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THE HIPPOCRATIC MYTH

WHY DOCTORS ARE UNDER PRESSURE TO RATION CARE, PRACTICE POLITICS, AND COMPROMISE THEIR PROMISE TO HEAL

M. GREGG BLOCHE (Palgrave-Macmillan, Basingstoke, Hampshire, United Kingdom, 2011), 272 pages, \$27.00.

*Reviewed by Frank Pasquale, J.D., M. Phil., Newark, New Jersey.**

THE HIPPOCRATIC MATH: HOW MUCH SHOULD SOCIETY SPEND ON HEALTH CARE?

How does American society address the vulnerability of the body? We rarely stop to think about how quickly a disease or accident can derail even the best of lives. For the hundreds of millions of people who live on a few dollars a day, medical care is rare and haphazard. The United States has gradually put in place a vast infrastructure of law and institutions designed to provide its citizens with quality, affordable, and accessible care. The proper limits of such care are hard to discern. Gregg Bloche's book *The Hippocratic Myth* gives some excellent examples to reflect upon as the Affordable Care Act slowly begins to influence the health care delivery system.

Not many policymakers or scholars can write with the authority of Gregg Bloche. Bloche is not only a law professor, but a physician, who knows his way around a hospital. Throughout *The Hippocratic Myth*, Bloche cements his authority in the mind of the reader by relating stories of his experience as a clinician. In each of these stories, his humane and insightful approach as psychiatrist shines through. I do not say this to imply that Bloche uses his book to brag about his own abilities. Rather, these fluently-written passages strike one as the work of one of those rare practitioners who manages to care deeply about the patient at hand while simultaneously contextualizing the encounter in a larger framework. Thus *The Hippocratic Myth* should take its

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place among other well-received books by physicians with a sense of the big picture, including Atul Gawande's *The Checklist Manifesto* and *Better* and Jerome Groopman's *How Doctors Think*.¹

In *The Hippocratic Myth*, Bloche leverages this authority to advocate for a more cost sensitive health care system, where individuals frankly acknowledge that they should expect trade-offs between cost and access to certain forms of care. My concern in this review is that Bloche the caring and expert physician would have a tough time in a health care world too deeply influenced by Bloche the cost-conscious author. To be sure, Bloche consciously shies away from proposing particular limits to care, and sets forth a surprisingly wide array of topics his work will not cover:

What does it take to make a health plan's cost-benefit balancing principles so vivid and clear to consumers when they sign up that we can say they have consciously chosen to abide by them? Should the health plans be required by law to adopt a single, shared way of declaring their trade-off policies—say, maximum dollar amount per expected life-year that they'll spend on tests and treatments? How about a checklist of representative services, ranging from urgent care services to screening tests, that are or aren't covered? And how much choice between health plans (and trade-off rules) is enough to make for a decent menu of options? Finally, what should be done about disparities in wealth? Is there a decent minimum of buying power (and public subsidies) below which real choice between trade-off rules isn't possible? These are matters of policy and politics, beyond my scope in this book. But they'll need to become the focus of public attention, leading to agreements, if we are to enlist the nation's support for limit setting by health plans and their doctors. [107]²

Nevertheless, it is clear throughout the book that Bloche is deeply concerned about cutting costs. The question is whether we can, in good conscience, rally behind his crusade for cuts based on individual choices without coalescing beforehand on the types of specific mechanisms or redistributive measures that would cushion the blow of a transition to more restrictions on care in America's comparatively market oriented healthcare system.³

MRS. PEARSON'S DIALYSIS APPOINTMENTS

Dialysis is a thorny issue in American health care. The United States guarantees payment for the vast majority of those with kidney failure in the United States. Robin Fields at ProPublica has exposed massive failings in our system: "the United States continues to have one of the industrialized world's highest mortality rates for dialysis care," even though the "two corporate

¹ ATUL GAWANDE, *THE CHECKLIST MANIFESTO* (2009); ATUL GAWANDE, *BETTER: A SURGEON'S NOTES ON PERFORMANCE* (2008); JEROME GROOPMAN, *HOW DOCTORS THINK* (2008).

² See also DANIEL CALLAHAN, *SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY 1* (2003).

³ Frank Pasquale, *Health Care Dilemma: Cost Control v. Profit Maximization*, CONCURRING OPINIONS (Feb. 10, 2008, 9:10AM), http://www.concurringopinions.com/archives/2008/02/health_care_cos.html.

chains that dominate the dialysis-care system are consistently profitable, together making about \$2 billion in operating profits a year.”⁴ Fields notes that, “if our system performed as well as Italy’s, or France’s, or Japan’s, thousands fewer patients would die each year.” Thus, dialysis has become for many a case study in both the pathologies of a profit driven health care system and the willful weakness of a national government that guarantees payment for care, but fails to ensure that it is high quality or up to international standards.

Few people realize how tiring and stressful life can be for those subject to dialysis sessions. In an excellent article on racial disparities in kidney transplants, Vanessa Grubbs discusses the travails of one dialysis patient she is close to:

The weekends were hardest for Robert. Without functioning kidneys, he struggled with limiting his liquid intake in the face of constant thirst. The stretch from late Friday morning to Monday morning, his longest time between [dialysis] sessions, was the worst. Without fail, Monday mornings I would wake to the sounds of Robert vomiting, even though he shut the bathroom door, ran the exhaust fan, and turned on the shower to drown out his retching as he prepared to leave for dialysis. His body was ridding itself of the excess fluid the only way it could.⁵

In Bloche’s book, we get another intimate look at dialysis, through the eyes of a Mrs. Pearson (a pseudonym), who has been undergoing the treatment for several years. Narrative matters in bioethics and health policy, and Bloche is a master at evoking critical details in Pearson’s story.⁶ Described as a “trim African-American woman in her late 50s,” Pearson decided at one point to discontinue dialysis. Her doctor called Bloche, a psychiatrist, to interview Pearson to assure that she was competent to make a decision that would result in her death within a few weeks. Bloche conducts a routine mental status exam, and quickly determines that Pearson is fully mentally competent to discontinue treatment. She states that she simply cannot continue to be jabbed with thick needles, often leading to painful wounds, to endure hours of blood filtration day after day. She is neither agitated nor depressed, but rather appears to be quietly resigned to the fatal consequences of giving up on the treatment. As Bloche observes:

From an ethical point of view, my duty was clear. If Mrs. Pearson grasped the stakes, and was alert and oriented, she had a right to refuse treatment. She passed these tests

⁴ Robin Fields, *In Dialysis, Life-Saving Care at Great Risk and Cost*, PROPUBLICA (Nov. 9, 2010, 8:00AM), <http://www.propublica.org/article/in-dialysis-life-saving-care-at-great-risk-and-cost>.

