The Ramifications Of Specialty-Dominated Medicine

The demand for specialists of unchallenged value spells an SUV policy for physician supply.

by Kevin Grumbach

Reading the paper by Richard Cooper and colleagues is like watching a television commercial for a sport-utility vehicle (SUV). “Buy more physicians” is the marketing pitch—and not just any physician, but the four-by-four (as in four years of medical school plus four or more years of residency training), gas-guzzling specialist model that creates an irresistible buying frenzy among American consumers eager to spend their discretionary income.

When I watch advertisements showing a mud-splattered SUV careening along a dirt road and coming to rest atop an impossibly remote mountain peak, I confess that I feel no automotive lust. I think about ruined natural habitats, global warming, depletion of natural resources, the nation’s economic addiction to petroleum, and the poor guy in the Honda Civic about to collide with the SUV. I rue the distortedly low sticker price of buying and operating an SUV that fails to account for the true social costs associated with SUVs. And I ponder the “utility” of an SUV that so often seems to carry only a single passenger on urban commutes.

Nonetheless, SUVs are an undeniably popular item in the United States, with sales continuing to soar. Lots of people desire them (some of my best friends even own them). As Sen. Trent Lott (R-Ms) recently asserted, “The American people have a right to drive a great big road hog SUV if they want to, and I’m gonna get me one.”

In the view of Cooper and colleagues, Americans also appear to have the right to an ever bigger and more expensive health system featuring a steadily increasing supply of physicians per capita, especially of specialists. The authors interpret their study as “consistent with the notion that a causal relationship exists between economic expansion and the growth of physician supply.” Based on the historical association between trends in physician supply and economic activity in the United States, they calculate that each 1 percent increase in gross domestic product (GDP) per capita produces a 0.75 percent increase in physicians per capita. Of note, virtually all of the growth in U.S. physician supply per capita in the past half-century has been in the supply of specialists. The high elasticity between GDP per capita and specialist supply suggests that specialty care (like SUVs) functions as a luxury good.

In the interpretation of the authors, this relationship is not merely a description of past trends but a rule for projecting future demand for physicians. Presented this way, the relationship between economic growth and increasing specialist supply takes on the properties of natural law. Social planners can attempt to tamper with this natural law and impose constraints on growth of specialist supply. But like the protagonists of a Greek tragedy, social planners reveal their hubris in challenging the national destiny for more physicians and must inevitably discover, to their
dismay, that their efforts to thwart the will of the market deity can come to no good. We might as well ask Americans to stop buying so many SUVs.

There are several reasons to take issue with this fatalistic view. Consumer demand for physicians is not the exogenous force implied by Cooper and colleagues. Physicians are able to induce demand for their services, creating a self-replicating cycle of more physicians begetting more demand begetting more physicians. Nor is the preponderance of health care purchased in an individual consumer market. Public funds pay for about 40 percent of health care, and funds pooled through private insurance purchase another 40 percent. The 20 percent of patients who generate 80 percent of health expenditures every year are for the most part spending someone else's money on health care. (That's the whole point of health insurance.) Collective financing of health care calls for collective decisions about how much to spend. Endowing individual consumer demand for health care with a preeminent role in determining the proper equilibrium level of health care spending and physician supply is as flawed a concept as promoting a universal automotive coverage plan that would give every household a third-party payment to purchase an SUV. The market and social objectives for health care are very different from those for automobiles.

The "Americans have a right to buy more specialists" view also raises the question of whether people are actually buying anything of benefit. Cooper and colleagues portray their analysis as one free of value judgments about what "ought" to be. The consumer is sovereign; social planners are presumptuous to question this sovereign being about how it wishes to spend its (or in the case of health care, someone else's) hard-earned cash. But as a taxpayer contributing to Medicare and Medicaid, and as a subscriber in my employer's group health insurance plan, I do want to know whether the extra tariff on my income that Cooper and colleagues would levy to pay for more specialists will in fact purchase better health for me and for the nation.

The evidence on this score is not reassuring. Many studies indicate that a greater supply of specialists is not associated with better population health. Lei Yu Shi has conducted a series of studies comparing physician supply and health indicators across U.S. states and substate regions, controlling for a variety of population characteristics. The studies have shown that a greater supply of primary care physicians is associated with lower mortality rates as well as lower disease-specific death rates in some categories. A greater supply of specialists has either no association with these health indicators or in some instances an association with worse health outcomes.

A second example is neonatology, a specialty that has proliferated in recent decades. And yet recent research by David Goodman has found that regions in the country with above-average numbers of neonatologists per capita do not have better outcomes for high-risk newborns than do regions with a lower supply.

A third example, appendicitis, is a common condition that has attracted greater specialist involvement in recent years. Many patients with clinical findings suggestive of possible appendicitis who formerly went straight to the operating room now make a detour to the radiology suite for a diagnostic sonogram or computed tomography (CT) scan of the abdomen. However, a statewide study of appendectomies in Washington State over the past decade found no reduction in rates of removal of normal appendices. Elliot Fisher and Gilbert Welch have cogently discussed the general case for "how might more be worse" in health care.

One final problem of unmitigated growth of physician supply and health spending is that it will accentuate inequities in health
extra tariff on my lilies would levy an unexpected tax on the nation.

The study is not reassuring that a greater supply of physicians per U.S. states and counties, controlling for group sizes of population, is associated with better outcomes. The studies find that a greater supply of primary care physicians per state with lower mortality rates as well as lower infant and specific death rates in large counties. A greater supply of specialists has either no correlation with these outcomes or a negative correlation."}

...onatology, a specialty that has been in recent decades. David Goodman questions whether we should be regulating physicians per county or state with a lower population density. Specialization, a concept that was first used to describe the practice of medicine in the late 19th century, is a concept that has been challenged in recent years. Many patients have grown skeptical of the doctors who were formerly their primary care physicians. The rise of the "doctor house call" has made it possible for patients to see their doctors outside of the office setting.

...evidence for a diagnostic test. CT scans, which are used in Washington State, and in other states, have no reduction in mortality among appendectomy patients. It is not clear whether these patients should be operated on for "how might be worse?"

...mitigated growth in health spending is essential in health care. Who is going to pay for that rising "projected demand" in Cooper's Exhibit I that looks as if it will never bend toward an asymptotic slope? Not most employers, who are moving to defined contribution plans to limit their health care outlays. Not government, in an era of investing in antiterrorism measures and tax rebates. Not the uninsured, clinging as best as they can to what's left of the health care safety net. And probably not the public at large, facing an economic downturn bordering on a recession. Unmitigated growth in health care spending means a widening gap between the medical haves and have-nots, producing more uninsured Americans as employers, individuals, and government find insurance less affordable, while the affluent and well-insured consume an ever greater share of the nation's health care resources.

The future that Cooper and colleagues project is the SUVification of U.S. health care. It is a future of more specialists, more high-tech care, higher costs, and greater disparities, of a system built out of proportion to the true needs of the public for efficient and effective health care. It threatens the proper ecology of medical care. It may even be harmful. Many nations have people driving automobiles of modest size and excellent fuel efficiency. Many nations have health care systems that provide health care for all residents in a less specialty-oriented manner and with better health outcomes than is true of the United States. It would be a mistake to believe that the future predicted by Cooper and colleagues is either preordained or desirable.

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