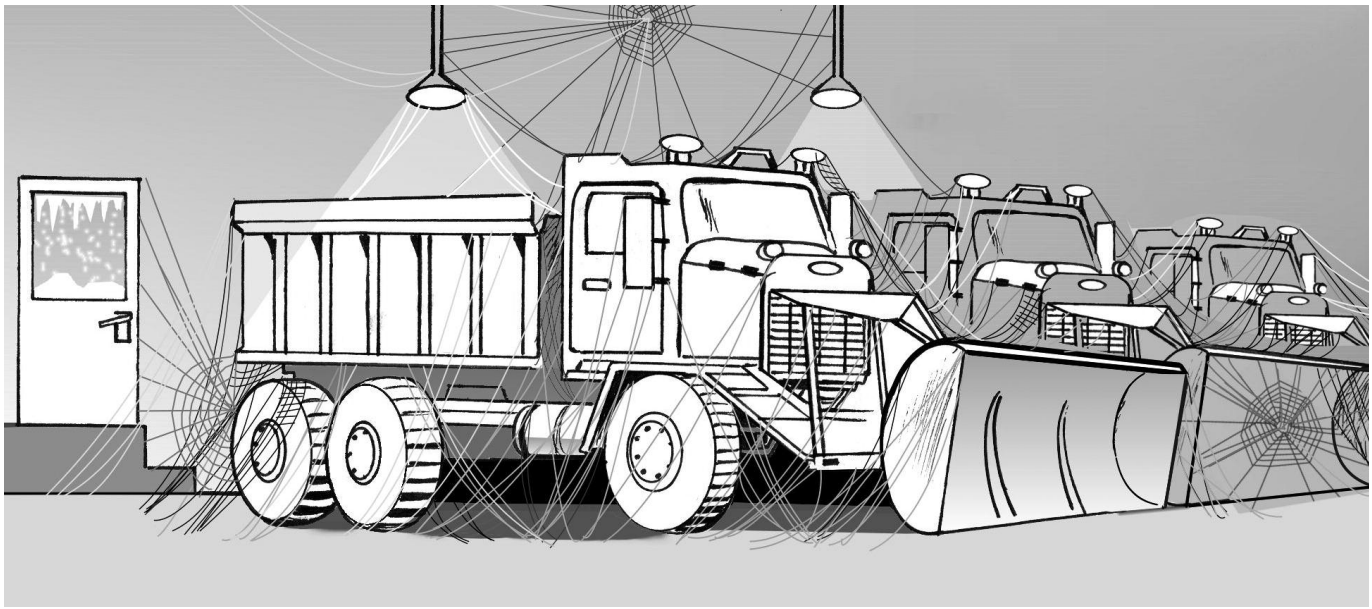
When DC Freezes Over

By Ike Brannon

Following Washington's record-breaking series of snowstorms last winter, commentators across the board groused about the city's inability to clear 20 inches of snow within hours of the first flake. Some argued that the city and surrounding suburbs should ramp up their spending on snow-removal equipment, claiming that such spending would more than pay for itself in increased economic activity from workers returning to work faster following future snowstorms.



KEVIN TUMA

Steven Pearlstein of the *Washington Post*, for one, suggested that local governments increase taxes by $50 million a year, with the money going to more plows and salt spreaders. With such a surfeit of equipment, Pearlstein said, District mayor Adrian Fenty and his cohorts could then pledge to clear all streets of snow within 24 hours of the next storm, regardless of its wrath.

But such a promise would never be kept, and should not be made. The current situation is about as good as it is likely to get — and that ain't bad. Suppose Mayor Fenty, who is up for re-election this year, adopted Pearlstein's proposal and the city's residents acquiesced to the plan. If Fenty is a rational politician (and he appears to be so, despite his penchant for angering almost everyone he encounters), he would have no incentive to spend a dime of this additional revenue on snow removal equipment. What hit the District was a once-in-a-century weather phenomenon (literally — the last snowstorm of such magnitude occurred in the 19th century) and the odds are exceedingly slim that a series of similarly massive storms will occur next year or anytime before the city's next several mayoral elections. The city *has* proven itself capable of clearing the streets in a timely manner after the typical worst-of-season five- or six-inch snowstorm — a tremendous improvement over the days when Marion Berry occupied the mayor's office and the city's method for removing snow was called "spring."

> The city has proven itself capable of clearing the streets in a timely manner after the typical worst-of-season snowstorm.

Spending the additional $50 million a year on snowplows and salt spreaders would buy the mayor no political goodwill other than (maybe) to insulate him from criticism were the city to be struck by another once-a-century storm. Accordingly, any politician worth his salt would use the new revenue to reward friends, smite opponents, and satisfy other political constituencies, rather than buy equipment that would sit largely unused until it depreciated into dust.