⁵ Vanessa Grubbs, *Good for Harvest Bad for Planting*, 26 HEALTH AFFAIRS 232 (2007), available at <http://content.healthaffairs.org/content/26/1/232.full>.

⁶ Frank Pasquale, *Why Narratives Do (and Should) Matter in Bioethics*, HEALTH REFORM WATCH (Mar. 10, 2011), <http://www.healthreformwatch.com/2011/03/10/why-narratives-do-and-should-matter-in-bioethics/>.

easily. The dialysis would have to stop. It was my job to write the note saying so. Without a competent patient's informed consent, no test or treatment is ethical—at least none more intrusive than a needlestick or Tylenol at bedtime. [98]

Bloche then adds the requisite note to Pearson's file. But he has lingering doubts about her decision, articulating his unease in a question—was her response to her predicament “too rational?” At first, this question reminded me of literature on the pathologization of shyness—do we need an emotional performance nowadays to generate evidence of a sound mind?⁷

But Bloche is the psychiatrist, not me, and it's a good thing he was in charge of this situation: his hunch panned out. In a follow-up interview, Bloche finds that a scheduling decision by the hospital sparked Pearson's desire to quit dialysis. She had been going during the day; they wanted her to come at night. Pearson felt powerless and angry. To Bloche, the decision to discontinue dialysis was the only way in which she could register a protest against authorities who were distant and arbitrary. Behind the scenes, Bloche arranges to keep the daytime scheduling, despite the extra costs it may incur. Pearson decided to continue the dialysis.

Here Bloche puts into action a conviction he had raised earlier in the book. It's worth quoting the context in full, to give a sense of the minefield of advocacy contemporary health policy encompasses.

That distrust, and the trials and humiliations that many experience when making their way through our health system, depresses the level and quality of the care that African-Americans receive. . . . [But] it's been urged that African-Americans and others who don't seek the best, life-prolonging care for themselves and their loved ones act irresponsibly and have themselves to blame. . . . Clark Havighurst, a retired law professor at Duke who was once Ronald Reagan's health policy advisor, complained to me that [those who complain about health disparities] missed the real unfairness: blacks who prefer less care pay the same insurance premiums as whites and thus subsidize whites' higher use of health services. The remedy, he told me, is cheaper health plans for those who want less care.

Whether clinical judgment should incorporate these purported African-American “preferences” for less care or aspire toward therapeutic equity is a political question. It's my belief that we owe black Americans—and members of other disadvantaged groups—an effort to address the fear and distrust that have led so many to miss out on life extending care and clinical relationships.⁸ [92-93]

Like Havighurst, other scholars at Duke have tried to demonstrate that minority groups may “prefer” to have less health care. But the empirical evidence they

⁷ Frank Pasquale, *The Market for Medicalization: Enhancing Evolution?*, CONCURRING OPINIONS (Oct. 29, 2007, 11:14AM), http://www.concurringopinions.com/archives/2007/10/the_market_for_1.html.

⁸ See also Elizabeth A. Jacobs et al., *Understanding African Americans' Views of the Trustworthiness of Physicians*, 21 J. GEN. INT. MED. 642 (2006).

adduce for this conclusion can be interpreted in many ways, as my colleague John Jacobi has demonstrated.⁹ Bloche is right to state that, given the endless series of studies documenting health disparities, the United States as a society owes underprivileged minorities special efforts to provide care, and to assure that choices are made in an informed way.

But Bloche chooses a strange locution for this call to justice. Whereas he has apodeictic certainty that health care costs must come down, he treats his commitment to equality as merely one “political” view. I believe that we can only engage in a constructive and just political debate about the overall level of health care spending after we have established a baseline commitment to a floor of care available to all. I have little faith that consumer choice of customized insurance plans will lead to such baseline commitments. Rather, I worry that “mini-med” and similar plans will flourish in such an environment, providing only an illusion of inclusion.¹⁰

BLOCHE ON RATIONING

Bloche’s approach to rationing will rekindle many of the health care debates of 2010. A former advisor to the Obama health policy team, Bloche opens the book with this diagnosis of what ails United States health care:

Medicine’s therapeutic potential has surpassed our ability to pay for it, but our elected officials are afraid to tell us. The historic health reforms enacted last year will protect 30 million Americans from the Darwinian cruelty of lack of access to care. But contrary to much wishful thinking in Washington, these reforms do little to stave off looming medical cost catastrophe. Our future fiscal and social stability will turn on our ability to gain control of spending without imperiling patients’ trust in their caregivers. [10]

Bloche believes that several obfuscating aspects of the current medical industry make this process difficult. For example, many insurers’ care protocols are kept secret, as proprietary information.¹¹ Insurers’ criteria for providing care are important aspects of the service they are providing. They should not be hidden from patients or doctors. Uwe Reinhardt has called hospital pricing “chaos behind a veil of secrecy.” And recently a shadowy “gray market” in drugs has taken advantage of shortages (and patient suffering) to gouge hospitals.

Each of these practices render suspect many consumer-directed ideals of medical care.¹² Yet Bloche seems committed to permitting consumers to

⁹ John Jacobi, *Getting Mental Health Coverage Wrong*, CONCURRING OPINIONS (Oct. 13, 2010 10:42AM), <http://www.concurringopinions.com/archives/2010/10/getting-mental-health-coverage-wrong.html>.

¹⁰ Frank Pasquale, *Mini-Med and the Hidden Backstop*, at <http://www.healthreformwatch.com/2010/12/01/mini-med-and-the-hidden-backstop/>.

