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Peter J. Hammer  
*Wayne State University*

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## **MEDICAL CODE BLUE OR BLUE LIGHT SPECIAL: WHERE IS THE MARKET FOR INDIGENT CARE?**

PETER J. HAMMER\*

The Journal of Law in Society at Wayne State University Law School is addressing important questions in its Symposium: "Detroit Health Care: Code Blue, or New Life?" Miners used to take canaries into the mine to provide advance warning of toxic conditions. Although the problems facing Detroit citizens and the Detroit health care community are severe, they are symptomatic of problems facing uninsured populations and urban hospitals throughout the nation. What happens in Detroit, both in terms of problems as well as solutions, will foreshadow developments nationally.

Underlying Detroit's health care problems are two distinct, but interrelated, sets of concerns. The first deals with the medical needs of the poor, uninsured and indigent people in Southeast Michigan. The second deals with the financial sustainability of traditional urban teaching hospitals, like the Detroit Medical Center (DMC). Ultimately, the medical needs of the indigent and the working poor are social problems invoking public obligations and public responsibilities. In contrast, despite their non-profit status, the financial stability of urban community hospitals implicates the need for rational business strategies in a changing health care economy. As one may anticipate, these objectives are in substantial tension with each other. There is very little private incentive to provide expensive medical care to people who don't have money. Just as the Beatles cautioned on A Hard Day's Night that "Money Can't Buy Me Love,"<sup>1</sup> markets can't be relied upon to buy you access. Indeed, it is just the opposite. The decisions of policy makers and politicians to introduce greater competition in health care over the past two decades have, quite predictably, made the problem of access to health care worse, not better.

Part I of this essay looks at the problems of the uninsured both nationally and in Detroit. Traditionally, the medical needs of the poor

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1. JOHN LENNON AND PAUL MCCARTNEY, *Money Can't Buy Me Love*, on A HARD DAY'S NIGHT (BBC, 1964).

were met through various cross-subsidies. Part II examines how economic and political developments have led to the demise of these cross-subsidies. Once cross-subsidies are removed, there are two logical options. First, policy makers could provide direct subsidies—make direct payments for the care that used to be paid for indirectly. This requires explicit political judgments about the amount and type of health care that the poor and uninsured are entitled to and presents a difficult test of the political will of the community. Alternatively, policy makers could free up markets to do what markets are good at, innovating to meet unmet consumer demand. Here, the unmet demand is for lower cost, and, what must openly be admitted, lower quality health care. These options are explored in Part III. Part IV concludes by returning to the problems of Detroit and thinking about future options.

## I. THE ANATOMY OF A CRISIS: DETROIT CODE BLUE

One barometer of how well political and economic markets for health care are functioning is the number of uninsured individuals. In 1987, there were some 29.5 million uninsured individuals.<sup>2</sup> In 1995, the number increased to 37.3 million.<sup>3</sup> By 2003, the number was 44.7 million, constituting some 17.7 percent of the population.<sup>4</sup> Some of this increase is due to population growth. Other aspects of the increase indicate growing problems, in absolute and relative terms, of the ability of people to gain access to the health care system.

Like many social issues, the problems of the uninsured are intertwined with problems of race and class. The fact that most of the uninsured are poor (near or below the poverty line) is not surprising. Readers who are not familiar with the problem, however, are often surprised to learn that most of the uninsured are employed, making uninsurance a problem largely of the working poor. These people do

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2. Institute of Medicine, *Uninsurance Facts and Figures: Overview available at* <http://www.iom.edu/file.asp?id=17736>.

