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A Comparison between the American Markets for Medical and Legal Services

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America's access to justice woes are paradoxical. We have more lawyers than every country except India and more lawyers per capita than every country except for Israel. We spend more on law as an absolute amount or as a percentage of GDP than any other country. At the high end, we provide best legal services in the world.

And yet we barely provide any legal services to the very poor, and our lawyers cost too much for the working poor or even the middle class. We graduate so many juris doctors that as many as a third fail to find work as a lawyer, despite clear signs of demand within the middle class. Why the mismatch between supply and demand? Why do we spend so much on law and provide so little? It turns out there is another American market for professional services that shares some of the same puzzling features: medicine. We spend more than any other country on law and medicine, and yet we have relatively poor outcomes in both.

This Article discusses the central puzzle in law and medicine: why do we pay so much and get so little? Law and medicine serve three different, very distinct American populations: the wealthy, the very poor, and the working poor. The wealthy and corporations get the very best in the world services. The very poor get at least some access to services. The working poor, however, are often worst off in America. Too "wealthy" to qualify for government subsidized services and too poor to pay out of pocket for a doctor or lawyer, this population is often squeezed out. The Article then asks what role professional regulation and education plays in this dynamic, and considers whether legislative help is very likely in law, using the passage of the Affordable Care Act as a model.

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INTRODUCTION

I recently finished a Fulbright year teaching Comparative Law at the University of Ljubljana to Slovenian and other EU students. In one class I tried to explain our ongoing controversies over providing access to justice. After my initial (and apparently poor) effort to explain it, one student remarked, "So the poor in America cannot afford a doctor or a lawyer. OK, I got it."

I had to correct the student though: "No, that's not right, the poorest Americans have government provided health care and sometimes lawyers."

The student replied, "Hmmm, ok then, who exactly doesn't get help with legal and medical services?"

"The working poor! They make too much to qualify and the services cost too much for them to be able to afford them on their own."

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"But I thought Americans were obsessed with pushing people off of government support and into work? Isn't it wrong and self-defeating to treat the working poor the worst?"

"Yes. Exactly. Now you get it."

That conversation launched my interest in this comparative study. America's access to justice woes are paradoxical in a number of ways. We have more lawyers than every country, except for India, and more lawyers per capita than every country, except for Israel.[1] We spend more on law as an absolute amount or as a percentage of GDP than any other country.[2] At the high end, our so-called "Big Law," we provide the best and most lucrative services in the world. Yet, we barely provide any legal services to the very poor, and American lawyers cost too much for the working poor or even the middle class. We graduate so many juris doctors that as many as a third fail to find work as a lawyer,[3] despite clear signs of demand within the middle class. Why the mismatch between supply and demand?

It turns out there is another American market for professional services that shares some of the same puzzling features: medicine. We spend more than any other country on law and medicine and yet we have relatively poor outcomes in both.

The solution to this puzzle is similar for both medicine and law. The American market for these professional services is actually best understood as divided into three portions. At the top end, where large law firms serve corporate clients and fancy hospitals serve wealthy Americans and foreigners, America does have an argument to the world's best medical and legal services. At the bottom end, America is hardly the best in the world. But in medicine (through Medicaid and the CHIP program), and in law (through public defenders, legal aid, and pro bono work) the poorest Americans have at least some access to services.

The real problem area is in the middle. Both before and after the Affordable Care Act ("ACA"),[4] also known informally as Obamacare, the working poor are the most likely to be uninsured.[5] Too "rich" to

1. *See* Drew Combs, *The Global Legal Market: By the Numbers*, AM. LAW., Oct. 23, 2014.

2. *See infra* Part II.

3. *See* Marc Gans, Not a New Problem: How the State of the Legal Profession Has Been Secretly in Decline for Quite Some Time (June 24, 2012) (unpublished manuscript) (on file with author).

4. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119-1025 (2010) (amending Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395(a)–(*lll*), by adding new § 1899), *amended by* the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029-84 (2010). The final amended legislation will be referenced throughout this Article as the ACA.

5. *See* Rachel Garfield et al., *The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid—An Update*, KAISER FAM. FOUND. (Jan. 21, 2016), http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/.

qualify for Medicaid, too poor to buy health insurance, and working jobs that rarely offer employer supported health insurance, these individuals bear the brunt of America's decision to rely on private insurance programs to pay for health care. Similarly, working class Americans do not qualify for legal aid, but cannot afford hundreds of dollars an hour for legal work, leaving them to ignore their legal problems or to do their best by proceeding pro se.

Nor are these poor results solely a consequence of market forces. While America often trumpets free market solutions to its problems, neither of these markets are particularly free. In law and medicine, occupational licensing (its length and cost and the nature of the training) is part of the reason why services are too costly for the working poor and the middle class. This is not to say that the licensing schemes are bad, just that efforts to increase access to either medical or legal services must either involve massive infusions of funds or changes to current regulation and professional education, or both.

In this regard, medicine is again a helpful model to study, since we have recently seen a massive change in the market for medical services. There are several lessons to be taken from the passage and implementation of the ACA for would-be reformers of the market for legal services, including the power of entrenched interests and the unusual political economy of lawyer regulation.

Some caution in drawing analogies is necessary. The market dynamics are quite different in medicine and law. For example, medicine deals more with issues of life and death. Medicine has a much bigger (and very powerful) private insurance market as well as massive players in pharmaceutical and medical devices. The size of the market for medicine dwarfs the market for law. Nevertheless, since at least the nineteenth century American law and medicine have been the twin "learned professions" and have looked to each other for guidance; thus a comparative perspective can teach us much about both markets.

This Article proceeds as follows: Part I lays out the basics of both markets—how much we spend, how many doctors and lawyers there are, what they earn, and how many law and medical students there are. Part II turns to a detailed description of the puzzle in law and medicine: why do we pay so much and get so little? Part III answers the question by describing three different American populations: (1) the wealthy, (2) the very poor, and (3) the working poor. This Part also describes what level of services each receives. Part IV considers professional regulation and education. Part V then asks if legislative or other regulatory access to justice help is likely, using the passage of the ACA as a model.

I. A Brief Comparison of Law and Medicine

The American market for medical services is much larger than its market for legal services. Medicine is also growing faster as an absolute matter and as a percentage of GDP. Figure 1 shows the size of the market for medical services[6] and legal services[7] as an absolute number, without adjusting for inflation, from 1997 to 2013.[8] Adjusted for inflation, the difference in size and growth is even more marked. Figure 2 shows the same data in chained 2009 dollars.[9]

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6. The Bureau of Economic Analysis ("BEA") count for medical services comes from the North American Industry Classification System ("NAICS") subcategory called "Health Care and Social Assistance." NAICS defines this category as follows:

> The Health Care and Social Assistance sector comprises establishments providing health care and social assistance for individuals. The sector includes both health care and social assistance because it is sometimes difficult to distinguish between the boundaries of these two activities. The industries in this sector are arranged on a continuum starting with those establishments providing medical care exclusively, continuing with those providing health care and social assistance, and finally finishing with those providing only social assistance. The services provided by establishments in this sector are delivered by trained professionals. All industries in the sector share this commonality of process, namely, labor inputs of health practitioners or social workers with the requisite expertise. Many of the industries in the sector are defined based on the educational degree held by the practitioners included in the industry.

About the Health Care and Social Assistance Sector, Bureau Lab. Stat., http://www.bls.gov/iag/tgs/iag62.htm (last visited May 29, 2016).

7. The Legal Services NCAIS category is more straightforward. For a detailed list of everything included, see *NAPCS Product Line for NAICS 5411: Legal Services*, U.S. Census Bureau, https://www.census.gov/eos/www/napcs/finalized/web_5411_final_reformatted_edited_US082208.pdf (last visited May 29, 2016).

8. The data for this chart comes from the GDP by Industry count by the BEA. *Gross-Domestic-Product-(GDP-)-by-Industry Data*, Bureau Econ. Analysis, http://www.bea.gov/industry/gdpbyind_data.htm (last visited May 29, 2016). The form I used is called "GDP by Industry / VA, GO, II." Figure 1 *infra* shows the "Value Added by Industry," defined by the BEA as:

> The value added of an industry, also referred to as gross domestic product (GDP)-by-industry, is the contribution of a private industry or government sector to overall GDP. The components of value added consist of compensation of employees, taxes on production and imports less subsidies, and gross operating surplus. Value added equals the difference between an industry's gross output (consisting of sales or receipts and other operating income, commodity taxes, and inventory change) and the cost of its intermediate inputs (including energy, raw materials, semi-finished goods, and services that are purchased from all sources).

Frequently Asked Questions: What Is Industry Value Added?, Bureau Econ. Analysis, http://www.bea.gov/faq/index.cfm?faq_id=184 (last visited May 29, 2016).

9. For an explanation of how chained dollar GDP estimates work, see J. Steven Landefeld et al., *Chained-Dollar Indexes: Issues, Tips on Their Use, and Upcoming Changes*, Surv. Current Bus. (Nov. 2003), http://www.bea.gov/scb/pdf/2003/11November/1103%20Chain-dollar.pdf.

FIGURE 1: VALUE ADDED GDP 1997–2003

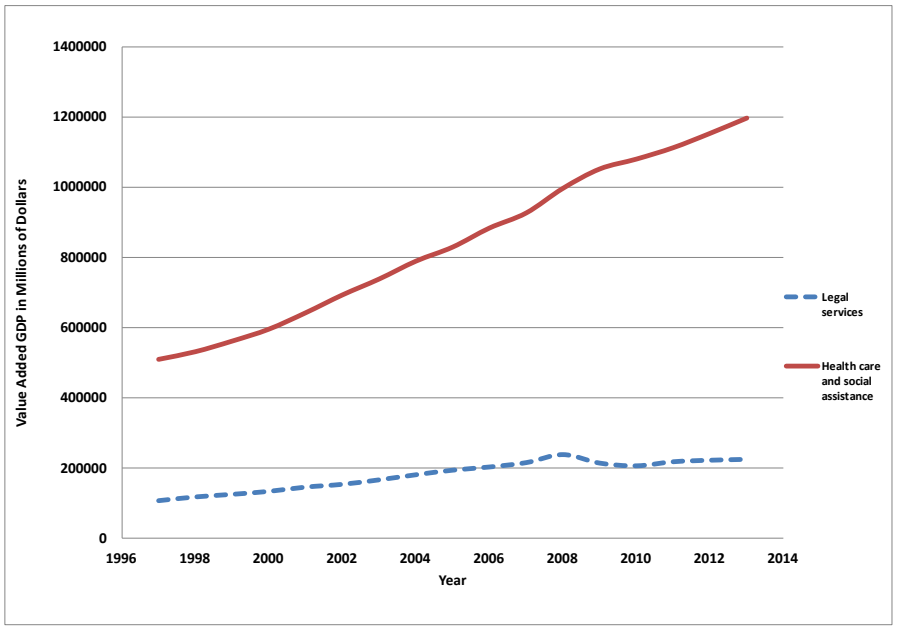
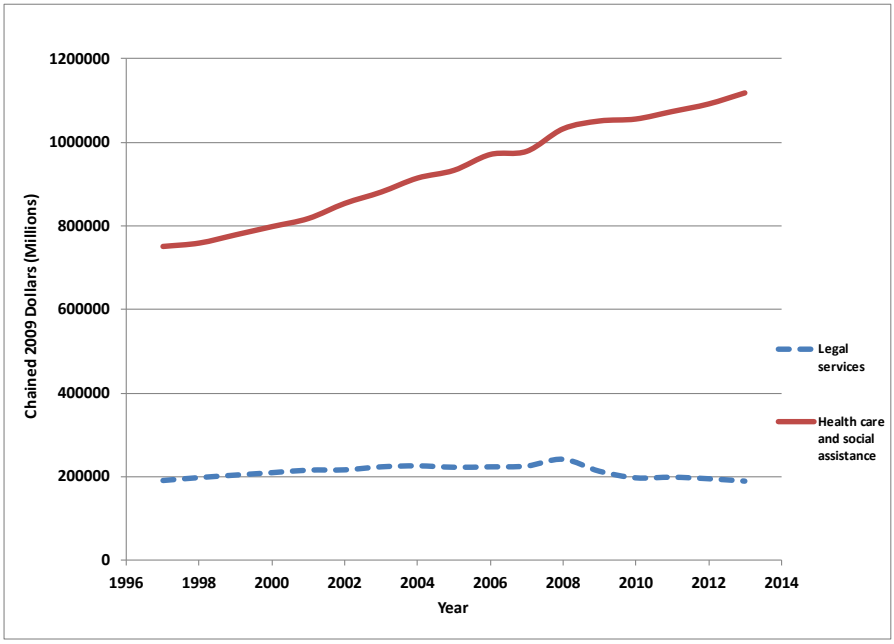