¹¹ Frank Pasquale, *Restoring Transparency to Automated Authority* (Seton Hall Research Working Paper No. 2010-28, 2011), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1762766.

¹² Pooja Awatramani, *Holiday Shopping for Health Care*, HEALTH REFORM WATCH (Nov. 30, 2009), <http://www.healthreformwatch.com/category/consumer-directed-health-plans/>; Interview by Leonard Lopate

make enforceable contracts for lower levels of care. Many scholars have challenged to the wisdom and practicality of such decisionmaking. The ideals of consumer-directed health care contracting now resurgent as right-wing challenges to the PPACA would not be very wise for the unhealthy or unwealthy. Celebrated economist and *New York Times* columnist Tyler Cowen recently evoked that possibility of ala carte insurance in his evaluation of the recent Ryan care proposal:

Let's say it's 2027 and I've just turned 65. I fill out a Medicare application on-line and opt for a plan with superior heart coverage (my father died of a heart attack), not too much knee coverage and physical therapy (my job doesn't require heavy lifting), no cancer heroics (my mother turned them down and I wish to follow her example), and lots of long-term disability. Is that so terrible an approach? Is it obviously worse than having the Medicare Advisory Board make all of those choices for me?¹³

Cowen worries that “[p]erhaps an individual will choose ‘no coverage for lung cancer,’ but the government cannot credibly precommit to the outcome of no coverage.” But Bloche makes a point in an NPR interview that suggests that a physician’s decision to withhold care in that instance would not violate the Hippocratic Oath:

The rationale there is that the doctor who stints on care three years later when you get really sick is acting in accordance with your preferences as you expressed them in the employee benefits office three years before. And therefore, the doctor is not violating the Hippocratic Oath. The doctor is merely complying with your preferences when you rolled the dice in the employee benefits office.¹⁴

Of course, that is in the private insurance context, not Medicare, and I do not know if that distinction would make a difference for Bloche. But it does help me see how the book attracted a blurb from a Heritage Foundation analyst. Contemporary conservative health policy experts are committed to giving individuals the chance to buy low-cost plans, and so far the Obama Administration has been quite accommodating in granting waivers for them.¹⁵

with Maxwell Gregg Bloche (Apr. 7, 2011), available at <http://www.wnyc.org/shows/lopat/2011/apr/07/hippocratic-myth/>.

¹³ Tyler Cowen, *Choice-based Medicare Cost Controls*, MARGINAL REVOLUTION (Apr. 5, 2011, 7:26AM), <http://marginalrevolution.com/marginalrevolution/2011/04/choice-based-medicare-cost-controls.html>; An advisor to former Sen. Pete Domenici also brought up the possibility of vouchers for Medicare, so that an individual who “ran triathlons” at age 65 could buy a cheap health care plan, while a frailer person would choose to spend his entire voucher on insurance. As many cost estimates of the Paul Ryan Medicare plan have made clear, it is highly unlikely that a sick 65-year-old would be receiving a voucher capable of paying for benefits similar to what Medicare now guarantees.

¹⁴ Interview by NPR Staff with Maxwell Gregg Bloche (Mar. 16, 2011), available at <http://www.npr.org/2011/03/16/134568775/medicines-rising-costs-put-hippocratic-oath-at-risk>.

¹⁵ Timothy Noah, *Crap Health Coverage Wins a Regulatory Victory*, SLATE (Nov. 23, 2010, 6:40PM), <http://www.slate.com/id/2275877/>.

My sense is that Bloche is committed to a minimum essential benefits approach that would allow consumers to opt out of “cancer heroics” (perhaps defined as biotechnology drugs costing over \$7 million over one’s lifetime?), but not to waive “lung cancer” coverage generally.¹⁶ However, Bloche also says that such minimum benefits definitions are “beyond my scope in this book.”

In theory, Bloche appears much more concerned about transparent procedures, whatever the outcome, than defining such a social minimum.¹⁷ Though I hate to disagree with his eloquent statements on tragic choices, I am troubled by his prioritization of process over substance. Given our current political and economic system, is not money saved from the health sector just as likely to fuel new adventures in the Middle East or dot-com, housing, and commodities bubbles than it is to be allocated to more constructive ends? Health care is only one of many sectors where United States-style casino capitalism has seriously distorted capital allocation. Moreover, I see little evidence that cost-benefit analyses of a “bloated” health care sector take into account the long-term value of surge capacity in the case of public health emergencies, in areas ranging from hospital beds to vaccine and drug research capabilities.

I also believe that the invocation of “we” here glosses over the moral role of redistribution in an extremely unequal economy. A privately insured person who really wants a procedure can spend himself down to bankruptcy, and then apply for Medicaid. At that point, the government must make a decision. Given that “the government collected less in taxes in 2010 than it has in over three generations, and tax rates are at historic lows”¹⁸ for the very wealthy, I do not think it is entirely fair to say “we” cannot afford certain care. Rather, those at the top of the income and wealth scale are increasingly supporting politicians who will not tax the wealthy.¹⁹ The current scarcity of care for the least well off is not a natural feature of the world; rather, it is

¹⁶ Jessica Mantel, *Setting National Coverage Standards for Health Plans Under Healthcare Reform*, 58 UCLA L. REV. 221 (2010), available at <http://uclalawreview.org/pdf/58-1-4.pdf>.

¹⁷ *Id.* Bloche argues in the book that:

[M]edicine’s capabilities and costs will inexorably grow. Increasingly, doctors will need to say no to care that’s technologically possible and that could prolong life, but that does so in competition with other national priorities. We must empower them to do so even when the consequences seem tragic. But we must give them this power without asking them to break faith at the bedside. To this end, the current regime of covert rationing, under cover of ‘medical necessity,’ should be supplanted by visible resource allocation rules—rules set for doctors and patients by social institutions. . . . Transparency of this sort will compel us to come to terms the truth that insurers must say no to beneficial care to stay within the limits we impose when we seek low prices for products for products and services, elect politicians who promise low taxes, and choose cheaper health care plans for ourselves. [58-59]

¹⁸ Tamara Draut & Robert Hiltonsmith, *Trends in Revenue and the Fiscal Condition*, DEMOS (Oct. 22, 2010), <http://www.demos.org/publication/trends-revenue-and-fiscal-condition>.