3. *Id.*

4. The Henry J. Kaiser Family Foundation, *THE UNINSURED: A PRIMER, KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE 20* (Table 1) (Nov. 2004).

not qualify for Medicaid and other safety net programs, but do not work at the type of jobs where their employer offers health benefits as part of the employment package. Race also plays a significant role. Barriers to health care access are borne disproportionately by members of minority populations. In 2003, 34.3% of Hispanic Americans, 28% of Native Americans, and 21% of African Americans lacked health insurance, respectively.<sup>5</sup>

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5. *Id.*

The problems facing Detroit are even more dramatic. For instance, 21 % of all Detroiters are uninsured. This number is significantly higher than the national average and is a rate that is twice as high as that in the surrounding area.<sup>1</sup> Also, 47% of all children in the city are living in poverty.<sup>2</sup> Meanwhile, despite the obvious needs, economic forces are driving providers out of, not into, the city. Some 20 hospitals have closed in the Detroit area since 1980.<sup>3</sup> 51% of the population lives in medically underserved areas (MUAs) as defined by federal standards.<sup>4</sup> A similar number live in federally designated Health Care Provider Shortage Areas (HCPSAs).<sup>5</sup> Detroit and its suburbs remain heavily segregated in terms of racial, social and economic differences. Some 42% of Detroiters who do have private health insurance typically leave the city for the suburbs to get medical care.<sup>6</sup> Despite the outstanding reputation of many of the specialties at the DMC and other urban providers like the Henry Ford Health System, a disproportionately small percentage of suburban dwellers venture into the city for medical care.

A lesson that cannot be repeated often enough is that the lack of access to timely health care services is deadly. Internationally, infant mortality rates are commonly used to contrast the performance of different health care systems. The infant mortality rate in Detroit is nearly twice as high as the state average – 14 infants in Detroit die in the first year of life per 1000 births, in contrast to 7.9 per 1000 births statewide.<sup>7</sup> Just as uninsurance rates track racial lines, so do adverse

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6. GREATER DETROIT AREA HEALTH COUNCIL, HEALTH AND HEALTH CARE IN SOUTHEAST MICHIGAN: CHART BOOK 61 (2003).

7. Kimberly Hayes Taylor, *Doctor on Mission for Poor: DMC Crisis Rattles Physician Commitment to Urban Care*, THE DETROIT NEWS, Feb. 9, 2004, at 1B.

8. *Id.*

9. Greater Detroit Area Health Council, *supra* note 6 at 44.

10. *Id.* at 45.

11. Taylor, *supra* note 7, at 1B.

12. Greater Detroit Area Health Council, *supra* note 6 at 26.

health outcomes. Health inequalities are pronounced in Michigan. “The infant mortality rate for Michigan African-Americans in 2000 was more than three times that for whites (18.2 vs. 6 per 1000 live births).”<sup>8</sup> Racial inequalities do not end at birth. They carry forward throughout life and death. “The death rate for Michigan African-Americans in 1999 was 35 percent higher than that for Whites.”<sup>9</sup> The same disparities affect older Detroit residents regardless of race. “Detroit area residents age 50-59 in region 1-A are dying at a rate 122% higher than the rest of the state. In the 50-59 age group there were 1,306 deaths per 100,000 persons compared to 587 in the rest of the state.”<sup>10</sup>

Recent experiences of the DMC illustrate the severe financial stress experienced by many urban medical centers. As reported in the *Detroit News*, financial losses of the DMC in 2003 amounted to \$113 million.<sup>11</sup> One important source of these losses was the amount of uncompensated care the institution provided medically indigent patients. The DMC provides a disproportionate amount of medical care for the poor and uninsured residents of the city. In 2003, such services cost the medical center \$109 million.<sup>12</sup> While a significant factor, the DMC’s financial problems cannot all be laid on the doorstep of providing indigent care. All hospitals face a difficult and constantly changing business environment. Some have fared better than others in managing these challenges. The DMC’s record over the

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13. *Id.* at 28.

14. *Id.* at 27.

15. *Dying before their Time: The startling Truth about Mortality and Detroit Area Seniors; A Synopsis of Three Research Report* (Detroit Area on Aging, Detroit, Mich. 2003) at 3.

16. Sheri Hall, *DMC Expects Profit in 2005: Center Slashes \$60 Million from Budget, Lays Off 40 Managers and Reduces Vendor Payments*, *The Detroit News*, Feb. 27, 2004, at 1B.

