RECOGNITION OF HEALTH CARE MARKET ANOMALIES

Comments on a Paper by Professor James Blumstein

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Professor Blumstein has presented a provocative and thorough overview of the rapidly changing paradigms in the delivery of health care in the United States and the effect that empirical evidence is having on these market-driven forces, the study of which is now much in vogue.[1]

I have little doubt that the free market approach to the allocation of resources in the health care field,[2] where structured properly, is probably the best method to achieve effective cost competition and quality products. Further, contrary to the view expressed by some authors,[3] I believe that the health care field reacts and responds to many, but not all, traditional market forces endemic to the free market system.

For example, providing financial incentives or disincentives clearly affects the provision of services, the utilization of services, the methods used to provide services, and probably the quality of the product.[4] The enactment of the Medicare prospective payment system for hospitals in 1983[5] and the expansion of Medicare coverage for such services as renal dialysis, home health care and others are merely the most noteworthy illustrations that the behavior of health care providers, and consumers, will radically change if money is withheld, as in the former example, or is provided as in the latter instances.

However, these examples serve only as indications that some market forces do function in the health care field in a manner similar to other markets where

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1. James F. Blumstein, *The Application of Antitrust Doctrine to the Healthcare Industry: The Interweaving of Empirical and Normative Issues*, 31 IND. L. REV. 91 (1998).

2. WEBSTER'S NINTH NEW COLLEGIATE DICTIONARY 491 (1987) defines free market as "an economic market operating by free competition." This necessarily implies an absence of government regulation or intervention. *See generally* Andrew Farris & Griffin Seiler, *Health Care Reform: A Free-Market Proposal*, 7 LOY. CONSUMER L. REP. 45, 45-46 (1995) (positing that "[t]he fundamental problems in the health care market are a result of government intervention" and proposing free-market reform which vests health care choice and responsibility directly in the consumer).

3. *See, e.g.*, Bengt Jönsson, *What Can Americans Learn from Europeans?*, 2 HEALTH CARE FINANCING REV. 79, 91-92 (Supp. 1989); Paul Starr, *The Framework of Health Care Reform*, 329 NEW ENG. J. MED. 1666, 1668 (1993).

4. *See* Robert H. Brook et al., *Does Free Care Improve Adults' Health? Results from a Randomized Controlled Trial*, 309 NEW. ENG. J. MED. 1426, 1432 (1983); Alan L. Hillman, *Financial Incentives for Physicians in HMOs: Is There a Conflict of Interest?*, 317 NEW ENG. J. MED. 1743, 1748 (1987).

5. Social Security Amendments of 1983, Pub. L. No. 98-21, § 601, 97 Stat. 65, 149-72 (codified as amended at 42 U.S.C. § 1395ww (1994 & Supp. I 1995)).

there is a desired product and consumers available to use the product and pay for it (or as is often the case in health care, have someone else pay for it).[6]

Professor Blumstein strongly argued in his presentation that it is far too early in the life of the market-based paradigm in health care to consider radical surgery and that efforts to craft special exceptions to a market system because of the uniqueness of health care were largely based on anecdotal evidence or outright hostility to market driven initiatives.[7] He cited the fairly widespread enactment of state hospital cooperation laws as an indication that incomplete data and strongly held beliefs, even if wrong, are a potent combination which should be resisted until there is better data and more significant education of the public as to the value of market driven systems.[8]

One of the major barriers to pro-competitive conduct among health care professionals has been a particularly long history of cooperation and collaboration encouraged by perceived community benefit.[9] Further, these joint activities of competitors may have even been lawful prior to *Goldfarb v. Virginia State Bar*.[10] Since *Goldfarb*, it has been difficult for many providers of health care to change their cooperative ways and to view competitive initiatives as being public minded and in the best interests of their communities.

In fact, purchasers of health care, legislative bodies, community leadership and other important constituencies of health care have in many and varying ways urged a continuation of the traditional policies of cooperation and collaboration.[11] Purchasers, for example, when discussing this topic will suggest that they desire

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6. Recent surveys indicate that over 80% of Americans have health insurance. Karen Donelan et al., *Whatever Happened to the Health Insurance Crisis in the United States? Voices from a National Survey*, 276 JAMA 1346, 1347 (1996). Nevertheless, 16% of the population said they had a problem in the past year paying medical bills, with the uninsured being three times more likely than the insured to give that response. *Id.*

7. Blumstein, *supra* note 1, at 91.

8. *Id.* at 102.