¹⁹ Frank Pasquale, *Economic Policy for Worried Wealthy*, BALKINIZATION (Apr. 2, 2011), <http://balkin.blogspot.com/2011/04/economic-policy-for-worried-wealthy.html>.

epiphenomenal of repeated decisions not to impose certain tax burdens today even though they would have seemed perfectly fair 50 years ago. Since a “Wall Street transactions tax of only 0.50% on short-term speculation could raise up to \$170 billion annually,” I fail to see an imperative to reduce incomes in the health sector until rent-seeking in much less socially productive sectors is addressed.²⁰

On the other hand, if our government “of the top 1%, by the top 1%, for the top 1%” continues, major cuts to the health sector are inevitable.²¹ If they must come, we need trusted and fair voices like Bloche’s at the table. As Daniel Alpert has observed: “[T]he U.S. has engineered a winner-take-all economy and indebted both the majority of its people and its government to keep a ‘don’t tax, but spend anyway’ fantasy alive.”²² Bloche helps us face the difficult task of unwinding the consequences of those bad economic decisions.

Bloche is also admirably restrained in his sense of how much current law can do to rationalize health care spending. As he notes:

[One study estimated that only] about 10 to 20 percent of medical procedures rest on “gold-standard” evidence—randomized clinical trials. . . . Risky and pricey therapies routinely make their way into common use without such studies. . . . Change is looming. The 2010 health reform law created a “Patient-Centered Outcomes Research Institute,” funded by levies on Medicare and private insurers, to sponsor such research. But the funding level, less than a tenth of a percent of what Americans spend on health care each year, will do little to increase the fraction of medical decisions that rest on science. And the Institute’s governing body—composed mostly of representatives from the hospital, insurance, and drug and device industries, as well as physicians—seems almost designed to enable stakeholders to block studies that threaten their interests. Moreover, multiple provisions in the law (sought by providers and drug and device makers) hobble Medicare’s ability to base coverage decisions on research the Institute sponsors.²³ [50]

The mix of hope and realism in the paragraphs above reflects the judicious sensibility of the many Bloche articles I have had the good fortune to learn from.

Nevertheless, I want to raise a few more questions about his certainty regarding the need to cut costs overall, and to encourage writers following this line of thought to re-examine assumptions about where the saved money will

²⁰ Dean Baker, *The Benefits of Financial Transactions Tax*, CERP (2008), <http://www.cepr.net/documents/publications/financial-transactions-tax-2008-12.pdf>.

²¹ Joseph Stiglitz, *Of the 1%, by the 1%, for the 1%*, VANITY FAIR (May 2011), <http://www.vanityfair.com/society/features/2011/05/top-one-percent-201105>.

²² Daniel Alpert, *This Is Your Debt . . . This Is Your Income Distribution on Debt: Not Your Grandfather’s Economy*, ECONOMIC MONITOR (Apr. 14, 2011), <http://www.economicmonitor.com/danalperts2cents/2011/04/14/this-is-your-debtthis-is-your-income-distribution-on-debt-not-your-grandfathers-economy/>.

²³ See also David H. Freedman, *Lies, Damned Lies, and Medical Science*, THE ATLANTIC (Nov. 2010), <http://www.theatlantic.com/magazine/archive/2010/11/lies-damned-lies-and-medical-science/82692/?single.page=true>.

go. I am all for eliminating costly and ineffective procedures. On the other hand, I am extremely doubtful that health care cost savings are going to reach workers who are privately insured. Employers are likely to simply pocket the savings, and transfer it to top managers (and perhaps shareholders—again, not that egalitarian an option, as the bottom 80% of households only hold about 9% of stocks). There is a better case for saving taxpayers money, especially given how much of Medicare is financed via payroll taxes and premiums.²⁴ However, if the past decade is any guide, the savings may just be channeled to wars and tax cuts tilted to the wealthy. I do not know if these goals are any more meritorious than providing expensive placebos, particularly if the spending on such doubtful cures maintains an infrastructure of research and care that eventually generates breakthroughs.

WHY REDUCE HEALTH CARE COSTS?

Bloche shares and reinforces an elite United States consensus that the country needs to reduce health care costs. Frightening graphs expose America as a spendthrift outlier. Before he decamped to Citigroup, President Obama's OMB director warned about how important it was to "bend the cost curve." The President's opponents are even more passionate about austerity.

Journalists and academics support that political consensus. Andrew Sullivan calls health spending a "giant suck from the rest of the working economy."²⁵ Bloche estimates that "the 30% of health care spending that's wasted on worthless care" is "about the price of the \$700 billion mortgage bailout, squandered every year."²⁶ [54] He calls rising health spending an "existential challenge," menacing other "national priorities." Perhaps inspired by *Children of the Corn*,²⁷ George Mason economist Robin Hanson compares modern medicine to a voracious brat:

King Solomon famously threatened to cut a disputed baby in half, to expose the fake mother who would permit such a thing. The debate over medicine today is like that baby, but with disputants who won't fall for Solomon's trick. The left says markets won't ensure everyone gets enough of the precious medical baby. The right says governments produce a much inferior baby. I say: cut the baby in half, dollar-wise,

²⁴ Lawrence Solum, *Kaplan on the Medical Payroll Tax & Health Care Reform*, LEGAL THEORY BLOG (Aug. 16, 2011), <http://solum.typepad.com/legaltheory/2011/08/kaplan-on-the-medicare-payroll-tax-health-care-reform.html>.

²⁵ Andrew Sullivan, *Rationing One Way or Another* (Apr. 8, 2011, 10:29AM), <http://andrewsullivan.thedailybeast.com/2011/04/rationing-one-way-or-another.html>.

²⁶ See also Maggie Mahar, *The New York Times Attacks the Dartmouth Research Part 1*, HEALTH BEAT (June 3, 2010), <http://www.healthbeatblog.com/2010/06/the-new-york-times-attacks-the-dartmouth-research-part-1.html>.