17. Sheri Hall and Paul Egan, *Delays Jeopardize DMC Sites: Problems in Creating Health Authority Could Close Hospitals, Leave Detroiters Without Care*, *The Detroit News*, Nov. 7, 2003, at 1B.

last five years reveals a number of questionable business decisions, all of which have contributed to its financial problems.<sup>13</sup>

In the spring of 2003, the DMC announced the possible closing of two of its facilities, Detroit Receiving Hospital and Hutzel Women's Hospital.<sup>14</sup> This triggered a strong community reaction and a coordinated public response to the crisis. There was an immediate \$50 million cash infusion to the DMC, coming from the city, the county, and the state.<sup>15</sup> There were further proposals to put together a Detroit-Wayne County Health Authority to address both the needs of the medically underserved in the community, as well as the financial difficulties faced by the DMC and other Detroit hospitals in providing uncompensated care.<sup>16</sup>

## II. THE RISE OF COMPETITION AND THE DEMISE OF CROSS-SUBSIDIES

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18. See, e.g., Joseph Godert, *Outsourcing: Before and After the Contract is Signed, Organizations that have outsourced I.T. operations discuss the lesson they have learned. Lesson No.1 – after the ink dries on the contract, there's still plenty of work to be done. Sidebar: When it all goes bad ...*, 12 HEALTH DATA MANAGEMENT 30 (March 2004) (describing DMC's financial difficulties in outsourcing information technology services); David Barkholtz, *OmniCare Adds DMC Medicaid Plan*, CRAIN'S DETROIT BUSINESS NEWS, Jan. 10, 2000, at 4 (detailing OmniCare's purchase of the DMC's failing Medicaid managed care program); Mark Taylor, *DMC Buys Back HMO: No Cash Trade with OmniCare to Keep Hospital Atop "Healthcare Food Chain,"* MODERN HEALTHCARE, April 9, 2001, at 4 (describing the DMC's reacquisition of its failing Medicaid managed care plan).

19. Sheri Hall, *DMC to Slash Services: One of Center's Hospitals Could Even Close if Turnaround Plan to Cut Costs Doesn't Work*, THE DETROIT NEWS, March 4, 2003 at 1A; Sheri Hall and Mike Martindale, *DMC Cuts Staff, Hospitals: Struggling Medical Center will Lay Off 1,000, Partially Close Detroit Receiving, Hutzel*, THE DETROIT NEWS, May, 21, 2003, at 1A.

20. Sheri Hall, *Taxpayers to Bail Out DMC: Granholm, Ficano, Kilpatrick Attach Strings to Money; Hospital Must Restructure Board*, THE DETROIT NEWS, June 17, 2003, at 1A.

21. Sheri Hall, *Changes to Proposed Health Authority Aid Uninsured*, THE DETROIT NEWS, March 19, 2004, at 1B.

Traditionally, cross-subsidies played an important role in providing medical access for indigent patients. With a cross-subsidy, profits from treating one group of patients are used to offset losses from treating another group of patients. Alternatively, the profits from one line of business in a hospital can be used to offset losses incurred by another department. This last example represents a form of “cost shifting” that was once common in community hospitals. Cost shifting, however is becoming less common as each hospital “revenue center” is expected to carry its own weight.

In the days before private insurance, Medicare or Medicaid, doctors would often engage in price discrimination.<sup>17</sup> If doctors treated patients from diverse social classes, they would charge higher prices to wealthier patients and lower prices to poorer patients. This type of price discrimination can be an effective means of expanding low-end market access. Price discrimination was not the only form of cross subsidy in health care. The community rating of traditional Blue Cross and Blue Shield plans was also a form of cross-subsidy, redistributing wealth from relatively healthier patients in the pool to relatively sicker patients. Community rating provided high-risk patients greater access at a lower cost. Finally, with the advent of public health insurance, certain cross-subsidies were built directly into Medicare and Medicaid. While ostensibly Medicare is designed to pay for the medical services of elderly beneficiaries, it has also been used as a vehicle to support teaching hospitals and those hospitals that provide a disproportionate share of medical services to the uninsured.<sup>18</sup>

Competition and cross-subsidies are like oil and water. They cannot easily be mixed. Just as night follows day, greater competition

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22. Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 957 (1963). For a discussion of changes in physician practices in providing charity care since Arrow’s writing, see Richard Kronick, *Valuing Charity*, 26.5 JOURNAL OF HEALTH POLITICS, POLICY AND LAW 993 (2001).