9. *See* Clark C. Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need,"* 59 VA. L. REV. 1143, 1148-51 (1973).

10. 421 U.S. 773 (1975). *See generally* John D. Blum, *A Consumer Perspective on the Pros and Cons of Antitrust Enforcement in Health Care: An Introduction*, 8 LOY. CONSUMER L. REP. 76 (1995-1996) (noting that *Goldfarb* "opened the doors for the application of the antitrust laws in the health care field.").

11. *See generally* James F. Blumstein, *Assessing Hospital Cooperation Laws*, 8 LOY. CONSUMER L. REP. 98, 103 (1996) (noting that at least 19 states allow cooperative agreements among hospitals by immunizing behavior that otherwise might be subject to federal antitrust scrutiny); James M. Lasley, *Hold Hospital Directors Accountable*, FLA. TODAY, Sept. 3, 1996, at 6A (letter to the editor in which the author writes "the duplication of very expensive medical services; i.e., building a new hospital within miles of another hospital, is completely beyond absurd."); Stephen P. Bunker, *Community Health Care Is a Top Priority*, FLA. TODAY, Sept. 10, 1996, at 6A (letter to the editor in which hospital administrator agrees with the previous letter that "[d]uplication of services does nothing to improve the health [of the community]. . . . In fact, it increases costs to the community.").

providers in a given service area to collaborate and not duplicate unnecessary services and equipment, but only to the extent that meaningful choices for consumers and bargaining alternatives for purchasers remain available. In other words, collaboration and cooperation should continue only to a point of mergers and consolidations which limit bargaining ability on the part of purchasers and choice on the part of consumers. This is a difficult concept for many managers in health care to embrace and still avoid the innumerable anti-trust land mines inherent in such collective endeavors.

A characteristic of the health care field that distinguishes it from most other commodities and services is the provision of a vital human service. Most other vital human services such as water and power are subject to state oversight in the form of public utility commissions or similar entities. This is based, at least in part, on the notion that such services are so significant that determining their availability by market forces is contrary to civilized values and should therefore not be subject to the varieties of the market system. While it is not clear that health care fits neatly into a box wherein a regulatory scheme is the only way in which resources can be allocated, it certainly has some characteristics which would suggest that solution.[12]

In considering the proper role of "the market" in the delivery of health care, empirical evidence can play an important role in framing public policy. Several important issues, however, should be considered.

(1) Health care is an area in which the public has considerable experience and perceived knowledge. This may make it more difficult to make policy decisions based largely on empirical data since the greater the knowledge or experience of the public in a policy area, the more arduous it is to formulate public policy based upon dispassionate empirical data. For example, duplication of services and equipment by health care providers is not always seen by the consuming public as being pro-competitive nor positive.[13] Such duplication of competing services may not result in better quality or lower prices.[14] Thus, there is considerable public support for the continuation of the existing cooperation and collaboration among health care providers in their community, particularly for tertiary and highly technical and expensive services. Thus, while empirical data might show competition is the best allocator of health care services, personal experience and convictions of the public may still greatly influence ultimate policy.

(2) Health care markets can be very imprecise economic models and often

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12. Consumers of health care oftentimes possess limited information, and their day-to-day choices are similarly limited by the dictates of their health insurance policy. Because the vast majority cannot finance their health costs out-of-pocket, however, they must rely on health insurance. Eliot Freidson, *The Centrality of Professionalism to Health Care*, 30 JURIMETRICS J. 431, 438 (1990).

13. *E.g.*, Lasley, *supra* note 11.

14. *E.g.*, Bunker, *supra* note 11. Significant efficiencies can result from hospital collaboration. *See generally* David Dranove et al., *Is Hospital Competition Wasteful?*, 23 RAND. J. ECON. 247 (1992).

very non-traditional, thus limiting the success of market-driven solutions.[15] For example, the public demand for health care goes beyond desire or need and is widely considered to be a right, not merely a privilege.[16] Further, federal and state laws require providing health care services irrespective of the user's ability to pay for such services.[17]

(3) Unlike many consumer products, health care is not readily capable of qualitative measurement. This lack of comparability to widely accepted standards of quality and value is particulary noteworthy as the service modality increases in complexity. Limited tools exist to determine the quality of the diagnostic skills of completing endocrinologists, for example.

