U.S. private health insurance industry*

How does the United States' system of private health insurance decrease the pool of money that health systems can work with? In the simplest terms it acts as a middle man between health systems and patients. These middle men employ their own processes and their own workers, which require their own sets of costs. The money needed to cover these costs could instead be utilized by health systems for patient care. Public payers (Medicare and Medicaid) generate funds through taxes. Private payers generate funds through premiums that they charge the members of their risk pool.

There is an argument to be made that our system of health insurance drives down health costs for consumers. Insurance providers hold negotiating power with healthcare systems because they provide hospitals with the majority of their business. Insurance provider's influence on pricing increases with the number of their patients that are treated in a particular setting. A 2017 study in JAMA Internal Medicine found that uninsured patients were typically paying rates 4.2 times higher for emergency department (ED) services, though some hospitals were charging nearly 12.6 times as much (19). However, this phenomenon is not the case with all hospitals. Many hospitals employ a practice called "cross-subsidization". Through cross-subsidization, hospitals compensate for decreased revenue from indigent care and patients with public insurance by charging patients with private health insurance more. In this sense, in our current system, private health insurance subsidizes the cost of charity and public care (20).

Needless to say, our current system of private health insurance has created an overly complicated bureaucracy and set of administrative processes which have led to inefficiencies arising in the system. Unfortunately, we can only identify those inefficiencies once someone takes the time to study and identify them. One such inefficiency is the concept of "in-network" and "out-of-network" billing. "In-

network" includes all of the healthcare systems and providers covered in a person's health insurance plan. "Out-of-network" includes everything else. However, an inefficiency arises when an out-of-network provider works at an in-network setting. Because, when a patient goes to the hospital, his/her concern is not whether he/she is being treated by an in-network physician. He/she just wants his/her life to be saved. The study found that, between 2010 and 2016, the percentage of ED visits with an out-of-network bill increased from 32.3% to 42.8% and the mean potential financial responsibility for these bills increased from \$220 to \$628. Similarly, the percentage of inpatient admissions with an out-of-network bill increased from 26.4% to 42.0% and the mean potential financial responsibility increased from \$804 to \$2,040 (21).

2019 saw significant increases in health insurance premiums. Analysis by the American Academy of Actuaries has attributed these increases mainly to the federal government's weakening of the Affordable Care Act and toughening of Medicaid eligibility requirements:

- (I) As required by the Affordable Care Act, the federal government had been paying subsidies to individual marketplace insurers in an effort to keep premiums low. These payments were discontinued in October 2017.
- (II) The federal government eliminated the individual mandate penalty. The individual mandate was a tax penalty which people who didn't purchase health insurance had to pay. Without the individual mandate, healthy members of the health insurance pool left, shifting the financial burden onto sicker members.
- (III) The federal government has been promoting short-term duration plans with high deductibles. These plans are outside the regulations put in place by the Affordable Care Act.
- (IV) Many states have opted to strengthen Medicaid work requirements, thus decreasing Medicaid eligibility and the pool of patients covered by Medicaid (22).

According to the 2020 Large Employer's Health Care Strategy and Plan Design Survey by the National Business Group on Health (NBGH), the aforementioned premium increases have led to increased financial burdens on employers, employees and dependents. Large companies estimate that their total cost of health care for employees and dependents will increase from \$14,642 per employee to \$15,375 per employee by 2020 (23). In addition, healthcare spending has outpaced wage increases over the past decade, with premium increases (55%) nearly doubling gains in employee earnings (26%) (24).



### *U.S. healthcare's reliance on financial buyouts and M&A*

Medical neoliberalism and increased commodification of healthcare delivery has left many systems in financially precarious positions. Consequently, healthcare systems have resorted to whatever means they could to remain financially solvent. Mainly, they have relied on mergers and acquisitions (M&A) and financial buyouts.

