

Transcript of Interview with Barry Furrow
Hamline University School of Law
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DAPHNE PONDS: My name is Daphne Ponds and I'm a third year law student at Hamline University School of Law and president of the Hamline Student Health Law Association. Today I'm interviewing Professor Barry Furrow, director of the Health Law Program at Earle Mack School of Law at Drexel University and co-author of the textbook *Health Law: Cases, Materials and Problems*. Thank you, Professor Furrow, for being here with us today.

BARRY FURROW: My pleasure to be here.

PONDS: Professor Furrow, you have written what has essentially become *the* health law textbook for law students across the country. When did your health law textbook first come out?

FURROW: It came out in 1987 with the first edition and I can give you a little history of it, it's kind of interesting. Three of my co-authors and I were at a Dartmouth institute on law and economics, and we sat down at lunch one day and we said, we realized that we all taught health law and were struggling with bad books. And we said, "You know what, we all seem to like each other, why don't we do a book?" So it was the classic on the back of a napkin drawing up an outline of the book. And we went on from there to do it, within a year.

PONDS: And what do you think was the most challenging part about writing a book for law students?

FURROW: Well the first question is what do you cover? And it's gotten more and more complicated as health law has gotten to be a much bigger field and has splintered into sub-specialties. So I think the first question is what are the topics that you use to frame what the issues are: access, quality, cost, and what we've come to call personhood issues, which is patients' rights, informed consent, how the system treats the individual. And that was our first struggle, just to frame the issues.

PONDS: And what do you think were maybe, some of the one or two topics, that were the most difficult, you felt, to maybe translate to law students to make it clear?

FURROW: I think it's always, to start with the simplest, it's always easy for law students to wrap themselves around liability issues. It's easy to understand the tort pieces of it. It's fairly easy to understand all of the common law material; physician credentialing and licensing and medical staff privileges is pretty easy to understand. But reimbursement is complicated. And the more you move into the Medicare and Medicaid system and how the federal government funds and controls healthcare, it's hard to make that teachable because it's very complicated, it's intricate, and it's hard to avoid being boring when you're developing a book that's supposed to engage the class. So that's always our biggest struggle, is to do the reimbursement part of it.

PONDS: And what one or two cases do you think really stand out as changing healthcare, changing the way that we practice today?

FURROW: Oh, that's a good question. From a liability point of view it's the line of cases that deal with hospital responsibility and corporate negligence. That's a developing doctrine and I think it's put hospitals much more as a target in terms of responsibility for patient care. With patient rights it's probably the cases like *Canterbury v. Spence* that make the patient central and [key to the] disclosure of information as to risks for services. Death and dying would probably be the *Cruzan* case and the Supreme Court decision struggling with physician-assisted suicide, like *Washington v. Glucksberg*.

PONDS: What do you feel was the most enjoyable part about putting this book together?

FURROW: Oh I think collaborating with really smart co-authors. It's great fun. I mean my co-authors now are Rob Schwartz at the University of New Mexico, who's a bioethicist and was at one point Commissioner of Medicaid in the State of New Mexico; Tim Jost at Washington and Lee, who has done a lot of work studying comparative systems, the German system for example, and has written a lot about patient savings accounts and the problems with them – very sophisticated, very sophisticated guy; Tom Greaney, who worked for the Federal Trade Commission and is an antitrust expert and [has a] wonderful sense of humor; and Sandy Johnson, who's now the dean at St. Louis University and was the provost, who is just brilliant at tying it all together. So I think it's the pleasure of working with different minds all with different skills, and coming and mixing it all together and coming up with this sausage, this book.

PONDS: Well, I'm [going to] switch gears just a little bit. I [want to] get your insight to the new healthcare/health reform legislation. What do you feel are really, as it stands now, the most beneficial pieces of the Affordable Care Act for the American people?

FURROW: I'm actually, I'm a big fan of the Act. Now that's not to say that I would not have preferred a rather different model that approached some of these problems. But the Act was primarily driven by a need to promote access for 50-some American, 50-some million Americans who didn't have access. And in theory it will increase access for 32 million of that population. That's a tremendous improvement if it happens. The Act does that in two ways and one of these ways is more problematic than the other. One, it reforms health insurance, and the small group and individual market for insurance, so that insurers have to play by rules that are fairer, they can't exclude people from coverage. It also mandates that everyone following the Massachusetts model – the Massachusetts Connector everyone has to buy insurance or pay what is really a tax penalty – and so we have presumably close to full coverage. And that's a good thing. I talked to somebody in Massachusetts this week and they're up to 98% coverage. It doesn't mean there aren't cost issues, but they've gotten coverage at a level that is ideal. And the Affordable Care Act won't achieve that high a level but it's going to be a big improvement. The other part of achieving better access is expanding Medicaid to 133% of the poverty level. Medicaid is a much more complicated program and providers don't like it because it doesn't pay as much. However, the federal government is picking up the tab for this expansion for several years. So the states, at least in the short term, ought to be happy because it's expanding coverage. In the long term it's [going to] be a battleground. And I think that's a problematic way to expand coverage because it's such a source of friction with the governors, who spend so much money on Medicaid out of the state budget. So that's not optimal, I think, as a way to do it.

PONDS: When you said also that it, that you support it but it wasn't necessarily the model that you would have chosen, what model do you think would have been more preferable?

