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Health Care, Markets, and Democratic Values

*Rand E. Rosenblatt**

I. INTRODUCTION

Proposals to restructure the health care industry by increasing market competition currently have much political and academic momentum.[1] Whether such proposals will work necessarily depends in part upon the criteria for success that are applied. Viewed from the market perspective, the question is whether procompetitive reforms will achieve their stated goals of containing costs, increasing efficiency, and enhancing consumer sovereignty over health care decisions. From a broader perspective, other questions are also of concern: whether increased competition in health care will actually improve people's health, and whether the operations and effects of health care competition are consistent with important values such as individual dignity, democracy, and equality. These questions need to be seriously addressed, if not finally answered, before the federal and state governments embark on a policy of widespread market reform. To contribute to the resolution of these issues, this Article briefly surveys the market advocates' articulated goals and their somewhat disparate means for achieving them. The Article then argues that the major market proposals are flawed seriously by internal contradictions, so that in all likelihood

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1. Academic work and political developments have tended overwhelmingly toward attempts to establish one or another type of market competition in health care delivery. *See, e.g.*, Fox, *From Reform to Relativism: A History of Economists and Health Care*, 57 MILBANK MEMORIAL FUND Q. 297 (1979) (discussing intellectual trends among health economists); Fein, *Commentary*, 57 MILBANK MEMORIAL FUND Q. 353 (1979). *See also* congressional bills noted in notes 4, 11, and 12 *infra*.

they will not be able to realize their goals even if their assumptions about human nature and the consumption of health care services are accepted.

More fundamentally, this Article goes on to challenge these underlying assumptions themselves by arguing that the market proposals depend upon and encourage three basic, untenable distinctions. First, the market perspective's emphasis isolates the economic aspect of individual decisionmaking about health from the broad range of ways in which individual human beings interact with their own bodies and environment. In this sense, the individual is separated or distinguished from his whole self. Second, the market approach conceives health care choices to be highly individual matters, which separates the already fragmented individual from the rest of society and makes conscious social choices even more difficult than they are presently. Last, although the market approach recognizes the inevitability of some social decisionmaking, it divides that decisionmaking into sharply distinct zones. The market advocates urge that most social policy should be devoted to the ostensibly apolitical goal of encouraging voluntary market transactions. Income redistribution—and perhaps certain preventive measures that are also crucial to health—occupy the corresponding political zone. In their attempt to maintain these distinctions, the market proposals almost certainly will fail to improve actual health and will probably reinforce, rather than reduce, the most costly and hierarchical aspects of American medicine.

In making these arguments this Article does not suggest that the current system of financing and organizing health care is desirable. The market advocates, along with analysts from several other perspectives,[2] are correct in criticizing the existing system of largely passive, open-ended insurance for "fee-for-service" medicine and "reasonable" hospital costs. The problem with the market approach lies in the perspective from which that criticism is made, as well as in its implications for our understanding of health care and of the proper directions for reform. In some contexts, and for some purposes, both the cost-benefit analysis and the competition that the market advocates endorse might be useful. These instances, however, do not foreclose disagreement on ei-

2. Analyses that favor either public regulation or countervailing consumer power, or both, include: B. ENSMINGER, THE $8 BILLION HOSPITAL BED OVERRUN (1975); J. FEDER, MEDICARE: THE POLITICS OF FEDERAL HOSPITAL INSURANCE (1977); S. LAW, BLUE CROSS: WHAT WENT WRONG? (2d ed. 1976); Starr, *Controlling Medical Costs Through Countervailing Power*, V WORKING PAPERS FOR A NEW SOCIETY 10 (Summer 1977).

ther the general value and applicability of the market approach or its associated modes of thought.

The typical three-cornered debate—the medical profession and the hospital and insurance industries in the first corner, government regulators in the second, and market advocates in the third—often focuses on particular regulatory programs, financing schemes or costly services. On a deeper level, however, the debate is concerned with fundamental orientations to a wide range of problems and the desirable human response to those problems. On particular issues, one or another side may have the better argument. As general perspectives, however, they all have serious limitations. The purpose of this Article is to articulate the major problems with the currently popular market perspective. The Article does not suggest that either the traditional fee-for-service system, which delegates an enormous amount of unaccountable power to the medical profession, or the compromised and limited efforts at government regulation, is markedly superior. Nor does it suggest that there is an easily available fourth perspective to help define and organize the complex task of necessary reform. This Article does contend, however, that a fourth perspective is both desirable and is beginning to be developed, at least in a preliminary form.[3] This perspective recognizes the inadequacy of both professional norms and individual income as the primary means of organizing and distributing health care, and attempts to build a democratic social process to make what are inevitably social as well as individual decisions about health care delivery.

II. THE MARKET APPROACH TO HEALTH CARE DELIVERY: AN OVERVIEW

A. Common Themes

The major market approaches to health care reform share a number of interrelated themes. First, each focuses on consumer and provider "decisions"—for example, the consumer's choice of

3. Elements of this fourth perspective can be found in the following works: S. LAW, *supra* note 2; S. LAW & S. POLAN, PAIN AND PROFIT: THE POLITICS OF MALPRACTICE (1978); Lander, *Doctor-Patient Models: Reformist Dilemmas*, IV HEALTH L. PROJECT LIB. BULL. 1 (Jan. 1979); Schneider, *Model Consumer Health Maintenance Organization Act and Commentary*, 6 RUT.-CAM. L.J. 266 (1974); Schneider & Stern, *Health Maintenance Organizations and the Poor: Problems and Prospects*, 70 NW. U.L. REV. 90 (1975); Sparer, *Punishing the Victim: A Comment on* Medical Society of New York v. Toia *and the Two Camps of Liberal Health Care Reformers*, II HEALTH L. PROJECT LIB. BULL. 1 (Oct. 1977); E. SPARER, CLASS MEDICINE (Oct. 1977) (unpublished book).

physician or the provider's recommendation of a particular treatment.[4] Second, each is grounded in a strong conviction that these decisions ought to be made as often as possible by rational economic actors, that is, by patients and doctors attempting to "maximize their utility" through voluntary transactions in which each party balances marginal economic costs against marginal health benefits.[5] An integral part of this second theme is the notion that government health care policy should encourage such transactions between patients and doctors.[6] Last, the major market approaches share the belief that these transactions do not occur now primarily as a result of widespread health insurance.[7] Market advocates consider much of modern American health insurance to be excessive because of its broad coverage and lack of substantial consumer cost-sharing. By relieving consumers of most of the "out-of-pocket" costs of both routine and complex care, this insurance is said to encourage the delivery of service without concern for its costs and benefits, which undermines rational economic health care decision-making.[8] The main causes of this wasteful financing system are rooted in the tax status of employer contributions to employee's health insurance, as well as in physician resistance to competitive forms of reimbursement. Since employers' contributions to em-

4. *See, e.g., Proposals to Restructure the Financing of Private Health Insurance: Hearing on H.R. 5740 Before the Subcomm. on Health of the House Comm. on Ways and Means*, 96th Cong., 2d Sess. 161-66 (1980) (statement of Dr. William B. Schwartz) [hereinafter cited as *1980 House Hearing*]; H.R. 7527, 96th Cong., 2d Sess. §§ 2(a), 3(2), 126 CONG. REC. H4683 (daily ed. June 9, 1980) (stressing importance of individuals' "own informed choice of the method by which their health care is provided, the persons who deliver it, and the price they wish to pay for it") (introduced by Congressman Gephardt and then Congressman Stockman, now Director of the Office of Management and Budget); Blackstone, *Market Power and Resource Misallocation in Medicine: The Case of Neurosurgery*, 3 J. HEALTH POL., POL'Y & L. 345, 356 (1978); Havighurst & Hackbarth, *Private Cost Containment*, 300 NEW ENG. J. MED. 1298, 1301 (1979), *reprinted in 1980 House Hearing, supra*, at 144, 150-51 [hereinafter cited to both the NEW ENG. J. MED. and the *1980 House Hearing*]; Seidman, *A Strategy for National Health Insurance*, XIV INQUIRY 321, 322-23 (1977).

5. *See, e.g.*, A. ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COSTS OF MEDICAL CARE 51 (1980); Havighurst & Blumstein, *Coping with Quality/Cost Trade-Offs in Medical Care: The Role of PSROs*, 70 NW. U.L. REV. 6, 15-20 (1975).

6. *See, e.g.*, A. ENTHOVEN, *supra* note 5, at 110-13; Havighurst & Blumstein, *supra* note 5, at 19.

7. Only some types of insurance (*e.g.*, hospital, surgical, and medical) are in fact widespread. For an analysis of the distribution of different types of health insurance, and a critique of the theory that insurance is a main cause of health care inflation, see Rushefsky, *A Critique of Market Reform in Health Care: The "Consumer-Choice Health Plan"*, 5 J. HEALTH POL., POL'Y & L. 720, 726-37 (1981).

8. *See, e.g.*, A. ENTHOVEN, *supra* note 5, at 16-19; Havighurst & Blumstein, *supra* note 5, at 13-15. *But see* Rushefsky, *supra* note 7, at 728-31.

ployees' health insurance are not includible in the employees' taxable income, these payments allegedly have become an attractive, tax-sheltered form of compensation.[9] Physician resistance to competitive and innovative forms of practice—such as prepaid group practice or Health Maintenance Organizations (HMOs)—further undermines consumer sovereignty by foreclosing consumer choice of insurance programs, health plans, hospitals, and treatments.[10] Given that the market advocates share these analytic themes, it is not surprising that they tend to agree on several proposals for reform. The most popular idea is to change the tax status of employment-related health insurance, so that part or all of the employer's payments for employee coverage would be includible in the employee's gross income.[11] A second related idea is to require the employer to pay his health insurance contribution as a fixed dollar amount toward the cost of any qualified health or insurance plan and allow the employee to keep any cash difference between the

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9. I.R.C. § 105. *See* A. ENTHOVEN, *supra* note 5, at 19-21; Havighurst, *Controlling Health Care Costs: Strengthening the Private Sector's Hand*, 1 J. HEALTH POL., POL'Y & L. 471, 475-77 (1977). A useful summary of the historical development and current impact of present tax policy regarding employer contributions to their employees' medical insurance expenditures is presented in *1980 House Hearing*, *supra* note 4, at 7 (statement of Emil M. Sunley, Deputy Assistant Secretary of the Treasury for Tax Analysis).

10. *See, e.g.*, A. ENTHOVEN, *supra* note 5, at 21-23, 72-75, 77.

11. *See, e.g., id.* at 121-23; Havighurst, *supra* note 9, at 475-77. The most typical elements of this proposal are (1) to place an upper dollar limit on the amount of the employer's contribution that could be excluded from the employee's gross income, and (2) to require compliance with certain conditions to make any amount excludable. For example, a bill introduced in the current (97th) Congress by Senator Durenberger of Minnesota, Chairman of the Health Subcommittee of the Senate Finance Committee, S. 433, 97th Cong., 1st Sess., 127 CONG. REC. S1019 (daily ed. Feb. 5, 1981) (introduced in similar form in the 96th Congress as S. 1968, 96th Cong., 1st Sess., 125 CONG. REC. S15699 (daily ed. Nov. 1, 1979)), would limit the amount of excludable employer contributions to $125 per month for family coverage in 1981, with appropriate adjustments for single individuals and married couples, and with future adjustments in amount based on changes in the medical care component of the Consumer Price Index. To qualify for tax-free treatment, an employer with more than 100 employees would have to meet a number of conditions, including the offering of three options by separate insurance carriers, an equal contribution to each employee regardless of the plan chosen, and a rebate to the employee in cash for an amount equal to the difference between the uniform employer contribution and the amount of the chosen premium if lower. Under the Durenberger bill, the rebate to the employee would be subject to federal income tax but not to social security, railroad retirement, or unemployment tax. Other examples of bills changing the tax status of employer contributions under very different requirements include S. 139, 97th Cong., 1st Sess., 127 CONG. REC. S136 (daily ed. Jan. 15, 1981), introduced by Senator Hatch of Utah, Chairman of the Senate Committee on Labor and Human Resources (introduced in similar form in the 96th Congress as S. 1590, 96th Cong., 1st Sess., 125 CONG. REC. S10656 (daily ed. July 26, 1979)), and H.R. 5740, 96th Cong., 1st Sess., 125 CONG. REC. H9970 (daily ed. Oct. 30, 1979), introduced by Congressman Ullman, former Chairman of the House Committee on Ways and Means.

employer's contribution and the price of a low cost plan.[12] Confronted with millions of consumers searching for lower premiums and fees, doctors and hospitals would, the argument goes, begin to provide more efficient and less costly forms of care.[13]

The most commonly asserted justification for the market approach, therefore, is clear: individual consumer choice that is motivated by cost is the best—and perhaps the only—feasible and legitimate mechanism for restraining aggregate health care expenditures and deciding which types of discretionary services are "worth" their costs.[14] The market advocates furthermore believe that these mechanisms can be used without significant harm—and perhaps even benefit—to the poor.[15] In addition, these advocates argue that increased competition would reduce the share of the Gross National Product that presently is devoted to health care services, a large part of which they believe yields few actual health benefits. This reduction in turn would free resources that could be employed more usefully to promote health through improvements in nutrition, housing, workplace safety, and environmental quality.[16] Perhaps most fundamental to the market advocates, however, is their belief that market mechanisms are more compatible than any other system with society's proper ethical, moral, and political commitments concerning the distribution of health care services.[17] The appropriate test for evaluating the health care financing system's performance, therefore, is said to be whether "it give[s] reasonable individuals what they want *and only what they want,* in the sense that, understanding the alternatives, they would purchase it for themselves assuming their income was not below a

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12. *See, e.g.,* A. ENTHOVEN, *supra* note 5, at 71-72; S. 1968, 96th Cong., 1st Sess., § 2(a), 125 CONG. REC. S15699 (daily ed. Nov. 1, 1979) (adding new § 86(d) to the Internal Revenue Code, which requires equal employer contribution to employee coverage regardless of the employee's choice among qualified options, and which mandates rebate to the employee of any savings generated through choice of a lower premium) (Durenberger bill).

13. *See, e.g.,* A. ENTHOVEN, *supra* note 5, at 89-92; Seidman, *supra* note 4, at 322-23.

14. *See* A. ENTHOVEN, *supra* note 5, at 110-13; Havighurst, *Speculations on the Market's Future in Health Care,* in REGULATING HEALTH FACILITIES CONSTRUCTION 249, 267-69 (C. Havighurst ed. 1974); Havighurst & Blumstein, *supra* note 5, at 19.