²⁷ CHILDREN OF THE CORN (New World Pictures 1984).

and throw half away! Our “precious” medical baby is in fact a vast monster filling our great temple, whose feeding starves our people and future. Half a monster is plenty.²⁸

But is the overall level of health care spending really the most important threat facing the country? Is it one of the most important threats? There are many ways to raise revenue to pay for rising health costs.²⁹ Aspects of the Affordable Care Act, like ACOs and pilot projects, are designed to help root out unnecessary care.³⁰

I am happy to join the crusade against waste. But why focus on total health spending as particularly egregious or worrisome? Let’s explore some of the usual rationales.

Employment-based insurance gets favorable tax treatment, and much Medicare and Medicaid spending is drawn from general revenues.³¹ So, the story goes, medicine’s big spenders do not have enough “skin in the game.” Once health and wealth are traded off at the personal level (as the Harvard Business School’s Clayton Christensen advocates), people will be much less likely to demand so much care. Government can attend to other national priorities, or individuals will enjoy higher incomes and will be free to spend more.³²

I respect these arguments to a point, but I worry they partake of the “nirvana fallacy.” If I could be certain that leviathan would repurpose all those wasted health care dollars on infrastructure, or green energy, or smart defense, or healthier agriculture, I would be ready to end tax-advantaged health insurance in an instant.³³ But I find it hard to imagine Washington going in any of these directions presently.

Giving tax dollars back to “taxpayers” also sounds great, until one processes exactly how unequal our income distribution is. Almost half of

²⁸ Robin Hanson, *Cut Medicine in Half*, CATO-UNBOUND (Sept. 10, 2007), <http://www.cato-unbound.org/2007/09/10/robin-hanson/cut-medicine-in-half/>.

²⁹ Chuck Collins, *We Don’t Need to Shut Down the Government: Tax the Wealthy and Deadbeat Corporations to Close Budget Gaps*, ALTERNET (Apr. 7, 2011), <http://www.alternet.org/economy/150550/we-don%27t-need-to-shut-down-the-government-tax-the-wealthy-and-deadbeat-corporations-to-close-budget-gaps/>.

³⁰ Jordan Cohen, *It’s Not the “Shared Savings,” Stupid: Why ACOs Under the Proposed Rule Will Change Medicine as We Know It*, HEALTH REFORM WATCH (Apr. 17, 2011), <http://www.healthreformwatch.com/2011/04/17/its-not-the-shared-savings-stupid-why-acos-under-the-proposed-rule-will-change-medicine-as-we-know-it/>; Frank Pasquale, *Ending the Specialty Hospital Wars: A Plea for Pilot Programs as Information-Forcing Regulatory Design* (Seton Hall Public Law Research Paper No. 2010-24, 2011), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1702394.

³¹ Ezra Klein, *The Liberal Critique of Wyden-Bennett*, THE AMERICAN PROSPECT (May 6, 2009, 12:45PM), http://prospect.org/csnc/blogs/ezraklein_archive?month=05&year=2009&base_name=the-liberal-criticism-of-wyden.

³² Clayton Christensen, *Disruptive Innovation*, PROMENADE SPEAKERS BUREAU, <http://www.promenadespeakers.com/page10.html>.

³³ Frank Pasquale, *The Question Concerning Finance: Party Like It’s 1929? Or Prepare Like It’s 1957?*, CONCURRING OPINIONS (Aug. 27, 2010, 9:19PM), <http://www.concurringopinions.com/archives/2010/08/the-question-concerning-finance-party-like-its-1929-or-prepare-like-its-1957.html>.

Americans are too poor to pay federal income taxes (in part because they pay so many other taxes). In 2004, “the top 0.1%—that’s one-tenth of one percent—had more combined pre-tax income than the poorest 120 million people.”³⁴ This disparity has only increased in the wake of the Great Recession. To the extent taxes are cut, very wealthy households may see millions per year in income gains; the median household might enjoy thousands of dollars per year.³⁵ Sure, middle income families will find important uses for those funds (other than bidding up the price of housing and education).³⁶ But at what price? What if the insurance systems start collapsing without subsidies, and more physicians (who are already expressing a desire to work less) start seeking out pure cash practices?³⁷ A few interactions with the very wealthy may be far more lucrative than dozens of ordinary appointments.³⁸ Even George Eliot identified the problem, as *Middlemarch’s* Dr. Lydgate gave up his idealistic medical service to write a treatise on gout.³⁹

Consider the math: billing a \$20,000 retainer from each of 50 millionaires annually may be a lot more attractive to physicians than trying to wrangle up 500 patients paying \$2000 each—or, worse, getting the money from their insurers. There are about 10 million millionaires in the United States; that’s a lot of buying power.⁴⁰ One \$10,000 score by a cosmetic dentist from such a client could be worth 400 visits from Medicaid patients seeking diagnostic procedures.⁴¹ Providers are voting with their feet, and a Medicaid card is already on its way to becoming a “useless piece of plastic” for many patients. Given those trends, simply reducing health care “purchasing power” generally

³⁴ George William Domhoff, *Wealth Income and Power, Who Rules America* (2011), <http://sociology.ucsc.edu/whorulesamerica/power/wealth.html>.

³⁵ Matthew Yglesias, *Fighting Cognitive Bias with the Assumption of Good Faith*, THINK PROGRESS (Apr. 19, 2011, 12:09PM), <http://thinkprogress.org/media/2011/04/19/184684/fighting-cognitive-bias-with-the-assumption-of-good-faith/>.

³⁶ Frank Pasquale, *Relative Deprivation, Location and Laudenfraude*, CONCURRING OPINIONS (Mar. 30, 2006, 10:33PM), http://www.concurringopinions.com/archives/2006/03/relative_depriv.html; FRED HIRSCH, SOCIAL LIMITS TO GROWTH (1976).

³⁷ Gardiner Harris, *More Physicians Say No to Endless Workdays*, N.Y. TIMES, Apr. 2, 2011, at A1, available at http://www.nytimes.com/2011/04/02/health/02resident.html?_r=2&scp=3&sq=emergency%20medicine&st=cse; Frank Pasquale, *The Three Faces of Retainer Care: Crafting a Tailored Regulatory Response* (Seton Hall Public Law Research Paper No. 890354, 2007), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=890354.