Private equity firms have taken an interest in the healthcare sector because it's considered to be a "recession resistant" field. Even when the economy is doing poorly, people still need to take care of their health. In addition to this, an aging population and increased prevalence of chronic diseases, have also led to increased demand for healthcare services. Between 2010 and 2017, the value of private equity deals involving a healthcare-related company increased 187% and totaled \$42.6 billion. Private equity firms have taken the most interest in specialties which generate the most revenue such as dermatology, ophthalmology, orthopedics, gastroenterology, urology and allergy. For example, though dermatologists only comprise 1% of physicians in the United States, around 15% of more than 200 medical-practice acquisitions by the private equity sector in 2015 and 2016 were of dermatology practices (25).

Struggling health systems have also relied on mergers with larger hospital chains in order to stay afloat. By 2017, approximately two-thirds of hospitals in the U.S. had been acquired by chains (26).

### *Concerning hospital system billing practices*

Though health systems have gotten the short end of the stick due to medical neoliberalism and increased commodification of healthcare delivery, they by no means are immune to the allure of predatory financial practices. The Health Care Cost Institute had analyzed emergency room prices from 2008–2017 and found that the average cost of emergency room entry (for just walking through the door) cost \$1,389 and that it had increased 176% over the decade. This figure did not include the cost of actual provision care. In addition to this, doctors often opted to bill for more complex care in order to collect higher fees. In 2008, 17% of hospital visits were charged the most expensive code. In 2017, this became 27%. The average price for the most expensive code increased to \$1,895 from \$754 over the same time period (27).

The percentage of ED visits resulting in a surprise bill increased from 32.3% in 2010 to 42.8% in 2016 while the

increase in surprise billing for inpatient admissions went up from 26.3% to 42% over the same time period. The cost of the top 10% of ED visits resulted in a bill of more than \$1,000 and that of the top 10% on inpatient visits resulted in a bill of more than \$3,000 (21). Also, as mentioned previously in the insurance portion of this article, in 2017, services provided by emergency medicine physicians had an overall markup ratio of 4.4 (340% excess charges) while services provided by internal medicine physicians had an overall markup ratio of 2.1 (110% excess charges). Higher ED markup ratios were associated with for-profit ownership (19).

Laser-guided focus on bottom-line profits also has negative implications for indigent care. Hospitals have been known to sue indigent patients for unpaid bills, garnish their wages and even put liens on their property. A 2017 case study among Virginia hospitals showed that 48 of 135 Virginia hospitals (36%) conducted garnishment. Despite a mean annual gross revenue of \$806 million, these hospitals still pursued garnishments amounting to \$722,342 (0.1% of gross revenue). The mean amount garnished per patient was \$2,783.15 (range, \$24.80–\$25,000). Garnishments were more likely among non-profit hospitals and those with higher markup ratios relative to Medicare rates (28).

### *Negative consequences of profit-driven streamlining*

With for-profit ownership of healthcare systems comes a newfound emphasis on profitability. For-profit systems have investors and, if publicly traded, have shareholders. Because of this, for-profit systems have a fiduciary duty, by law, to create a return on investment. Hospital leadership may pursue organizational restructuring with this in mind. In particular, leadership may enact:

- (I) Means of employee tracking (such as electronic time-cards);
- (II) Push employees to increase patient turnover;
- (III) Influence employees to increase production numbers for procedures;
- (IV) Prescribe/sell costlier products;
- (V) Use higher reimbursement insurance billing codes and
- (VI) Influence employees to refer patients to internal affiliated specialists and technicians.

These phenomena have been particularly apparent in healthcare systems owned by private equity companies (25). The increased stress on physicians to produce can be attributed to increased incidence of physician burnout. An analysis published in the *Annals of Internal Medicine* estimates the cost of physician burnout to be \$4.6 billion.

This is a conservative estimate that includes:

- (I) Decreased revenue when physicians reduce their hours;
- (II) Having to advertise vacancies and
- (III) Having to train replacements.