15. *See* A. ENTHOVEN, *supra* note 5, at 139-40; Havighurst, *Health Maintenance Organizations and the Market for Health Services,* 35 LAW & CONTEMP. PROB. 716, 729-30, 750-51 (1970).

16. *See, e.g.,* A. ENTHOVEN, *supra* note 5, at xvi, 50-51; Fuchs, *Economics, Health, and Post-Industrial Society,* 57 MILBANK MEMORIAL FUND Q. 153, 155-57 (1979); Havighurst & Blumstein, *supra* note 5, at 11 n.20, 23 n.56, 60-61.

17. *See, e.g.,* Blumstein & Zubkoff, *Perspectives on Government Policy in the Health Sector,* 51 MILBANK MEMORIAL FUND Q. 395 (1973).

certain level, perhaps the median in the population."[18]

B. Major Differences

Although the market advocates agree on the basic themes and proposals discussed above, it is equally true that they differ among themselves on certain more particular points. Among these are the nature of the health care commodity that people desire most; the transactions through which that commodity should be exchanged; and the extent to which market reform is necessary in the current health care system. While the views among market advocates vary widely on these issues, most of the differences can be grouped into three models of market competition, which can be termed "individual," "entrepreneurial," and "organizational."[19]

1. Individual Competition

Those market advocates who follow the individual model focus almost exclusively on the health care consumer. From this perspective, the commodity being purchased is a service such as a particular diagnostic test or surgical procedure. The important transactions are the consumer's choice of physician, and the decision whether to follow the physician's advice or perhaps seek a second opinion.[20] To make these decisions economically rational ones, the market proponents recommend tax policies that would induce consumers to limit their health insurance to catastrophic or major risks.[21] Under this model, most of the patient's health care costs—up to ten, fifteen, or even twenty percent of annual income—would be paid for out of current assets. According to the market advocates, this cost-sharing would make patients highly conscious of the relative costs and benefits of treatment and would lead to consumer pressure on hospitals and doctors to operate more efficiently, without requiring other major changes in the financing or organization of health care.[22] The model of reducing insurance and imposing heavy costs on individual patients generally is not viewed as including the poor, whose lack of funds would make their choices coerced rather than rational.[23] Instead, propo-

18. Havighurst & Blumstein, *supra* note 5, at 15-16 (emphasis in original).

19. For a somewhat similar categorization of market approaches, see Marmor, Boyer & Greenberg, *Medical Care and Procompetitive Reform*, 34 VAND. L. REV. 1003 (1981).

20. *See, e.g.*, Blackstone, *supra* note 4; Seidman, *supra* note 4.

21. *See, e.g.*, Seidman, *supra* note 4, at 321-22, 325.

22. *See, e.g.*, Seidman, *supra* note 4, at 322-23.

23. *See, e.g.*, Havighurst & Hackbarth, *supra* note 4, at 1301, *1980 House Hearing* at

nents of the individual competition model usually favor—though without extensive discussion—some form of subsidy for low income persons to enable them to have the same purchasing power as persons with average or median income.[24]

2. Entrepreneurial Competition

Some market advocates accept many of the premises of individual competition but take a more complex view of both the commodity that is or should be sold and the difficulty of promoting efficient health care delivery. One of these advocates, Professor Clark Havighurst, believes that health transactions not only involve particular medical services, but also have a brokering or "middleman" function. Havighurst suggests that the patient needs an "expert intermediary"[25] to help him make efficient choices in the complex world of health care. While an individual physician facing a cost-conscious patient might play this role, the current system of reimbursing doctors for particular services rendered creates a powerful economic incentive for doctors to provide services of doubtful medical benefit, and thereby to fail as expert intermediaries dedicated to efficiency.

Havighurst would change the physicians' financial incentives through a system of entrepreneurial competition. He argues that more efficient providers may be able to supply necessary health care to a given population at a cost of ten to forty percent less than the existing fee-for-service system.[26] Furthermore, he believes that "[n]o more than a fraction of these savings . . . would have to be shared with consumers to induce their enrollment in the plan."[27] The balance could be divided between insurance companies or other entrepreneurs and the participating physicians. Thus, under Havighurst's model, the present system of insurance payments to doctors and hospitals who often provide services of dubious medical benefit would be replaced by a price competitive system that rewards those who provide only necessary services in the most efficient manner possible. To create and maintain this type of entrepreneurial market, Havighurst would give insurance companies and health plan entrepreneurs great latitude in desiguing benefit

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24. *See, e.g., id.*

25. Havighurst, *More on Regulation: A Reply to Stephen Weiner*, 4 AM. J.L. & MED. 243, 247 (1978).

26. Havighurst & Hackbarth, *supra* note 4, at 1302, *1980 House Hearing* at 153.

27. *Id.*

packages and provider arrangements, which would allow them to appeal to a wide range of provider interests and consumer tastes and incomes.[28] His approach would entail two principal legal changes: (1) tax incentives to allow employees to choose among competing plans and keep part of their premium savings; and (2) increased antitrust enforcement to prevent physician and hospital resistance to entrepreneurial influence.[29]

To the extent that Havighurst relies on cost-sharing to stimulate consumer cost-consciousness, he would apparently exempt low income persons, who would be given "more comprehensive coverage" on a subsidized basis, without any or with less cost-sharing.[30] Havighurst also believes, however, that market competition and the profit motive actually will provide advantages for the poor, since "[p]rofit-seekers are less fastidious . . . and could be expected to create opportunities for those physicians who might be attracted into deprived-area practice by the right offer . . . ."[31]

3. Organizational Competition

The various models of market competition share the general theory that price competition in some form will reduce unnecessary and inefficiently provided services. They differ, however, on the complexity of the mechanisms that should be employed to instill this competition. The individual model focuses on the competition that operates at the level of the individual patient and physician. The entrepreneurial model relies on profitmaking middlemen to translate consumer demand for lower premiums into provider arrangements that will lower costs. A third model, developed primarily by Professor Alain Enthoven, relies on competing "organized systems" of health care delivery to provide efficient services.[32] Enthoven's approach overlaps with the entrepreneurial model in the sense that some health plans or insurance programs would be sufficiently complex and comprehensive to qualify as "organized systems." Enthoven is less optimistic than Havighurst,

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28. *See, e.g., id.* at 1300, *1980 House Hearing* at 148; Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303, 321-26; Havighurst, Blumstein & Bovbjerg, *Strategies in Underwriting the Costs of Catastrophic Disease*, 40 LAW & CONTEMP. PROB. 122, 192-93 (1976).

29. *See* Havighurst, *supra* note 28, at 342-43 (tax incentives), 343-83 (antitrust enforcement).

30. *See* Havighurst, *supra* note 15, at 736, 741-42 n.76; Havighurst & Hackbarth, *supra* note 4, at 1301, *1980 House Hearing* at 150.

31. Havighurst, *supra* note 15, at 750.

32. A. ENTHOVEN, *supra* note 5, at 67-68.

however, about the effects of unrestrained entrepreneurial competition and attempts to structure competition with a view toward particular health policy goals.[33]

Enthoven's "Consumer Choice Health Plan"[34] is built around four basic principles. First, as in other market approaches, consumers would be offered a choice among competing health and insurance plans.[35] Second, all employer contributions to employees' health insurance would be includible in the employees' taxable income, which eliminates the current tax incentive for broad insurance coverage and raises employees' tax liability.[36] Third, each consumer would be entitled to a fixed health care tax credit to offset at least some of the increased tax liability, as well as some of the premium costs of qualified health plans.[37] Enthoven states candidly that the dollar amount of the tax credit should be determined by a sophisticated political calculus. On the one hand, the tax credit must be high enough to avoid sharp increases in tax liability for most employees, which would make the plan politically unpopular.[38] On the other hand, the tax credit must be low enough to force consumers to spend a substantial amount of their own after-tax dollars on health insurance and therefore induce them to shop for the lowest available premium.[39] Enthoven suggests that to achieve these results, the tax credit could be set at sixty percent of the average health insurance cost for various categories of consumers, leaving consumers to pay the balance out of current, after-tax income.[40] As in the other market approaches, low income persons would receive a somewhat larger, income-related subsidy, which

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33. *See id.* at 70-82.

34. Enthoven's Consumer Choice Health Plan originally was presented in September 1977 in a memorandum to HEW Secretary Joseph Califano, *see id.* at 115, and was published in an earlier version as Enthoven, *Consumer Choice Health Plan (Part I): Inflation and Inequity in Health Care Today: Alternatives for Cost Control and an Analysis of Proposals for National Health Insurance,* 298 NEW ENG. J. MED. 650 (1978); *Consumer Choice Health Plan (Part II): A National-Health-Insurance Proposal Based on Regulated Competition in the Private Sector,* 298 NEW ENG. J. MED. 709 (1978).

35. *See* A. ENTHOVEN, *supra* note 5, at 71, 127.

36. *See id.* at 121-22.

37. *See id.*

38. *See id.* at 122.

39. *See id.*

40. *See id.* By "categories" of consumers, Enthoven has in mind the broad actuarial criteria such as age, marital status, and geographical location currently used to set health insurance premiums. *See id.* at 120. Thus, each person in a given age group in a particular geographic location would be entitled to a health care tax credit of a specific dollar amount, which would be based upon a percentage of the average cost of providing health insurance to that particular group under the current system.

Enthoven hopes will be sufficiently large "to purchase membership in a good-quality comprehensive health care plan."[41] Last, to qualify for the tax credit, all plans would have to meet certain government criteria that are designed to achieve what Enthoven terms "socially desirable competition."[42] These criteria would include both governmentally supervised open-enrollment and community rating of premiums, which would insure access for the aged, poor, and other "high-risk" individuals.[43] Plans qualifying under Enthoven's scheme would also be required to provide basic health services coverage and catastrophic expense protection.[44] These rules are necessary, Enthoven argnes, "to ensure that all health plans are competing to provide good-quality comprehensive care at a reasonable cost," and not profiting by practices such as preferred risk selection—limiting enrollment to the healthy—or selling inadequate coverage.[45]

Enthoven believes that the creation of a structured competitive market will stimulate the development of "alternative delivery systems," which will be characterized not only by prepayment but also by organized responsibility for providing comprehensive care to an enrolled population.[46] These systems ostensibly would have both the economic incentive and the organizational capability to limit unnecessary services and to develop new, efficient patterns of care. For example, contracts could be made with high volume medical centers for specialized services such as open-heart surgery. This would reduce per patient cost, increase quality, and promote the beneficial concentration of cardiac surgery in a small number of centers, a concept known as "regionalization."[47] On a somewhat broader scale, Enthoven argues that an organized system of health care delivery possesses greater opportunities to control costs and promote efficiency because it has far more capacity than an insurance company or an individual doctor to influence the "key variables":

> An organized system can control the style of care and the accessibility of its services and can [within limits] . . . design its program to appeal to one or another type of patient. It might deemphasize hospitalization and apply the savings to improved access to outpatient care. It might allocate more re-

41. *Id.* at 81.
42. *Id.* at 126.
43. *See id.* at 127.
44. *See id.* at 128-29.
45. *Id.* at 72.
46. *Id.* at 56-57.
47. *See id.* at 37-41.

> sources to convenient neighborhood primary-care centers and to a more personal style of care [and use less specialty care]. It might emphasize home care at the expense of high-technology care. It might achieve [efficiency] savings . . . and apply them to broadening its benefits in . . . preventive care and mental health.[48]

Implicit in Enthoven's scheme is the notion that competing organized systems have incentives and capacities somewhat different from those of competing entrepreneurs or individual physicians. In his model, organizational competition is not designed simply to finance—either on a prepaid or a self-paid basis—the existing patterns of medical care, nor is it "merely [an] incentive schem[e] for lowering costs or use of services."[49] Rather, organizational competition is a framework in which providers can emphasize different values and combinations of services depending upon the varying desires of the patients they serve.[50]

III. Market Competition and Health Care: The Efficiency Issues

A. *Introduction*

All of the market proposals seek to achieve efficiency through competition. "Efficiency" is generally understood in the literature to have two meanings: (1) efficiency in the *use* of health services, that is, providing only services whose demonstrated health benefits exceed their costs; and (2) efficiency in the *delivery* of health services, namely, providing even cost-effective services in the most efficient manner and setting possible—for example, by taking advantage of economies of scale.[51] "Competition," on the other hand, is used by market advocates in different and somewhat inconsistent ways. This part of the Article examines the connection between the three major models' concept of health care competition and their stated goal of promoting both types of efficiency. It argues that even though various forms of competition might promote efficiency under certain conditions, the market advocates have neither articulated adequately what those conditions are, nor incorporated

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48. *Id.* at 67.

49. *Id.*

50. *Id.*

51. Some analysts refer to efficient use as "levels and patterns of utilization" and efficient delivery as "technical efficiency," which is defined as "obtaining any particular quantity and mix of health services with minimum resource commitments." M. Barer, R. Evans & G. Stoddart, Controlling Health Care Costs by Direct Charges to Patients: Snare or Delusion? 22-23 (Ontario Economic Council, 1979) (I am indebted to Dr. Theodore Marmor for bringing this study to my attention).

them into their policy proposals. Consequently, even if one accepts the market advocates' definitions of efficiency and competition, together with their assumptions about consumer behavior in response to economic constraint, their proposals are not likely to lead to the type of competition that actually improves efficiency.

B. Individual Competition

In order to promote the efficient *use* of health services in an individual competition model, a patient cost-sharing scheme[52] must satisfy at least three major conditions. First, patients must be able not only to compare the costs of care against its benefits but also to act on this comparison. Second, patients must be deterred from buying additional insurance to cover most if not all of the cost-sharing amount. Last, the scheme must discourage providers from reacting to whatever economic constraints that cost-sharing generates in ways that offset its positive effects. Moreover, in order to promote the efficient *delivery* of services, a fourth condition must be met as well; there must be price competition among providers, and patients must be able to "shop" comparatively among providers for the best price.[53]

With respect to in-patient hospital care, where the great majority of health care costs are generated,[54] the evidence strongly suggests that cost-sharing will have virtually no impact.[55] The reasons are obvious: price comparisons among hospitals are difficult to make, and illnesses are often sufficiently serious that the patient will rely on the physician's judgment. Even with respect to non-hospital care, each of these four conditions will be quite difficult to satisfy, yet advocates of individual competition generally have not proposed methods that are adequate to overcome these obstacles.

