Rise of US Health Care & Redistribution of Income & Wealth

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Health and Wealth

● Rise of US health care led to new and affluent class
  ○ Substantial shift in resources toward health care since early 20th century
  ○ High levels of protection
    ■ Monopoly power
    ■ Occupational licensure
    ■ Asymmetric information
Licensure Very Widespread in Healthcare

**FIGURE 14A.**
Licensed Share of Workers, by Occupation

**FIGURE 14B.**
Differences in Likelihood of Moving for Licensed and Certified Workers

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Source: BLS 2016–17; authors’ calculations.
Note: Sample is restricted to workers age 25 to 64. We define workers as licensed only if their government-issued credential is required for their job.
Healthcare as Share of US GDP
United States is an Outlier
Origins of Health Care

Neolithic humans engaged in trepidation

- Global phenomenon
- Relieve pressure and ritualistic
- Finds date back 7,000 years
Origins of Health Care

- Ancient Egypt
  - Mummification
  - Sutures
  - Dentistry
  - Nile River for cleaning
  - Antiseptics: copper, salts, honey, grease
  - Adhesive bandages
Origins of Health Care

- Ancient Greece
  - Medical Legacy
  - Humorism: air, water, earth & fire
  - Hippocrates: Father of Western Medicine
  - Galen
Health Care in the Middle Ages

- Byzantine Empire
  - Hospitals developed
  - Black Death

- Islamic Medicine
  - Integrated knowledge
  - Blood circulation
  - Ophthalmology
  - Poppy extracts for pain
  - Eye surgery
  - Avicenna
  - Al-Nafis
Evolution of America’s Healthcare Professions
Flexner Report of 1910

- Problems within medical schools across the country
  - Quality of education not standardized
  - Lack of inquiry
  - Failure to focus on professional identity
- Requirements
  - Entrance requirements
  - Size and training of the faculty
  - Size of endowment and tuition
  - Quality of laboratories
  - Availability of a teaching hospital whose physicians and surgeons would serve as clinical teachers
Flexner Report of 1910

- John Hopkins Medical school selected as model
- Majority of medical schools eventually shut down
- Adversely effecting less wealthy institutions
North Carolina Medical College

- Criticized for inadequate facilities in 1910
- Unable or unwilling to upgrade to the Carnegie standards
- Closed in 1914
- Students transferred to Medical College of Virginia
- Building became luxury apartments
Flexner Report of 1910: Black Medical Schools

- Howard University Medical School, est. 1868 Washington, DC
- Meharry Medical College, est. 1876 Nashville, TN
- Leonard Medical School (Shaw University), 1882-1914 Raleigh, NC
- New Orleans University Medical College, 1887-1911 New Orleans, LA
  - Renamed Flint Medical College
- Knoxville College Medical Department, 1895-1900 Knoxville, TN
  - Became Knoxville Medical College in 1900 and closed in 1910
- Chattanooga National Medical College, 1902-1908 Chattanooga, TN
- University of West Tennessee College of Physicians and Surgeons, 1904-1923 Memphis, TN
The Healthcare Class
Top 1% by Occupation

Detailed industries with most top 1% earners, sorted by percentage in top 1%

- Offices of physicians: 7% share, 8% percent in top 1%
- Hospitals: 2% share, 7% percent in top 1%
- Legal services: 2% share, 7% percent in top 1%
- Securities and financial investments: 6% share, 8% percent in top 1%
- Management and related services: 4% share, 5% percent in top 1%
- Insurance: 2% share, 3% percent in top 1%
- Computer systems design: 2% share, 3% percent in top 1%
- Real estate: 2% share, 3% percent in top 1%
- Banking and related activities: 2% share, 2% percent in top 1%
- Colleges and universities: 1% share, 2% percent in top 1%
- Offices of dentists: 2% share, 2% percent in top 1%
- Accounting and related services: 2% share, 3% percent in top 1%

Source: Author's analysis of IPUMS-USA, University of Minnesota.
Annual mean wages for selected healthcare occupations, May 2017

Data from US Bureau of Labor Statistics
Income Inequality

Wealth Inequality


Note: 2016 dollars.
Rise of Healthcare Class, Inequality and Policy

- What can be done?
  - Address licensure
    - Reciprocal state agreements
    - Expanded scope of practice
    - More use of certification
    - Federal engagement with states
  - Address educational bottlenecks
  - Consumer-driven health care
  - Ease Corporate Practice of Medicine control to facilitate disruptive and productivity enhancing technology