³⁸ Frank Pasquale, *Access to Medicine in an Era of Fractal Inequality*, 19 ANNALS HEALTH L. 269 (2010).

³⁹ ROY PORTER, GOUT: THE PATRICIAN MALADY 168 (2000) (“Lydgate withdraws pathetically into writing a treatise on gout—his surrender to the values and lifestyle of a world he despises but which has entrapped and enslaved him.”).

⁴⁰ Frank Pasquale, *Economic Policy for the Worried Wealthy*, CONCURRING OPINIONS (Apr. 2, 2011, 3:46PM), <http://www.concurringopinions.com/archives/2011/04/economic-policy-for-the-worried-wealthy.html>.

⁴¹ Ryan Hughes et al., *Dentists’ Participation and Children’s Use of Services in the Indiana Dental Medicaid Program and SCHIP*, 136 J. AM. DENT. ASS’N 517 (2005), available at <http://www.jada-plus.com/content/136/4/517.full>.

risks some very troubling outcomes for the very people the health care cost cutters claim to protect.⁴² No one should welcome a health care plutonomy, where the richest 5% consume 35% of services, regardless of how sick they are.⁴³

Health commentators rightly draw attention to big insurer CEO paydays.⁴⁴ Top layers of management at hospitals and pharma firms are also getting scrutiny.⁴⁵ Wonks are up in arms about specialist pay.⁴⁶ But for every high-flying specialist making over \$500,000 annually, there's probably at least one primary care physician struggling to pay med school loans. For every insurance or pharma CEO who's made tens of millions of dollars, there are thousands of poor home health care workers.⁴⁷ A *JAMA* study estimated that, by 2020, "the United States could face a shortage of up to 800,000 per year nurses and 200,000 doctors."⁴⁸ The usual solution to a labor shortage is higher, not lower, pay. A United States gastroenterologist's pay may seem extremely high compared to a French one's, but may be well below that of a 24-year-old bond trader making \$800,000 per year two years out of college. If we're going to shrink a sector, maybe we should focus on finance first, as the Kauffman Foundation suggests.⁴⁹

Again, I have no quarrel with countless studies showing fraud, abuse, and waste in the health care sector. I find it hard to believe how many unproven treatments and devices are business successes and public health failures. But I have no idea whether funds now spent on them should be reallocated to other health care initiatives, or kicked out of the sector altogether. For example, what if half the current funds dedicated to marginally useful drugs went to antibiotic research?⁵⁰ I'd be much happier to see that reallocation than to see drug researchers simply close up shop and move to cosmetics firms.

⁴² Robert Pear, *Cuts Leave Patients with Medicaid Cards but No Specialist to See*, N.Y. TIMES, Apr. 2, 2011, at A1, available at <http://www.nytimes.com/2011/04/02/health/policy/02medicaid.html>.

⁴³ Michael Lind, *Is America a Plutonomy?*, SALON (Oct. 5 2010, 07:01AM), http://www.salon.com/news/opinion/feature/2010/10/05/lind_america_plutonomy.

⁴⁴ Michael Ricciardelli, *Health Insurance CEO Total Compensation in 2009*, HEALTH REFORM WATCH (Mar. 16, 2011), <http://www.healthreformwatch.com/2011/03/16/health-insurance-ceo-total-compensation-in-2009/>.

⁴⁵ Maggie Mahar, *High CEO Salaries at Nonprofit Hospitals Under Scrutiny ... Once Again*, HEALTH BEAT (Mar. 24, 2011), <http://www.healthbeatblog.com/2011/03/high-ceo-salaries-at-nonprofit-hospitals-under-scrutinyonce-again.html>.

⁴⁶ Frank Pasquale, *RUC's Role in Medicare*, BALKINIZATION (Oct. 27, 2010), <http://balkin.blogspot.com/2010/10/rucs-role-in-medicare.html>.

⁴⁷ *Better LTC Jobs Will Boost Economy, Says Kuttner*, PHI BLOG (Nov. 13, 2008), <http://phinational.org/archives/job-of-direct-care-worker-featured-on-npr/>.

⁴⁸ Laurie Garrett, *The Challenge of Global Health*, 86 FOREIGN AFFAIRS 14 (2007), available at http://www.surmang.org/pdf/Garrett_Challeng_G_Health.pdf.

⁴⁹ Ben Branham & Barbara Pruitt, *The Cannibalization of Entrepreneurship in America: Expanding Financial Sector Depleting Pool of Potential High-Growth Company Founders*, KAUFFMAN FOUNDATION (Mar. 25, 2011), <http://www.kauffman.org/newsroom/expanding-financial-sector-depleting-pool-of-potential-high-growth-company-founders.aspx>.

⁵⁰ Frank Pasquale, *Antibiotic Resistance on the Rise, Thanks to Capital Misallocation on a Grand Scale*, HEALTHLAWPROF BLOG (Apr. 7, 2011), <http://lawprofessors.typepad>.

Bloche, however, thinks that health care costs are still a problem, even if *all* waste were eliminated:

Even if it were possible to slash the entirety of the 30% spent on useless care, plus the 10% spent on excess administration, the resulting savings would pale by comparison with the cost control challenge ahead. Suppose (implausibly!) that a package of reforms [could eliminate this 40% in 5 years]. That's a formidable accomplishment, but it would only temporarily offset the 5 to 10 percent annual increase in health spending that's been near-constant over the past few decades.⁵¹ [54]

Bloche therefore worries that health care could go from 16% of GDP (as of 2007) to 30% or more, a percentage he appears to regard as outrageously high. But would that number alone, as a feature of the United States economy, doom us? Or even significantly impair the United States in, say, 2030 (to pick a year recently novelized into a madcap extrapolation of health care cost trajectories, by Albert Brooks)?