In theory, cost-sharing can promote the efficient use of services without price competition. The single physician in a small town may be insulated from competition from other providers and still find his patients, who now must pay out of their own pockets, resisting treatments or tests such as recommended X-rays unless he can explain convincingly why they are needed. In practice, of course, the physician may well be able to persuade the ill and worried patient that the X-rays are necessary—a transaction that

52. *See* notes 20-23 *supra* and accompanying text.

53. For an enumeration of similar conditions, see M. BARER, R. EVANS & G. STODDART, *supra* note 51, at 29.

54. *See id.* at 30.

55. *See id.*

hardly approaches the ideal of a fair bargain. Conversely, the economic constraint may be effective, and the patient—particularly the lower income patient—may decide to forego the test or, even more likely, not see the doctor at all. There is nothing inherent in the patient cost-sharing mechanism, however, to insure that the foregone services are either the unnecessary or the less valuable ones. On the contrary, the evidence suggests that cost-sharing may diminish patient demand for a variety of services, including office visits, annual checkups, immunizations, pap smears, and prenatal care.[56] Some of these services (such as annual checkups) may indeed cost more than their health benefit justifies. Others (such as prenatal care), however, clearly have benefits beyond their costs, especially for low income patients, who are the ones most likely to be influenced by out-of-pocket costs. It is not surprising, therefore, that a careful review of the American and Canadian literature on the effects of cost-sharing concluded that "[t]here is *no* evidence of any kind suggesting that the selective utilization reductions which result from coinsurance [a form of cost-sharing] are in fact those involving frivolous or unnecessary services."[57] In other words, while cost-sharing may reduce patients' use of some health care services, there is no justifiable basis for concluding that this pattern of use is either efficient or cost-effective.

The ineffectuality of cost-sharing as a tool for achieving both the efficient use and the efficient delivery of health care is compounded because it is often impossible to determine the price of a medical treatment in advance.[58] Diagnostic work usually must be done first, and by the time the patient receives a reliable estimate of the overall price, a considerable investment in time and money already has been made. To begin shopping for a new physician at this point would entail new office visits, new tests, additional work time lost, travel expenses, and personal aggravation. Indeed, the costs incurred in these added efforts quite conceivably could exceed any competitive advantage that the patient might obtain in the treatment price. On the other hand, attempts to shop at an earlier stage—for example, by visiting several doctors and seeking a variety of estimates based upon potential yet unknown diagnoses—would still involve considerable time, office fees, and a bewildering range of speculative options. Moreover, if the symptoms are

56. *See id.* at 40.
57. *Id.* at 48 (emphasis in original).
58. *See* A. ENTHOVEN, *supra* note 5, at 34-35.

at all uncomfortable, as they often are, the individual competition model becomes still more unrealistic. As Enthoven has stated, "The sick or worried patient is in a poor position to make an economic analysis of treatment alternatives."[59] The size of many suggested cost-sharing proposals—ten or even twenty percent of the patient's income, which easily could be $1,000 to $10,000[60]—demonstrates that patients with serious medical conditions could be expected to respond to a substantial economic pinch. It is precisely these patients, however, who are in the worst position to behave as rational economic decisionmakers.

In addition to these barriers to comparison shopping, there is a more fundamental problem: while consumers under the individual competition model would have to pay for services out of their own current assets, providers in all likelihood would not engage in price competition. In small communities especially there are usually only a few sources of care—for example, one hospital, one obstetrician, and a small number of general practitioners. These providers are not liable to experience any large degree of competitive pressure, unless travel to providers in other areas is economically and practically feasible. Furthermore, in medium-sized communities, the supply of specialists and specialized hospital units may be low, which in turn creates monopoly power in these particular areas of care. Finally, even when there is a sufficient number of providers to make price competition theoretically possible, it nevertheless may not occur because of more or less conscious professional collusion. While formal collusion in the nature of medical association pressure to maintain "accepted" charges probably could be discouraged by antitrust enforcement, numerous techniques "for informal collusion and 'conscious parallelism' persist."[61] As Barer, Evans, and Stoddart cogently point out,

> [h]ow the real social interest in close co-operation between health care providers for purposes of continuity and co-ordination of patient care, consultation over therapy, and continuing education can be reconciled with the social interest in complete separation of economic behavior is not clear. It is difficult to believe that physicians, for example, coming from a background of many years of training in close proximity to ensure a common value system, subsequently working together every day in clinics and hospitals performing similar tasks, and further extending their contacts socially, can avoid co-operating on prices when it is so obviously in their interest to do so. Yet the

59. *Id.* at 34.

60. *See, e.g.*, S. 1590, 96th Cong., 1st Sess., 125 CONG. REC. S10656, § 1922(a)(1) (daily ed. July 26, 1979).

61. M. BARER, R. EVANS & G. STODDART, *supra* note 51, at 75.

usefulness of direct patient charges as an inducement to provider efficiency is critically dependent on the absence of collusion.[62]

If providers do not engage in price competition, health care services likely will be delivered at the same price before and after the imposition of patient cost-sharing. Therefore, the efficiency or cost of health care will undergo little if any change, while the party who bears the cost will shift from insurance companies or the government to individual patients at the time of illness.

In response to this situation, patients faced with substantial cost-sharing obligations will probably purchase additional insurance to cover most if not all of the additional cost. Consumer distaste for large deductibles and other forms of cost-sharing has been manifest in many contexts, notably in the purchase of private insurance to supplement Medicare coverage.[63] As Havighurst has noted, it is possible to attempt to discourage this insurance through tax incentives.[64] It is also true that predicting consumer behavior might be more uncertain if the tax treatment of health insurance is substantially changed. Nevertheless, it is reasonable to assume that substantial cost-sharing obligations, which place consumers at risk for costs up to ten, fifteen, or twenty percent of their income, will induce those who can afford it to buy additional coverage and leave the incentive for "rational economic behavior" to only the lower income groups on whom cost-sharing might impose genuine hardship. If this were to occur, the large number of more affluent persons exempted from cost-sharing would undermine further any pressure for improved efficiency.

C. *Entrepreneurial Competition*

The leading advocate of entrepreneurial competition,[65] Professor Havighurst, simultaneously embraces and rejects the premises of individual competition. On the one hand, he paints a favorable picture of the doctor and patient, liberated from the shackles of insurance, together making a "benefit-cost assessment" of a proposed treatment and "taking all the immediate circumstances into account. The physician would be expected to act in the time-honored capacity of professional adviser and fiduciary, with responsibility for the patient's financial situation as well as his

62. *Id.*

63. *See* Marmor, Boyer & Greenberg, *supra* note 19, at 1011-16.

64. Havighurst, *Competition in Health Services: Overview, Issues and Answers*, 34 VAND. L. REV. 1117, 1146-47 (1981).

65. *See* notes 24-31 *supra* and accompanying text.

health."[66] To the extent that this concept merely restates the model of individual competition, it is subject to the same difficulties of that approach noted above. By shifting the emphasis of the model to the physician as *fiduciary,* however, Havighurst at least implicitly recognizes that the patient is in a relatively poor position either to second-guess the doctor or to shop for alternatives. The concept of a fiduciary relationship seems inconsistent with the image of arm's-length, economically rational decisionmakers that dominates the pro-market literature. Thus, it is not surprising—though it is somewhat contradictory—that Havighurst's main mechanism for achieving efficient use and delivery of health care is not the physician's motivation as a fiduciary, but rather the physician's economic self-interest, to which insurance companies and health plan entrepreneurs would appeal.

The entrepreneurial model, as developed by Havighurst, implicitly rests on the understanding that individual patients under economic constraint in most circumstances can neither decide which services are cost-effective nor stimulate price competition among providers. These crucial functions, therefore, are shifted to entrepreneurs, whose task it is to aggregate consumer demand and bargain as experts with providers.[67] Under Havighurst's model, insurance companies and health plans, rather than individual patients, will decide which services are not cost-effective and either exclude them from coverage or impose on them high cost-sharing requirements. Insurance companies and health plans also will decide which modes of practice are efficient for delivering care and will induce providers to participate in their policies through higher pay and threats of nonreimbursement. As a result, consumers will receive the benefit of increased efficiency in the use and delivery of health care through lower premiums. As previously noted, however, Havighurst suggests that the entrepreneurs and physicians will retain the bulk of the savings as profits.[68]

Three major problems undermine the asserted connection between entrepreneurial competition and improved efficiency. First, deciding which services are not cost-effective is a difficult scientific and political undertaking when done properly. Scientifically, to establish that a procedure does not contribute to health involves, in most cases, "rigorous demonstration, presumably in multi-centre,

66. Havighurst & Hackharth, *supra* note 4, at 1301, *1980 House Hearing* at 150.
67. *See* Havighurst, *supra* note 9, at 485.
68. *See* notes 27-29 *supra* and accompanying text.

controlled, randomized trials," that compares the procedure to "the next best alternative."[69] Moreover, the results of these trials are likely to show not that the procedure is never cost-effective, but rather that it is cost-effective only for a selected class of patients who may or may not be easy to identify.[70] Politically, the criteria for a health benefit must be well defined, particularly on the question of the extent to which society values anxiety reduction, increased "caring" capacity, and other "quality-of-life" factors that go beyond the simple benefits of lower mortality and morbidity rates.[71] Whatever difficulties the professions of medicine, nursing, mental health, social work, economics, sociology, and hospital administration may have had in addressing these issues in a humane and responsible way, there is no reason to believe that insurance companies and for-profit health plans have any capacity or interest in doing any better.[72] On the contrary, the entrepreneurial tradition in a free enterprise economy is to quickly reduce complex social judgments to a financial "bottom line." Thus, it is quite possible under the entrepreneurial model that certain beneficial medical procedures would be excluded from coverage on the basis of either inadequate tests and oversimplified cost-benefit criteria or the bargaining power of a particular professional specialty.

The second reason that entrepreneurial competition is unlikely to lead to improved efficiency is that there are much easier ways to make profits than by increasing efficiency. The dominant method presently used in the insurance industry, for example, is termed "preferred risk selection"—insuring groups of relatively healthy people who represent good risks because their claims are likely to be infrequent. Havighurst does not address this problem in many of his writings that advocate a major cost containment role for insurance companies.[73] In his 1970 article on market competition and HMOs,[74] however, Havighurst does discuss briefly the need to prevent insurance companies and HMOs from excluding high risk individuals. His proposed solution to this problem is a government regulation that requires coverage plans to enroll indi-

69. M. BARER, R. EVANS & G. STODDART, *supra* note 51, at 100.

70. *See id.*

71. *See id.* at 9-10 n.7.

72. *See* note 77 *infra.*

73. *See, e.g.*, Havighurst, *supra* note 9; Havighurst, *Health Care Cost-Containment Regulation: Prospects and an Alternative*, 3 AM. J.L. & MED. 309 (1977).

74. Havighurst, *supra* note 15.

viduals on a "first-come, first-served" basis—apparently without regard to their preexisting medical condition—subject to a waiver for those plans whose enrollees are "excessively risk-prone."[75] The question that arises from this proposal, however, is whether such a simple requirement will provide adequate protection to disfavored patients. Even with the community rating system, in which the same premium is established for individuals who satisfy gross criteria such as age and family size, health plans effectively can discourage minorities, the poor, and high risk individuals from enrolling due to their geographic location. In addition, these plans can use broad benefit packages (and hence high premiums), selective exclusion of conditions and treatments, and provider arrangements to make access inconvenient for disfavored groups. These tactics could, of course, be prohibited or regulated by law, but this regulation is inconsistent with the ideal of entrepreneurial competition.

The last major problem with Havighurst's thesis is that even if entrepreneurial competition does manage to improve efficiency in the use and delivery of health care, consumers will receive only limited ecnomic benefits. Of course, consumers would benefit from reduction of unnecessary and often harmful hospital and surgical care. The economic price to consumers of this newly efficient system, however, would be almost as high as the presently inefficient, fee-for-service system. This is because the entrepreneurs and physicians would retain as profits most of the savings realized from improved efficiency. Havighurst argues that when competition becomes more widespread, a greater percentage of the savings will have to be shared with consumers to prevent entrepreneurs and doctors who are willing to earn lower incomes—or who are more efficient—from capturing the patient market.[76] The problem with the entire model, however, is precisely that it envisions substantial profits for both entrepreneurs and physicians; indeed, the main economic result of entrepreneurial competition is likely to be a redistribution of income from certain specialists and high technology hospitals to insurance companies, enterpreneurs, and less specialized physicians who are willing to act as "gatekeepers" to higher priced services.

D. Organizational Competition

It is the thesis of this Article that the individual and the

75. *Id.* at 788.

76. Havighurst & Hackbartb, *supra* note 4, at 1302-03, *1980 House Hearing* at 153.

somewhat more plausible entrepreneurial models of health care competition are unlikely to promote efficiency. The former is defective because it overestimates the willingness and capacity of *consumers* to exercise economic power at the point of delivery. The latter fails because it overestimates the willingness and capacity of *insurance companies* not only to define and enforce efficiency but also to persuade providers and consumers to participate in these efforts.[77] Professor Enthoven also has recognized these problems and generally has avoided them. Enthoven's Consumer Choice Health Plan[78] is by far the most comprehensive, sophisticated, and realistic version of pro-market reform being discussed today. If implemented under the proper political and social conditions, Enthoven's proposal could contribute significantly to cost control, improved quality, and increased equality in American health care. The main difficulty with Enthoven's work lies in its failure to articulate adequately what conditions will be necessary to achieve its goals. Enthoven also fails to appreciate the tensions between the letter and spirit of the market approach on the one hand, and the individual, social, and political initiatives necessary for reform on the other.[79]

Within Enthoven's framework, however, two points deserve mention. First, to increase efficiency in the use and delivery of health care, Enthoven relies heavily on the capacity of "alternative delivery systems," which consist of prepaid plans that deliver relatively comprehensive care to enrolled populations.[80] For both theoretical and empirical reasons, this strategy is more likely to be successful than reliance on either individual patient cost-sharing or insurance company competition. Alternative delivery systems do provide an economic incentive to hold down costs and *may* have more capacity and willingness to do so through increased efficiency than either individual physicians or insurance companies.

The ambiguous track record of existing HMOs, however, generates much uncertainty about their actual ability to increase effi-

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77. As Professor Havighurst concedes, insurance companies have, with rare exceptions, traditionally heen uninterested in and even hostile to such a role. *See* Havighurst, *supra* note 25, at 248 & n.28 (noting that while the private sector is not anxious to take responsibility for cost-containment, and that "[i]nsurance companies, in particular, would rather not bave this ticklish responsibility . . . . [c]ompetition should force them to accept it, however."); *see* Havighurst, *supra* note 28, at 336-42.