Insuring against any such extremely rare event is problematic for *any* entity, public or private. The recent financial crisis was to a large degree the result of AIG's struggling with an unprecedented decline in home prices, against which it in effect offered insurance to various investment banks. AIG eventually stopped investing the revenue it received from its credit default swap contracts so as to make sure it would have sufficient funds to meet its obligations in case home prices collapsed. Unfortunately, it parked the money in other turbo-charged investments that were also likely to tank in the event that home prices were to collapse, which is precisely what happened.

Similarly, a government that increased taxes to prepare for an exceedingly rare snowstorm would quickly forget its promises and spend the money elsewhere. What was the cost to AIG execu-

Ike Brannon is an economist in Washington, DC.

tives for their dereliction? Any stock they owned in the company evaporated and most of the senior execs lost their jobs — harsh, but most will manage to scratch out a living. For Adrian Fenty, being caught unprepared for a second mega-blizzard would cost him re-election in four years time — maybe. Again, no big deal.

Governments pretend to dedicate new revenue streams to specific purposes all the time, and usually to no avail. Most states sold their citizenry on lotteries by promising to use the money generated to fund education. Untold governments have pledged higher tobacco taxes to smoking cessation and the treatment of tobacco-related illnesses, but almost without exception spending on those programs goes up much less than the revenue that comes in. The powers-that-be explain away such differences — if they are forced to — by saying that while all the new money does indeed go to schools or smoking cessation or drug rehab or pre-K, some of the other dollars that had been going to those programs got redirected elsewhere. Of course these are ruses — no one cares exactly which dollars go to what project, only how much money is spent overall.

Governments should certainly spend money to prepare for real disasters. The blizzards of 2010, though they inconvenienced practically everyone in the region, did not qualify as a disaster in any sense of the word. Soon after the storms ended, the streets were plowed, Metro Rail returned to its usual state of dysfunction, and life got back to normal with little lost but a few days of work. Let us not pretend that a munificent government can — or would — prevent another such occurrence if only it had more of taxpayers' money. R

A Tale of Two Doctors

By Erwin A. Blackstone
Temple University

A common lament among health care policy analysts is that physicians hold considerable political and economic power. In saying this, these analysts are usually referring to doctors of allopathic medicine — what are commonly referred to as MDs. But there is another group of physicians that, though smaller and less well known, sometimes serves as a check on MDs and their powerful American Medical Association. Doctors of osteopathic medicine, DOs, are fully licensed in all states to practice medicine and surgery. These physicians are like MDs in that they employ all healing modalities. In 2004, DOs comprised about 6 percent of all physicians, up from 4 percent in 1970. This article examines the substantial benefits society derives from having a small competitor that helps constrain the power of organized allopathic medicine.

Erwin A. Blackstone is professor of economics at Temple University.

Background Osteopathy was founded by Andrew Still in the years following the U.S. Civil War. Still lost three of his children to spinal meningitis and, as a result, had become sharply critical of conventional allopathic medicine. He theorized that many diseases were the product of structural deficiencies around the joints — an idea that seems naïve today, but that sparked osteopathic medicine's attention to the body's movements and manipulation of the joints.

