

ing seminars at a “nonaccessible restaurant” in southern California. In fact, most Medicare HMOs market their plans on television and over the radio, and the advertisements emphasize features that appeal to lower-income beneficiaries — namely, greater benefits coverage at a lower price than those of standard Medigap plans.

These stories make for provocative reading, and Geyman does diagnose Medicare’s problems correctly. There is a lot of churning in this program; enrollment remains low, at approximately 15 percent; benefits have been cut in recent years; and the HMOs compete for enrollees at low risk for needing health care services. Much of Medicare spending is wasted on services that have little social value, and the high cost of services that are truly necessary limits enrollees’ access to them. Beneficiaries face high costs for care, and problems of access and quality of care abound.

But Geyman’s solutions are a bit disappointing. Who can argue with improving quality, reducing health disparities, expanding coverage, increasing access, and lowering costs? These issues deserve more depth than he provides. Central to Geyman’s argument is that eliminating private insurers will save vast sums of money. He notes repeatedly that Medicare has lower administrative expenses than do private insurers. This argument has often been used by proponents of national health insurance — which Geyman also advocates — to justify great savings.

There are two problems with the administrative-costs argument that are not suitably addressed. First, Medicare is ripe with abuse — especially in the overuse of unneeded services — and there is little incentive for politicians to weed it out. This is a hidden cost that is often ignored in administrative-cost calculations. Furthermore, there are economic costs associated with financing Medicare through taxes, especially payroll taxes borne by a proportionately shrinking base of young workers.

Second, and perhaps more important, even if we could wring some savings by eliminating private health insurance, this effort would be a single reduction in the level of spending. The real problem for Medicare is the growth in spending. For this reason, many industrialized countries with nationalized health care have increases in spending (and rates of increase) that are similar to those in the United States. A one-time decrease in health care spending — even if it could be

claimed — would be nice, but it would only postpone the really painful choices. Geyman would argue that Medicare does a better job controlling health care spending than do private insurers, but here the evidence (through no fault of his) is decidedly mixed.

Geyman’s take on means testing of Medicare — charging more affluent patients more for participation in the program — leaves the reader wanting more explanation. Readers may have a hard time accepting his thesis that means testing is a Republican plot to dismantle the program eventually. Faced with painful policy choices, such as raising the eligibility age or increasing taxes to avoid fiscal insolvency, such a reform probably deserves more consideration than is offered in this book. In countries such as Canada, national health insurance is financed through a progressive tax structure; why not use such a mechanism in the United States?

Ultimately, Geyman’s personal diagnosis of the Medicare program makes for entertaining reading. Readers looking for innovative policy prescriptions, however, will need to go elsewhere.

Dana P. Goldman, Ph.D.

RAND

Santa Monica, CA 90403

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**WE ALL FALL DOWN: GOLDRATT'S  
THEORY OF CONSTRAINTS  
FOR HEALTHCARE SYSTEMS**

By Julie Wright and Russ King. 353 pp. Great Barrington, Mass., North River Press, 2006. \$27.50. ISBN 0-88427-181-1.

**S**OME THINGS ARE UNIVERSAL. HEALTH CARE systems do not work optimally, especially in hospitals — regardless of whether they are academic or community hospitals. Managing throughput is a challenge, resources are constrained, the number of beds is often limited, and patients experience long delays in the emergency department while waiting for beds. Most institutions have tried many solutions without sustained improvement. Clinicians and managers blame each other and act to protect their own turf. Business consultants appear, and they suggest further changes, but their “tweaks” provide only temporary relief.

These undesirable events are not unique to

medicine; they occur in abundance in other professions and industries. During the past two decades, an approach dubbed the “theory of constraints” has grown in popularity and success in industry. This approach began with Eliyahu Goldratt’s particularly readable “business novel” entitled *The Goal*, which is currently in its third edition (North River Press, 2004). Several related books have been published since then. The newest book in that array, *We All Fall Down*, extends the principles and analytic approaches of the theory of constraints to health care systems. The story is set in a mid-sized academic hospital in the United Kingdom, and the characters and their foibles are so familiar as to be both comforting and frightening.

Coauthor Julie Wright, an adherent of Goldratt’s approach, directed a hospital admissions department and then managed an after-hours service that provided primary care to half a million people in Britain’s National Health Service. Coauthor Russ King is a freelance writer who tries to smuggle humor into science. Together they identify the core problem in the hospital; that is, the inability of the system and its managers to solicit and integrate the knowledge and experience of front-line workers (physicians, nurses, and support staff) and to shape and establish adequate “buy-in” for quality improvement plans. They also consider the inefficiencies created when patients are located on many different floors throughout the hospital; this arrangement makes it impossible for physicians to see all their patients in a timely fashion. Although the authors consider the inefficiencies (e.g., extra admissions) produced when less experienced physicians compose the staff of the emergency department, they do not consider the effect of tighter supervision on the education of young physicians. The authors describe the limitations of manual administration systems that track the flow of patients throughout the hospital, and they hypothesize that posting information about patient flow on an electronic “bed board,” akin to a hotel reservation system, will improve throughput. The familiarity — or perhaps the universality — of these problems (or undesirable effects) to academic physicians in the United States leads me to believe that the authors’ analysis (or at the very least, their approach) is probably widely applicable.

Aside from important insights about the hospital setting, the book briefly introduces many

of the tools associated with the theory of constraints. It provides a useful review for physicians and managers who may have seen these tools before, but the descriptions are quite telegraphic and not sufficiently detailed to allow a novice to apply them. However, the book might motivate practitioners and managers to approach Goldratt’s previous business novels such as *The Goal* and *It’s Not Luck* (North River Press, 1994), or even Lisa Scheinkopf’s *Thinking for a Change: Putting the TOC Thinking Processes to Use* (Boca Raton, Fla.: CRC Press, 1999) and H. William Dettmer’s *Breaking the Constraints to World Class Performance* (New York: McGraw-Hill, 1998). Wright and King’s book provides useful approaches to managing change and overcoming resistance to change. It also offers a guide to the identification and management of bottlenecks or constraints to patient flow. In medicine, as in other environments, one core problem is variation. Advocates of “total quality improvement” and the “six sigma” approach try to stamp out variation, whereas advocates of the theory of constraints recognize that variation cannot always be eliminated. Rather, good physicians and administrators should be able to manage variation. Advocates of the theory of constraints argue for establishing and communicating a common goal within a system and developing measurements that support progress toward that goal in all parts of the system.

*We All Fall Down* should be a respected addition to the libraries of clinicians who practice in a health care system and of managers of clinical enterprises.

Stephen G. Pauker, M.D.

Tufts–New England Medical Center  
Boston, MA 02111  
spauker@tufts-nemc.org

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### MEASURING MEDICAL PROFESSIONALISM

Edited by David Thomas Stern. 311 pp. New York, Oxford University Press, 2006. \$49.50. ISBN 0-19-517226-4.

**T**HIS BOOK ON THE MULTIFACETED PROBLEM of measuring medical professionalism is interesting and valuable. It has something for any reader seeking to understand whether, why, or how professionalism in medicine might be evaluated.

The editor, David Thomas Stern, asks whether