78. *See* notes 32-50 *supra* and accompanying text.

79. *See* Parts IV & V *infra*.

80. A. ENTHOVEN, *supra* noto 5, at 56-57; *see* notes 46-50 *supra* and accompanying text.

cient use and delivery of care. It is true that most types of HMOs achieve lower hospital *use* per enrolled patient than exists among comparable patients in traditional fee-for-service systems. This is certainly the case with the classic prepaid group practices such as the Kaiser plans and Group Health Cooperative of Puget Sound.[81] It is unclear, however, whether this lower rate of hospital use actually reflects increased efficiency, or whether it is a result of factors such as patient self-selection—the idea that HMO patients generally are healthier individuals—or "undertreatment" in some form.[82] As Marmor, Boyer, and Greenberg point out elsewhere in this Symposium, if patient self-selection is in fact the dominant factor, then the savings achieved by HMOs do not represent more efficient use of hospital care, but rather are a version of preferred-risk selection, that is, a separate health care system for the healthy.[83]

The evidence concerning HMOs' delivery efficiency is even less clear. For example, there is little evidence to suggest that HMOs have increased delivery efficiency through the innovative use of personnel or the consolidation of facilities.[84] This lack of evidence may not be decisive, however, since most HMOs suffer from the following common ailments: they have only a small share of the health care market; they are in the early years of operation; and they must function in a climate often hostile to promoting efficiency.[85] These doubts about the capacity of competing organized systems to promote efficiency do not mean that Enthoven's proposal, or something like it, should not be attempted, but rather that if it is attempted it must be designed and monitored with great care. This particularly should be the concern when dealing with aged and low income consumers who have greater than average health care needs.

The second point worthy of mention in Enthoven's plan is that even if competing organized systems could be established, the dynamics of competition among them is unclear. Certain features of Enthoven's analysis favor the concentration of market power

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81. *See* Luft, *Assessing the Evidence on HMO Performance*, 58 MILBANK MEMORIAL FUND Q. 501, 510-11 (1980). An excellent study of the historical origins and performance of prepaid group practices up to 1971 can be found in Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, 84 HARV. L. REV. 887 (1971).

82. *See* Luft, *supra* note 81, at 512; Luft, *How Do Health Maintenance Organizations Achieve Their "Savings"? Rhetoric and Evidence*, 298 NEW ENG. J. MED. 1336, 1342 (1978).

83. *See* Marmor, Boyer & Greenberg, *supra* note 19, at 1020-21.

84. *See* Luft, *supra* note 81, at 508-11.

85. *See* A. ENTHOVEN, *supra* note 5, at 55-68.

and envision large health care systems establishing networks of primary clinics and community hospitals, which then bargain with large regional medical centers for specialized services such as cardiac surgery.[86] The capital, managerial, and staff requirements of these systems would be substantial and in all likelihood would lead to monopoly or near monopoly power in those localities that could not support more than one or two health care plans. Thus, the extent to which competition will flourish under Enthoven's scheme is open to question. Similarly, while the concentration of specialized services in large regional medical centers might lower per unit costs for some services, it might raise per unit costs for others at the same time. In any case, regionalization might result in strong bargaining power for specialists, who thus could undermine efficiency gains over time. These problems do not mean that the existing system of generally uncontrolled reimbursement for high technology services is desirable. They do, however, reflect the potential inherent in any market approach for the concentration of economic power and suggest the need for carefully designed mechanisms of consumer accountability and social regulation.

IV. Market Competition and Health Care: The Human and Social Issues

A. *Introduction*

Market advocates attempt to structure the patient's relationship to health care as an economic transaction, namely, as an exchange of a commodity for money in a competitive market setting. A primary justification for increasing market competition in health care is to promote efficiency in the use and delivery of services.[87] Some proponents argue that market competition also has value in its own right as a uniquely legitimate method of defining and promoting efficiency. It is argued that collective social decisions, however made, are inherently coercive and inevitably inefficient.[88] Market mechanisms are said to promote only the value of individual liberty, which enables consumers to express their own preferences by their economic "votes"; otherwise, these mechanisms are

86. *See id.* at 37-44, 67-68.

87. *See, e.g.*, A. Enthoven, *supra* note 5, at xvi-xvii, 37-54, 89-92; Havighurst, *supra* note 25, at 248; Havighurst & Blumstein, *supra* note 5, at 64-66.

88. *See, e.g.*, A. Enthoven, *supra* note 5, at 112-13; Havighurst, *supra* note 73, at 312, 316-17.

considered to be value-neutral.[89]

Despite its considerable superficial appeal, this position is misguided. The distribution of health services through competitive markets promotes at least three major and related nonneutral values. First, in a competitive market individuals are encouraged to make decisions about health care primarily from an economic perspective, as opposed to a broader, more realistic view.[90] Second, individuals also are encouraged to perceive health care choices and health itself as an individual matter, rather than as a matter based upon a close interrelationship between individual decisions and social patterns concerning nutrition, work, environmental quality, economic opportunity, and many other factors.[91] Last, in a competitive market, individuals in their role as citizens or government officials are encouraged to believe that the proper goal of most government policy is to encourage voluntary market transactions. As a result, issues of equality become confined to the special and limited sphere of redistributing purchasing power, the purpose of which is to permit deserving low income persons to participate in the free market.[92] These three values may be defensible, but they

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89. *See, e.g.*, A. ENTHOVEN, *supra* note 5, at 112-13, 133; Havighurst, *supra* note 25, at 248 n.26, 251-52.

90. Examples of broader ways in which people might conceive of the costs and benefits of health care are presented in the discussions of electronic fetal monitoring and heart disease. *See* notes 113-56 *infra* and accompanying text. These discussions highlight two particular factors that are usually discounted in the economic perspective: (1) the processes or relationships through which decisions are made (other than the sale of commodities); and (2) the social context of individual illness. For more general discussions of these and other limits of the economic or market perspective, see Tribe, *Policy Science: Analysis or Ideology?*, 2 PHIL. & PUB. AFF. 66 (1972); Thurow, *Government Expenditures: Cash or In-Kind Aid?*, 5 PHIL. & PUB. AFF. 361 (1976).

91. The extensive pro-market literature in health care is devoted overwhelmingly to the problem of individuals, or their competitive "agents" such as insurance companies and health plans, trying to find the most efficient way to provide health care services to individuals and to avoid unnecessary care. *See, e.g.*, A. ENTHOVEN, *supra* note 5, *passim;* Havighurst, *supra* note 25, at 247-52. The social context of health is occasionally referred to in the literature, *e.g.*, Havighurst, *supra* note 73, at 318; Havighurst & Blumstein, *supra* note 5, at 11 n.20, 23 n.56, but it is not treated as a major theme. Market advocates take the general position that resources saved through more efficient use and delivery of health care to individuals might be allocated to more effective social investment in nutrition, work, environmental quality, and so on. *See id.* Unfortunately, the same type of market or cost-benefit analysis that is used to restrict the social financing of health care is also used to restrict other redistributive and regulatory programs such as nutrition for low income individuals or environmental regulation. *See* notes 159-67 *infra* and accompanying text.

92. An articulate general statement of this perspective can be found in Tobin, *On Limiting the Domain of Inequality*, 13 J.L. & ECON. 263 (1970). For specific examples in the pro-market health care literature, see A. ENTHOVEN, *supra* note 5, at 81; Havighurst, *supra* note 9, at 490-91 (market imperfections and social justice can be addressed by a "market-

certainly are not neutral, at least not in the sense of simply allowing individuals to express their own preferences. On the contrary, they are designed to exert influence over what those preferences might be, as well as to limit the kinds of social settings in which preferences can be expressed and satisfied.[93] This part of the Article argues that in addition to inhibiting desirable improvements in efficiency, these three aspects of the market approach generally will have a negative effect on people's health.[94]

B. Markets, Health, and Whole Individuals

1. The Nature of the Problem

Most advocates of the market approach to health care assert that the central advantage of their plans is the encouragement of cost-benefit decisions by various decisionmakers in the context of economic constraint. The meanings of the terms "cost," "benefit," "health," and "health care" in the pro-market literature usually are assumed to be obvious. Cost typically is understood to mean the monetary equivalent of providing a unit of service such as a diagnostic test, surgical procedure, or hospital day.[95] Benefit normally is assumed to represent one or another quantifiable measure of treatment outcome such as mortality rate, length of stay in the

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oriented strategy"; "[a]ll that is essential is that the market's basic integrity not be undermined by measures dealing with specific problems"); Havighurst, *supra* note 15, at 741 & n.76 (government has failed in its responsibility to redistribute purchasing power to the poor); Havighurst & Blumstein, *supra* note 5, at 64-66.

93. For more general analyses of this point, see Gintis, *Consumer Behavior and the Concept of Sovereignty: Explanations of Social Decay*, 62 AM. ECON. REV. 267 (1972); Kelman, *Choice and Utility*, 1979 WIS. L. REV. 769; Kelman, *Consumption Theory, Production Theory, and Ideology in the Coase Theorem*, 52 S. CAL. L. REV. 669 (1979).

In addition, the ostensibly sharp distinction between "coercive" government regulation and "voluntary" market transactions is untenable. As Robert Hale pointed out in 1943,

> while there is no explicit legal requirement that one enter into any particular transaction, one's freedom to decline to do so is nevertheless circumscribed. One chooses to enter into any given transaction in order to avoid the threat of something worse—threats which impinge with unequal weight on different members of society. The fact that he exercised a choice does not indicate lack of compulsion.

Hale, *Bargaining, Duress, and Economic Liberty*, 43 COLUM. L. REV. 603, 606 (1943). *See also* C. LINDBLOM, POLITICS AND MARKETS 45-51 (1977); Kennedy, *Form and Substance in Private Law Adjudication*, 89 HARV. L. REV. 1685, 1748-49 (1976). Lindblom notes that both impersonal and personal coercion permeate market exchanges, especially since bargaining power is inextricably linked to distribution of resources and the distribution of wealth "is a consequence of centuries of conflict . . . ." C. LINDBLOM, *supra*, at 46.

94. For an examination of the impact of these values on low income consumers, see Part V *infra*.

95. *See, e.g.*, A. ENTHOVEN, *supra* note 5, at 37-41.

hospital, or probability of cure.[96] For some purposes, or in some contexts, these criteria may be adequate. The market advocates rarely, however, specify the conditions, contexts, or purposes that justify these criteria.[97] On the contrary, the pro-market literature is replete with summary references to studies that cast doubt on the effectiveness or efficiency of a wide range of procedures and practices,[98] together with a general endorsement of cost-benefit decisions as the major virtue of competitive markets. This approach radically over-simplifies the way in which patients, considered as whole individuals, actually experience the costs and benefits of health and health care.

Health can be understood rather simply as the absence of disease and death, and health care as a "curative defence" against both.[99] When this is the accepted criterion, a particular medical procedure can be evaluated in terms of whether it contributes to reduced morbidity and mortality—disease and death respectively. Health care, however, also must be understood as a caring rather than purely a curative activity, the goal of which is to reduce pain and anxiety and increase the patient's sense of self-determination and quality of life.[100] In some contexts, these two goals may come

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96. *See, e.g., id.* at 45-50.

97. *See, e.g.,* A. ENTHOVEN, *supra* note 5, at 37-54. Enthoven reports on and apparently endorses numerous studies advocating "economies of scale" and cost-benefit analysis without apparently distinguishing between, for example, open-heart surgery and hospital services for normal childbirth. For a discussion of childbirth services, see notes 113-31 *infra* and accompanying text. Like Enthoven, Havighurst and Blumstein appear to apply the same cost-benefit methodology to all health services and procedures. They advocate reliance on individual choice to make cost-benefit decisions "[a]s long as measures are taken to make income discrepancies affect choices only where they can legitimately be regarded as primarily dependent on individuals' preferences." Havighurst & Blumstein, *supra* note 5, at 64. While the meaning of this condition is not entirely clear, it appears to advocate not only some degree of income redistribution to protect low income persons against effectively coerced choices, but also insurance against catastrophic expenses that would effectively coerce all except the most wealthy. The numerous difficulties of this redistributional strategy are explored in Part V of this Article.

98. *See, e.g.,* A. ENTHOVEN, *supra* note 5, at 37-54; Havighurst & Blumstein, *supra* note 5, at 29 n.75.

99. M. BARER, R. EVANS & G. STODDART, *supra* note 51, at 10 n.7.

100. *See, e.g., id.*; E. CASSELL, THE HEALER'S ART (1976); Fuchs, *supra* note 16, at 165-67 (growth of medical care sector due in substantial part to reallocation of caring functions away from family and religion); E. SPARER, *supra* note 3, at I-63 ("To reestablish self-confidence, to aid the patient's self-control, to restore the broken links of the sick person with the world, to help a dying patient him or herself to cope with death—are . . . prime goals of medical care."). In a similar vein, the Constitution of the World Health Organization (as amended in 1960) defines health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." *See also* Lander, *supra* note 3 (articulating a preliminary alternative to the "biomedical model" of health care).

into conflict: whereas intensive, high-technology treatment needed to keep a terminal patient alive may delay death and hence promote health in the first sense, it may at the same time reduce the patient to a miserable object and thereby undermine health care in the second sense. In most contexts, however, the two senses of health are usually interdependent and mutually supportive. A patient who is being treated with dignity, who feels emotionally supported and assisted in making decisions, is more likely to have a favorable outcome in terms of disease and death as well.[101] From this perspective, a central need of health care reform is not more refined quantitative cost-benefit analyses, but rather a restructuring of the patient-provider relationship that ideally could increase the sense of self-determination and satisfaction for both.

The market advocates recognize that much of modern health care has both a caring and a curing function.[102] While conceding that caring services are of "undeniable value,"[103] the market advocates also argue that this value is very difficult to measure in quantitative or statistical terms.[104] Because of our inability to measure the benefit generated by caring services, Enthoven argues that "we cannot give a clear answer to the question of whether or not we are getting much health improvement for [the] large increases in [health] spending."[105] In other words, although the market advocates in theory recognize the importance and value of caring services, as a practical matter these benefits are excluded from the cost-benefit analysis. The rationale for this de facto exclusion is that since the benefits of many types of health care are not clear in curative or statistical terms, they are best treated as matters of individual consumption to be paid for out of patients' own current assets,[106] instead of from collective funds such as government programs or insurance.