(4) The isolation of the consumer from the economic consequences of purchasing health care in most instances is a clear departure from most economic models in the free market.[18] Apart from deductibles and co-pay provisions in many third-party payment plans, there is often little to deter the consumer from obtaining the product even beyond necessary usage. Contrast this with the provision of food to individuals of need. Where the government provides this assistance, the consumer is given food stamps and remains a direct purchaser accountable for the prudent use of limited resources.

(5) The increasing inability of providers of health care services to charge consumers for the proportionate total economic cost of providing care to the providers' universe of patients presents significant problems. The idea of "cost shifting" from one patient class to another is becoming a thing of the past.[19] Often purchasing groups want to pay only "their share" for services provided.

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15. *See* Terese Hudson, *Mirror, Mirror*, HOSPITALS & HEALTH NETWORKS, April 5, 1996, at 24, 26.

16. *See* James F. Blumstein, *Health Care Reform: The Policy Context*, 29 WAKE FOREST L. REV. 15, 33 (1994).

17. The Hospital Survey & Construction (Hill-Burton) Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946) (codified as amended at 42 U.S.C. §§ 291a to 291o-1 (1994)), provided federal financing for the construction of health care facilities while also requiring the provision of necessary medical services to those unable to pay. *See* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 628 (2d ed. 1991).

Several state statutes also require the provision of medical care to all person, regardless of their ability to pay. *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-2905 (West 1993) (defining "medically needy" persons and setting forth procedures by which they can obtain state-assisted care); CAL. WELF. & INST. CODE § 16704.1 (West 1991) (stating that "[n]o fee or charge shall be required of any person before a county renders medically necessary services . . . ."); S.D. CODIFIED LAWS ANN. § 28-13-32.3 (Michie Supp. 1997) (noting that a "medically indigent" person can receive assistance for the cost of hospitalization by applying to his or her county of residence).

Both the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (1994), and provisions within provider agreements, 42 C.F.R. § 489.24 (1995), require hospitals to provide emergency care irrespective of a patient's inability to pay.

18. *See supra* notes 6 and 12.

19. *See* Jack Hadley, *Financial Pressure and Competition: Changes in Hospital Efficiency and Cost-Shifting Behavior*, 276 JAMA 1010 (1996).

Thus, few classes of purchasers are willing to provide the resources necessary to care for those persons who are uninsured or otherwise unable to pay for needed health care services.

Ultimately to determine whether the market paradigm in medical care should be fully embraced, it must be asked whether the market should be the sole determinant as to the provision of this basic human commodity. There are some who would have considerable discomfiture with a complete surrender to the market to determine who receives life saving treatments and who does not.[20]

A possible solution is to permit the market to allocate health care resources in areas where reasonable competitive models exist or can exist and to permit some accommodation to the market in those areas where competition probably cannot occur. It is in this latter environment where empirical evidence may be most useful in providing education to policy makers as to when and where such alternatives to the market should be developed. Changing the existing health care system to encourage market initiatives while addressing systemic structural deficiencies will require considerable information being provided to the public since they will be instrumental in influencing legislative bodies. Health care policy to date has often been based on anecdotal evidence, personal experiences, and often the relative influence of various interest groups.[21]

Because of the rapid and complex changes occurring in the delivery of health care in the United States, neither a rigid application of the usual anti-trust principles nor the creation of special immunities or exemptions should be the standard. It seems premature in the life cycle of the market-based health care system to rush to judgment, whether that judgment is in favor of a complete unfettered market-driven system or a regulatory scheme based on comprehensive state or federal oversight.

Empirical data has not yet been a significant tool in driving public policy in those areas where legislators have considerable experience or deeply held convictions. However, there is some promise that particularly ill conceived public policy may be modified by public education based on valid empirical data. Thus, empirical evidence might still serve a major role in crafting necessary refinements in the current market-based paradigm.

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20. *See supra* note 3 (neither author supports a complete surrender of health care to the free market).

21. *See* James F. Blumstein, *Distinguishing Government's Responsibility in Rationing Public and Private Medical Resources*, 60 TEX. L. REV. 899, 911 (1982).