The study did not include measures such as:

- (I) The cost of mental healthcare;
- (II) Malpractice costs and
- (III) Patient care quality (29).

For-profit leadership may opt to emphasize on more profitable departments (mentioned earlier) and downsize employees that it views as inessential. With the country's aforementioned physician shortage, there has been a demand in particular for physician-independent healthcare practitioners [nurse practitioners (NP) and physician's assistants (PA)]. It is also true that NP and PA wages are not as high as a physician's. This factor may lead to physician downsizing and increased reliance on NPs and PAs in unsupervised settings (25).

The fiduciary motives of for-profit systems might conflict with patient care quality as well. For example, a recent JAMA study shows that the likelihood that renal failure patients will get on a kidney transplant list is lower at for-profit facilities than it is at nonprofit facilities (30). The study attributes this to there being no financial incentives for dialysis providers to refer patients for kidney transplant. In fact, one could argue that there is plenty of incentive for for-profit dialysis centers not to refer their patients for kidney transplant in order to keep them on dialysis and continue to charge the patients a commission.

Finally, if for-profit ownership cannot make their for-profit healthcare business profitable, it may opt to cannibalize the entity and sell it for parts. The means by which for-profit entities extract value from their acquisitions vary from case-by-case. Private equity companies have been known to take out debt in the business' name and keep it for themselves while the business suffers. In the case of Hahnemann University Hospital in Philadelphia, the hospital was shuttered and ownership planned to sell the property as real estate (31).

### *Monopolization of care delivery*

When it comes to healthcare M&A, concerns over development of monopolies understandably arise. The most obvious concerns pertain to quality care delivery and pricing. A 2015 article published by the Healthcare Pricing Project showed that prices at monopoly hospitals were 12% higher than those in markets with four or more rivals. Also,

through examining 366 mergers between 2007 and 2011, it found that prices rose over 6% when merging hospitals were geographically close (32).

Another 2017 article published in the journal, Health Affairs, showed that most increases in physician practice size and market concentration resulted from numerous small transactions rather than one large transaction. Only 28% of these mergers contained any individual acquisition that would be considered anticompetitive under federal merger guidelines. Also, federal regulations require notification to anti-monopoly authorities at the Federal Trade Commission only for mergers worth greater than \$80 million. Most of these acquisitions were under this dollar amount, leaving federal authorities limited ability to address consolidation in healthcare markets (33).

In the case of the healthcare industry, monopolies were born out of the financial need of struggling health systems to stay afloat. However, if the practice of healthcare systems is deemed by federal authorities to be exclusionary or predatory, there may be grounds for legal action. These practices include:

- (I) Formation of exclusive supply agreements which prevent suppliers from selling to different buyers;
- (II) Tying the sale of a second product to another more successful product;
- (III) Predatory pricing and
- (IV) Using market dominance to influence who partners do business with (refusal to deal) (34).

## **Discussion**

The U.S. healthcare industry is multifaceted and has a lot of moving pieces, which have highly complex interactions. It would still be very complex even if its privatized aspects were removed. As things stand now:

- (I) The exorbitant pricing of the private health insurance and biopharmaceutical industry is siphoning off healthcare dollars which could be used by hospital systems to treat patients. This exorbitant pricing is the direct result of a desire to maximize return on investment and a lack of governmental regulation.
- (II) Because of the precarious financial situation many healthcare systems are in, they too may resort to exploitative means in order to maintain bottom-line profits. Not only do these means come at the expense of the patients; healthcare employees suffer as well.
- (III) All of this has led to the undeniable reality of

dwindling access to primary care and declining health among the U.S. population.

There are no easy fixes to these issues. However, if we as a nation do ever hope to turn around the direction in which the state of U.S. healthcare is headed, medical advocacy groups must be motivated to action in order to create awareness around issues of medical neoliberalism. Furthermore, though many of our elected officials will be hesitant to act, they must be convinced that the needs of the public good outweigh the financial overreaches by private industry.

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