It is interesting that some market advocates on occasion claim

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101. *See, e.g.*, E. CASSELL, *supra* note 100, *passim*.

102. *See, e.g.*, A. ENTHOVEN, *supra* note 5, at xvi, 6; Fuchs, *supra* note 16, at 165-67; Havighurst & Blumstein, *supra* note 5, at 12.

103. Havighurst & Blumstein, *supra* note 5, at 12. *See also* A. ENTHOVEN, *supra* note 5, at 6.

104. Havighurst & Blumstein, *supra* note 5, at 12. *See also* A. ENTHOVEN, *supra* note 5, at xvi.

105. A. ENTHOVEN, *supra* note 5, at xvi.

106. *See id.*; Havighurst & Blumstein, *supra* note 5, at 12-13, 64; Havighurst, Blumstein & Bovbjerg, *supra* note 28, at 180 n.265 (arguing that long-term care, being expensive "but nonlifesaving and only semi-medical," should be paid for substantially out of individual and family assets).

that price competition will enable the patient to exercise self-determination over the professional and self-interested biases of physicians. According to Enthoven, the professional view of quality of care is "the maximum that medical care can do to prolong life or alleviate suffering, costs not considered."[107] Enthoven argues, however, that consumers do not in fact share this view. In other areas of life, people routinely take risks—they "drive cars [and] fly in airplanes . . . not to mention smoke and drink excessively."[108] Enthoven questions, therefore, why people should be expected to prefer minimal risk, regardless of cost, when considering medical care:

> People's preferences for risk reductions, compared with the benefits they would receive from other uses of resources, ought to be considered. . . . Even from the point of view of health, at some point dollars are better spent on other things, such as food and housing, rather than more medical care. Some terminal patients may not want a few more days or weeks of suffering life.
>
> The best quality care is not that care which ekes out the last possible day of life expectancy [or, presumably, degree of risk reduction]. Rather, the best quality of care reflects society's preferences in the use of resources. It is being provided when the extra health benefits yielded by expenditure of another dollar of resources on medical care are valued by consumers the same as they value the benefits obtained from the same expenditure in other activities . . . .[109]

The striking feature of this passage is its assumption that the market is the best means of achieving individual self-determination. Few would quarrel with the need to help individual patients, their families, and society as a whole grapple with the profound problems inherent in maintaining life or reducing risk at great expense, which expense necessarily impinges upon numerous alternative uses of scarce resources. The question, however, is whether the market approach actually would contribute to resolving these problems.

Enthoven uses the example of the terminal patient who may not desire life-prolonging treatment as a case in support of his thesis. Under current financing arrangements, most insurance policies would cover the expenses of such care, assuming these costs did not exceed some stated dollar or service limit. In these circumstances, the decision whether to prolong life would be made on

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107. A. ENTHOVEN, *supra* note 5, at 50. Physicians certainly do not universally share this view. *See, e.g.*, Duff & Campbell, *Moral and Ethical Dilemmas in the Special-Care Nursery*, 289 NEW ENG. J. MED. 890 (1973) (reporting that "[m]any pediatricians and others are distressed with the long-term results of pressing on and on to save life at all costs and in all circumstances.")

108. A. ENTHOVEN, *supra* note 5, at 50.

109. *Id.* at 51.

quality of life grounds, without consideration of monetary cost to the patient. A market approach presumably would add the factor of economic cost in some form to the decision. Havighurst, for example, advocates the marketing of cheaper insurance policies that would exclude one or another form of costly care for catastrophic illnesses.[110] As Enthoven suggests, the consumer would be permitted in such a market to opt for greater financial risk in return for more cash to expend on immediate consumption. It is more likely, however, that the vast majority of patients faced with the decision whether to incur a $25,000 liability for continued treatment, for example, would not feel that their capacity for self-determination had been expanded, nor would they be consoled by the knowledge that they had exercised their self-determination in the prior choice of premium.[111]

2. Childbirth, Heart Disease, and Problems in Market Approach Application

Despite the market advocates' claims that price competition gives more power to the consumer as a whole human being, their analyses inevitably reduce consumer choice to a forced acceptance of narrowly defined risk or efficiency in the face of economic constraint. In addition, the unequal impact of that constraint, which

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110. *See* Havighurst, *supra* note 9, at 483-84. Havighurst advocates the exclusion from coverage

> of a number of extremely expensive measures whose value is less than clear and in some measure dependent on the patient's preferences and circumstances. Examples [of these exclusions] might include coronary bypass surgery, exotic treatments for terminal cancer, some organ transplants, bone marrow replacements, and experimental procedures such as artificial heart implantation . . . . Although one would not want patients to waive their rights to beneficial technology, some extravagantly expensive treatments are surely candidates for explicit exclusion by rational insurance purchasers.

Id.

111. Havighurst and Hackbarth suggest that "noncovered but necessary treatment should be easily handled by the health-care system's remaining capacity for extending free care." Havighurst & Hackbarth, *supra* note 4, at 1300, *1980 House Hearing* at 149. *See also* Havighurst, Blumstein & Bovbjerg, *supra* note 28, at 180-81. The history of hospital noncompliance with the Hill-Burton free care and community service provisions does not inspire optimism on this score. *See, e.g.*, Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 YALE L.J. 243, 269-71 (1978). Even if low income patients were adequately subsidized, which would be unlikely in a market system, *see* notes 168-203 *infra* and accompanying text, hospitals would still have to decide how to allocate limited amounts of charity care to underinsured patients. Havighurst, Blumstein, and Bovbjerg suggest that they might do so based on their determination of "who could be saved most cheaply" or who could be "restored to the most useful existence" or "most satisfactory quality of life," an approach they concede "might . . . offen[d] commonly held notions of equity." Havighurst, Blumstein & Bovbjerg, *supra* note 28, at 181.

results from substantial income inequality,[112] and the pressures to transfer even this degree of choice to an insurance company or health plan, further restricts the consumer's already diminished capacity for choice. Enthoven's discussions of childbirth and heart disease most clearly reveal these reductionist features of the market approach, and for that reason they will be examined in detail here.

Enthoven has suggested that market competition would improve efficiency in childbirth services in two ways: (1) it would reduce the use of electronic fetal monitoring (EFM)[113]—an electronic process for measuring both the fetal heart rate and uterine contractions during labor—and (2) it would concentrate hospital care for childbirth in large centers.[114] In either case, his argument relies on oversimplified cost-benefit criteria. In the case of electronic monitoring, Enthoven compares the average cost per delivery —from thirty-five to seventy dollars—with newborn mortality rates in various "risk groups" and concludes that for the majority of births, the newborn mortality rate benefits probably do not justify the EFM costs.[115] Similarly, on the issue of the volume of childbirths performed in hospitals, Enthoven relies on a study which claims that the concentration of births in large centers reduces costs per admission by fifty percent, presumably through spreading capital and labor costs over a larger number of cases, and also that it increases quality by "maintain[ing] the proficiency

112. In 1977, under the official federal poverty line of $6,191 annual income for a family of four, almost 25 million Americans qualified as poor, which then constituted 12% of the population. *See* NATIONAL ADVISORY COUNCIL ON ECONOMIC OPPORTUNITY, TWELFTH REPORT: CRITICAL CHOICES FOR THE 80's 7, 23 n.48 (1980). Under other, more realistic standards of need, the number of "poor" Americans has been estimated variably at 35 million, 46 million, and 65 million. *Id.* at 7 n.4. In addition, the distribution of poverty has become even more unequal in the sense that the most traditionally disadvantaged groups—minorities and women—are statistically more likely to be poor now than they were a decade ago. *Id.* at 9.

113. *See* A. ENTHOVEN, *supra* note 5, at 48-49. Enthoven does not expressly argue that the organizational competition advocated in his work necessarily will reduce the use of electronic monitoring or promote other particular improvements in efficiency. Nevertheless, the clear implication of his argument is that market competition among alternative delivery systems will reduce the kinds of inefficiencies presently identified with the current system. *See, e.g., id.* xxi-xxv, 54, 69.

114. *Id.* at 41. A large childbirth center is defined as one that handles more than 1200 births per year.

115. *Id.* at 48-49. Enthoven relies primarily on a study by Neutra, Fienberg, Greenland & Friedman, *Effect of Fetal Monitoring on Neonatal Death Rates*, 299 NEW ENG. J. MED. 324 (1978). Most of the factors used to define the risk groups such as gestational age, placental or umbilical cord abnormality, maternal age (under 15 or over 40), and the existence of certain diseases such as diabetes are known before or after the beginning of labor. Other factors may become apparent during labor.

of the specialized personnel."[116] In both cases, using the simple criteria of cost and benefit alone seriously distorts the issues, which in turn undermines the possibility of increased consumer self-determination.

From the perspective of the patient as a whole person, the issue whether and under what circumstances electronic monitoring should be used requires more complex, patient-centered judgments than are required in a comparison between unit costs and newborn mortality rates. At a minimum, these judgments should include the following three considerations: (1) an understanding of the childbirth process; (2) a comprehension of the advantages and limits of electronic monitoring, specifically its positive and negative effect not only on the woman's physical and mental condition, but also on her relationship to professional as well as lay care-givers; and (3) an awareness of the implications of EFM for other types of intervention such as Caesarean section operations and their attendant risks. Furthermore, it can be argued convincingly that these considerations are relevant to both the caring, quality of life model of health and the reduction in morbidity and mortality rates model. In childbirth, the preguant woman's own subjective feelings can have a significant influence on the length of labor and other factors relating to successful delivery.[117] Indeed, such psychosomatic reactions are typical in all areas of health care, with the exception of extreme life and death emergencies.

Not surprisingly, the arguments both for and against EFM are inextricably linked to these considerations. Many obstetricians advocate widespread use of EFM on the grounds that it enables trained personnel to detect problems in the fetal heart rate that are not detectable by the human ear and stethoscope, which allows a more accurate and individualized assessment of whether inter-

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116. A. ENTHOVEN, *supra* note 5, at 41. For extensive criticism of the reasoning relied on by Enthoven, see Basham, Luce, Norsigian, Pfeufer, Sugarman & Swenson, *Analysis and Critique of a Regionalization Proposal with Recommendations for Alternatives*, I COMPULSORY HOSPITALIZATION OR FREEDOM OF CHOICE IN CHILDBIRTH? 81 (D. & L. Stewart eds. 1979); Sugarman, *Regionalization of Maternity and Newborn Care: Facts, Fantasies, Flaws and Fallacies*, I COMPULSORY HOSPITALIZATION OR FREEDOM OF CHOICE IN CHILDBIRTH? 67, 69-70 (D. & L. Stewart eds. 1979); Sparer, *Health Planning For—or Against—Innovative and Improved Maternity Care*, V HEALTH L. PROJECT LIB. BULL. 291 (1980).

117. *See, e.g.*, Fitzgerald v. Porter Memorial Hosp., 523 F.2d 716 (7th Cir. 1975). In *Fitzgerald*, plaintiff produced an affidavit from a University of Chicago Medical School Clinical Professor of Obstetrics and Gynecology to the effect that the father's presence in the delivery room "has an extremely stabilizing effect on the mother, thereby aiding her in the second stage of labor" and that the mother's cooperation and calmness contribute to shorter and safer labor. *Id.* at 722-23 (Sprecher, J., dissenting).

vention is necessary.[118] When an experienced, patient-oriented staff properly administers and interprets the process, these benefits arguably can be obtained without major discomfort to or loss of autonomy of the pregnant woman. Indeed, it is precisely in this patient-oriented setting that electronic monitoring can be used selectively to increase most women's sense of self-determination, while at the same time respecting the choice of those women who decide not to use it.

Such a supportive setting is rare, however, and critics of EFM argue that its resulting overuse has been extremely damaging. For one thing, the EFM procedure is uncomfortable and intrusive.[119] Many physicians and nurses require women to lie continuously on their backs in order to obtain accurate electronic readings, which increases the woman's discomfort, possibly prolongs labor, and actually threatens the fetus' oxygen supply—the very danger the machine was designed to help prevent.[120] The machinery of electronic monitoring can and often does dominate the labor room and can substantially undermine support for and attention to the laboring woman herself. One leading consumer guide to pregnancy and childbirth, which does not oppose the use of EFM, describes the problem this way:

> The staff and even your coach can become absorbed in watching the strip that is continuously advancing from the machine. It is not uncommon for a doctor or nurse to walk into a labor room and the first thing they look at is the machine. They may not even make eye contact with you [the pregnant woman] as they say "How are you doing?" They pick up the long chart of paper that the machine has produced. It's almost as if they're asking the machine how things are going. The piece of paper has become the laboring woman. Even *you* may come to think of the machine as the controlling influence on your labor . . . . There is no use in having a coach and a well-trained obstetric nurse or a carefully chosen doctor or nurse midwife if you aren't getting the attention and support from them that you want. Even the best-intentioned attendants can unwittingly fall into the trap of focusing on the monitor. There are serious pitfalls in it for you if the emphasis is on a machine.[121]

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118. *See* T. HOTCHNER, PREGNANCY & CHILDBIRTH: THE COMPLETE GUIDE FOR A NEW LIFE 245, 249-50 (1979).

119. Under "indirect" monitoring, the fetal heart rate and uterine contractions are monitored by sensors secured to the pregnant woman's abdomen by wide plastic straps; the straps "must be fairly snug" and the pregnant woman "must lie quite still." T. HOTCHNER, *supra* note 118, at 241. "Direct" or "internal" monitoring, which is more accurate, entails the insertion of a clip or screw electrode through the cervix, which is then attached to the baby's scalp. A second catheter is often passed into the uterus to measure the intensity of contractions. *Id.* at 241-42.

120. *Id.* at 249.

121. *Id.* at 247-48 (emphasis in original).