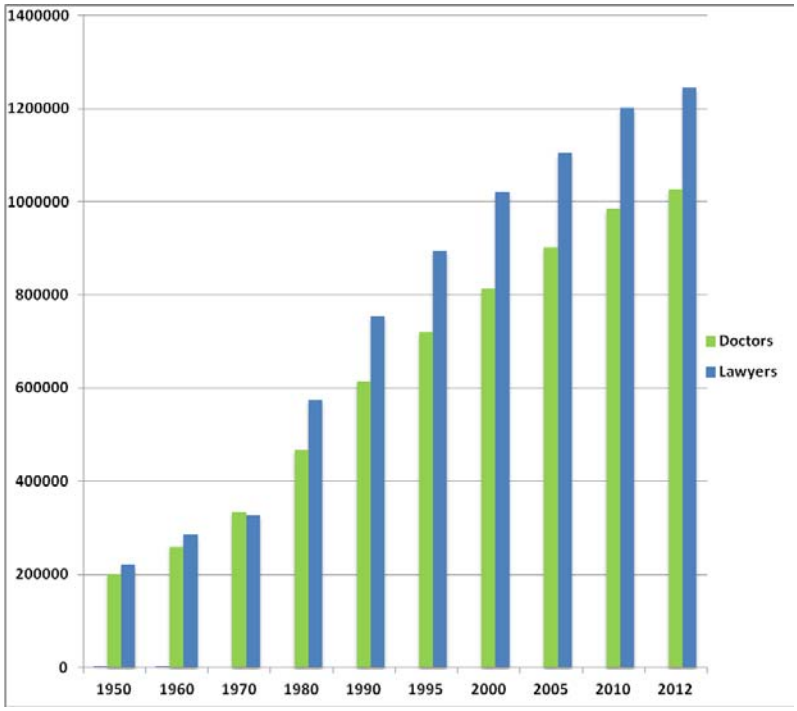
FIGURE 2: GDP IN CHAINED 2009 DOLLARS



As an overall percentage of GDP, health care dwarfs legal services. In 2013, overall health care expenditures were 17.4% of America's GDP,[10] while legal services were 1.3%, the lowest percentage since 2000.[11] Legal services have seen a decline since 2008 and have been basically flat since 1997.

Yet there are more licensed lawyers in America than there are doctors. Figure 3 shows the number of licensed doctors and lawyers in America from 1950 to the present.[12]

FIGURE 3: NUMBERS OF LICENSED AMERICAN DOCTORS AND LAWYERS



10. Abe Dunn et al., *Introducing the New BEA Health Care Satellite Account*, BUREAU ECON. ANALYSIS (Jan. 22, 2015), http://www.bea.gov/scb/pdf/2015/01%20January/0115_bea_health_care_satellite_account.pdf.

11. *See Gross-Domestic-Product-(GDP-)-by-Industry Data*, *supra* note 8.

12. The data for Figure 3 comes from *Total National Lawyer Population Survey*, A.B.A., http://www.americanbar.org/content/dam/aba/administrative/market_research/total-national-lawyer-population-1878-2015.pdf (last visited May 29, 2016) and *Total Number of Doctors of Medicine in the U.S. from 1949 to 2012*, STATISTA, http://www.statista.com/statistics/186260/total-doctors-of-medicine-in-the-us-since-1949/ (last visited May 29, 2016). Note that the doctor count for 1950 on Figure 3 is actually the number of doctors in 1949.

Both law and medicine have seen tremendous growth since 1970, with the number of licensed doctors tripling and the number of lawyers almost quadrupling. In 1970, America had more licensed doctors (334,028) than lawyers (326,842). From 1970 until 2000 the legal profession grew faster than the medical profession, but since 2000, the growth has been about even.

The United States has an unusually large number of lawyers per capita, one lawyer for every 254 people in 2011.[13] This is more than every country except for Israel.[14] By comparison, in 2011 America had one doctor for every 310 people.[15] There are fewer doctors per capita in the United States than in fifty other countries, including Russia, Cuba, the United Kingdom, Germany, and Australia,[16] and by some counts we are actually facing a worsening *shortage* of doctors.[17]

The gap might start to close as medical schools expand enrollment and law schools shrink. Figure 4 shows medical school and law school matriculation from 2003 to 2014.[18]

13. *See* BENJAMIN H. BARTON, GLASS HALF FULL: THE DECLINE AND REBIRTH OF THE LEGAL PROFESSION 34 (2015).

14. *See* Combs, *supra* note 1.

15. This number is generated by dividing the 2011 U.S. population of 311.7 million from the number of licensed doctors in 2011 (1,004,635). *See Total Number of Doctors of Medicine in the U.S. from 1949 to 2012*, *supra* note 12.

16. *See The World Factbook*, CENT. INTELLIGENCE AGENCY, https://www.cia.gov/library/publications/the-world-factbook/fields/2226.html (last visited May 29, 2016).

17. *See* Samuel Weigley et al., *Doctor Shortage Could Take Turn for the Worse*, USA TODAY, (Oct. 20, 2012, 2:45 PM), http://www.usatoday.com/story/money/business/2012/10/20/doctors-shortage-least-most/1644837/.

18. The medical school data comes from ASS'N OF AM. MED. COLLS., MATRICULANTS TO U.S. MEDICAL SCHOOLS BY STATE OF LEGAL RESIDENCE, 2006–2007 THROUGH 2015–2016 (2015). The law school data comes from *Enrollment and Degrees Awarded 1963–2012*, A.B.A., http://www.americanbar.org/content/dam/aba/administrative/legal_education_and_admissions_to_the_bar/statistics/enrollment_degrees_awarded.authcheckdam.pdf (last visited May 29, 2016). The 2013 data came from *Fall 2013 1L Enrollment*, A.B.A., http://www.americanbar.org/content/dam/aba/administrative/legal_education_and_admissions_to_the_bar/statistics/2013_fall_aba_approved_law_school_entering_class_information.xlsx (last visited May 29, 2016), and the 2014 data came from *ABA Section of Legal Education Reports 2014 Law School Enrollment Data*, A.B.A. (Dec. 16, 2014), http://www.americanbar.org/news/abanews/aba-news-archives/2014/12/aba_section_of_legal.html.

FIGURE 4: LAW SCHOOL AND MEDICAL SCHOOL MATRICULANTS 2003–2014

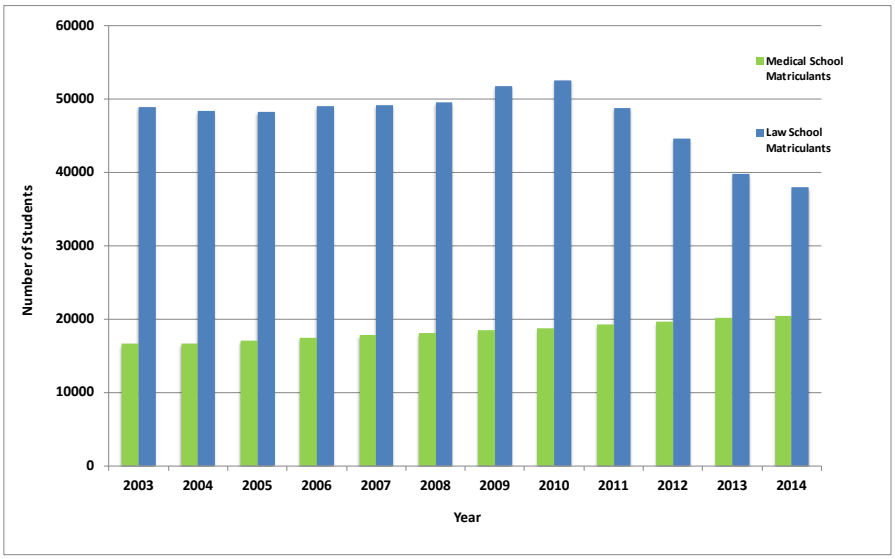


Figure 4 shows that law school matriculation is falling as medical school rises. Figures 3 and 4 present a strange mismatch, though: if there are so many more students starting law school than medical school (more than twice as many in the time period presented), how are the numbers of lawyers and doctors growing at roughly the same pace so far this century?

Part of the answer is foreign medical schools. About one quarter of the licensed doctors in America graduated from a foreign medical school.[19] Graduates of foreign medical schools must jump through a number of hoops, including an American residency program and a number of examinations,[20] but they are otherwise free to join the profession, and many try to do so. In 2015, for example, more than 6300 graduates of foreign medical schools were admitted into American residency programs.[21] The number of foreign educated lawyers in the United States is much smaller.[22]

19. *See About ECMFG*, EDUC. COMMISSION FOREIGN MED. GRADUATES, http://www.ecfmg.org/about/index.html (last visited May 29, 2016).

20. *See id.*

21. *See* Brian Palmer, *Unmatched*, SLATE (Apr. 2, 2015, 10:15 AM), http://www.slate.com/articles/health_and_science/medical_examiner/2015/04/match_day_for_medical_residency_the_scramble_foreign_doctors_and_a_shortage.html.

22. *See* Carole Silver, *The Case of the Foreign Lawyer: Institutionalizing the U.S. Legal Profession*, 25 FORDHAM INT'L L.J. 1039 (2002).

Another part of the answer is that many American law school graduates—approximately one third, by some estimates—do not end up practicing law.[23] By comparison, the category of non-practicing doctors is smaller, at about 200,000 or under twenty percent of all licensed doctors.[24] Some of these licensed professionals are not practicing law or medicine by choice, either because they are happily working in other industries or are semi-retired or staying home for family responsibilities. The larger percentage of licensed lawyers choosing not to practice law, however, likely reflects the overall weakness in the employment market for legal services.