Here, some historical perspective (and forward-thinking extrapolation) are helpful. As David Cutler has noted, experts used to fret that an economy that spent 10% of its GDP on health care was unsustainable.⁵² Cutler offers the following assessment of a world where health spending takes up 25% of income:

While that amount seems clearly excessive, there is a good reason not to worry: people in the future will earn more than people do today, and that will make their spending burden smaller. . . . [The average] family is expected to earn nearly \$75,000 by mid century. Even if medical care took one quarter of that amount (nearly \$19,000), non-medical consumption would still be large. In fact, it would be significantly greater than today. The trade-off we face is that if we have more rapid medical spending, we get slower increases of everything else—new cars bought less frequently, less frequent updating of new computers, houses being built with a longer delay, and so on. People have different views about whether that is reasonable, but I see no reason that this trade-off cannot be made.⁵³

Admittedly, Cutler may be too sanguine about health cost increases. Imagine a future where basic commodities, such as oil and food, cost far more than they do now. In that scenario, even middle-class families will find their paychecks inadequate to support a bloated healthcare infrastructure. Some economists might welcome that possibility. For example, David Dapice has argued that

com/healthlawprof_blog/2011/04/antibiotic-resistance-on-the-rise-thanks-to-capital-misallocation-on-a-grand-scale.html.

⁵¹ See also Susan Dentzer, *Rolling the Rock Up the Mountain*, 28 HEALTH AFF. 1250 (2009).

⁵² DAVID CUTLER, *YOUR MONEY OR YOUR LIFE* 4 (2005).

⁵³ *Id.* at 74. "The typical American family will continue to be able to afford increased medical spending, but not all families will. Those at the bottom of the income ladder will find it increasingly difficult . . . [and] government will have to help [them] afford insurance."

“lowering United States health care costs may help the world,” given the flows of debt that now enable them.⁵⁴

But we should think clearly about why commodities might become more expensive for the United States. Part of the answer is a long overdue “global rebalancing” of buying power. Perhaps the United States could continue to import a disproportionate share of the world’s oil if its productivity were equally disproportionate.⁵⁵ But that is not the case; we persistently run trade deficits. The easiest way to cure these deficits is to devalue the dollar, but as that happens we should expect higher prices for oil and all that is based on it. Our vaunted “weightless economy” only persists thanks to the recycling of petrodollars and loans from Saudi Arabia, China and other creditors.⁵⁶ In this respect, Michigan is the canary in the coal mine, learning that the new economy needs some old foundations:

The sputtering Michigan economy is dragging down the state’s once-strong health-care system, offering a preview of how a lingering recession could corrode Americans’ hospitals, savings and health. . . . Years of auto-industry layoffs and benefit cuts to white-collar retirees have left hundreds of thousands of Michigan workers . . . without employer-provided health coverage.⁵⁷

In other words, the expense of the health care sector may be less a sign of its own lack of efficiency, than of the rotting foundations of the manufacturing and other sectors surrounding it.⁵⁸

Inequality also plays a major role here. Health costs may seem astronomical because most workers’ contributions to their sectors’ productivity have been captured by their top managers:

Globalization is making U.S. companies more productive, but the benefits are mostly being enjoyed by the C-suite. The middle class, meanwhile, is struggling to find work, and many of the jobs available are poorly paid. . . . [T]echnology has had a

⁵⁴ David Dapice, *Stopping the Death Spiral*, YALEGLOBAL (May 26, 2009), <http://yaleglobal.yale.edu/content/stopping-death-spiral>. “United States healthcare costs are nearly double that of other developed nations, and are without any attendant benefits: United States life expectancy is no greater. . . . In one sense, the United States is starving investment in growth by swallowing up so much of the world’s savings. With a lower budget deficit, capital flows that are directed to funding United States debt might now go toward developing nations.”

⁵⁵ Barry Ritholtz, *Oil Consumption Around the World*, THE BIG PICTURE (June 11, 2010), <http://www.ritholtz.com/blog/2010/06/oil-consumption-around-the-world/>.

⁵⁶ MAHMOUD EL-GAMAL & AMY MYERS JAFFY, OIL, DOLLARS, DEBT, AND CRISES 2 (2010).

⁵⁷ EAMONN FINGLETON, IN PRAISE OF HARD INDUSTRIES (1999). “The seven-hospital St. Joseph system lowered its operating margin and projects it will cut \$60 million from next year’s budget, about 7% of its revenue. The William Beaumont Hospital system, which traditionally attracted well-insured patients at its hospitals in the affluent suburbs of Grosse Pointe and Royal Oak, reported its first net loss last year.”

⁵⁸ Frank Pasquale, *Independence Day Thoughts: From Richard Rorty to Andy Grove*, CONCURRING OPINIONS (July 4, 2010), <http://www.concurringopinions.com/archives/2010/07/independence-day-thoughts-from-richard-rorty-to-andy-grove.html>; Paul Krugman, *Autor! Autor!*, N.Y. TIMES (Mar. 6, 2011), <http://krugman.blogs.nytimes.com/2011/03/06/autor-autor/>.

“polarizing” impact on the U.S. work force—it has made people at the top . . . better paid and hasn’t had much effect on the “hands-on” jobs at the bottom of the labor force. But opportunities and salaries in the middle have been hollowed out.⁵⁹

To the extent United States workers are competing head-to-head with those in less developed countries, they can expect their health benefits (like their wages) to converge with their competitors’. Wasunna and Callahan have described the stark features of those catch-as-catch-can, cash-based systems.⁶⁰ Journalistic accounts also give a sense of how bleak a “low health costs” equilibrium can get. A doctor in China might refuse to fix a grandmother’s broken hip until she deeds over the family home; hospitals there may balance the benefits of rationed care against the risk of angry mobs.⁶¹ That is cost-containment with a vengeance. If health costs seem astronomical to the average United States family, perhaps the answer is less to reduce their power to buy health care (by, say, taxing purchases of employer-sponsored insurance plans), than it is to increase their wages.

Maybe Americans spend too much on health care, but our trade and budget deficits, and consumer debts, indicate we spend too much on many things. That borrowing is not mere profligacy; rather, it reflects a deeper pathology in our economy. Whether we solve that pathology by becoming more export-oriented, or autarkic, a few humane groundrules should govern future discussion of America’s economic possibilities, and the place of health spending in them.