23. CENTER FOR MEDICARE & MEDICAID SERVICES, ACUTE INPATIENT PROSPECTIVE PAYMENT SYSTEM: BACKGROUND (discussing “add-on” adjustments for disproportionate share hospitals and expenses for indirect medical education), available at <http://www.cms.hhs.gov/providers/hipps/background.asp> (last modified Sept. 16, 2004).

in health care markets inevitably leads to the erosion of cross-subsidies. The story unfolds on the private and public side of the market. On the private side, the growth of managed care has introduced greater competition in the market for insurance, as well as the market for medical services. Under ideal conditions, competition drives prices to marginal costs. Economic profits indicate an area where more resources should be directed for future growth. Losses, in contrast, represent an area justifying the investment of fewer private resources and a potential candidate for complete elimination (not a candidate for a cross-subsidy). To the extent that revenues from “profitable” services (or patients) were historically relied upon to offset losses from unprofitable services (or patients), that discretion disappears in a competitive environment. Moreover, effective competition transforms the producer surplus (profits) held by medical providers, into “consumer surplus” enjoyed by paying patients. Those without sufficient resources to enter the market are excluded from the process entirely.

Reflecting upon the tools and tactics of managed care provides intuition about the mechanics of this process. “Selective contracting” is employed to bargain with individual health care providers over price, with credible threats to exclude high priced sellers from the network. Particularly in markets with substantial excess capacity, providers are motivated to make substantial price concessions to maintain a flow of private patients. These negotiations drive prices down to more closely reflect costs, and “surplus” is shifted to from the sellers to the buyers (or at least the buyers’ agent – the managed care company or the employer). In theory, this leads to greater economic efficiency and a better allocation of social resources. But it is also an outcome that logically precludes the possibility of continued cross-subsidies as a means of providing care to those who cannot independently access the system as paying patients.

Intuition can also be gained by reflecting on the fate of traditional Blue Cross and Blue Shield insurance plans. Just as competition and selective contracting drives out cross-subsidies on the provider side, competition between managed care companies drives out cross-subsidies on the insurance side. A viable system of broad-based community rating requires the existence of some degree of

monopoly power on the part of the insurer.<sup>19</sup> Again, competition and cross-subsidies do not mix. Initially, Blue Cross and Blue Shield plans were in near monopoly positions. As health insurance markets became more competitive, it inevitably led to the erosion of cross-subsidies in the form of community rating. In a competitive insurance market, risk pools are progressively segmented so that only relatively like risks are pooled and shared.<sup>20</sup> Today, broad-based community rating is a thing of the past. Indeed, many Blue Cross & Blue Shield Plans have themselves become for-profit entities, and even the remaining non-profit plans price and act largely like their competitive rivals.

Significant changes are also taking place on the public side of the market. Fiscal pressures create strong incentives to reduce Medicare and Medicaid payments. Subsidies for graduate medical education, which are an important source of revenue for urban teaching hospitals, are primary candidates for reduction. The Medicare Payment Advisory Commission (MedPac), the policy commission overseeing Medicare, has proposed changes in the funding methodology for medical education. MedPac proposes to shift funding for graduate medical education from the Medicare program, where it is an entitlement, into the category of general federal revenue.<sup>21</sup> The logic behind the proposal mirrors developments on the private side of the market – Medicare should get out of the business of cross-subsidies. According to MedPac’s theory, funding for each component of public spending, like graduate medical education, needs to be looked at and supported on its own merits as a candidate for direct subsidy. They should no longer be the recipient of cross-subsidies under the guise of Medicare.