FURROW: Well, I mean it seemed to be, on the right there was a much more market-driven model. You know I think the fantasy of the Republicans that is you just give everybody money and they buy

insurance in the private market; they're convinced the private market is the way to go. On the other hand you might go to what was the Kennedy, the Ted Kennedy model. Back in 1972, Kennedy proposed a "health care for all" bill that would have simply taken Medicare and applied it to everybody. And it had lots of other features that were complicated and politically unpalatable, but the simple idea [is] Medicare works and is quite efficient – everybody just gets a Medicare card and they're good to go. That's really much like a national health system in terms of Italian, French, German, Scandinavian plans. If you're a citizen you get a card and you get access. You've got other problems always to deal with, but at least you get around the access problem by making it simple. This is not simple. This just reforms the complicated private market, insurance still is in place and with all the costs of insurance, and it doesn't reform Medicaid it simply expands coverage. So it's kind of messy.

PONDS: And what do you feel was Obama's, President Obama's, overall goal with his administration? What do you feel like he really was trying to accomplish with the Affordable Care Act?

FURROW: I think he was trying to accomplish primarily the goal of improving access, of giving many more people the chance to at least have insurance, to have coverage. And it doesn't solve the problem of whether there are enough physicians, whether they're located in the right places, it doesn't solve those kinds of questions, but it gives you – I think it relieves anxiety. I think Americans suffer from chronic anxiety about access to healthcare because it's employment based. If you lose your job you lose it, if you're an artist you don't get it or you have to pay outrageous premiums. So Americans I think are always anxious about losing their job, historically. Alright, and you almost think you have to marry strategically if you're an artist – you better marry somebody with benefits – otherwise you can't pursue some careers. That's kind of crazy. So I think this was primarily an access-driven, anxiety-reducing piece of legislation. Now there are lots of other pieces to it – there are 9 parts, there are 10 parts in this Act – and they do a lot of different things. So there are other goals, but this was the central political goal, I think.

PONDS: When do you think that there is the support behind those goals where he can actually expand the access?

FURROW: I don't know. I think the insurers are [going to] respond and they're [going to] want to sell on the exchanges, they're [going to] want to continue to be in the business of insurance. Their role changes quite a bit but I think they're [going to] play. They're not [going to] resist this because for them it is millions of new paying customers. So from the point of view of a business, this is an attractive thing for insurance if they can figure out how to do it cost-effectively. I think the problem is Medicaid. You know, what about the 29 states that are suing, declaring the Act unconstitutional? You know, the governors are just worried. I don't think the Act is unconstitutional, but they're making a lot of pushback.

PONDS: I think a lot of push back's been that there's not the resources, there's not the money, where is all the money and the resources [going to] come from. Do you think that the Affordable Care Act can be sustainable over the long haul?

FURROW: That's just a question of political will. I mean, in theory the Affordable Care Act over time will improve quality while lowering spending, so on a per unit basis over time it should have cost-effectiveness benefits. If you coordinate care – there are for example kind of anecdotal evidence. Gawande wrote an article in the New Yorker on hot spotters, which is high utilization patients, often poor, often obese, diabetic, lots of co-morbidities. They use the ER all the time, they cost millions of dollars for the system, and if you focus on those patients and you manage them very intensely you can

cut their usage in half and make them much healthier. So the focus on coordinated management throughout a patient's lifecycle has enormous benefits. It's just, we're very fragmented as a system, so the Affordable Care Act is pushing toward better integration. It's pushing toward, you know there's [going to] be a lot of resistance, there are lots of questions about what works, but if it all worked even close to what is expected, it should, it should slow the rise of the cost curve. Never [going to] flatten it because we're all getting older and technology is getting more and more expensive, but it should bring us back to what is the European level of expenditure. We're way above it on a per-population basis; we spend way too much for what we get. If we can bring that down, it is at least the beginning of savings. And the rest of it's political will. How much are we willing to tax ourselves to achieve care for everybody?

PONDS: And do you feel that we can achieve care for everyone?

FURROW: I don't see why not. Other countries do it without as much political brouhaha as we have: the Italian, the French system, the Italian system, the German system, the British system, you know they have... I wouldn't want to have a quadruple bypass procedure in Italy, if I went, if I were a British citizen I probably couldn't get a hip replacement in my 70s or 80s, it's simply not within the clinical standard of practice, but they give superb care up [until] old age. They don't often have as good high technical care, although the French probably do, so you could criticize these companies – countries – and say well, they have flaws, but in general they provide much better care over the life cycle, I think, than we do. We should be ashamed of ourselves, frankly. There are a lot of other models that do superbly, we just can't quite get there.

PONDS: Do you feel the Affordable Act – Care Act – eventually can get us there?

FURROW: Well it's a good first step, you know, and there's a lot of experimentation in the Act. The other part of the Act is it's a kind of catch-all of experimentation. Even the pay-for-performance stuff is constantly [going to] be measured and re-evaluated and so on. There are new websites that are [going to] compare everybody in infections in hospitals and so on and make them much more transparent. We'll see what happens. Do we really shop for healthcare as consumers or are we too scared? Do we fall back on our doctor who doesn't know very much? So we don't know, we don't know how some of this shakes out. There are lots of demonstration projects, you know, little projects that try out medical homes and transitional care and so on, and some of those will fail, some of those won't. So the Act is also, it's not a rigid kind of federal law that says we shall do twelve different things, it's let's try a bunch of different things and see what sticks. I think that's probably a pretty good strategy: the government as innovator, experimenter, ready to shut down something that's a dead end.

PONDS: Well, Professor Furrow, I thank you on behalf of the Hamline Health Law Institute for being here with us today. We appreciate your insights and [are] glad that you were able to come here and share with us today.

FURROW: I'm delighted to be here, you have a great program.

PONDS: Thank you.

FURROW: And I intend to steal some of your ideas and bring them back to Drexel.

PONDS: [Laughter] Thank you very much.