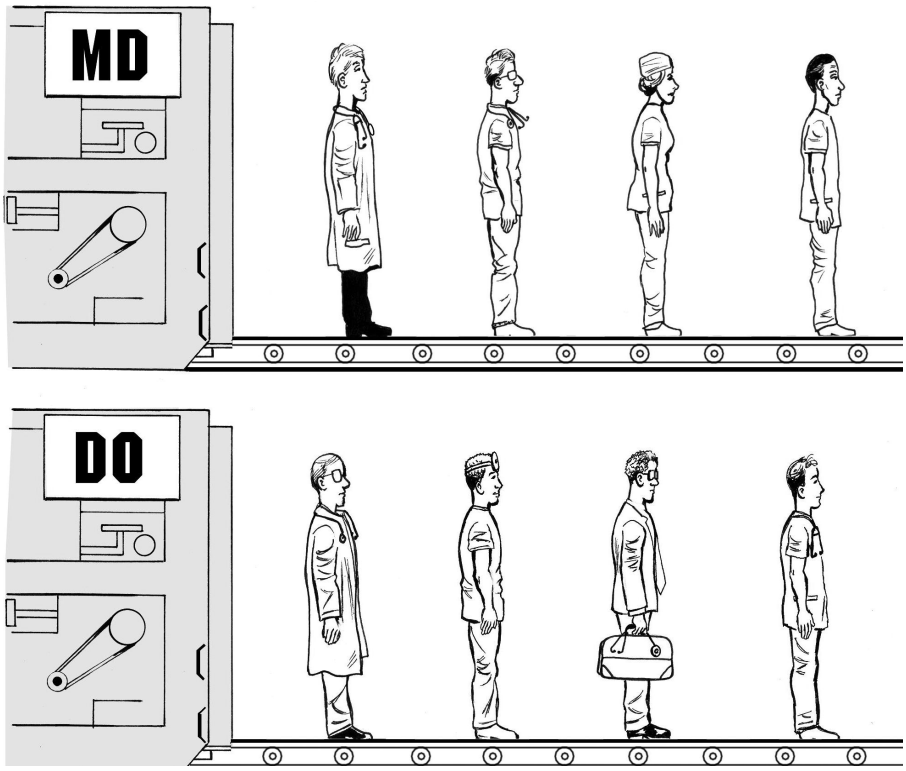
The first osteopathic medical school was established in Kirhsville, MO in 1894, and by 1900 11 other schools had opened. The formation of the American Osteopathic Association in 1897 and the 1910 Flexner Report on the state of medicine in the United States led to the gradual improvement in the education of osteopathic physicians and the closing of some schools. By 1940, osteopathic education in its six schools was comparable to that of MD education, except for osteopaths' additional training in osteopathic manipulation. By 1956, 36 states provided DOs unlimited licenses to practice medicine and surgery. In 1973, osteopathic physicians gained unlimited practice rights in all 50 states and were, in all important aspects, full competitors to MDs.

Such gains were made in spite of substantial opposition from the AMA and other allopathic organizations, which labeled osteopaths as "cultists." Allopathic medicine tried to prevent DO licensure, prevent DOs from practicing in allopathic hospitals (which led to osteopaths developing their own hospital system), keep them from serving as military doctors, and deny them insurance reimbursement, among other policies. In 1961, allopathic medicine even used the technique of merger to stymie osteopathy, as the California DOs merged with their MD counterparts and the California osteopathic medical school became an MD school.

Benefits of Duopoly DOs, like many small firms that challenge the dominance of a much larger firm, have historically attempted to fill niches in the market left unexploited by allopathic medicine. In the 1960s and 1970s, when MDs largely became specialists and relatively few entered general (later termed "family") practice, DOs helped fill the market void. As an example from the city where I teach, in 1975, 82 percent of Philadelphia's DOs were generalists, as compared to only 40 percent of its MDs.

In the latter part of the 20th century, osteopathic medicine entered into rural and small-town practice, which had been largely vacated by allopaths. In 1979, 39 percent of DOs practiced in communities with populations of less than 20,000. DOs also tended to practice in inner-city areas to a greater extent than did MDs. For example, in 1970, 22 percent of the 3,000 physicians practicing in metropolitan Philadelphia were DOs, but 37 percent of those practicing in inner-city West Philadelphia were DOs.

DOs have served to counter the dominance of MDs with respect to dealing with insurance companies and other third-party payers, including the government. For example, when, in 1973, the allopathic New Jersey Medical Soci-



KEVIN TUMA

ety recommended withdrawing support from the state's Medicaid program in response to a 10 percent reduction of Medicaid fees, the New Jersey Association of Osteopathic Physicians, in spite of its displeasure with the fee cut, indicated that its members would still serve Medicaid clients.

DOs have also supported some health care legislation that organized allopathic medicine opposed. For example, in 1961 the AMA opposed government provision of health care for the elderly (what eventually would become the Medicare program) while the AOA supported the bill. DOs have also been among the leaders in promoting continuing education. For example, in 1967, at the urging of organized osteopathy, 12 states required continuing education for DOs as a condition for re-licensing, but no state did so for MDs. MDs ultimately were forced to follow suit, so that by 1978, 19 states required such continuing education. Further, when discrimination in the 1930s and 1940s prevented many Jewish applicants from becoming MDs, many chose to become DOs. Jewish enrollment in osteopathic medical schools increased from 9.1 percent to 20.3 percent between 1935 and 1946, largely attributable to their being discriminated against in admission to MD schools.

DOs have provided consumers with doctors that emphasize the whole patient and provide manipulative therapy for some ailments. They have also helped to counter the "conspiracy of silence" for medical malpractice by, on occasion, being willing to testify against MDs. Of course, such willingness to testify may decrease as DOs and MDs increasingly work together in practices and hospitals.