American doctors earn more than American lawyers. In 2014, the Bureau of Labor Statistics ("BLS") estimated that there were 603,310 individuals working full time as lawyers, and that their median earnings were $114,970 and their mean earnings were $133,470.[25] These numbers are a little skewed because they account for less than half (603,310 individuals) of the total 1,281,432 licensed American lawyers.[26] According to the BLS, the rest of these licensed individuals are not working as lawyers. It is likely that some are working other types of jobs while carrying their license, some are retired, and some are staying home to care for their children.

By comparison, the BLS estimates that there are 633,480 physicians and surgeons working full time and earning a mean salary of $194,990. In 2012, there were 1,026,788 licensed physicians in the United States, so the BLS estimate is for around two-thirds of all licensed doctors.

The BLS estimates of the number of doctors and lawyers are interesting because they show more people employed as doctors than lawyers, despite the fact that there are many more licensed lawyers than doctors. The BLS gathers this estimate based on surveys of businesses,[27]

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23. *See* Gans, *supra* note 3.

24. *See Statistics and Facts About U.S. Physicians*, STATISTA, http://www.statista.com/topics/1244/physicians/ (last visited May 29, 2016).

25. The data come from the BLS. BUREAU LAB. STAT., MAY 2014 NATIONAL OCCUPATIONAL EMPLOYMENT AND WAGE ESTIMATES (2014), http://www.bls.gov/oes/special.requests/oesm14nat.zip. All of the salary data in the next three paragraphs also come from this source.

26. The 1.2 million figure comes from the annual ABA count of every licensed lawyer in America. A.B.A., ABA NATIONAL LAWYER POPULATION SURVEY (2015), http://www.americanbar.org/content/dam/aba/administrative/market_research/total-national-lawyer-population-1878-2015.authcheckdam.pdf.

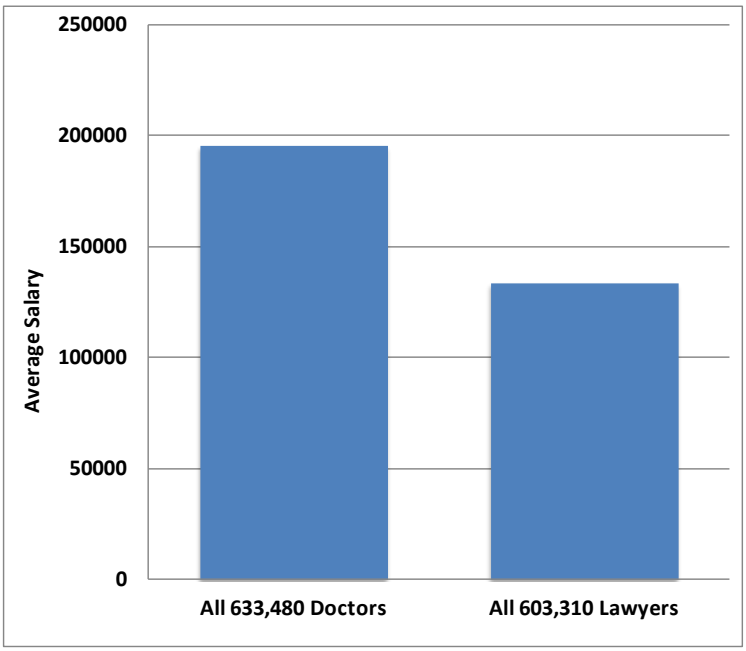
27. Here is how BLS describes how the survey is conducted:

> The OES survey is a semi-annual mail survey of non-farm establishments. The BLS produces the survey materials and selects the establishments to be surveyed. The sampling frame (the list from which establishments to be surveyed are selected) is derived from the list of establishments maintained by State Workforce Agencies (SWAs) for unemployment insurance purposes. Establishments to be surveyed are selected in order to obtain data from every metropolitan and nonmetropolitan area in every State, across all surveyed industries, and from establishments of varying sizes. The SWAs mail the survey materials to the selected establishments and make follow-up calls to request data from nonrespondents or to

and the number of working lawyers in the United States is puzzlingly low, while the average salary they earn is puzzlingly high. Part of the answer is that *a lot* of law graduates are not working full time as lawyers.[28] Anecdotally, one expects that anyone with a medical degree who wants to work full time as a doctor can work as a doctor, and the BLS data supports that supposition. In fact, the BLS thinks that there are *more* Americans working full time as doctors than there are full-time lawyers, despite the extra 200,000 licensed lawyers.

There is a particularly marked difference at the low end of each market. For example, the lowest paid medical specialty the BLS estimates is pediatricians. The BLS estimates that 30,010 pediatricians earn an average of $175,400. As Figure 5 shows, at the tenth percentile (meaning ninety percent of all others in the category earn more) pediatricians still earn $93,120. At the tenth percentile for lawyers the earnings are $55,400.

FIGURE 5: 2014 BLS AVERAGE SALARIES



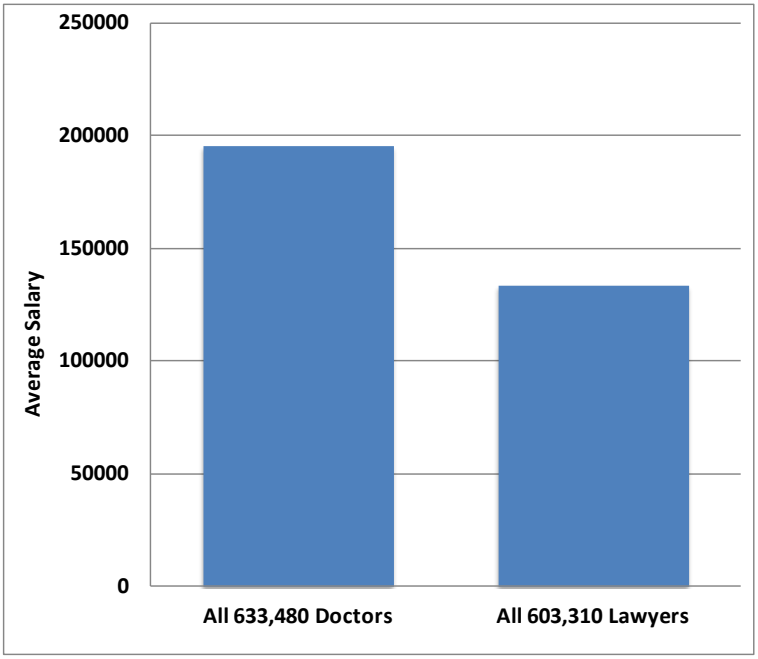
clarify data. The collected data are used to produce occupational estimates at the National, State, and sub-State levels.

OES Data Overview, BUREAU LAB. STAT., http://www.bls.gov/oes/oes_ques.htm#overview (last visited May 29, 2016).

28. *See* Gans, *supra* note 3.

The Internal Revenue Service ("IRS") data for lawyers is similarly bad. In 2012 (the most recent year of the data), 354,415 lawyers filed as solo practitioners and reported an average income of $49,130.[29] The same figures for doctors filing as sole proprietors showed that 188,183 doctors earned an average income of $84,523.

FIGURE 6: 2012 IRS DATA–SOLE PROPRIETORSHIPS



The BLS also makes predictions about future employment. The BLS expects that between 2012 and 2022 there will be 74,800 new jobs as a lawyer[30] and 123,300 as a physician or surgeon.[31] Over that same period it seems likely that American law schools will continue to produce many more graduates than medical schools.

In sum, the market for medical services is much larger than the market for legal services. It is also growing much faster than the market

29. All of the income data in this paragraph comes from INTERNAL REVENUE SERV., SOI TAX STATS–NONFARM SOLE PROPRIETORSHIP: INCOME STATEMENTS, BY INDUSTRIAL SECTORS, TAX YEAR 2012 (2012), http://www.irs.gov/pub/irs-soi/12sp02is.xls.

30. *See Lawyers*, BUREAU LAB. STAT., http://www.bls.gov/ooh/legal/lawyers.htm (last visited May 29, 2016).

31. *See Physicians and Surgeons*, BUREAU LAB. STAT., http://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm (last visited May 29, 2016).

for legal services. There are fewer licensed doctors than lawyers, although the BLS estimates that there are actually more Americans working full time as doctors than as lawyers. Doctors earn more than lawyers on average and at the low end of the market.

II. The Puzzle of American Spending and Outcomes

At a high level of generality, these markets seem pretty distinct. And yet they share a central puzzle: why do we spend so much on medicine and law and get so little?

A. Medical Services

America's market for medical services is quite strange. According to the Organization for Economic Co-operation and Development ("OECD"), America spends more on medical services than other rich countries as a percentage of GDP, per capita, adjusted for purchasing power, and as an absolute number.[32] Not only do we spend more, but in the years before the passage of the ACA our spending started at a higher baseline and then grew faster than in other countries.[33] No matter how you count it, the United States is an outlier in health care expenditures, and it has been for decades.

Since we spend so much, our health outcomes must be great, right? Hardly. System-wide the results are relatively poor. For example, in 2013 our average national life expectancy was 81.2 years.[34] The OECD lists twenty-eight countries ahead of us, including the Czech Republic, Chile, Estonia, Costa Rica, and Slovenia. We find ourselves tied with Poland on the list, just ahead of the Slovak Republic. In 1991, we were nineteenth in the world in life expectancy. In 1960 (the first year of the OECD statistics) we were eleventh.[35] In 1960 we spent just five percent of GDP on medical care.[36]

So, as our spending has increased, our comparative results have worsened. The Commonwealth Fund has measured the United States against other developed countries since 2004, and we have consistently

32. *See Health Expenditure and Financing*, Org. Econ. Co-operation Dev. Stat., http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT (last visited May 29, 2016) (displaying tables on health expenditure and financing).

33. *See* Uwe E. Reinhart et al., *U.S. Health Care Spending in an International Context*, 23 Health Aff. 10 (May 2004), http://content.healthaffairs.org/content/23/3/10.full.pdf+html.

34. *See Health Status: Life Expectancy*, Org. Econ. Co-operation Dev. Stat., http://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT (last visited May 29, 2016) (displaying tables on life expectancy).

35. *Id.*

36. The data come from Ctr. for Medicare & Medicaid Servs., National Health Expenditures, 1960–2013 (2013), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHEGDP13.zip.

finished dead last in measures of access to care and medical equity.[37] Over time the ACA might change some of these results,[38] but the most recently available statistical profiles remain pretty poor.

There is an additional wrinkle: at the high end, American providers of medical services are among the best in the world. The easiest way to establish this is to look at America's trade surplus in medical services. In 2011, America ran a trade deficit of $558 billion overall,[39] but a trade *surplus* of $1.9 billion in medical services.[40] The United States also runs a (shrinking) trade surplus in medical devices.[41]

If you narrow the focus just to cross-border purchases of medical services, the United States runs a significant trade surplus.[42] In other words, citizens from foreign countries traveled to the United States for medical services at a much higher rate than Americans travelled abroad for such services. The countries that make up the surplus are mostly wealthy industrialized countries, the top ten countries being Mexico, the United Kingdom, Canada, Germany, France, Japan, Spain, Italy, Australia, and Brazil.

