

# The Grand Unification Theory of Healthcare - An Overview

My book, *Fixing American Healthcare - Wonkonians, Gekkonians and the Grand Unification Theory of Healthcare*, provides a complete explanation of the GUTH. I hope you will read it.

But to allow you to get the most you can from this website, I offer this abbreviated version of the GUTH. The GUTH in a Nutshell

As it turns out, we can represent the healthcare universe with a simple, two-dimensional graphic model, as shown in this figure.

This model takes into account:

- Who makes healthcare decisions (the horizontal axis in the figure)
- Whether those decisions are of high or low quality (the vertical axis)

Within the universe defined by this model, we can fully characterize the behaviors of any healthcare system we could plausibly devise.

On the horizontal axis, we ask if healthcare decisions are made by the individuals most directly affected by them (the patients and their doctors) or, instead, if they are under the control of some centralized authority (such as the federal government or giant insurance carriers). On the vertical axis we ask if the decisions are of high quality, based on good, solid, scientific evidence or if they are of low quality, made on some other basis, such as political considerations, intuition, superstition, or emotion.

These two axes (individual vs. centralized decision-makers, and high-quality vs. low-quality decisions) divide the healthcare universe into four quadrants. Each of these four quadrants carries with it a set of inherent properties that largely determine the behavior of any healthcare system operating within that quadrant. This four-quadrant model of the healthcare universe, along with four corollaries that we will derive from it, constitute the GUTH.

In this brief discussion of the GUTH, I will give a general overview of the GUTH and attempt to demonstrate its potential. To this end, I will show that:

- Until recently, the American healthcare system operated in Quadrant IV of the healthcare universe.
- Operating in Quadrant IV was always an unstable and time-limited proposition; there was never any possibility that we could stay there.
- The momentum of change has moved us into Quadrant III.
- The defining characteristics of Quadrant III explain the strange behavior of today's healthcare system.
- By understanding where we are on this healthcare landscape and how we got here, we can see how to advance to a more favorable position (Quadrant I or Quadrant II).

## Quadrant IV healthcare

Beginning around 1950 and until the early 1990s, the American healthcare system resided in Quadrant IV of the healthcare universe. Medical decisions were made, for the most part, by individual doctors and their patients, based on what was perceived to be best for the patient (or sometimes, we must admit, for the doctor). But for several reasons healthcare decisions were not driven by high-quality, data-guided reasoning. The decisions were generally of low quality. A system of low-quality decisions made by individual doctors and their patients planted us squarely in Quadrant IV.

Quadrant IV healthcare was ushered into existence by the advent of third-party funding, beginning with Blue Cross and Blue Shield, followed by private employer-provided insurance, and cemented by the introduction of Medicare and Medicaid. Thanks to this new third-party funding mechanism, we in the U.S. evolved a mentality that remains unique when it comes to healthcare. We expect and insist on nothing but the best healthcare available, whenever we want or need it, and the Tooth Fairy picks up the tab. Such a system, where the individuals making the purchasing decisions are spending someone else's money, made Quadrant IV healthcare financially unstable from the beginning and doomed it to failure. (Furthermore, spending someone else's money also encourages profligate spending, and thus inherently produces low-quality decisions.)

The Tooth Fairy financing system yielded many benefits. It was this system, fiscally unstable as it was, that triggered fifty years of industry-driven advances in healthcare (if you build it and it works, someone will pay for it). Countries with saner financing systems contributed relatively few medical innovations during that period. The Tooth Fairy has been the lifeblood of the American pharmaceutical and biotech industries and the patients they serve. And for a few decades it seemed as if we had enough money in the system (if we didn't look too closely) to finance the insanity.

But the Tooth Fairy has been pushed beyond her limits. Providing every kind of useful healthcare to anyone who needs it is a fiscal black hole, the cost to payers is outstripping revenues, and insurance premiums and Medicare costs are growing at many times the rate of overall inflation. The government and insurance carriers are becoming more aggressive in their efforts to curb spending.