Restricting Doctors The principal benefit DOs have provided society, and the reason why, in the past, organized allopathic medicine attempted — albeit unsuccessfully — to curtail DOs, is their ability to expand their numbers when MDs have attempted to restrict their own supply. As in the case of filling a niche, output restrictions by MDs provide an opportunity for DO expansion. The experience of the 1980–2005 period is instructive.

MDs in 1976 were concerned about a supposedly impending physician surplus. In the previous 10 years, the number of allopathic medical schools had grown from 85 to 126, and their graduates increased from 7,081 to 15,113. The Graduate Medical Education National Advisory Committee determined that a large surplus of physicians would occur and recommended limiting medical school output and restricting foreign medical entrants into the United States. The growth of managed care that reduced use of physician services, along with the rapid expansion in medical school graduates during the 1965–1975 period, fueled organized allopathic medicine's concerns of an impending physicians surplus. In any event, organized allopathic medicine in the form of the Council on Graduate Medical Education issued reports in 1992 and 1998 warning of the potential surplus.

> The principal benefit DOs provide is their ability to expand their numbers when MDs have attempted to restrict their own supply.

Organized allopathic medicine in the form of the College of Physicians recommended in 1998 that no new allopathic or osteopathic medical schools be created, and that their enrollment not increase. The group noted that "voluntary efforts by allopathic medical schools in the United States have been largely successful in keeping first-year enrollment relatively constant at about 17,000 students." However, the group added with chagrin, first-year osteopathic enrollment grew from 1,724 in 1986–1987 to 2,535 in 1995–1996, and the number of osteopathic medical schools increased from 15 to 19. The group reiterated its position in 2000, even calling for a reduction in total medical school enrollment (allopathic and osteopathic), and for no net increase in the number of osteopathic and allopathic medical schools.

The osteopathic group is outside the control of organized allopathic medicine and, like other small competitors, will often exploit the opportunity to increase its output. Organized allopathic medicine's statements reflect its inability to prevent osteopathic expansion in the face of allopathic restriction. Allopathics'

frustration with this predicament is reflected by this comment from a position paper: "Thus while U.S. Allopathic schools responded to public policy concerns about producing too many physicians, the growth in osteopathic medical school graduates and [international medical graduates] worked to counter efforts aimed at limiting the number of physicians produced in the country." Organized allopathic medicine also encouraged restricting the number of residency positions for post-doctorial training that were funded by Medicare, a goal that was largely achieved in 1997.

Fortunately, the new century has brought allopathic medicine's acknowledgement that a physician surplus is not occurring. In fact, there is evidence of shortages in some medical fields. In addition, patients have been experiencing difficulty finding physicians who will accept new patients, wait times for appointments are increasing, 30 percent of physicians are not accepting Medicaid patients, and some patients are paying a premium to assure sufficient access to physicians under the new concept of "boutique" or "concierge" medicine. Indeed, the American Association of Medical Schools in 2005 recommended that U.S. medical schools increase their enrollment by 15 percent by 2015.

It is noteworthy that the relative growth in osteopathic medicine is continuing. In 2007, for example, there were 28 osteopathic medical schools educating 20 percent of U.S. medical students. The number of osteopathic physicians is expected to double between 2002 and 2020, growing from about 49,000 to 95,000. Had osteopathy not increased its output, the doctor shortage would have been much greater, again suggesting the advantage provided by competition in the medical field.

Conclusion A small competitor has a clear desire and interest to expand, so as to secure and strengthen its position. Osteopathic medical schools (the majority of which are private) rely heavily upon tuition as a source of revenue. Private osteopathic schools in 1995 derived 70 percent of their revenues from tuition and fees, compared to only 6 percent for private MD schools. Increasing enrollments add to the osteopathic schools' revenues and surplus. In fiscal 2003 for example, private osteopathic schools enjoyed a 10.9 increase of revenues over expenditures and transfers.

There are substantial benefits from duopolistic rivalry. Even a small competitor can greatly help to check the power of a much larger, dominant firm. R

Readings

- "Competition within the Physicians' Services Industry," by Erwin A. Blackstone. *American Journal of Law and Medicine*, Vol. 8, No. 2 (Summer 1982).
- "The AMA and the Osteopathic: A Study of the Power of Organized Medicine," by Erwin A. Blackstone. *Antitrust Bulletin*, Vol. 22, No. 2 (Summer 1977).
- "The Medical Monopoly: Protecting Consumers or Limiting Competition?" by Sue A. Blevins. *Cato Policy Analysis* #246 (December 15, 1995).
- "Weighing the Evidence for Expanding Physician Supply," by R. A. Cooper. *Annals of Internal Medicine*, Vol. 141 (2004).