In fact, almost half of the cross-border traffic into the United States came from countries in Europe, all of which have better overall health outcomes than the United States.[43] Why do they come to the United States for treatment? Because at the high end of the market, and for cutting edge treatments of life threatening ailments like cancer, the United States is second to none.[44] Hospitals like the Mayo Clinic are considered among the very best in the world,[45] as is Harvard Medical

37. *See* COMMONWEALTH FUND, MIRROR, MIRROR ON THE WALL, 2014 UPDATE: HOW THE U.S. HEALTH CARE SYSTEM COMPARES INTERNATIONALLY (2014).

38. Or it might not change them. Much of the overall life expectancy challenge is that poorer Americans die so much younger than the wealthy do. Since many poor Americans already have Medicaid it is clear that medical coverage alone is not enough. *See* Annie Lowrey, *Income Gap, Meet the Longevity Gap*, N.Y. TIMES (Mar. 15, 2014), http://www.nytimes.com/2014/03/16/business/income-gap-meet-the-longevity-gap.html.

39. *See* Robert E. Scott, *U.S. Trade Deficit Up in 2011; China Accounted for Three-Fourths of Rise in Non-Oil Goods Trade Deficit*, ECON. POL'Y INST. (Feb. 10, 2012), http://www.epi.org/publication/trade-deficit-2011-china-accounted-fourths/.

40. *See* U.S. INT'L TRADE COMM'N, RECENT TRENDS IN U.S. SERVICES: 2013 ANNUAL REPORT 4-1 (2013).

41. *See* ROBERT D. ATKINSON & STEPHEN J. EZELL, INNOVATION ECONOMICS: THE RACE FOR GLOBAL ADVANTAGE 47 (2012).

42. *See id.* at 6–15.

43. *See id.*

44. *See* Ronald Brownstein, *U.S. Healthcare Is the Best! And the Worst.*, ATLANTIC (Mar. 13, 2014), http://www.theatlantic.com/politics/archive/2014/03/us-health-care-is-the-best-and-the-worst/430719/.

45. *See* Max Nisen, *Mayo Clinic CEO: Here's Why We've Been the Leading Brand in Medicine for 100 Years*, BUS. INSIDER (Feb. 23, 2013, 10:53 AM), http://www.businessinsider.com/how-mayo-clinic-became-the-best-brand-in-medicine-2013-2. One website ranking of the world's top hospitals claims the United States has the seven best hospitals in the world, and that it has thirteen of the fifteen best hospitals in the world (France and Taiwan have the other two). *See World*, RANKING WEB HOSPITALS, http://hospitals.webometrics.info/en/world (last visited May 29, 2016).

School. In one ranking of the world's medical schools America has six of the top eight schools.[46]

So to recap: the United States spends much more on medical services than other countries for relatively worse results overall. And yet international rankings, the trade surplus, and the inflow of international patients suggest that at the high end, the U.S. market for medical services is second to none.

B. The American Market for Legal Services Presents the Same Puzzle

While unusual, the American market for medical services has a relatively close analogue in terms of expenditures and results: its market for legal services. Like medicine, America spends an overlarge amount on legal services. The international statistics for the cost and efficiency of legal services are not as well developed or collected as those for medicine,[47] but there is statistical evidence that the U.S. market is unusually expensive. For example, legal services make up approximately 1% of world GDP, 1.1% of the GDP of the European Union, and somewhere between 1.8% and 1.3% of American GDP.[48] On a global basis, Europe accounts for 36% of the market for legal services, the Asia-Pacific region 9%, and the Americas (with America the dominant market) a whopping 54%.[49] In 2014, American consumers spent over $98 billion on legal services.[50] Like medical services, the problem is getting worse: the cost of legal services in the United States outpaced inflation between 2001 and 2012.[51]

And yet, system-wide, America fares rather poorly on international access to justice measures. The most recent and comprehensive study is the 2015 World Justice Project ("WJP") Rule of Law Index.[52] The WJP is an ABA-supported non-profit that seeks to measure and advance the rule of law around the world.[53] It conducts over 100,000 consumer

46. *See Top Medical Schools in 2015*, QS Top U., http://www.topuniversities.com/university-rankings-articles/university-subject-rankings/top-medical-schools-2015 (last visited May 29, 2016). The United States has six of the top eight medical schools in the world according to this ranking. *See id.*

47. This is a theme for legal statistics versus medical ones: the legal ones are consistently worse.

48. *See* George Yarrow & Christopher Decker, Assessing the Economic Significance of the Professional Legal Services Sector in the European Union 51 (2012). Admittedly some of this is good news: the United States is a net exporter of legal services. *See* Barton, *supra* note 13, at 241.

49. *See* Yarrow & Decker, *supra* note 48.

50. *See Personal Consumption Expenditures: Legal Services*, Econ. Res. Fed. Res. Bank St. Louis, https://research.stlouisfed.org/fred2/series/DGALRC1A027NBEA (last visited May 29, 2016).

51. *See Guilty as Charged*, Economist (Feb. 2, 2013), http://www.economist.com/news/leaders/21571141-cheaper-legal-education-and-more-liberal-rules-would-benefit-americas-lawyersand-their.

52. World Justice Project, The World Justice Project Rule of Law Index 2015, at 26–29 (2015).

53. *Who We Are*, World Justice Project, http://worldjusticeproject.org/who-we-are (last visited May 29, 2016).

surveys annually in more than 100 jurisdictions to determine a nation's adherence to the rule of law from the view of its citizenry. Overall, the United States ranked nineteenth out of 102 countries studied, between France and the Czech Republic, and behind Singapore, Korea, and Estonia.[54] The United States ranked twenty-third on the WJP's separate measure of criminal justice (between Poland and the Czech Republic) and twenty-first on civil justice (between France and Slovenia).[55] These results were actually an improvement from 2014, when the United States again finished nineteenth overall, but just twenty-seventh in civil justice (between Chile and Botswana) and twenty-second on criminal justice (between France and Botswana again).[56]

These results should not be surprising. Multiple studies have shown that many Americans lack basic access to the legal system. Other studies show that the American system of civil litigation is significantly more expensive than that of other industrialized nations.[57] The wave of exonerations in our criminal courts adds evidence that our criminal justice system is seriously flawed.[58]

Like medicine, however, at the top end, America's lawyers are among the very best in the world. America runs a healthy and growing trade surplus in legal services. The United States is the largest exporter of legal services in the world and has consistently run a trade surplus in law.[59] In 2001, the U.S. legal services industry ran a $2.4 billion trade surplus.[60] That trade surplus grew to $4.9 billion in 2007,[61] and $5.3 billion in 2011.[62] Like medicine, America has some of the world's most highly respected law schools in the world (four of the top six and six of the top

54. *See* WORLD JUSTICE PROJECT, *supra* note 52, at 6.

55. *See id.* at 30–31.

56. *See id.*

57. *See, e.g.*, U.S. CHAMBER, INST. FOR LEGAL REFORM, INTERNATIONAL COMPARISONS OF LITIGATION COSTS 2 (2013); *see also* LAWYERS FOR CIVIL JUSTICE, LITIGATION COST SURVEY OF MAJOR COMPANIES 3 (2010).

58. *See* NAT'L REGISTRY OF EXONERATIONS, EXONERATIONS IN THE UNITED STATES, 1989–2012, at 9 (2012).

59. *See* Letter from Thomas M. Susman, Dir., Governmental Affairs Office, A.B.A., to Devin Nunes & Charles Rangel, U.S. House of Rep. (Mar. 27, 2013) (on file with author).

60. *See* Ryan W. Hopkins, *Liberalizing Trade in Legal Services: The Gats, the Accountancy Disciplines, and the Language of Core Values*, 15 IND. INT'L & COMP. L. REV. 427–28 (2005).

61. *See* Laurel S. Terry, *From GATS to APEC: The Impact of Trade Agreements on Legal Services*, 43 AKRON L. REV. 875, 881 n.23 (2010).

62. *See* Letter from Thomas M. Susman, *supra* note 59.

ten law schools in the world by one ranking).[63] America's corporate law firms are also the largest and most profitable in the world.[64]

Thus, America's market for legal services presents a puzzle. We spend more for legal services and get less: studies suggest that Americans have less access to justice than the citizens of our peer nations. But our poor results overall are belied by our success at the top end of the market. More so even than medicine, America's high end lawyers are the envy of the world.

Why, then, do we pay more and get less? The causes of these discrepancies are complex, multiple, and open to much debate (as are the possible cures), but one explanation is the way these markets break down into distinct submarkets.

III. AMERICA'S THREE-TIERED SYSTEM

Looking at America's overall spending and outcomes in law or medicine is helpful because it aggregates the data and clarifies the challenges we face in these markets. That said, aggregating the spending and the outcomes is a little misleading because these markets are not monolithic. In fact, there are at least three different markets for medical and legal services: (1) the market for those at or near the poverty line; (2) the market for the wealthy and corporations; and (3) the market for the working poor and the middle class.

Basically, in America we face a donut hole of coverage in both medicine and law, wherein a significant portion of Americans have little or no access to doctors or lawyers. Yet the donut hole is differently shaped in the respective fields. Medicine offers much more comprehensive coverage of the poor through Medicaid (and for the elderly poor Medicare) than either legal aid or the provision of public defenders offers. Likewise, employer-sponsored health insurance and the newly created health exchanges under the ACA mean that many more middle class Americans have access to health care than medical care. One recent study estimated that more than eighty-eight percent of Americans now have some level of medical insurance—an all-time high.[65]

It is harder to measure access to justice than access to medical care, but based on the existing studies there is no chance that eighty-eight

63. *See QS World University Rankings by Subject 2015–Law*, QS TOP U., http://www.topuniversities.com/university-rankings/university-subject-rankings/2015/law-legal-studies#sorting=rank+region=+country=+faculty=+stars=false+search= (last visited May 29, 2016).

64. *See* Chris Johnson, *2015 Global 100: Top-Grossing Law Firms in the World*, AM. LAW. (Sept. 28, 2015), http://www.americanlawyer.com/id=1202471809600/2015-Global-100-TopGrossing-Law-Firms-in-the-World-#ixzz3wCuAolK4.

65. *See* Jenna Levy, *In U.S., Uninsured Rate Dips to 11.9% in First Quarter*, GALLUP (Apr. 13, 2015), http://www.gallup.com/poll/182348/uninsured-rate-dips-first-quarter.aspx.

percent of Americans have a baseline of access to needed legal services.[66] The inverse percentage is likely more accurate. The donut hole in law is both more shallow (less coverage of the poor) and larger (larger swaths of the middle class go without).

Nevertheless, separating out the submarkets in law and medicine helps explain some of America's strange results. For example, considering the market for medical and legal services for the rich helps explain why many claim with a straight face that America has the best health care system and lawyers in the world. For the rich and large corporations that is likely true.

It also explains why at the same time others can claim with a straight face that America has the worst medical and legal systems in the developed world. If you focus on the health and access to justice results for the poor, and the working poor this claim also seems true. More so than other developed economies, America allows different segments of the population to live together nominally, but it seems fair to say that we live in such distinct circumstances we might as well live in different countries.