The most serious of these pitfalls lies in the tendency of physicians and nurses to conclude erroneously from the monitor's data that a fetal heartrate problem has occurred, which may cause them to intervene needlessly, perhaps with Caesarean surgery. The United States Office of Technology Assessment has stated that the sharp rise in Caesarean section deliveries—from 5.5 percent of deliveries in 1965 to 12.5 percent in 1976—is due to the growing use of electronic monitoring, and that many of these surgical interventions were unnecessary.[122] Unnecessary Caesareans not only raise costs enormously—from $700 to $3,000 per delivery at 1976 prices—they also entail increased health risks, as well as considerably increased discomfort and disability for the mother.[123]

An examination of the debate among providers and consumers over electronic fetal monitoring reveals that an accurate assessment of its costs and benefits is heavily dependant upon the relationship between providers and patients. If that relationship is oriented toward the proposition that the pregnant woman's need for support and self-determination is an integral part of assuring a healthy outcome for mother and child, then the true costs of EFM—discomfort, machine-generated risks, and price—may be low in comparison to the true benefits of increased capacity to detect both normality and complications. If that relationship is poor, however, in the sense that the providers allow the machine to dominate the process, the true costs of increased discomfort and machine-generated risks are far higher than the price of thirty-five to seventy dollars.[124] In these circumstances, the reason for disallowing the use of EFM in most cases would not be its monetary cost in relation to newborn mortality rates, but its actual cost in terms of the health risks and human suffering that poor provider-patient relations can cause.

Enthoven's simplified cost-benefit approach seems to yield the same suggestion as the perspective of the patient as a whole person, namely, that the use of EFM should be restricted to a small number of high risk cases. The *reasons* for the restriction under

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122. OFFICE OF TECHNOLOGY ASSESSMENT, UNITED STATES CONGRESS, ASSESSING THE EFFICACY AND SAFETY OF MEDICAL TECHNOLOGIES, CASE 7: ELECTRONIC FETAL MONITORING (1978). *See also* T. HOTCHNER, *supra* note 118, at 250.

123. OFFICE OF TECHNOLOGY ASSESSMENT, *supra* note 122. Undue reliance on electronic monitors as the primary means of evaluating the progress of labor is also associated with a lower staff-patient ratio, which itself can increase the risks and discomforts of childbirth. *See id.* at 40; H. BANTA & S. THACKER, COSTS AND BENEFITS OF ELECTRONIC FETAL MONITORING: A REVIEW OF THE LITERATURE, 14-15 (1979).

124. *See* note 115 *supra* and accompanying text.

the market approach are, however, very different from those of the patient-centered approach, and the difference has important consequences. A health plan or insurance company that followed Enthoven's approach apparently would restrict reimbursement for EFM without inquiring into either the nature of the provider-patient relationship or the relationship of EFM to the childbirth process as a whole. The decisive criteria would be unit costs when compared to an outcome measure such as newborn mortality. As a result, a device that might be cost-effective—if changes in provider-patient relations and staff training were made—would be deterred, with little incentive to develop or analyze these changes. Moreover, the negative effects of poor provider-patient relations would continue, regardless of technology, and would not be "flagged" for review by Enthoven's concept of efficiency. In contrast, restrictions on the use of EFM for patient-centered reasons would make clear to providers and consumers what problems existed with EFM in particular and, perhaps, with childbirth services as a whole. These restrictions presumably would be lifted if conditions were changed, which would provide an incentive for positive improvement.

Two potential market advocate responses to this critique deserve consideration. First, it might be argued that cost-benefit criteria are not limited to simple quantitative factors and can encompass a wide range of complex values.[125] Moreover, these criteria can themselves be seen as aids in a more complex process of decisionmaking.[126] From this perspective, the unit cost/mortality comparison for EFM would not be the only basis for the decision, but rather would be part of either a more complex cost-benefit analysis or a more complex combination of market and political decisionmaking.

It is relatively easy to imagine a more complex analysis of the costs and benefits of EFM and other health care services than is typically found in the pro-market literature; indeed, this section has argued precisely that expanding the meanings of cost and benefit is essential. The important point is that the market approach inherently generates narrow conceptions of these terms and thus resists considering the full range of values and relationships that actually affect the costs and benefits of health care. Professor Lau-

125. *See, e.g.*, A. ENTHOVEN, *supra* note 5, at 50.

126. *See id.* For a general statement of these arguments and of a critical response to them, see Tribe, *supra* note 90.

rence Tribe has argued that cost-benefit analysis, policy science, and related modes of thought intrinsically are biased against certain important values or aspects of human experience in three important respects: (1) they focus on quantifiable results rather than on the process of reaching them;[127] (2) they reduce human action and institutions from wholes into quantifiable parts;[128] and (3) they use abstract, technical language to "anesthetize moral feeling."[129]

Enthoven's analysis of EFM, regionalizaton of hospital maternity services, and other health care issues is consistent with the characteristics that Tribe describes. Despite the implicit promise of a more complex range of variables, the examples Enthoven uses repeatedly are based on simple criteria, focused solely on quantifiable results, and unconcerned with institutional process and provider-patient relations, except as they are influenced by economic incentives. Not surprisingly, therefore, the results often are highly questionable. Concentration of maternity care in large hospitals, for example, may not even lower costs because economies of scale probably would be offset by the tendency of large hospitals to rely on expensive technology and combine patient care with medical education.[130] Moreover, aside from the issue of monetary cost, concentration of births in high volume institutions is likely to increase routinization and impersonality of care, which in turn will undermine patient self-determination and other important aspects of the quality of care.[131] None of these concerns appear in Enthoven's discussion; on the contrary, their importance is implicitly denied by a lexicon that stresses efficiency and technical competence but not human relations.

The use of oversimplified and inadequate concepts of cost and benefit is not unique to the market approach; ironically, some of the studies cited by Enthoven and other market advocates reflect

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127. *Id.* at 79-83.

128. *Id.* at 84-97.

129. *Id.* at 97.

130. *See* Sugarman, *supra* note 116, at 70; Sparer, *supra* note 116, at 303-04 (documenting higher than average length of stay for childhirth in medical school hospitals).

131. *See* Sugarman, *supra* note 116, at 69-70. *Cf.* H. BANTA & S. THACKER, *supra* note 123, at 14-15. Lack of concern for provider-patient relations is likely to have particularly serious consequences for the poor. The most dramatic improvements in neonatal mortality rates in recent years have heen achieved by patient-oriented nurse-midwifery programs serving low income communities. *See* Sparer, *supra* note 116, at 302. While a high volume of births is not necessarily inconsistent with patient-oriented care, most large medical centers appear to have a technological and medical education orientation. *See* Sugarman, *supra* note 116, at 70-71.

the policies of government regulatory programs such as health planning that have been the persistent targets of the market advocates' criticism.[132] As a prominent example, the dubious policy of regionalizing normal childbirth in large volume hospitals has been promoted not by competitive health plans, but by a coalition of large medical centers, obstetrical specialists, and federal, state, and local health planning bureaucrats.[133] That government agencies also use inadequate cost-benefit criteria does not, however, justify their use in a health care market or break the connection between these criteria and the premises of market competition. As an initial matter, cost-benefit analysis, policy science, and related modes of thought were developed precisely to insure that government decisions replicate as far as possible the processes and outcomes of the economic market.[134] Indeed, the entire subdiscipline of public finance is designed explicitly—and perhaps proudly—to serve that end.[135] Moreover, even if public regulatory agencies and private market competitors tend to use the same criteria of cost and benefit, the decision to channel most resources and decisions into the market still presents a major additional danger. In the public sector, the modes of decision are at least in theory open to public scrutiny and participation.[136] In contrast, the tradition in the private market is very much the opposite, with the modes of decision-making normally being considered trade secrets and part of private management prerogatives. This is true even in the quasi-public hospital and health plan industry, in which hospitals still routinely claim and exercise the rights of private management despite widespread nonprofit status and assertions of community service.[137]

The second potential market advocate response to this critique of the cost-benefit approach is that the example of childbirth is atypical, and that most health services are not as dependent as childbirth services on caring and patient self-determination. It is

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132. For criticism of existing regulatory programs from a market perspective, see A. ENTHOVEN, *supra* note 5, at 93-113; Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need"*, 59 VA. L. REV. 1143 (1973); Havighurst & Blumstein, *supra* note 5. I am grateful to Julie Greenberg and Theodore Marmor for commenting on the use of cost-benefit analysis by both government agencies and private market competitors.

133. *See* Sparer, *supra* note 116.

134. *See* Tribe, *supra* note 90, at 68-75.

135. *See* Blumstein & Zubkoff, *supra* note 17.

136. *See, e.g.*, Rosenblatt, *supra* note 111; Stewart, *The Reformation of American Administrative Law*, 88 HARV. L. REV. 1669 (1975).

137. *See, e.g.*, Wilmington Gen. Hosp. v. Manlove, 54 Del. 15, 174 A.2d 135 (1961); Doe v. Bridgetown Hosp. Ass'n, 71 N.J. 478, 366 A.2d 641 (1976), *cert. denied*, 433 U.S. 914 (1977); Hospital Ass'n v. MacLeod, 478 Pa. 516, 410 A.2d 731 (1980).

true that there are extreme situations—particularly life and death emergencies—in which technical competence is the essential matter. Moreover, for some highly specialized and risky procedures such as open-heart surgery, an economizing strategy based on the simple criteria of unit costs and mortality rates may well be appropriate. For example, Enthoven presents data showing that the cost of open-heart surgery per patient might drop from over $21,000 in a hospital doing 50 operations per year to approximately $8,700 in a hospital doing more than 500 operations per year.[138] The "average annual death rate" for open-heart surgery in the first, low volume group of hospitals would be 11.5 percent, while the rate for the second, high volume group would be only 6.5 percent.[139] Despite a variety of qualifications about these studies, Enthoven concludes that consumers "would get much better care at much lower cost if heart surgery were done at thirty regional centers rather than at the current ninety-one hospitals."[140] This conclusion is consistent with common sense; in most contexts, skill improves with practice, and it is reasonable to spread the high costs of equipping and staffing a specialized unit over the largest number of patients consistent with a high quality of care.

While Enthoven's price competition among health plans might encourage the beneficial regionalization of cardiac surgery, serious questions remain about how a market approach would affect the other, less economic aspects of heart disease. Many analysts now believe that the incidence of heart disease is substantially related to social and behavioral causes such as stress, diet, and smoking.[141] How a price competitive health care system is likely to respond to this fact is a far more difficult question than how it will enhance surgical techniques and procedures. In theory, a prepaid health plan has an economic incentive to keep its patients healthy, which in turn reduces both the patients' need for care and the costs to

138. A. ENTHOVEN, *supra* note 5, at 38. Enthoven relies on Finkler, *Cost Effectiveness of Regionalization: The Heart Surgery Example*, 16 INQUIRY 264 (1979), and notes the qualifications of the data necessitated by Finkler's assumptions regarding lack of alternative uses for heart surgery facilities and staff.

139. A. ENTHOVEN, *supra* note 5, at 38-39.

140. *Id.* at 40-41.

141. *See, e.g.*, UNITED STATES DEPT. OF HEALTH, EDUCATION & WELFARE, HEALTH UNITED STATES: 1979, at 33-35 (1980) [hereinafter cited as HEALTH 1979]; UNITED STATES DEPT. OF HEALTH, EDUCATION & WELFARE, HEALTH UNITED STATES: 1978, at 31-32 (1979) [hereinafter cited as HEALTH 1978]; Eyer & Sterling, *Stress-Related Mortality and Social Organization*, 9 REV. RADICAL POL. ECON. 1 (1977); Jenkins, *Psychologic and Social Precursors of Coronary Disease (Part I)*, 284 NEW ENG. J. MED. 244 (1971); Jenkins, *Psychologic and Social Precursors of Coronary Disease (Part II)*, 284 NEW ENG. J. MED. 307 (1971).

the prepaid fund. Indeed, the very term "health maintenance organization" reflects this ideal.[142] If the theory were true in practice, price competition would induce competitive health plans to impose both "carrot" and "stick" incentives on consumers to avoid unhealthy behavior. Positive incentives might include extensive patient education programs, nutritional counseling, mental health services, and investigation of the social factors contributing to health problems. Negative incentives, on the other hand, might include either higher premiums or selective cost-sharing for people who continue to engage in unhealthy behavior such as smoking, alcoholism, or obesity.

The market approach, however, is more likely to *discourage* the development of positive incentives for behavioral change. Devices such as patient education programs and mental health services are expensive and, in the short run at least, might yield uncertain benefits in the form of a lowered incidence of heart disease.[143] Plans competing with lower premium prices would be unlikely to add expensive new services of unproven economic worth. More fundamentally, market advocates generally are suspicious of affirmative efforts to change consumer behavior for any goal other than the sale of a particular commodity. Sophisticated advertising to persuade consumers of their need for a new product, for example, is perceived as desirable. On the other hand, market advocates might well regard similar efforts to persuade consumers to change their behavior "for their own good" as manipulative and paternalistic.[144] Indeed, market theory in health care focuses almost exclusively on negative incentives to change behavior such as higher premiums or cost-sharing for smokers, or refusal to cover certain procedures that are described as "discretionary" or "self-induced."[145]

Several important elements of the market approach help explain this preference for negative economic incentives. First, health behavior is perceived overwhelmingly as a matter of individual choice. Victor Fuchs, a prominent health economist, explains that

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142. *See, e.g.*, Havighurst, *supra* note 15, at 718-19.

143. *See, e.g.*, HEALTH 1978, *supra* note 141, at 31-32. This government publication reports on the Stanford Heart Disease Prevent Program's apparent success in using community education to change behavior and measured cardiovascular risk factors at the end of 2 years of intervention: "final conclusion, [however, awaits] the demonstration of a decline in cardiovascular mortality." *Id.*

144. *See, e.g*, Blumstein & Zubkoff, *supra* note 17, at 407-10.

145. *See, e.g.*, Havighurst, Blumstein & Bovbjerg, *supra* note 28, at 192-93.

poorly educated Englishmen experience higher rates of smoking because they are "unwilling (or unable) to give up a present pleasure for a distant and uncertain benefit."[146] Similarly, the generally better health status of well-educated people is believed to result from "differences *among individuals* in the willingness and/or ability to invest in human capital."[147] Fuchs does concede that "some individuals have much better access to capital than do others."[148] Aside from this summary observation, however, he makes no reference to the social factors that might influence people in the lower socioeconomic classes to have worse health and perhaps a higher incidence of unhealthy behavior.[149]

Second, the market advocates contend that the best—and often the only—legitimate way to influence individual behavior is to insure that the true costs of the behavior, including all externalities, are reflected in its price, so that individuals can then decide "voluntarily" whether to pay that cost. In the health care context, this general market principle leads many advocates to argue that as many costs as possible should be shifted from collective funding even in the privately owned form of insurance to individual funding out of current assets.[150] This perspective sharply discourages the addition of affirmative education, mental health, and social in-

146. Fuchs, *supra* note 16, at 160.

147. *Id.* at 159 (emphasis added). For a critique of this perspective, see Berliner, *Emerging Ideologies in Medicine*, 9 REV. RADICAL POL. ECON. 116 (1977).