A system where individuals can choose whatever healthcare they want and someone else picks up the tab is not sustainable. It might have worked when medical science didn't have much to offer sick people, when doctors were still lancing boils and getting paid in chickens and couldn't spend much money delivering healthcare no matter how hard they tried - a situation that existed not so many decades ago. But the medical advances financed by the Tooth Fairy system have produced an environment in which this system can no longer exist. We had to exit Quadrant IV. And the direction of movement as we did so was resolutely to the left, toward centralized decision-making.

### Moving leftward

Two powerful forces are moving us leftward within the healthcare universe:

1) Individual patients (and their doctors) do not take the needs of society into account when they decide how much of society's money to spend on their own healthcare. Thus, society has a strong incentive to take those spending decisions out of the hands of individuals and place them in the hands of some central authority.

2) We have a growing conviction that healthcare is an entitlement for all Americans. This conviction itself is at least partly a result of latter-day Quadrant IV healthcare, where exploding healthcare costs (fueled by exploding expectations) have outstripped the ability of individuals to pay for their own care.

Declaring healthcare to be an entitlement forces the centralization of healthcare, as any large entitlement requires the redistribution of wealth, which is possible only with a powerful central authority. If there were no such authority (but, of course, there is), a healthcare entitlement would necessitate creating one.

So: both the need to curb the profligacy of individuals and the entitlement mentality have driven the American healthcare system leftward in the healthcare landscape, toward the centralization of medical decision-making. Such centralization enjoys, if not popular support, at least popular resignation.

Given this strong move to the left within our healthcare landscape, it is now time to introduce the First Corollary of the GUTH: First Corollary of the GUTH: Left = Rationing

When any healthcare system is operating in either of the two left-hand quadrants of the healthcare universe, whether Quadrant I or Quadrant III, it is necessarily operating under a system of rationing.

Why is the First Corollary true? Why is it that any healthcare system operating on the left half of healthcare landscape must necessarily employ rationing? It is because centralized decision-making means that some central authority is controlling a pool of money, created by society, from which healthcare costs are to be paid. Because there will always be limits to how much money can be placed into such a pool, while there will never be limits on what can potentially be spent on healthcare, whenever the healthcare system is operating in one of the two left quadrants, rationing is occurring. A fuller discussion of just why rationing is an economic imperative in the two left quadrants of the healthcare landscape can be found in the Understanding It section of this website, and in my book.

The American healthcare system is not just moving leftward within the healthcare landscape, however; it is moving downward, away from Quadrant I and toward Quadrant III.

### Why Quadrant III is inevitable

Just as there are powerful forces pushing the healthcare system leftward, toward centralized decision-making and thus

toward rationing, so is there an equally powerful force pushing it downward, into Quadrant III, and away from Quadrant I.

That force is the culture of no limits. That and the entitlement mentality are the two main cultural imperatives shaping the American healthcare system today. Unlike the entitlement mentality, which is nearly universal in Western countries, the culture of no limits is uniquely American.

The Culture of No Limits In America we have and will continue to have the best healthcare in the world, the best doctors, the best hospitals, and the best technology. Since one cannot place a price on human life, everything that can be done for a sick person must be done, as long as there is some small hope of a beneficial outcome. Finally, every disease is potentially curable, and as a matter of policy we will strive to learn how to cure every disease, death itself being merely a manifestation of insufficient technology. In summary, where healthcare is concerned there are and can be no limits.

So, at the same time we find ourselves up against inherent spending limitations that require rationing, we find that there can be no limits.

These two fundamental tenets—the entitlement mentality and the culture of no limits—are incompatible with one another. And our need to simultaneously hold onto these two incompatible but necessary imperatives is strongly driving our healthcare system toward Quadrant III, toward a system of centralized, low-quality healthcare decisions. Quadrant III is the only place on the healthcare landscape where we can create a centralized entitlement program operating under the fiction that no rationing is necessary.