A. The Rich and Corporations

America has a highly competitive medical market serving wealthy individuals or corporations. The great bulk of American health care spending is not out-of-pocket spending, accounting for only 11.6% in 2010.[67] The rest of the expenses were covered by private insurance (32.7%), Medicare (20.2%), Medicaid (15.5%), or other third-party sources.[68] The government itself is the customer in more than a third of health care expenditures.[69] Another third of health care expenditures come from the highly regulated private insurance market.[70] As such, through either spending or regulation, state and federal governments dominate the bulk of the American market for medical services. The ACA takes aim at the most expensive insurance plans (the so-called "Cadillac" plans), with an excise tax that is scheduled to kick in 2018.[71]

66. For my favorite overview of this issue, see Deborah L. Rhode, Access to Justice (2004). For other outstanding overviews of the various studies, see Rebecca L. Sandefur, *Access to Justice: Classical Approaches and New Directions, in* Access to Justice, at ix (Rebecca L. Sandefur, ed. 2009) and Gillian K. Hadfield, *Higher Demand, Lower Supply? A Comparative Assessment of the Legal Resource Landscape for Ordinary Americans*, 37 Fordham Urb. L.J. 129 (2010).

67. *See* Kaiser Family Found., Health Care Costs: A Primer—How Much Does the U.S. Spend on Health and How Has It Changed? (2012).

68. *See id.*

69. *See id.*

70. *See id*; *see also* Timothy Stoltzfus Jost, The Regulation of Private Health Insurance (2009).

71. *See* Julie Piotrowski, *Excise Tax on 'Cadillac' Plans*, Health Aff. (Sept. 12, 2013), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=99.

There is also a side market for medical services that mostly serves the wealthy. These are the growing number of doctors that no longer accept insurance[72] or offer services that most insurance plans do not cover (like elective cosmetic surgery or the newest cancer treatments).

One new-style version of this type of service is the concierge practice. These doctors usually work outside of the traditional insurance system and charge more, but also deliver more in terms of attention and time. They take phone calls and some even make house calls. Appointments are easier to get and the care is more personalized.[73] This is a small, but growing, segment of the American health care system.[74] The early results suggest that health outcomes are better under this sort of care.[75]

The equivalent market in legal services—so-called "Big Law"—is much bigger and better developed. The 100 largest law firms in America grossed over $80 billion in 2014 and employed nearly 92,000 lawyers.[76] More than fifteen percent of American lawyers in private practice work at firms of 200 lawyers or more, almost all of them representing corporations or wealthy individuals.[77]

In medicine and in law the wealthy are willing to pay more for world-class service and results, and the market in the United States provides these services in spades. Because law more directly serves corporations[78] this market segment is bigger, older, and better established than the equivalent in medical services.

We spend a lot in America and we demand excellence, at least at the high end. Part of why our expenditures are so high is that we sell to the wealthy at top prices, reaping the benefits of offering "best in class"

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72. *See* Steve Hargreaves, *Cash-Only Doctors Abandon the Insurance System*, CNNMONEY (June 11, 2013, 1:44 PM), http://money.cnn.com/2013/06/11/news/economy/cash-only-doctors/.

73. *See* A.C. Shilton, *The Doctor Won't See You Now*, SLATE (May 4, 2015, 1:12 PM), http://www.slate.com/articles/health_and_science/medical_examiner/2015/05/concierge_medicine_only_rich_people_can_find_a_doctor_in_naples_florida.html.

74. *See* Nina Lincoff, *The Future of Healthcare Could Be in Concierge Medicine*, HEALTHLINE (June 30, 2015), http://www.healthline.com/health-news/the-future-of-healthcare-could-be-in-concierge-medicine-063015#1.

75. *See* John C. Goodman, *Everyone Should Have a Concierge Doctor*, FORBES (Aug. 28, 2014, 11:23 AM), http://www.forbes.com/sites/johngoodman/2014/08/28/everyone-should-have-a-concierge-doctor/.

76. *See* Chris Johnson, *Am Law 100 Analysis: The Superrich Firms Pull Away*, AM. LAW. (Apr. 27, 2015), http://www.americanlawyer.com/home/id=1202724028829.

77. *See Lawyer Demographics: Year 2015*, A.B.A., http://www.americanbar.org/content/dam/aba/administrative/market_research/lawyer-demographics-tables-2015.authcheckdam.pdf (last visited May 29, 2016).

78. American corporations tend to purchase medical services via insurance plans for their employees. Some of these plans are more generous than others, with some corporations like Google offering in-house medical services, as well as highly subsidized full coverage. *See Google Health Insurance*, GLASSDOOR, http://www.glassdoor.com/Benefits/Google-Health-Insurance-US-BNFT1_E9079_N1.htm (last visited May 29, 2016).

service. But these efforts reach only a small percentage of the population, which helps explain our overall struggle.

B. Below the Poverty Line

In both medicine and law, federal and state governments provide some level of medical or legal services to individuals and families below the poverty line. Medical coverage is more comprehensive, as Medicaid and the CHIP program provide a baseline of coverage for medical expenses to qualifying individuals and families.

Eligibility levels and the range of benefits are generally set by the individual states so it is hard to generalize, but there is helpful national data about the programs and what they offer.[79] Medicaid is the single largest source of public health coverage in the United States and covers nearly seventy million people.[80] Medicaid funding comes with a list of required beneficiaries and required services such that a large percentage of America's poorest citizens have at least a baseline level of medical coverage.[81]

The program is not without its critics—both from the right[82] and the left[83]—but Medicaid is a centerpiece of the ACA and one of the relative successes of the war on poverty.[84] Nevertheless, in a country with relatively poor health outcomes, the outcomes for the poor are worse yet.[85] When pressed to explain America's low life expectancy, many experts point to the prevalence of poverty in America and the fact that poorer Americans have worse health outcomes across the board,[86] which is hardly an endorsement for the effectiveness of Medicaid. American poverty is knotty, however, so the provision of medical insurance, or the bare provision of a lawyer, is unlikely to provide a solution for the multifaceted and multilayered challenges the poorest Americans face. It is thus unfair to blame Medicaid for low life expectancies, although it is fair to question its overall efficacy.

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79. *See*, Nat'l Health Policy Forum, The Basics: Medicaid Eligibility and Benefits (Jan. 5, 2016).

80. *See* Julia Paradise, *Medicaid Moving Forward*, Kaiser Fam. Found. (Mar. 9, 2015), http://kff.org/health-reform/issue-brief/medicaid-moving-forward/.

81. *See The Basics: Medicaid Eligibility and Benefits*, *supra* note 79.

82. *See, e.g.*, Michael Patrick Leahy, *47 Years Later, Medicare and Medicaid Are Financial Disasters*, Breitbart (July 26, 2012), http://www.breitbart.com/big-government/2012/07/26/47-years-later-medicare-and-medicaid-are-a-financial-disaster/.

83. *See* Oliver Willis, *Children on Medicaid Get Second Class Care*, Oliver Willis Blog (June 16, 2011), http://oliverwillis.com/2011/06/16/children-on-medicaid-get-second-class-care/.

84. *See* The Council of Economic Advisors, The War on Poverty 50 Years Later: A Progress Report 40 (2014).

85. *See* Elizabeth Mendes, *In U.S., Health Disparities Across Incomes Are Wide-Ranging*, Gallup (Oct. 18, 2010), http://www.gallup.com/poll/143696/health-disparities-across-incomes-wide-ranging.aspx.

86. *See* Allan Detsky, *Why America Is Losing the Health Race*, New Yorker (June 11, 2014), http://www.newyorker.com/tech/elements/why-america-is-losing-the-health-race.

America also provides legal services to the very poor, in civil cases primarily through the Legal Services Corporation,[87] and in criminal cases pursuant to *Gideon* and its progeny through government paid public defenders or private attorneys.[88] Unlike Medicaid, the federal law underlying the Legal Services Corporation does not guarantee any set of services to any set of people. To the contrary, for its entire history Legal Aid has struggled to meet the legal needs of the poorest Americans.[89]

How big is the gap between what Medicaid provides and what legal aid does? Medicaid is roughly *100 times larger* than legal aid. In 2013, LSAC "closed" 758,689 cases. Of those, 457,874 were "counsel and advice" and 122,330 were "limited action."[90] By contrast, Medicaid covered sixty-eight million people in 2011.[91] This is not a critique of legal aid, which does a lot with very little. In 2014, the federal expenditure for LSC was $375 million, which was almost two-thirds less than the 1979 funding high point.[92] The 2014 Medicaid expenditure was almost $505 billion.[93] Indigent Americans are also guaranteed the services of a government supported lawyer if they face criminal charges that carry the threat of any jail time.[94] The efficacy of these programs, however, is open to question.[95]

Overall, the very poor in America have better access to medical care than legal services. Their access in both areas has not resulted in particularly strong outcomes, however. This is partially due to funding and desire. Part of it is the Gordian knot of American poverty. In both law and medicine the very poor face a complicated, undifferentiated, and tangled mix of problems, only some of which are suitable for help by a lawyer or a doctor.

Part of it is the insistence of doctors and lawyers that the very poor deserve the same level of care (preferably by a licensed and well-paid

87. *See Who We Are*, LEGAL SERV. CORP., http://www.lsc.gov/about/what-is-lsc (last visited May 29, 2016).

88. For an overview, see KAREN HOUPPERT, CHASING GIDEON: THE ELUSIVE QUEST FOR POOR PEOPLE'S JUSTICE (2013).

89. *See* RHODE, *supra* note 66.

90. LEGAL SERVS. CORP., 2013 LEGAL SERVICES CORPORATION BY THE NUMBERS: THE DATA UNDERLYING LEGAL AID PROGRAMS (2013).

91. *See* Paradise, *supra* note 80.

92. LEGAL SERVS. CORP., 2014 LEGAL SERVICES CORPORATION BY THE NUMBERS: THE DATA UNDERLYING LEGAL AID PROGRAMS (2014).

93. *See The Facts on Medicare Spending and Financing*, KAISER FAM. FOUND. (July 24, 2015), http://kff.org/medicare/fact-sheet/medicare-spending-and-financing-fact-sheet/.

94. *See id.* at 122–44.

95. *See id.* For a more pointed (and humorous) take on the state of indigent criminal defense, see *Last Week Tonight with John Oliver: Public Defenders (HBO)*, YOUTUBE (Sept. 13, 2015), https://www.youtube.com/watch?v=USkEzLuzmZ4.

doctor or lawyer) that the wealthy receive.[96] This admirable sentiment means that valuable funds are used on individual doctors and lawyers representing and treating individual clients rather than finding less expensive and more routinized alternatives, whether that means loosening licensing or promoting computerization. But at least America provides this segment of the population with some services. Our next group has much more limited options.