148. Fuchs, *supra* note 16, at 159-60.

149. Fuchs does note that "[f]or most of man's history, income has been the primary determinant of health and life expectancy . . . ." *Id.* at 157. He then claims that "in the United States the relation between income and life expectancy has tended to disappear . . . . Other things equal, there is no longer a clearly discernible effect of income on health except at the deepest levels of poverty." *Id.* Other health indicators continue to suggest a link between socioeconomic status and health. For example, in 1977, the black infant mortality rate was still twice as high as the rate for white infants—23.6 versus 12.3 infant deaths per 1,000 live births. HEALTH 1979, *supra* note 141, at v, 91. Persons with incomes below the median—not only those in extreme poverty—reported more poor health and disability in 1979 than those with higher incomes. *Id.* at v, 117. Mortality rates from cardiovascular disease and kidney disease, as well as from infant mortality, are associated with rises in the official unemployment rate. *See* NATIONAL ADVISORY COUNCIL ON ECONOMIC OPPORTUNITY, *supra* note 112, at 56-57.

150. *See, e.g.*, Havighurst & Hackharth, *supra* note 4, at 1301, *1980 House Hearing* at 150. Havighurst and Hackbarth anticipate and apparently approve an increase in the size of deductibles to "perhaps as much as 10% of income. Most physician-patient encounters would then take place without insurance in the picture." *Id. See also* Havighurst & Blumstein, *supra* note 5, at 64 n.220. These authors argue that because individual preferences about health care vary widely, collective financing—including insurance—should be confined "to those things about which there is a broad consensus in the covered group that benefits are no less than costs." Havighurst and Blumstein also feel that covered groups should be "smaller [and] more homogeneons." *Id.*

vestigation programs to insurance or health plan coverage. Furthermore, it encourages negative economic sanctions such as higher premiums and selective cost-sharing for conditions associated with unhealthy behavior.[151]

Underlying the market advocates' preference for negative economic incentives is their fundamental conception of human nature, society, and an individual's relationship to his or her own health. The market perspective encourages people to view health care as a commodity that is external to themselves, rather than as part of a process in which the individual patient, together with his or her society, are interdependent actors. Indeed, the market perspective encourages people to view their *own bodies* as commodities, which is reflected in the concept of health as a "product" that consists in part of "human capital."[152]

The market advocates further assume that individuals do and should exercise free choice with respect to health care through an economic market. There is no doubt that individual liberty regarding health care choices does exist in many important ways and that it should be protected and supported by social policy. But the market advocates' assumption that free choice exists under market conditions discounts the many elements of health care and health that are beyond individual control, and thus diminishes free choice rather than enhances it. For example, pro-market reforms might, under certain conditions, increase the freedom of employees to choose among types of insurance coverage. At the same time, the reduction of government regulation of enviroumental quality and work place health and safety—which is also a key component of the market perspective[153]—would sharply reduce the employees' capacity, and hence freedom, to protect themselves against actual health risks. The example of occupational health and safety highlights the inconsistency of pro-market health policy. On the one hand, one of the paramount values of liberty is said to be the freedom to engage in risky and even self-destructive behavior, as long

151. *See, e.g.*, Havighurst, Blumstein & Bovbjerg, *supra* note 28, at 192-93 (arguing that "creative use of cost sharing" might include "higher rates . . . for smokers or others whose health problems are partly self-inflicted."). Enthoven notes that since sickness "is a complex mixture of misfortune and self-inflicted ill-health . . . there would be a case for making people pay for their self-inflicted illnesses," but he rejects this technique as impractical. A. ENTHOVEN, *supra* note 5, at 80. Enthoven's failure to mention foreseeable social causes of illness and death such as occupational health and safety risks, environmental pollution, and economic policy is striking.

152. *See* Fuchs, *supra* note 16, at 159.

153. *See* text accompanying notes 157-67 *infra*.

as the actor is prepared to pay the price. On the other hand, exacting this price in the form of higher premiums or even denial of care is seen as appropriate *punishment* for short-sighted indulgence. The market itself, however, profoundly weakens social disapproval of that indulgence, since it stresses the legitimacy of immediate gratification for those able and willing to pay for it. For example, unhealthy, short-term self-indulgence—notably tobacco, fast food, and a wide range of legal drugs—are marketed widely.[154] In the case of heart disease, these contradictions become acute.

By shifting resources—including human labor—to the areas of their highest marginal return, the market society creates the considerable stress of entrepreneurial competition, rapid technological change, substantial unemployment, and social disruption.[155] Meanwhile, social programs that might mitigate the inevitable human suffering are being reduced to insure adequate investment capital and work incentives.[156] Health care under the market advocates' models would become more of an economic transaction and even less of a caring relationship than it is presently. In this proposed setting, the idea that the individual should behave on the basis of wholistic, long-range health considerations unfortunately would be misplaced; instead, it would be only a decent memory no longer supportable in a world based on different premises.

C. *Markets, Health, and Social Context*

The preceding subsection argues that the market approach to health care tends to discount the caring relationship element of health and distorts the concepts of cost and benefit. A reluctance to examine and respond to the social causes of illness and unhealthy behavior, except through imposing negative economic in-

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154. The Department of Health, Education & Welfare noted in 1978 that "[p]owerful stimuli in the social environment, including advertising, promote unhealthy choices." HEALTH 1978, *supra* note 141, at 32.

155. Former President Carter's Commission for a National Agenda for the Eighties recommended a fundamental change in national policy from support for economically depressed areas to encouragement of large scale migration of individuals and capital to areas in which the economy is expanding. *See generally* President's Commission for a National Agenda for the Eighties, 17 WEEKLY COMP. OF PRES. DOC. 2919, 2920 (Jan. 20, 1981). The Reagan Administration's budget proposals, which proposed very large reductions in welfare, job training, and economic development programs, are consistent with this strategy. *See* Program for Economic Recovery, 17 WEEKLY COMP. OF PRES. DOC. 130, 132, 133 (Feb. 23, 1981).

156. *See generally* Program for Economic Recovery, 17 WEEKLY COMP. OF PRES. DOC. 138 (Feb. 23, 1981); Donnelly, *Reagan Calls for Deep Cuts in Social Programs, Return of Authority to the States*, 39 CONG. Q. WEEKLY REP. 448 (Mar. 14, 1981).

centives on individuals, causes part of this distortion. The market advocates' strong preference for individual negative incentives affects their approach in another context as well.

Most market advocates recognize and indeed stress that additional expenditures for health services to individuals, at least in industrial societies, yield few measurable benefits in terms of actual health indicators such as mortality and morbidity.[157] The argument is then made that most health care is not a life and death matter at all; rather, it is a consumption choice much like any other that should be subject to the usual constraints of price competition and income inequality.[158] The point also is made that society as a whole probably would obtain more health benefits for health dollars if the latter were spent on nutrition, environmental quality, and workplace safety, rather than on costly, inefficient, and often ineffective individual health services.[159]

The central problem with this contention is that the same pro-market arguments currently used in the area of health care are also being advanced to reduce substantially nutrition programs for low income people,[160] environmental regulation,[161] and regulation of occupational health and safety.[162] Cost-benefit analysis, it turns out,

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157. *See, e.g.*, A. ENTHOVEN, *supra* note 5, at xvi; Fuchs, *supra* note 16, at 155-56; Havighurst & Blumstein, *supra* note 5, at 10-11.

158. *See, e.g.*, A. ENTHOVEN, *supra* note 5, at xvi, 6. Enthoven argues that since much of modern medical care "relates to the *quality* of life—to the relief of suffering and the restoration of function," its value is unclear, and people should have to pay for it with their own current funds to insure that the services are "worth the cost." *Id.* at xvi (emphasis in original).

159. *See, e.g.*, A. ENTHOVEN, *supra* note 5, at xvi; Blumstein & Zubkoff, *supra* note 17, at 425-26. *See also* Havighurst & Blumstein, *supra* note 5, at 11 n.20, 23 n.56.

160. *See, e.g.*, Interview with the President, March 3, 1981, in 17 WEEKLY COMP. OF PRES. DOC. 229, 238 (Mar. 9, 1981) (defending budget reductions in Food Stamps and Supplemental Food Programs on the grounds that persons who are made ineligible "are perfectly able to provide [milk] for themselves . . . [when] other people of no better circumstances are providing it for themselves"); Donnelly, *Bitter Congressional Battle Seen on Food Program Cuts*, 39 CONG. Q. WEEKLY REP. 450 (Mar. 14, 1981) (detailing Reagan Administration budget reductions in food programs announced March. 10, 1981).

161. *See, e.g.*, Program for Economic Recovery, *supra* note 156, at 142, 151-53. This report argues that regulations contribute to unemployment and inflation by reducing both competition and investment in new plant and equipment, as well as by increasing labor costs. It also announces postponement of the effective date of 29 pre-March Environmental Protection Agency regulations "to assure that they are cost-effective."

162. On March 27, 1981, Thorne G. Auchter, Director of the Occupational Safety and Health Administration (OSHA) in the Reagan Administration, announced a decision "to review—and possibly relax—the entire list of federal standards limiting worker exposure to poisonous substances . . . [such as] chlorine, asbestos, lead, benzene, and coke-oven emissions." The review would apply cost-benefit analysis to new and existing regulations, including the cotton dust standard that the Supreme Court currently is considering. *U.S. To*

is not contained easily. For example, scholars in the academic literature,[163] industry in litigation,[164] and now the Reagan Administration[165] make the argument that costs should not be incurred to improve workplace health and safety unless they can be justified by health benefits that are measurable in terms of morbidity and mortality. Since many major occupational health hazards contain carcinogens with complex and long-delayed chains of causal impact, this showing often cannot be made, at least not to the extent necessary to satisfy industry challengers of OSHA regulations.[166] In addition, the pro-market approach to OSHA relies on much the same individualism as the pro-market approach to health care. Thus, the OSHA market advocates argue that workers in high risk industries prefer receiving high wages and assuming the inherent risks of their trades to any increased safety that would be financed out of their wages.[167] The result of the market approach, therefore, is not a reallocation of resources from ineffective individual care to preventive regulation, but rather an overall reduction in both types of social investment in health.

V. THE MARKET, SOCIAL CLASS, AND THE ASSAULT ON THE UNITARY IDEAL

A question of great importance about the market approach to health care delivery is how it will affect people with low incomes. By their very nature, markets respond to those consumer preferences that are expressed with money, and people with the least money, therefore, tend to have their preferences given the least attention. Market advocates are aware that some number of low in-

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study cost, benefit of health rules, Philadelphia Inquirer, Mar. 28, 1981, § A, at 3, col. 4.

163. *See, e.g.*, R. SMITH, THE OCCUPATIONAL SAFETY AND HEALTH ACT: ITS GOALS AND ITS ACHIEVEMENTS 19-37 (American Enterprise Institute 1976).

164. *See, e.g.*, American Petroleum Inst. v. OSHA, 581 F.2d 493 (5th Cir. 1978), *aff'd on other grounds sub nom.* Industrial Union Dep't, AFL-CIO v. American Petroleum Inst., 100 S. Ct. 2844 (1980).

165. *See* note 162 *supra*.

166. *See* American Petroleum Inst. v. OSHA, 581 F.2d 493 (5th Cir. 1978), *aff'd on other grounds sub nom.* Industrial Union Dep't, AFL-CIO v. American Petroleum Inst., 100 S.Ct. 2844 (1980).

167. *See* R. SMITH, *supra* note 163, at 26-34. Smith argues that "[t]he decision rule which should guide safety and health policies is . . . exactly the same as the one that is used to decide on how many color television sets and pounds of beef should be produced: are the people who derive benefits from the product willing to pay for it?" *Id.* at 26. Since workers are seen as the people who derive benefits from health and safety measures that are conceived of as a "product," they are expected to pay for them out of their wages.

come people[168] could not afford to pay for services or insurance in a competitive health care market. Consequently, they usually propose the simple solution of income transfers—typically effected through a voucher for medical care—that would be sufficient to purchase "basic or necessary" services.[169] Some market advocates have been more generous; Enthoven, for example, advocates income-related subsidies that would be "large enough to enable the poor to purchase membership in a good-quality comprehensive health care plan."[170] Their basic strategy, however, is the same: while it may be justifiable for government to redistribute income and thereby provide purchasing power for the poor, it is important that government not be "the purchaser of medical care,"[171] much less its direct provider. It is the market advocates' belief that redistribution of wealth is a concept entirely separate from the efficient allocation of resources and provision of services. Public policy is split into what James Tobin termed "two departments, one for equity and one for efficiency."[172] In pursuit of equity goals, government must act to change the tax and income transfer systems.[173] Government should not, however, "intervene in particular labor or product markets on behalf of distributive justice,"[174] because these interventions necessarily produce inefficiency and paternalism. The market advocates argue, therefore, that in almost all areas of economic life, the government's appropriate role is first to "make markets work competitively,"[175] and then to supply the poorest people with redistributed purchasing power—if that is seen as politically desirable.

This straightforward separation of the social systems of redistribution and efficiency has considerable appeal at first glance. The existing pattern of both explicit and hidden subsidies, which are inextricably linked to licensing standards,[176] tax exemptions,[177]

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168. For varying estimates of how large that number is, or should be, see note 112 *supra*.

169. *See* Blumstein & Zubkoff, *supra* note 17, at 411.

170. A. ENTHOVEN, *supra* note 5, at 81.

171. *Id.*

172. Tobin, *supra* note 92, at 264.

173. *See id.*

174. *Id.*

175. *Id.*

176. *See, e.g.*, ILL. ANN. STAT. ch. 111 ½, § 86 (Smith-Hurd 1977) (requiring hospitals to provide emergency care without regard to ability to pay).

177. See charitable obligations of tax-exempt hospitals defined in Rev. Rul. 56-185, 1956-1 C.B. 202; Rev. Rul. 69-545, 1969-2 C.B. 117. *See also* Eastern Ky. Welfare Rights Org. v. Simon, 506 F.2d 1278 (D.C. Cir. 1974), *vacated on other grounds sub nom.* Simon v.

capital construction programs,[178] investment planning,[179] reimbursement formulae,[180] and common law tort doctrines,[181] is chaotic, exceedingly uneven, and often unenforced.[182] Thus, it might seem far better to centralize the redistributional issue into one highly visible legislative decision, and allow the health care industry to deliver its product in the most efficient manner possible under the proper competitive stimuli.