Quadrant III allows for low-quality healthcare decisions, and so offers a haven from which to entertain our two mutually exclusive cultural imperatives. We can ration while declaring there are no limits. We can deny that any rationing is occurring at all. We can ration deceptively. We can ration covertly.

Thus, we reach the Second Corollary of the GUTH: Second Corollary of the GUTH: Quadrant III Healthcare = Covert Rationing

That is, Quadrant III healthcare and covert rationing are identical, one and the same. Life in Quadrant III

The Second Corollary shows that covert rationing is the hallmark of Quadrant III healthcare. This goes a long way toward explaining the chaos, confusion, and inefficiency that plague today's healthcare system. I give the mechanisms and consequences of Quadrant III healthcare a full treatment in my book, and in the Understanding It section of this website. Here I just want to mention two of its more important manifestations, which are embodied in the Third and Fourth Corollaries of the GUTH. Third Corollary of the GUTH: Covert Rationing Destroys the Doctor-Patient Relationship The central authorities we have deputized to control healthcare costs have a lot to gain by accepting this responsibility (for governmental bureaucracies, incredible power; for insurance executives, incredible profits). But they have to work hard for that gain, because it is going to be difficult, if not impossible, to control healthcare costs under even the best of circumstances.

And the central authorities are not working under the best of circumstances. Their only option is to institute some form of rationing. But they cannot ration openly. They cannot accomplish the necessary rationing by decree or even by open negotiation, nor can they be ham-fisted in enforcing the rationing. Instead, a subtle, covert, plausibly deniable kind of rationing is necessary. This constraint leaves them with only one good choice: They need to coerce the doctors into doing the rationing for them. So covert rationing must occur at the bedside, during the physician-patient encounter.

The central authorities have many methods for coercing the behavior of physicians, because they have empowered themselves to determine the individual physician's viability as a practitioner. The central authorities have at their disposal an arsenal of subtle weapons, and an occasional nuke, to assure that doctors relegate the needs of their patients to a secondary position and instead take pains to keep their true customers—the central authorities—satisfied. The medical profession has mostly caved in to this pressure, albeit under duress.

A direct result of covert rationing is the systematic destruction of the classic doctor-patient relationship—the relationship under which doctors are supposed to act from a position of trust, solely as their patients' advocates, and to place the needs of their individual patients above all other considerations. We cannot have both covert rationing and an intact doctor-patient relationship at the same time.

The loss of the traditional doctor-patient relationship has profound implications, which are discussed in the Understanding It section of this website.

Fourth Corollary of the GUTH: Covert Rationing Corrupts Everything It Touches My book spends an entire section elaborating on the Fourth Corollary. There I show how covert rationing has corrupted the principles of managed care, the regulatory environment of the healthcare system, the conduct and analysis of medical research, the ethical issues surrounding end-of-life care, and even the founding principles of American society. Much of this material can be found in the Understanding It section of this website as well.

But a less obvious manifestation of the Fourth Corollary is that covert rationing abhors simplicity and straightforwardness. Byzantine policies, self-contradictory directives, tangled incentives, and endlessly shifting regulations help keep the flow of money and resources in the healthcare system a mystery. The resulting confusion is essential for creating many of the subtle incentives necessary to produce covert rationing. This is why the efforts periodically initiated to simplify and streamline healthcare, sometimes introduced with great fanfare, get stuck in the bureaucratic molasses, just one more layer of glom in a vast conglomeration of regulations. All this systematic confusion is inefficient and wasteful and negates most if not all of the savings produced by rationing in the first place.

Herein lies the great irony of Quadrant III healthcare, the final joke: In Quadrant III, the need to keep the rationing covert quickly becomes the primary objective, even more important than actually reducing costs. Indeed, improvements in practices, processes, or technologies that, if implemented, would reduce the cost of healthcare often, through the transparencies they create, threaten the bureaucracies that keep rationing covert-and therefore they are stifled or suppressed.

Quadrant III healthcare is therefore a black hole, utilizing the most unfair, dangerous, and destructive methods of healthcare rationing that can be devised - and at the same time guaranteeing that cost savings (the original reason for rationing) are not realized.