C. The Working Poor

The provision of medical care to the working poor is currently in flux. Before the passage of the ACA, America had a substantial hole in its provision of medical insurance. The very poorest Americans and elderly Americans received government insurance through Medicaid or Medicare. Many white-collar and unionized blue-collar workers received insurance through their employers. This left a hole in the system. Low-wage, hourly workers, also known as the working poor, frequently were not provided insurance through their employment, but could not afford to buy private insurance.[97] In an emergency they could try to get treatment in an emergency room, but without insurance to pre-negotiate and/or cover the charges, even brief visits, could lead to bankruptcy or other debt-related problems.[98]

If these uninsured individuals had a preexisting condition they frequently could not afford medical insurance even if they were relatively wealthy.[99] Some patients with preexisting conditions were literally uninsurable—private insurers would not sell insurance at any price.[100]

The ACA attempted to fill in both of these gaps by forcing insurers to take patients with preexisting conditions by expanding Medicaid to more of the working poor, and by offering tax credits and other sweeteners to higher-income, uninsured persons.[101] These efforts have

96. For an emblematic ABA statement, see William T. Robinson, *Legal Help for the Poor: The View from the A.B.A.*, N.Y. Times (Aug. 30, 2011), http://www.nytimes.com/2011/08/31/opinion/legal-help-for-the-poor-the-view-from-the-aba.html. For how nurse practitioners see the American Medical Association, see Debra Hain & Laureen M. Fleck, *Barriers to NP Practice That Impact Healthcare Redesign*, Online J. Issues Nursing, http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-19-2014/No2-May-2014/Barriers-to-NP-Practice.html.

97. *See, e.g.*, Ellen Meara et al., *State and Federal Approaches to Health Reform: What Works for the Working Poor* (Nat'l Bureau of Econ. Research, Working Paper No. 14125, 2008), http://www.nber.org/papers/w14125.pdf; *see also* Karen Seccombe & Cheryl Amey, *Playing by the Rules and Losing: Health Insurance and the Working Poor*, 36 J. Health & Soc. Behav. 168 (1995).

98. *See Key Facts About the Uninsured Population*, Kaiser Fam. Found. (Oct. 5, 2015), http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.

99. *See* Ray Fisman, *The Wisdom of the Ailing*, Slate (Mar. 12, 2012, 6:10 PM), http://www.slate.com/articles/business/the_dismal_science/2012/03/pre_existing_conditions_the_real_reason_insurers_won_t_cover_people_who_are_already_sick_.html.

100. *See id.*

101. *See* Garfield et al., *supra* note 5.

received mixed reviews. There are reports of insurers gaming the requirement to enroll customers with preexisting conditions,[102] and more famously, twenty-two states have declined to expand Medicaid, leaving the working poor in those states generally uncovered and unassisted (since the tax credits and other sweeteners are aimed at middle class Americans).[103]

It appears, however, that the ACA has helped, as the total number of uninsured Americans has declined since its passage, with a special boost in coverage for the working poor in the states that have expanded Medicaid.[104] But while coverage is improving in some parts of the country, the working poor are still less likely to have coverage than other categories of Americans.[105]

Yet, the working poor have much better access to medical services than legal services. In America the donut hole for legal services is gaping—stretching from just above the federal poverty line (the cut off for legal aid or a public defender is frequently 125% of the Federal poverty line)[106] to the upper-middle class. In between, the majority of Americans cannot afford legal services of much complexity at all. Professors Gillian Hadfield, Deborah Rhode, and Rebecca Sandefur have written extensively and persuasively on this exact problem.[107]

There is of course one notable exception: injured Americans of any income level have access to a lawyer if the opposing party is an insurance company or a wealthy corporation, business, or individual.[108] One of the strangest aspects of the American market for legal services is that a mother of two who earns $35,000 a year working at Home Depot is

102. *See* Lindsey Cook, *Insurance Plans May Have a Loophole for Pre-Existing Conditions*, U.S. NEWS (Sept. 22, 2014, 4:06 PM), http://www.usnews.com/news/blogs/data-mine/2014/09/22/obamacare-insurance-plans-may-have-a-loophole-for-pre-existing-conditions.

103. *See* Garfield et al., *supra* note 5; *see also* Sabrina Tavernise & Robert Gebeloff, *Millions of Poor Are Left Uncovered by Health Law*, N.Y. TIMES (Oct. 2, 2013), http://www.nytimes.com/2013/10/03/health/millions-of-poor-are-left-uncovered-by-health-law.html.

104. *See* Troy Griggs et al., *Is the Affordable Care Act Working?*, N.Y. TIMES (Oct. 26, 2014), http://www.nytimes.com/interactive/2014/10/27/us/is-the-affordable-care-act-working.html; *see also* Chris Evans, *After 5 Years, Here Are 5 Ways the Affordable Care Act Is Working for America:*, WHITE HOUSE BLOG (Mar. 23, 2015, 7:26 PM), https://www.whitehouse.gov/blog/2015/03/03/after-five-years-heres-five-ways-affordable-care-act-working-america; Andrew Sprung, *Obamacare Is a Boon for the Working Poor and That's Probably Good for All of Us*, MOTHER JONES (May 5, 2015, 9:00 AM), http://www.motherjones.com/kevin-drum/2015/05/obamacare-working-poor.

105. *See* Garfield et al., *supra* note 5.

106. *See* Earl Johnson, Jr., *Equality Before the Law and the Social Contract: When Will the United States Finally Guarantee Its People the Equality Before the Law that the Social Contract Demands?* 37 FORDHAM URB. L.J. 157, 212 (2010).

107. *See* RHODE, *supra* note 66; *see also* Sandefur, *supra* note 66; Hadfield, *supra* note 66; Gillian K. Hadfield & Jamie Heine, *Life in the Law-Thick World: The Legal Resource Landscape for Ordinary Americans* (USC Gould Sch. of Law, Ctr. for Law & Soc. Sci., Legal Studies Research Paper No. 15-2, 2015).

108. *See, e.g.*, RICHARD MOORHEAD, CIVIL JUSTICE COUNCIL, IMPROVING ACCESS TO JUSTICE (2008).

unlikely to qualify for Legal Aid and cannot find a lawyer to affordably handle a child custody dispute or a relatively complicated will. But she could find a dozen lawyers to help her if she was injured in a car accident.

The American choice to pay for most medical expenses through either private or governmental insurance presents a unique set of problems in that market,[109] but it does mean that most Americans have access to some level of medical care. There is no comparable insurance market for lawyers (although there are some relatively small prepaid or union provided plans for legal services).[110] As a result, a large number of Americans cannot afford needed legal services.

D. THE UPSHOT

In both medicine and law the working poor are often stuck with either lumping it or taking extreme measures. The uninsured poor often put off medical treatment until it becomes an emergency, and then arrive at a hospital emergency room.[111] In law they are often stuck with proceeding pro se or hoping the problem goes away.[112]

When medicine is considered alongside law, it becomes clear that America has an implicit three-tier system: one for the wealthy (the envy of the world), one for the very poor (limping along in medicine, providing even less in law), and finally one for the working poor. It is also clear that the working poor are getting the worst of the deal. Too "rich" to qualify for government supported services and too poor to pay for insurance or the services themselves, the working poor are stuck betwixt and between.

The irony is that America has long been obsessed with pushing the very poor out of poverty and into working, in essence, out of qualification for government support and into the ranks of the working poor.[113] The working poor put in longer hours at jobs that are often more physically taxing and always lower paying,[114] so it adds insult to injury to take away their access to medical or legal services as they grow too "rich" from their efforts. In this regard, and many others, we talk a big game,

109. *See* Gerald Friedman, *The ACA and America's Health-Care Mess*, COMMON DREAMS (Jan. 21, 2014), http://www.commondreams.org/views/2014/01/21/aca-and-americas-health-care-mess.

110. *See* Brian Heid & Eitan Misulovin, Note, *The Group Legal Plan Revolution: Bright Horizon or Dark Future?*, 18 HOFSTRA LAB. & EMP. L.J. 335 (2000).

111. *See* Soumya Karlamangla, *For Those in California Illegally, Health Services Vary Greatly by County*, L.A. TIMES (June 11, 2015), http://www.latimes.com/local/countygovernment/la-me-remaining-uninsured-20150611-story.html.

112. *See* Hadfield & Heine, *supra* note 107.

113. *See* R. G., *Making Work Pay*, ECONOMIST (Sept. 5, 2013, 2:38 PM), http://www.economist.com/blogs/democracyinamerica/2013/09/welfare-and-work-america.

114. *See* OXFAM AMERICA, WORKING POOR IN AMERICA (2014).

but disincentivize exactly the behavior we theoretically want to encourage.[115]

IV. Comparative Regulation

So why is access to law and medicine unevenly distributed in the United States? While there are multiple factors, one sure culprit is professional regulation. Both doctors and lawyers have done their best to keep competition out, which depresses competition and raises prices. Both doctors and lawyers have also stubbornly stuck to an old fashioned and very expensive delivery model that focuses almost solely on individualized services.

A. An Extra Brief History in Parallel Regulation

The American regulatory history of doctors and lawyers is intertwined. The American Medical Association ("AMA") was formed in 1847[116] by a relatively small group from the elite of the medical profession.[117] Among its first and primary concerns were education and licensing. The initial meeting in 1847 resulted in resolutions concerning the prerequisites necessary for entering medical school,[118] the length and content of a medical school education,[119] and the creation of a single licensing board in every state.[120] Existing medical schools objected to these suggestions as impracticable and some attendees worried that the prerequisites would limit access to the medical profession to the wealthy.[121] But the AMA pressed on because the medical profession had become "corrupt and degenerate, to the forfeiture of its social position."[122]

Naturally it took a while for the AMA to achieve its goals. First it encouraged the creation of state and local medical societies to lobby legislatures and to challenge local medical schools.[123] By 1855, this mission had apparently succeeded to the point that the first historian of the AMA called the organization the most influential voluntary social

115. For example, a Congressional Budget Office Report established that as poor Americans transition from government support to working, they can face marginal tax rates on their earnings as high as sixty percent, making working much less attractive than not working. Cong. Budget Office, Effective Marginal Tax Rates for Low- and Moderate-Income Workers (2012).

116. *See* Morris Fishbein & Walter Bierring, A History of the American Medical Association 27–50 (1947).

117. *See* N.S. Davis, History of the American Medical Association from Its Organization Up to January, 1855, at 33 (1855).

118. *See id.* at 42.

119. *See id.* at 44.

120. *See id.* at 45.

121. *See id.* at 53–54.

122. *See id.* at 56.

123. *See id.* 135–41.

organization in the country.[124] Over the second half of the nineteenth century the AMA succeeded in centralizing licensure in most states.[125]

The AMA still lacked authority over medical schools, however, so centralizing licensure was only half of the battle. In 1904, the AMA established its Council on Medical Education, which inspected and rated medical schools.[126] The Council was an immediate success in reducing the number of schools: by 1910 America's 166 medical schools has been reduced to 126.[127]

The AMA was still unsatisfied. It contracted with the Carnegie Foundation to create a report studying medical education in the United States.[128] The highly influential Flexner Report was released in 1910.[129] Flexner and his team visited 155 different medical schools in America and Canada, and lambasted most of them. Flexner concluded that America needed "fewer and better doctors" and thus fewer and better medical schools.[130] The Report recommended formal regulation of medical schools and closure of all but thirty-one schools in America.[131] The AMA leveraged the report and its own growing political muscle into becoming the accrediting body for medical schools.[132] By 1920, there were only eighty-five medical schools in America.[133]

In each historical step the ABA has lagged and imitated the AMA. The AMA was founded and thrived during a period when bar associations were largely moribund. As bar associations began to reform in the 1870s, they were modeled after medical societies like the AMA.[134] Like the AMA, the American Bar Association ("ABA") was founded in 1878 by a relatively small number of elite lawyers.[135] Also like the AMA, the ABA lambasted an undesirable element in the bar: that these lawyers "believe themselves immune, the good or bad esteem of their co-laborers is nothing to them provided their itching fingers are not thereby stayed in their eager quest for lucre."[136]

The ABA determined that the answer consisted of raised entry standards and centralized control of licensing. In 1891, the ABA Committee on Legal Education produced a sixty-page report that recommended a

124. *See id.* at 18–19.

