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ECONOMIC VIEW

Maybe a New Day for Doctors' Pay

By ROBERT H. FRANK

EVEN without a robust [public option](#), any of the [health care reform](#) bills now under consideration would expand coverage greatly. But they would also start a competitive dynamic that would eliminate the fundamental conflict of interest that has made American health care so expensive.



The United States spends twice as much per capita on health care as many other nations, yet achieves inferior outcomes by such varied measures as life expectancy, preventable

deaths from specific illnesses, and [infant mortality](#). Much of the performance gap stems from the fact that many of the nation's 45 million uninsured fail to receive needed care.

The spending gap stems largely from a conflict inherent in how American physicians are paid. Elsewhere, most doctors are salaried. But under most American health plans, including [Medicare](#) and [Medicaid](#), doctors are reimbursed according to how many tests and procedures they perform.

Most doctors undoubtedly recommend only those tests and procedures that they sincerely believe to be in their patients' best interests. Yet those interests are seldom completely clear. And when doctors know that their incomes will be higher if they recommend additional procedures, many may tilt in that direction.

Physicians, like everyone else, are also subject to herd behavior. If some doctors in a given city begin prescribing additional procedures, others may feel pressure to follow suit — not just because patients expect it, but also to keep pace with colleagues' incomes.

In an [article in The New Yorker](#), for example, Atul Gawande described an entrepreneurial medical subculture in McAllen, Tex., in which doctors prescribe roughly half again as many tests and procedures as those in otherwise similar Texas communities. McAllen, he argued, is where American health

care is heading.

Current reform bills do little to curtail such spending, and all include subsidies to help meet insurance mandates, which would shift substantial existing health spending onto the [federal budget](#). So enacting one of these bills would intensify pressure to cut costs.

The good news is that Dr. Gawande also identifies at least some health plans, like that of the [Mayo Clinic](#) in Minnesota, that have sidestepped the incentive problem by putting doctors on salary and operating their own [hospitals](#). Such plans, which provide superb care and high patient satisfaction at significantly lower cost than conventional fee-for-service plans, would become more attractive under the proposed legislation.

But that raises a puzzling question: If the Mayo model is better and cheaper, why hasn't it swept the market like wildfire?

Part of the answer lies in the so-called adverse selection problem, a market failure that explains why so many Americans remain uninsured. When the decision to buy insurance is left to individuals, the young and healthy often opt out, thinking — generally correctly — that their premiums are likely to far exceed any reimbursement they will get.

But that means that the remaining members of the insured pool, on average, are significantly less healthy, so premiums must rise further. This puts pressure on the healthiest remaining members to drop out, causing still further increases in premiums, and so on.

Adverse selection affects all models of health care delivery. The reform bills under discussion would eliminate the problem by requiring insurance companies to sell at roughly the same rates to all applicants and by requiring everyone to buy insurance. Accordingly, they would greatly expand the proportion of citizens who could obtain more efficient models of health care delivery.

But adverse selection can't explain why the Mayo model hasn't gained ground faster in the employer-provided [health insurance](#) market. That market doesn't suffer from adverse selection, because insurance is tax deductible only if insurers accept all employees on equal terms.

Dr. Gawande reports that Mayo has recently opened a clinic that serves employers in the high-cost Florida market. But given how bitterly businesses complain about rising health care costs, we might have expected much more movement.

One explanation may be residual prejudice against the for-profit H.M.O. wave of the 1990s, which entailed a conflict of interest of a different sort. Patients paid a fixed annual fee,

which meant that H.M.O.'s made more money each time they avoided prescribing a procedure. Because clinics like Mayo's are nonprofits, they may avoid this conflict.

ANOTHER factor militating against quick expansion of the Mayo model is that many current doctors chose their profession hoping to earn lucrative pay, which they might not be able to do in a nonprofit clinic. But across the economy, we see talented professionals whose career choices are driven by concerns far broader than pay. Many top graduates from elite law schools, for example, turn down lucrative positions in corporate law to work for public-interest groups paying a third as much.

Doctors who choose to work in nonprofit clinics seem to view their professions more as a calling than as a job. There is evidence that when medicine was less adversarial than it is now, American doctors were both happier and more respected, even though their incomes were much lower. Doctors elsewhere also remain satisfied and respected, though they are paid less than their American counterparts.

In time, [medical schools](#) will be able to attract plenty of talented people willing to accept positions under the Mayo model, where they would spend more time healing patients and less time fighting insurers. Any of the current health reform bills would help start this transition.

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