How can we fix it?

We have seen that Quadrant IV healthcare is unsustainable, and Quadrant III healthcare is intolerable. Is there a better quadrant in which to run our healthcare system?

Both Quadrant I and Quadrant II healthcare, in theory, have the potential of being far less destructive to individuals and to society than Quadrant III healthcare. Unfortunately it is difficult to imagine how we can achieve either. Quadrant I healthcare

In Quadrant I, healthcare decisions are still made by a central authority (and so it is still rationed), but the rationing employs high-quality decisions. That is, the decisions are based on good scientific and economic information appropriately and equitably applied, using processes that are open to, vetted by, and monitored by the public.

Rationing healthcare openly and transparently, while necessary for high quality rationing choices, is a daunting prospect, and it is hard to think of circumstances that would render American society willing to engage in such a thing.

But if it were somehow to happen, there would be many advantages over Quadrant III healthcare. Because the rationing would be open instead of covert, there would no longer be a reason to separate the interests of doctors from the interests of their patients, and the doctor-patient relationship could be restored. Doctors, working within a universal and well-defined set of rules, could advocate actively and aggressively for the needs of their individual patients within those rules. (More routinely than doctors can get away with today, their role might become more like that of attorneys, who aggressively work within the confines of the law to offer every advantage to their clients.) Patients would still be subject to rationing, just as they are today - but the rationing would be open for all to see, and it would be far more equitable. Everybody's access to the benefits of healthcare would be constrained by the same set of rules. The elimination of covert rationing would remove the impetus to corrupt the science of medicine and would encourage instead of stifle genuine reforms aimed at streamlining healthcare and maximizing efficiency.

Quadrant I healthcare is compatible with and actually encourages a civil, long-lasting, stable society. Implementing a successful Quadrant I healthcare system would be a challenge, likely the greatest non-wartime challenge America has ever faced; but the current alternative-Quadrant III healthcare-promises to become a disaster. Quadrant II healthcare

In Quadrant II, medical decisions would be made where they should be made - on the ground, by individual doctors and patients. What differentiates this from Quadrant IV (that is, the Tooth Fairy system) is that in Quadrant II patients will be paying for these decisions themselves, out of their own pockets. Obviously, the sophisticated and costly healthcare we now have is far too expensive for individuals to purchase themselves, and a self-pay healthcare system - no matter what the tax incentives - is impossible. But if we were able to institute a Quadrant II healthcare system, many benefits would accrue.

Fundamentally, because the individuals receiving the medical services would be paying for them, healthcare economics would begin to look like other, more typical economic spheres, and the quality of purchasing decisions would increase. The quality of medical decisions made in Quadrant II would rely on solid, well-designed clinical science, just as it would for decisions made under open rationing in Quadrant I. But as patients would be paying for their own care, the quality of their decisions must be more broadly defined; that is, "quality" would be less dependent on what's good for society, less reliant on randomized data for therapies whose benefits are intuitively obvious to the purchaser, and more dependent on what the patient perceives as being good. Just as a person buying a car might gain more satisfaction from buying a Lincoln Town Car than a Ford Focus, so a person buying a healthcare product might gain more satisfaction from, say, a feature-laden medical device than a bare-bones device. And not only would that more expensive purchase be perfectly okay, from an economic standpoint it might be something to encourage - just as we encourage people to upgrade when they buy their next car. (On the other hand, if it were seen as the government's responsibility to provide transportation to everybody, under the theory that in today's mobile society a car is every bit as important to wellbeing as healthcare, then we would all-except for legislators-drive Yugos.)

Whereas it becomes possible to restore the doctor-patient relationship under a Quadrant I system of open rationing, Quadrant II makes restoration of this relationship automatic. This is because in Quadrant II, doctors aren't paid by a central authority anymore-they are paid by their patients. Patients become once again their doctors' primary customers, the ones who determine their doctors' professional viability, and the ones their doctors will need to answer to above all others.