125. *See* GREGORY L. WEISS & LYNNE E. LONQUIST, THE SOCIOLOGY OF HEALTH, HEALING, AND ILLNESS 30 (2015).

126. *See* RUTH CLIFFORD ENGS, THE PROGRESSIVE ERA'S HEALTH REFORM MOVEMENT 14–15 (2003).

127. *See id.*

128. *See* WEISS & LONQUIST, *supra* note 125, at 30.

129. *See* ABRAHAM FLEXNER, MEDICAL EDUCATION IN THE UNITED STATES AND CANADA (1910).

130. *Id.* at 11–19.

131. *See* WEISS & LONQUIST, *supra* note 125, at 31.

132. *See id.*

133. *See* ENGS, *supra* note 126, at 15.

134. *See* ALFRED REED, TRAINING FOR THE PUBLIC PROFESSION OF THE LAW 60 (1921).

135. *See id.* at 220.

136. 29 A.B.A. Rep. 601–02 (1906).

number of changes similar to those sought by the AMA, including state supreme court control over entry, written bar exams, a three-year requirement for law schools, and specific law library and facility requirements.[137] The report's very first resolution was to "strongly recommend that the power of admitting members to the Bar, and the supervision of their professional conduct, be in each State lodged in the highest courts of the State[.]"[138]

Each of these steps took longer for lawyers than doctors. By 1912 the AMA and state medical regulators had a firm grip on the profession. How firm? In 1900, there were 160 medical schools and 25,213 medical students; by 1920, there were eighty-five schools and 13,789 students.[139] By contrast, in 1900 there were 110 law schools and 12,516 law students. From 1920 to 1921, there were 148 law schools and 27,313 students.[140] Over the two decades of the twentieth century, law schools and medical schools switched places, partially due to the AMA's tremendous success in restricting entry to medical school.[141]

The ABA certainly noticed.[142] In 1921, the Carnegie Report published its report on American law schools,[143] and yet it was not until the Great Depression that the ABA found much purchase in regulating lawyer entry and law schools.[144]

Nevertheless, since the 1950s both lawyers and doctors have faced very steep educational and licensing requirements. Most AMA accredited medical schools require an undergraduate degree.[145] The Federation of State Medical Boards has a color-coded flow chart that details all of the various examinations, classes, and residencies that are required before being licensed as a doctor.[146] After four years of undergraduate education there are four more years of AMA-accredited medical school, three different required national licensing tests, and a year or more of a required residency.[147] It is expensive in time, money, and debt to become a lawyer, but the time to completion, the tuition

137. *See* 14 A.B.A. Rep. 301–60 (1891).

138. 14 A.B.A. Rep. 349 (1891).

139. *See* RICHARD ABEL, AMERICAN LAWYERS 48 (1989).

140. *See id.* at 277.

141. *See id.* at 48.

142. As early as 1901, the ABA was comparing its regulatory efforts unfavorably to those of the AMA. *See* 24 A.B.A. Rep. 400 (1901).

143. *See* REED, *supra* note 134.

144. *See* BARTON, *supra* note 13, at 28–32.

145. *See* TANIA HELLER, ON BECOMING A DOCTOR 17–18 (2009).

146. *See* FED'N OF STATE MED. BDS., PATHWAY TO MEDICAL PRACTICE IN THE U.S. (2014), http://www.fsmb.org/Media/Default/PDF/pathway_to_licensure_portrait2014.pdf.

147. *See id.*

costs, and the associated debt are all greater for doctors.[148] The fact that it is longer and more expensive to become a lawyer or a doctor in the United States than most other countries[149] also suggests that doctors and lawyers have been successful lobbyists.

The AMA has been more successful than the ABA in limiting the supply of doctors, but the ABA has had greater success in keeping others out of the legal market. The ABA has led a crusade against the unauthorized practice of law and has largely pushed other professions aside, even from offering legal advice, let alone clear legal services like appearing in court. The AMA, by comparison, has had to accept (often at the prompting of antitrust regulators or lawsuits)[150] the presence of competitors, from chiropractors, osteopaths, or nurse practitioners, to Reiki healers and the many other types of individuals who sell what might broadly be called medical services.

One reason why the working poor cannot afford services is because we have both doctors and lawyers in charge and operating largely on an individualized basis. Doctors and lawyers have made themselves a choke point in the system. For many medical or legal services the *only* product available is an individual doctor or lawyer offering individualized services to individual clients. These protectionist efforts have a clear effect on the market, and price many Americans out.

The donut hole in law and medicine is also advertising to the middle class, because individuals who try to go it alone suffer publically, encouraging potential clients to consult a lawyer or a doctor. When a small business owner comes to court and sees pro se litigants struggle, she decides to hire a lawyer. When a middle-class person goes to the ER and sees the uninsured hassling with paperwork or seeking treatment for something they should have handled with a family practitioner months ago, she remarks, "Thank God I have good medical insurance!"

B. Some Clear Benefits to Medical Regulation—Hands on Training

Medicine, unlike law, has long been dedicated to the scientific method. This means that medical schools and medical practitioners have long gathered and analyzed data on treatment and educational methods. From the Flexner Report forward, medical school has focused intensely

148. *See, e.g.*, Ass'n of Am. Med. Colls., Medical Student Education: Debt, Costs, and Loan Repayment Fact Card (2015); *see also Class of 2014 Law Graduate Data*, A.B.A., http://www.americanbar.org/groups/legal_education/resources/statistics.html (last visited May 29, 2016).

149. For medicine, see Ezekiel J. Emanuel & Victor R. Fuchs, *Shortening Medical Training by 30%*, 307 JAMA 1143 (2012). For law, see Mary C. Daly, *Thinking Globally: Will National Borders Matter to Lawyers a Century From Now?*, 1 J. Inst. for Study Legal Ethics 297, 305 n.19 (1996).

150. *See* Lori B. Andrews, *The Shadow Health Care System: Regulation of Alternative Health Care Providers*, 32 Hous. L. Rev. 1273, 1287–98 (1996).

on the scientific method and practical training. Medical school consists of two years of classroom study followed by two years working with professors who are also practitioners in hospitals and other actual service settings.[151] These two years come *before* a mandatory residency of one to two years, where the apprentice doctor again trains her profession under close supervision.[152]

Thus, doctors pay more for their education, but they may get more hands-on training and value for their expenditures. By the time an American doctor becomes licensed, she has extensive training in her field and is expected to be able to step right into practice. The training and licensing process itself guarantees medical consumers quite a lot: their newly minted doctor will have already treated multiple patients.

By contrast, legal licensing guarantees almost no hands-on training outside of the small (and loose) ABA requirement of some practical training.[153] A new member of the bar might have never tried a case or drafted a legal document, or even spoken to a client before officially entering into practice. Clinical legal education has helped this shortcoming, but clinical experiences are required at only a handful of law schools.[154]

C. Standardization

Medicine has also embraced standardization because of its proven superior outcomes. So, for example, there is a growing movement in medicine to reduce some repeated surgeries or treatment plans into a checklist.[155] This reduces individual autonomy, but provides better results.[156]

Medicine has adopted checklists because research establishes that it saves lives.[157] Do checklists restrict individual and professional autonomy? Yes. In some cases does it mean that especially able doctors are constricted or that outlier patients are put at risk? Yes. But does it save lives and improve outcomes system-wide? Yes. This is because system-wide it reduces human errors and makes health professionals

151. *See* Michael Martinez, *Legal Education Reform: Adopting a Medical School Model*, 38 J.L. & Educ. 705, 708 (2009).

152. For a description of the residency process, see Joseph H. King, *The Standard of Care for Residents and Other Medical School Graduates in Training*, 55 Am. U. L. Rev. 683, 690–92 (2006).

153. *See* A.B.A., Standards and Rules of Procedure for Law Schools 2014–15, at 15–19 (2015).

154. *See Schools Requiring Experiential Courses*, Alb. L. Sch. Ctr. for Excellence in Teaching, http://www.albanylaw.edu/celt/reform/Pages/Schools-Requiring-Experiential-Courses.aspx (last visited May 29, 2016).

155. *See* Atul Gawande, The Checklist Manifesto: How to Get Things Right 35 (2009).

156. *See* Steven Novella, *Checklists and Culture in Medicine*, Science-Based Med. (Feb. 10, 2010), https://www.sciencebasedmedicine.org/checklists-and-culture-in-medicine/.

157. *See* Gawande, *supra* note 155, at 15–32.

stick to a script designed around medically proven best practices. And for medicine that is reason enough.

By contrast, law schools (almost always) teach students that legal cases resist standardization, and that law is made up of gray areas, not clear answers. Many schools also teach the students as if they will all work in a large law firm on complicated corporate transactions or disputes. This makes our "best-in-class" lawyers even better (standardization of practice is of little interest to Big Law), but harms many lawyers who head out to represent ordinary people.

One reason for our access to justice crisis is that we have trained lawyers in only one mode of practice: individualized services for individual clients. This helps explain why there are unemployed lawyers who are *still* unwilling to meet the price point of the average American: bespoke legal work is just too hard to do cheaply and American lawyers have *no* training in standardization.

Legal licensing is the same: conflicts of interest, the duty of zealous representation, and other rules all assume individualized representation. This is not cost supportable for the working poor or the middle class, and legal education, licensing, and regulation is a part of the problem.

What we need is a standardized, checklist-style solution to the access to justice crisis. Fortunately, while lawyers and legal regulators snooze the fact that the revolution is actually happening all around us.[158] LegalZoom, Rocket Lawyer, and various state-provided free forms are all examples of standardization creating a lower price point for legal services. Right now the regulation is actually holding lawyers back from competing in this market. Harmful lawyer regulation is thus being turned on its head. Instead of keeping consumers from buying standardized services it is blocking lawyers from a lucrative and potentially huge market.

D. Empirical Study

But a precursor to a checklist and standardization is a willingness to study methods and outputs. Medicine has long been data-driven in everything that it does, while lawyers and law schools have largely resisted output measurements. For example, we have only recently begun to measure the effects that lawyers have on court results. This symposium is an outstanding addition to that literature, but the first fully randomized study of the effect of a lawyer on case outcomes happened

158. *See* Barton, *supra* note 13, at 193–213.

this decade![159] Professor Sandefur generated the first metastudy in 2010.[160]

This is not to criticize the scholars like Professor Sandefur, James Greiner, Anna Carpenter, or Coleen Shanahan, who are building this literature. It is to note just how rudimentary our current study is. Counting wins and losses is very helpful, especially when it has not been done before, but it is akin to measuring medical outcomes solely on survival rates.

As a comparison point, imagine if you asked your doctor what the studies showed about a particular cancer treatment and she responded "we have a few brand-new studies showing that in some circumstances seeing a doctor for a medical issue is a positive. As to that particular treatment, we don't know, we don't study that sort of thing. I've done it in the past and it's what they taught me in medical school, so we should be okay."