In a global labor market, all workers gain when those at the bottom get more access to basic care. Today’s managers confront workers with tough choices: “Strike, and you’re fired. Don’t strike, and your pay is probably going to be cut. Don’t like it? Sorry, we can open a plant abroad.”⁶² If the plants abroad have to offer some kind of health care, that is at least one small buffer against a broader “race to the bottom.”

Global rebalancing can be a positive sum game. But there have been painful transitions toward it, and these will only get more painful in the short run. That sacrifice must be shared. One should not propose a general reduction in health care spending to address the deficit without simultaneously proposing new revenues from those at the top of the winner-take-all economy.

⁵⁹ Crystia Freeland, *Capitalism Is Failing the Middle Class*, REUTERS (Apr. 15, 2011, 10:37EDT), <http://blogs.reuters.com/chrystia-freeland/2011/04/15/capitalism-is-failing-the-middle-class/>.

⁶⁰ DANIEL CALLAHAN & ANGELLA WASUNNA, *MEDICINE AND THE MARKET: EQUITY V. CHOICE* 117 (2006).

⁶¹ Joseph Kahn, *Boy’s Death at China Hospital Spurs Riot Over Care and Fees*, N.Y. TIMES (Nov. 13, 2006), <http://query.nytimes.com/gst/fullpage.html?res=9D03E4D9163EF930A25752C1A9609C8B63&scp=1&sq=hospital%20china%20boy&st=cse>.

⁶² Matt Stoller, *The Liquidation of Society v. the Global Labor Revival*, NAKED CAPITALISM (Feb. 24, 2011), <http://www.nakedcapitalism.com/2011/02/matt-stoller-the-liquidation-of-society-versus-the-global-labor-revival.html>.

Finally, let's focus on the real problem: wasted care, rather than some magic number of 10 or 20 or 30% of GDP going to the medical sector. If our cable TV, food, furniture, and other bills shrink over the coming years, and health care looms comparatively larger in our budgets, that's not necessarily a problem.⁶³ Ask anyone who has been gravely ill: there is not much you can enjoy if you are in constant pain or discomfort.

CONCLUDING THOUGHTS

Bloche's compassion for his patients and deep knowledge of policy jumps off the page for anyone who reads *The Hippocratic Myth* carefully. I was particularly impressed by his sensitive account of the travails of a PTSD patient, and an accompanying footnote discussing how a Chapter 5-13 discharge from the army can hurt veterans. [242] We need many more accounts like this, which take suffering seriously and interpret how law can exacerbate or relieve it. Whether Bloche discusses child custody, obesity, criminal punishment, or the many other places where doctors "have become key political and legal decision-makers," he mixes a realistic assessment of difficult situations with a reasoned commitment to make things better.

But just as hard-headed realism can be a critical tool for the tragic clinical contexts Bloche relates, it can also snuff out the vision necessary to reduce the overall number of such individual tragedies. Bloche takes the Washington consensus on health care cost-cutting as his given, and structures his book around the stories and steps that exemplify good and bad ways of implementing that agenda. His guiding light is transparency. The result is a theory of medicine that is infinitely flexible, ready for application in both wretchedly unequal and commendably egalitarian societies. But we should note that the current "budget crisis" that makes health care costs such a hot political issue was itself largely created by a group of George W. Bush aides that rejected Bloche's "reality based" community.⁶⁴ They pushed the tax cuts and wars that caused the great bulk of our budget problems, and their latter-day followers scuttled the public option that would be the best health care cost control mechanism. As one of their number said in 2004, as reported by Ron Suskind:

⁶³ Frank Pasquale, *A "Content Loss Ratio" for Cable Companies?*, CONCURRING OPINIONS (Jan. 4, 2010, 7:23PM), <http://www.concurringopinions.com/archives/2010/01/a-content-loss-ratio-for-cable-companies.html>.

⁶⁴ Kathy Ruffing & James Horney, *Critics Still Wrong on What's Driving Deficits in Coming Years*, CBPP (June 28, 2010), <http://www.cbpp.org/cms/?fa=view&id=3036>.

The aide said that guys like me were “in what we call the reality-based community,” which he defined as people who “believe that solutions emerge from your judicious study of discernible reality.” . . . “That’s not the way the world really works anymore,” he continued. “We’re an empire now, and when we act, we create our own reality. And while you’re studying that reality—judiciously, as you will—we’ll act again, creating other new realities, which you can study too, and that’s how things will sort out. We’re history’s actors . . . and you, all of you, will be left to just study what we do.”⁶⁵

It is Bloche’s job as a doctor to judiciously study the condition of the patient before him. As an author, he had more latitude to propose changes to a reality that leaves so many Americans sick and broke. Unfortunately, the same discipline and focus that have made Bloche such a skillful physician and careful scholar appear to have led him to overlook the larger context of today’s fiscal debates. The fixed point of a modern ethics of health care must be the provision of a minimum baseline of care for all—not mere transparency of decisionmaking in an increasingly unequal society.

That said, one could hardly wish for a better introduction to modern health policy debates than Bloche’s book. I have barely mentioned the many sensitive, insightful, and occasionally brilliant discussions of bioethical dilemmas in the book, largely because I have little but praise for them. (I assume that book reviews should focus on the differences between the reviewer and the author.) Full of careful discussions of relevant law and policy, *The Hippocratic Myth* never bores, leavened as it is with engaging narratives of individual patients and providers. It is one of those rare volumes that merits careful study from the scholar, classroom reading by students, and a broad popular audience.

⁶⁵ Ron Suskind, *Faith, Certainty and the Presidency of George W. Bush*, N.Y. TIMES (Oct. 17, 2004), <http://www.nytimes.com/2004/10/17/magazine/17BUnitedStatesH.html>. Mark Danner has identified the aide as Karl Rove. Mark Danner, *Words in a Time of War: On Rhetoric, Truth and Power*, in WHAT ORWELL DIDN’T KNOW: PROPAGANDA AND THE NEW FACE OF AMERICAN POLITICS 17 (Szántó, András 2007). “[T]he unnamed official speaking to Suskind is widely known to be none other than the self-same architect of the aircraft-carrier moment, Karl Rove. . . .”