Quadrant II healthcare would revolutionize the business model for healthcare entrepreneurs. For the first time it is the patients, those whose money is being spent, who ultimately would make purchasing decisions (with the assistance and advice of their doctors, now in their employ). This means that companies for the first time would begin developing medical products that appeal directly to patients and give those patients what they need and value. Quadrant II healthcare thus would stimulate a new kind of medical innovation-it would stimulate the invention of products and services aimed at helping patients determine their own medical destiny. Medical innovation would explode, and in an entirely new direction.

So at least in theory, Quadrant II healthcare seems more desirable than Quadrant III healthcare.

Unfortunately, it is extraordinarily difficult to visualize how we Americans would ever be able to achieve either Quadrant I or Quadrant II healthcare. We may be able, however, to achieve a synthesis of the two. A synthesis of upper quadrant healthcare

What Quadrant I and Quadrant II healthcare have in common is that in both upper quadrants healthcare decisions are of high quality; that is, these decisions satisfy the needs of, and create value for, the respective purchasers. Because the purchasers are not identical (in Quadrant I the purchaser is society; in Quadrant II the purchaser is the individual patient), the healthcare decisions that are made in these two quadrants may not be the same. But in both quadrants those decisions will be made by the entity that is spending the money, with knowledge of the medical options, their respective costs, and the potential risks and benefits of each one.

Given that either upper quadrant would create an environment for high quality and high value healthcare decisions, each of them has a strong potential of being less destructive to society and less dangerous to individuals than the system we have today. But neither of these upper quadrant models is ideal. And it is hard to imagine how either could be feasible.

However, a synthesis of Quadrant I and Quadrant II healthcare - an "upper quadrant" healthcare system - may be possible. Such a synthesis, if designed with some care, could provide the advantages inherent to each of the upper quadrants while minimizing the disadvantages. In my book I describe such a system in detail, and in the Fixing It section of this website I offer an outline of such a system. For now I will just say that the GUTH not only explains the vagaries of today's healthcare system but it also suggests at least one achievable model for a future healthcare system that is equitable and efficient.

With at least some small hope that such a thing is possible, then, it is reasonable to begin thinking about how we might escape Quadrant III.

How can we escape Quadrant III?

Denying the inevitability of healthcare rationing ultimately pushes us into Quadrant III. That is, it is mass self-deception that makes covert rationing necessary. The same self-deception makes covert rationing possible. For, not seeing all the widespread rationing behavior - which is quite apparent all around us - requires a willful failure to see it. Covert rationing utterly depends on this willful self-deception.

This observation has important implications. When motivated individuals concerned with their own wellbeing acknowledge that they are navigating a healthcare system founded on covert rationing, the healthcare system can no

longer practice covert rationing against them. Covert rationing requires that patients remain passive and compliant, trusting that their doctors, the insurers, and the federal authorities - but especially their doctors - have their individual welfare at heart, will do right by them, and will tell them whatever they need to know. Patients are strongly encouraged by society to trust their doctors and their health plans, and traditionally they have willingly done so. Indeed, when such "ideal" patients notice activities and behaviors that seem contrary to their best interests, they usually attribute those events to aberrations, mistakes, inadvertent inefficiencies, or just someone having a bad day. They might sue someone for malpractice, but it never occurs to them that these events are systematic and even intended.

On the other hand, for those who are appropriately suspicious during each and every encounter with the healthcare system and who entertain the possibility that a chief goal of their doctors, the insurers, and the federal authorities may not be so much to improve their individual health but to avoid spending too much money on them, covert rationing becomes much more difficult to pull off. If a critical mass of citizens were to take this attitude, each one acting in enlightened self-interest, then covert rationing as a national modus operandi would become impossible. If enough individual citizens were to see the light, the healthcare system could no longer operate in Quadrant III. Knowledge is power

Intelligent patients who understand that covert rationing is occurring and that they can no longer rely on their doctors or their insurers to do what is right for them know that they need appropriate knowledge to protect themselves from the dangers of hidden rationing. Covert rationing depends on patients trusting their doctors to be the main, and preferably only, source of healthcare advice. If their doctor doesn't tell them about it, the paradigm goes, it doesn't exist (which, is why controlling physician behavior is essential to a healthcare system based on covert rationing). Knowledgeable patients wreck covert rationing.