Despite this apparently benign intention of the market advocates, there are strong reasons to believe that poor and low income persons will suffer grievously. A society that embraces a market approach to most of its daily economic life, including the socially sensitive area of health care, is unlikely to redistribute adequate purchasing power to people in economic need. Whether it is theoretically possible for a market society to be strongly egalitarian as well need not be definitively resolved;[183] it is sufficient to note the major reasons why the market perspective is often inconsistent with egalitarian redistribution.[184] First, such a society, or the dominant groups within it, are likely to have a strong belief that the

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Eastern Ky. Welfare Rights Org., 426 U.S. 26 (1976).

178. *See* Hospital Survey & Construction Act (Hill-Burton Act), 42 U.S.C. § 291c(e) (1976); 42 C.F.R. § 124 (1980) (promulgating new final regulations on provision of service to persons unable to pay, as well as on community service by federally assisted health facilities).

179. *See, e.g.*, New Jersey State Regulations on Hospital Long-Range Planning, directing hospitals' attention to, *inter alia*, the problem of "underserved" groups, N.J.A.C. 8:31-16, appendix II, at 72, 74.

180. *See, e.g.*, N.J. STAT. ANN. § 26:2H-18(d) (West Supp. 1980-1981) (defining hospital cost base for reimbursement to include costs of providing care to indigent patients, which allows hospitals to bill paying patients for the costs of the indigent).

181. *See, e.g.*, Guerrero v. Copper Queen Hosp., 112 Ariz. 104, 537 P.2d 1329 (1975) (hospital liable in tort for failing to provide emergency care).

182. *See, e.g.*, Rose, *Federal Regulation of Services to the Poor Under the Hill-Burton Act: Realities and Pitfalls*, 70 NW. U.L. REV. 168 (1975) (documenting long history of federal and state failure to enforce the redistributive requirements of the Hill-Burton Act); Sparer, *supra* note 116 (documenting failure of local Health Systems Agency (HSA) to enforce either standards of its own health plan or federal guidelines on access to innovative childbirth services).

183. For example, Isaiah Berlin has argued that substantial redistribution of economic and social resources can be justified by a deep commitment to individual liberty. Indeed Berlin contends that a market society's failure to correct the distributive consequences of the market would violate the value of "negative" individual freedom by withholding from individuals the means of enjoying it. *See* Berlin, *Introduction* to I. BERLIN, FOUR ESSAYS ON LIBERTY at xlv-xlvi (1969).

184. In addition to the general and theoretical conflict between the market perspective and redistribution, it is significant that American social policy historically has perceived the conflict in much sharper terms than other capitalist societies such as Sweden. *See, e.g.*, N. FURNISS & T. TILTON, THE CASE FOR THE WELFARE STATE: FROM SOCIAL SECURITY TO SOCIAL EQUALITY (1977).

income distribution produced by the market is just.[185] Moreover, they are likely to see unequal economic rewards as necessary incentives for socially desirable qualities such as hard work, risk taking, and entrepreneurial initiative.[186] Income redistribution—even in the form of in-kind vouchers for medical care—probably will be viewed as threatening work incentives and efficient allocation of resources.[187] The result is likely to be policies that bear harshly particularly on the "near-poor" or "working poor," that is, persons who are able and willing to work, but whose earnings place them substantially below the median income. These workers do not fall within the traditional categories of people who are excused from the workforce such as the aged,[188] disabled,[189] and single parents with young children,[190] nor are they usually so destitute that they need government assistance for survival.[191] Income supplementation for them will tend to be viewed both as unnecessary and as threatening to the fragile work incentives at the lower end of the wage scale. Indeed, this view appears to lie behind much of the Reagan Administration's initial budget proposals.[192]

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185. A leading contemporary discussion of the philosophical basis of this position can be found in R. NOZICK, ANARCHY, STATE, AND UTOPIA (1974). For important critical analysis, see Walzer, *In Defense of Equality*, in 25 YEARS OF DISSENT 297 (I. Howe ed. 1979); Lukes, *Socialism and Equality*, in THE SOCIALIST IDEA 74 (L. Kolakowski & S. Hampshire, eds. 1974).

186. *See, e.g.*, Tobin, *supra* note 92, at 263-64.

187. *See id.*

188. Social Security Amendments of 1972, Pub. L. No. 92-603, § 1602, 86 Stat. 1465 (codified at 42 U.S.C. § 1381a (1976)).

189. *Id. See also* Liebman, *The Definition of Disability in Social Security and Supplemental Security Income: Drawing the Bounds of Social Welfare Estates*, 89 HARV. L. REV. 833 (1976).

190. Act of Aug. 14, 1935, ch. 531, § 401, 49 Stat. 627 (current version at 42 U.S.C. § 601 (1976)).

191. As part of the Administration's budget policy President Reagan and his staff have articulated the survival standard for government assistance. The proposed budget reductions in domestic programs were designed to "affect nearly every segment of our economy except the truly needy." Program for Economic Recovery, in 17 WEEKLY COMP. OF PRES. DOC. 138, 144 (Feb. 23, 1981). President Reagan explained in an interview that reductions in programs such as Food Stamps and milk to children and pregnant women were not designed to "tak[e] those things away from the people who would have no other means of getting them." Interview With the President, Mar. 3, 1981, in 17 WEEKLY COMP. OF PRES. DOC. 229, 238 (Mar. 9, 1981). Presidential Press Secretary James Brady has described the "truly needy" as persons who "would not survive" without government benefits. *Funds for Poor Spared*, Philadelphia Inquirer, Feb. 11, 1981, § A, at 3, col. 1. Inclusion of social security retirement benefits, which are paid to all insured employees regardless of wealth or income, as one of the programs for the "truly needy," *see* Program for Economic Recovery, *supra*, at 144, suggests that political considerations also are influential.

192. *See* note 191 *supra*. According to Congressional Quarterly Weekly Report, the Reagan Administration's proposed budget "would make the most severe reductions in aid to

A second reason why the market approach is often inconsistent with egalitarian redistribution is that a market society adopts as one of its major political and ethical ideals the proposition that most goods and services should be distributed according to ability to pay in a competitive market. Under this system there inevitably will be a strong presumption against exceptions to this approach. Income transfers to provide purchasing power will be regarded as one kind of exception, even if not of the same degree as direct interference with the market. Thus, James Blumstein and Michael Zubkoff maintain that a pro-market theory of government policy supports redistribution to the poor only to provide "medical services that could be characterized as basic or necessary."[193] They argue that

> [o]nce the duty of society to provide adequate care is met, . . . inequality in provision of additional services is no more (and no less) of a societal problem than any other inequality in access to goods or services. The "specialness" of medical care exists only up to a certain threshold; beyond that it becomes just another consumer item.[194]

The implications of this perspective are profoundly important for the design, operation, and what might be termed the "spirit" or ethical ideal of the health care delivery system. During the twentieth century, most health care reformers apparently have agreed upon the general ideal of universal access—regardless of ability to pay—to a broadly adequate package of socially financed benefits delivered under a single standard that is termed "mainstream" quality of care.[195] To be sure, there was a distinct disparity between reality and this unitary ideal. Beginning in the late 1960s, for example, federal and state Medicaid policies increasingly attempted to provide only those benefits considered minimally necessary, rather than to achieve the original ideal of comprehensive benefits and mainstream care.[196] These restrictions, however, at

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people just above the level of abject poverty." Donnelly, *supra* note 156, at 448.

193. Blumstein & Zubkoff, *supra* note 17, at 411.

194. *Id.*; *see also* Fried, *Equality and Rights in Medical Care*, 6 HASTINGS CENTER REP. 29 (Feb. 1976).

195. *See* Fox, *supra* note 1, at 307-14. Fox describes the existence of this sort of consensus among health care reformers associated with the Committee on the Costs of Medical Care in the 1930s, but he also notes the ambivalence in the Committee and traces the gradual rise to dominance of a more economic point of view.

196. *See* Rosenblatt, *Book Review*, 44 U. CINN. L. REV. 643, 649-50 (1975) (describing concepts of comprehensive coverage and high quality care embodied in original Medicaid legislation and regulations); *id.* at 650-53 (describing obstacles to these goals). The states' efforts to restrict Medicaid benefits has generated a large volume of litigation. *See, e.g.*, Medical Soc'y v. Toia, 560 F.2d 535 (2d Cir. 1977); Virginia Hosp. Ass'n v. Kenley, 427 F.

least were perceived as unfortunate deviations from the ideal, which uncontrollable health cost inflation and the pressures of the national economic and taxing systems had made necessary. The market approach not only accepts these constraints; it affirmatively *encourages* them, claiming that they are consistent with a redefined ideal. The market advocates, therefore, do not view the ethical ideal of health care delivery as universal access to *broadly* adequate, mainstream benefits, but rather as universal access to *minimally* adequate necessary benefits, coupled with *differential* access to most health care based on ability to pay.[197]

Some market advocates, including Blumstein and Zubkoff, do not specify either standards of necessity or a process by which they should be determined.[198] Others contend that a market strategy does not necessarily have to result in minimum redistribution to the poor.[199] As noted above, Alain Enthoven argues that subsidies should be adequate to purchase enrollment in a "good quality com-

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Supp. 781 (E.D. Va. 1977); Bass v. Rockefeller, 331 F. Supp. 945 (S.D.N.Y. 1971); Rosenblatt, *supra* note 111, at 294-98 (discussing these cases).

In addition to the great difficulties that must be overcome to achieve the unitary ideal, many have criticized the ideal itself as not only too dependent upon the medical profession's conceptions of quality of care but also as insufficiently responsive to cousumer needs—particularly those that arise from the social causes of disease and disability. The most thorough presentation of this position is found in E. SPARER, *supra* note 3. *See also* Lander, *supra* note 3; Sparer, *supra* note 3. While this porspective overlaps at several points with the market approach—for example, in criticizing unnecessary surgery and other costly and invasive procedures—it is concerned with a fundamentally different set of values and principles.

197. *See* Blumstein & Zubkoff, *supra* note 17, at 411; Havighurst, Blumstein & Bovbjerg, *supra* note 28, at 123 n.5. These market advocates all apparently endorse Charles Fried's argument that health policy should provide a "decent minimum" rather than "complete equality." *See* Fried, *supra* note 194, at 32.

198. Restricting benefits to minimally necessary services likely would cause substantial hardship to low income persons. First, the market advocates themselves argue that much of modern medicine cannot be proven to increase life expectancy or otherwise improve outcomes. If government subsidies were based on this standard, the poor would be excluded from a large range of services and relegated to a kind of health care system distinctly different from the rest of the population. Such a policy is not merely hypothetical. *See* Medical Soc'y v. Toia, 560 F.2d 535 (2d Cir. 1977). The Second Circuit in *Toia* reversed a preliminary injunction against a New York statute that restricted Medicaid reimbursement for surgery to cases involving "severe pain" or "immediate" threat of death or disability. Plaintiff had claimed that the cost of her medically necessary surgery would not be reimbursed because her pain was not sufficiently severe and her condition, though uncomfortable, was not immediately disabling. *See* Medical Soc'y v. Toia, [1977 New Developments Transfer Binder] MEDICARE & MEDICAID GUIDE (CCH) ¶ 28,364 (E.D.N.Y.), *rev'd*, 560 F.2d 535 (2d Cir. 1977).

199. *See, e.g.*, A. ENTHOVEN, *supra* note 5, at 81, 123-24, 139-40; Havighurst, *supra* note 15, at 741.

prehensive health care plan."[200] He also would require these plans to be available to low income and high risk individuals through open-enrollment periods, community-rated premiums, and required comprehensive coverage.[201] For several reasons, however, Enthoven's plan is unlikely to emerge from a general market orientation. First, it would be expensive, which would inflate the federal budget at a time when pro-market forces are exerting strong pressure to reduce nonmilitary government spending. Second, as previously noted, an increasingly market-oriented society probably would view extensive redistribution as undermining work incentives for lower income workers and possibly stimulating what market advocates would perceive as undesirable pressure for additional social spending.[202] Third, insuring that the poor were actually integrated into middle class systems of health care delivery probably would require extensive regulation, itself at odds with the general market perspective. Enthoven assumes that vouchers worth the amount of the average premium would provide a sufficient economic incentive to bring comprehensive delivery plans into low income neighborhoods. The performance of the market in other sectors such as food or consumer credit, however, strongly suggests that the costs of serving low income persons are higher than average, which results in higher prices, lower quality, and numerous practices that would be regarded as unfair in a middle class context.[203] Fourth, Enthoven's repeated argument that most health care services are not necessary to preserve life, but are instead forms of discretionary consumption, would contribute to strong resistance to substantial redistribution. Last, granting adequately subsidized coverage to large numbers of lower income workers might threaten the basic market strategy of forcing consumers to experience an economic "pinch" when paying for services or premiums. In order for the pinch to effect efficiency, persons with average and even below average incomes will have to be subject to it. The result likely would undermine the unitary ideal, since people at the lower end of the nonsubsidized group—probably a large portion of the "working poor"—react to the pinch by foregoing care and coverage, while people with higher incomes obtain it without difficulty.

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200. A. ENTHOVEN, *supra* note 5, at 81. *See* note 170 *supra* and accompanying text.
201. A. ENTHOVEN, *supra* note 5, at 126-29.
202. *See* notes 184-92 *supra* and accompanying text.
203. *See, e.g.*, D. CAPLOVITZ, CONSUMERS IN TROUBLE (1974).

VI. Conclusion

For someone committed to equality and increased consumer power in health care, immersion in the pro-market literature produces a first impression of familiar goals and values. For example, the market advocates are skeptical about high technology services and professional conceptions of quality. They express concern for expanded benefits to low income persons and apparently support increased preventive and primary care. On closer examination, however, this impression of shared values disappears. The reason is that the market advocates propose to achieve these values with a minimum of social decisionmaking—"politics" in the broad sense of the word—and with primary reliance on the automatic, impersonal mechanisms of market competition. Even if one knew nothing about health care, the performance of the general economy in the areas of quality, safety, and other consumer needs would provide grounds for doubt. Moreover, when one considers the long traditions of professional dominance, consumer passivity, and class, race, and gender inequality in health care, the likelihood of any automatic success seems slim at best. Finally, when one adds a measure of practical politics—the policies that a government dedicated to the market is most likely to pursue—the need for an alternative to market conceptions of goals and means becomes increasingly clear.