Legal education is not much better. The most basic building blocks of legal education are supported by a shocking dearth of data. Does the Socratic method work? Do clinics provide a greater benefit than supervised externships? The ABA and the AALS have started to suggest "outcomes and assessment[s]," but what we have so far pales in comparison to the work done by medical schools.[161]

Last but not least, both law and medicine are undergoing information technology transformations that are only in their infancies. At the same time that the ACA is attempting to provide medical care to more Americans than ever before, and lawyers are working hard on access to justice issues, the forces of computerization, outsourcing, and insourcing are also transforming law and medicine around us. Reformers must carefully consider the effects of technology on these markets, and should endeavor first and foremost to do no harm. Reform efforts must harness and channel technology, not retard its salutary effects.

V. Comparative Political Lessons

Advocates of increased access to justice have had limited political success. The easiest way to measure this is the continuous and deep cuts in federal legal aid funding since the 1980s[162] and the starvation level

159. *See* D. James Greiner & Cassandra Wolos Pattanayak, *Randomized Evaluation in Legal Assistance: What Difference Does Representation (Offer and Actual Use) Make?*, 121 Yale L.J. 2118 (2012).

160. Rebecca L. Sandefur, *The Impact of Counsel: An Analysis of Empirical Evidence*, 9 Seattle J. for Soc. Just. 51 (2010).

161. *See* Memorandum from the A.B.A. on Managing Director's Guidance (June 2015) (on file with author).

162. *See, e.g.*, Rachel M. Zahorsky, *Everything on the Table: LSC Looks to ABA to Help Meet Legal Needs of the Poor*, A.B.A. J. (Jan. 1, 2012, 7:20 AM), http://www.abajournal.com/magazine/article/everything_on_the_table_lsc_looks_to_aba_to_help_meet_legal_needs.

funding for many public defender systems.[163] There have been some sporadic, state-level successes, like California's pilot civil *Gideon* program,[164] but it is fair to say that access to justice for the poor is in a holding pattern or worse, let alone any efforts to reach the working poor or the middle class.

Medicine has recently seen a break in this cycle. Federal and state governments have passed major legislation to offer medical insurance to a greater number of Americans. For partisans of increased access to justice, the ACA might offer some hope as a political model.

A. The Affordable Care Act as a Model?

The first thing to note about the ACA is that it came after a long period of frustration. Franklin Roosevelt, Harry Truman, Richard Nixon, Jimmy Carter, and Bill Clinton all attempted to pass legislation ensuring universal healthcare coverage.[165] Clinton's efforts were the most recent and most crushing to the hopes of reformers. Clinton included universal health care as a key plank in his election campaign, and viewed its potential passage as an unassailable political legacy.[166] Immediately following the announcement of the Clinton plan, surveys showed broad public approval and hopes were high for universal care of one kind or another.[167] And yet, a week after the plan's announcement the AMA came out in opposition,[168] and between partisan politics and lobbying by doctors and insurance companies, the plan died.[169]

The single lesson from these failed attempts is that reform is impossible without significant buy-in from doctors and insurance companies. These entrenched interests are better organized than the uninsured and underinsured and have more at stake in any changes to the system.[170]

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163. For a good overview, see *The Issue, Gideon* at 50, http://gideonat50.org/the-issue/ (last visited May 29, 2016).

164. Clare Pastore, Gideon *Is My Co-Pilot: The Promise of Civil Right to Counsel Pilot Programs*, 17 U.D.C. L. Rev. 75, 76 (2014).

165. *See* Vinita Andrapalliyal, *"Healthcare for All"? The Gap Between Rhetoric and Reality in the Affordable Care Act*, 61 UCLA L. Rev. Discourse 58, 70 (2013).

166. *See* Paul Starr, *What Happened to Health Care Reform?*, Am. Prospect (1995), http://prospect.org/article/what-happened-health-care-reform.

167. *See id.*

168. *See* Robert Pear, *Clinton's Health Plan; A.M.A. Rebels over Health Plan in Major Challenge to President*, N.Y. Times (Sept. 30, 1993), http://www.nytimes.com/1993/09/30/us/clinton-s-health-plan-ama-rebels-over-health-plan-major-challenge-president.html.

169. *See* Colin Gordon, Dead on Arrival: The Politics of Health Care in Twentieth-Century America 249–60 (2003).

170. *See id.* at 1–45.

The ACA and Clinton's health care plan faced an additional hurdle: the majority of Americans already had some form of health insurance.[171] As such, opponents to any changes had a natural political advantage if they could pit those who already had insurance against any reforms. Opponents argued that the proposed changes would make those who were happy with their existing coverage worse off.[172] In contrast, the passage of the ACA was possible because of significant buy-in from the AMA and insurance and pharmaceutical companies.[173]

Any change to legal regulation will likewise require either great political will to overcome lawyer objections, or the cooperation of lawyers. Suggested reforms that will likely benefit lawyers—like additional funding for legal aid[174] and public defenders,[175] or the creation of a civil *Gideon* right[176]—have long been supported by the ABA. Less lawyer friendly reforms, like loosening restrictions on the unauthorized practice of law[177] or allowing nonlawyer ownership of law firms[178] have not been so supported.

And yet even the legislative reforms supported by the ABA have been slow to materialize. Why?

B. The Political Economy of the Market for Legal Services is Unique

Part of the answer is the strange, dual nature of the regulation of the market for legal services. To a lesser or greater extent in all fifty states, state supreme courts, not state legislatures, govern lawyer regulation in the first instance, typically as part of their claimed "inherent authority" as common law courts.[179] There have been various incursions on this power, especially among Federal agencies like the Securities Exchange Commission or the Justice Department and some of the friskier state

171. *See* Paul Starr, Remedy and Reaction: The Peculiar American Struggle Over Health Care Reform 194–238 (2011).

172. *See id.*

173. *See* Arthur Daemmrich, *U.S. Healthcare Reform and the Pharmaceutical Industry* 3 (Harvard Bus. Sch., Working Paper No. 12-015, 2011).

174. *See* James R. Silkenat, *ABA Day Is a Chance to Lobby Capitol Hill for Support on Key Legal Issues*, A.B.A. J. (Apr. 1, 2014. 10:00 AM), http://www.abajournal.com/magazine/article/aba_day_is_a_chance_to_lobby_capitol_hill_for_support_on_key_legal_issues.

175. *See* Norman Lefstein, Securing Reasonable Caseloads: Ethics and Law in Public Defense (2011).

176. *See* Am. Bar Ass'n, Civil Right to Counsel (2006).

177. *See* Deborah L. Rhode & Lucy Buford Ricca, *Protecting the Profession or the Public? Rethinking Unauthorized-Practice Enforcement*, 82 Fordham L. Rev. 2587, 2588–89 (2014).

178. *See* Gillian K. Hadfield, *The Cost of Law: Promoting Access to Justice Through the (Un)Corporate Practice of Law* (forthcoming).

179. *See* Benjamin H. Barton, The Lawyer-Judge Bias in the American Legal System 113–59 (2011).

legislatures.[180] Nevertheless, American lawyers are certainly unique insofar as some or all of their regulation starts in a political body outside of the legislative or executive branches. I have argued elsewhere that state supreme courts (and their former lawyer justices) are less receptive to public lobbying and more receptive to lawyer lobbying, and that lawyers are thus uniquely self-regulated and powerful.[181] It also means that some regulatory changes must please lawyers *and* judges.

State legislatures, however, still hold the purse strings. This is why changes to the market that require new funds, like hiring more public defenders or legal aid lawyers, are much less likely to occur than changes to the market like higher barriers to entry.

The political calculus for legal services is also different because lawyers are much less popular than doctors and because medical services seem like a more pressing basic human need than legal services. The comparative sizes of Medicaid and Legal Aid speak volumes about how legislators view the comparative importance of law and medicine. The end result for lawyers is that they are surely better off than doctors in areas that state supreme courts control, but are probably worse off when legislatures call the shots.

C. Some Obvious Solutions Are Thus off the Table (at Least for Now)

In both law and medicine, one obvious solution is to have the government take over some or all of the market. Most other developed countries run a single-payer medical system, for example. Barack Obama has admitted that if he were reforming our medical system from scratch he would institute a single-payer system, but the political realities made an ACA-style compromise much more realistic.[182] There are downsides to a single-payer system, but it has concomitant and obvious benefits in terms of cost and control.[183]

The civil law system is not a direct analogue to a single-payer system (the market for legal services is not mostly government controlled), but it

180. *See, e.g.*, Robert L. Nelson & David M. Trubek, Lawyers' Ideals/Lawyers' Practices: Transformations in the American Legal Profession 135–37 (1992).

181. *See* Barton, *supra* note 179, at 105–59.

182. *See* Angie Drobnic Holan, *Obama Statements on Single-Payer Have Changed a Bit*, Politifact (July 16, 2009, 3:39 PM), http://www.politifact.com/truth-o-meter/statements/2009/jul/16/barack-obama/obama-statements-single-payer-have-changed-bit/.

183. For a brief overview of some pros and cons of a single-payer system, see Darshak Sanghavi & Sarah Bleiberg, *Can Canadian-Style Healthcare Work in America? Vermont Thinks So*, Brookings (Jan. 22, 2014, 10:29 AM), http://www.brookings.edu/blogs/up-front/posts/2014/01/22-can-canadian-style-healthcare-work-vermont-sanghavi. For a longer form discussion, compare T.R. Reid, The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care (2010) with John Goodman et al., Lives at Risk: Single-Payer National Health Insurance Around the World (2004).

is similar. In the civil law system there are more judges and they handle much more of the "legal work" of conflict resolution.[184] In the common law system the lawyers do the great bulk of the work: they find the evidence and often the law, they decide what documents and witnesses to present, they lead the questioning and cross-examination, and so on. The opposite is true in a civil law setting: the default setting is judicial control, not lawyer control, and the final responsibility for gathering and analyzing the facts and applying the law belongs to the judge, not a lawyer or a jury.[185] This does not eliminate the role for lawyers, but it greatly diminishes it. Generally speaking, this means it is cheaper for all citizens to access the courts.

In law and medicine, European governments pay for a system where the government is the primary mover, which helps control costs, but tends to lessen individual agency and the professional hegemony of doctors and lawyers. Partially because of the political power of doctors and lawyers, partially because the American electorate has a limited appetite for government-first solutions, and partially due to the challenges of entrenched power structures these solutions are, for now, off the table.

CONCLUSION

As many of the other articles in this symposium establish, we are actually living through exciting times for increased access to justice. After a long period where it seemed sort of hopeless, progress is seemingly coming on multiple fronts. Maybe it is too much to hope for an ACA-style expansion of legal services to the working poor. But maybe it is not too much to hope that a combination of technology, good policy, and desuetude by lawyer regulators can do more than a law-style ACA could.

184. All of the facts in this paragraph come from JOHN HENRY MERRYMAN & ROGELIO PEREZ-PERDOMO, THE CIVIL LAW TRADITION: AN INTRODUCTION TO THE LEGAL SYSTEMS OF EUROPE AND LATIN AMERICA (3d ed. 2006).

185. *See id.* at 27–47.

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