Becoming sufficiently knowledgeable is difficult. Patients are trying, though. American adults are going to the Internet by the tens of millions to find out what their doctors are supposed to be telling them and doing for them. This quest for knowledge is difficult, because so much contradictory, incomprehensible, and just plain wrong information abounds. Even reliable sources cannot tell them whether the information applies specifically to them.

Can patients become sufficiently empowered to block covert rationing? Yes, they can. Looking at the healthcare system historically, it seems likely that many of them will. For we are in the midst of a revolution in information technology that is radically changing every economic sphere it touches. This revolution is just beginning to affect the healthcare system.

A hallmark of the information revolution is that it puts the end user in direct contact with the source of products and services, thus eliminating or marginalizing the middlemen (those who traditionally served as high priests of data, guarding the information that was too sacred or too complex for the small minds of the masses and doling it out, piecemeal, in exchange for appropriate consideration). Examples of formerly powerful, now displaced middlemen include the medieval Church (violently opposed to laymen having direct access to the word of God), stock brokers, music publishers, travel agents, real estate agents, and educators.

Healthcare has been relatively impervious to the information revolution. Here, the high priests of data mongering include doctors, managed care organizations, and the government. All three groups see the information revolution coming but seem confident they'll be able to manage it. They are anxious to have the data themselves but intend to keep it locked up and out of sight (they all agree that medical information is far, far too complex for mere patients to grasp, and so it is clearly in the patients' best interest for the experts to husband that data for them). They'll interpret the data and parse it out to the patients on a need-to-know basis, thank you. And before it's distributed, it can be spun to support covert rationing.

The middlemen here are fighting history. They're also fighting the growing demands of patients, who sense they've been marginalized by the healthcare system (though they don't yet realize how systematically they have been marginalized), and who-based on their experience in other economic spheres-don't understand why they can't have the information they need to guide their own healthcare. The elderly patients that doctors see today may not yet have this attitude, but many aging boomers do. In ten years the demand by patients for empowering information will be much greater than it is today.

This analysis shows what seems like a pretty good way to make some big bucks in healthcare while simultaneously saving lives: Figure out how to empower patients. Any enterprise that can supply patients with clear, correct, relevant, personal, and specific knowledge that enables them to protect themselves and their loved ones within our hostile healthcare system will endear itself to those patients. Furthermore, anyone supplying such knowledge will be feeding a growing need for more. People's desire for the information to manage their own healthcare and the means to act on that information will become more than just a desire-it will become an expectation. A massive business opportunity awaits. Three points bear repeating:

- 1) Individuals who recognize that the healthcare system operates under a model of covert rationing can immediately take steps to prevent themselves and their loved ones from being victims of that rationing. It is hard to covertly ration against

enlightened patients.

2) Once a critical mass of the population becomes so enlightened, Quadrant III healthcare will no longer be feasible.

3) Given the history so far of the information revolution and given the information-seeking behavior of a growing proportion of American patients, the enlightenment that will render Quadrant III healthcare impossible seems inevitable.

Thus does the GUTH finally lead us to a place that a while ago may have seemed almost incomprehensible. It leads us to a place of optimism or, at least, relative optimism. There may be a path out of Quadrant III, and it is a path we're likely to find ourselves taking. It's a path that does not require legislation, political action committees, tax incentives (or disincentives), a majority vote of the entire population, or bloodshed. It merely requires that a critical mass of Americans begin acting in their own enlightened self-interest and that a cohort of doctors and entrepreneurs find ways of enabling them to do so.

For more on what we can do both to protect ourselves as individuals within the dysfunctional American healthcare system, and how we can help catalyze a reformation in healthcare, read on.