While cross-subsidies are being eliminated on the demand-side of the market, the range of supply-side substitutes competing against traditional hospitals has grown dramatically. Technology now permits

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24. See Arrow, *supra* note 22 at 963-64.

25. *Id.*

26. Richard A. Cooper & Linda H. Aiken, *Human Inputs: The Health Care Workforce and Medical Markets*, in *UNCERTAIN TIMES: KENNETH ARROW AND THE CHANGING ECONOMICS OF HEALTH CARE* at 71, 77-78 (P. Hammer, et al. eds. 2003).

many services to be performed on an out-patient basis that once required hospitalization. This significantly alters the economics of health care. The economies of scope that once justified centralizing a wide range of services in a single community hospital are not as strong as they once were. Similarly, the costs of market entry are lower and many services now can be provided on a stand-alone basis. In one sense, this is good. Greater service-line competition increases the pressure to price at marginal costs. New entrants will rationally be responding to profit opportunities. This further assists markets in allocating resources towards profitable service-lines and away from unprofitable service-lines, illustrating how the competitive system operates. Competition is a systematic, methodical and sometimes relentless process of continuously fracturing and segmenting products and services and reassembling them into their most viable (profitable) combinations. This same process systematically redirects social resources towards economically productive (profitable) ends and away from socially unproductive (unprofitable) endeavors.

Under appropriate circumstances, competition enhances efficiency, but there are some important caveats to this economic story. The efficiency of the competitive system is premised on the assumption that prices act as accurate signals, representing the real social value of the underlying resource or service in question. Value in this context is a measure of the opportunity cost of the resource in its next-best social use. Computer experts are fond of the adage “garbage in, garbage out.” The same applies here. If the prices that the economic market is responding to are wrong (garbage in), then the allocation of resources determined by the market will be inefficient (garbage out). In health care, the “prices” that the market is responding to are more often than not dictated by political and administrative processes (Medicare and Medicaid policy). Ironically then, the economic assertion that competition in health care is “efficient” necessarily presupposes the belief that these publicly determined “prices” reflect real social costs, a contestable, if not highly questionable assumption.

The current debate over specialty hospitals is illustrative. Recently, there has been a substantial increase in the number of ambulatory surgery centers, typically owned by large physician practice groups, and specialty hospitals, which provide only one type of care, such as orthopedic or cardiac services. These new entities

compete against traditional community hospitals, but they can target and segment patient populations by particular ailments and potentially by payor status. If these new providers are successful because they have lower costs (exploit new developments in technology) or better respond to unmet consumer demand, then one would view their rise as efficiency enhancing. If, however, the rise of specialty hospitals is in response to loopholes in self-referral laws, efforts to avoid EMTALA obligations or are forms of regulatory price arbitrage exploiting shortcomings in administratively determined prices<sup>22</sup> (garbage in), then one would question the efficiency of specialty hospitals (garbage out).

Regardless of their efficiency attributes, the rise of specialty hospitals is consistent with the broader story of how competition inevitable leads to the erosion of cross-subsidies. The growth of these facilities threatens the viability of the business model underlying the traditional community hospital. Furthermore, they symbolically represent the progressive fracturing and segmentation of medical services and payor classes characteristic of dynamic competitive processes. In a world where each medical service is discretely provided and sold to paying patients at its marginal cost, there is no room for cross-subsidies. Ironically, then, competition in health care has effectively raised the market barriers facing the uninsured even higher. Increasingly, the uninsured are on the outside of the market, looking in.

### **III. WHAT IS TO BE DONE?: DIRECT SUBSIDIES OR WALMART MEDICINE?**

A lesson I stress with my students is that government decisions regarding health care can be thought of as classic “make or buy” decisions. General Motors must decide whether to produce certain parts internally (make), or contract with other companies for their production (buy). Similarly, some countries, like the United Kingdom, provide public health benefits largely through public

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27. Peter J. Hammer & William M. Sage, *Critical Issues in Hospital Antitrust Law*, 22 HEALTH AFFAIRS 88, 93-94 (Nov./Dec. 2003) (discussing the economic and regulatory issues raised by specialty hospitals).

facilities like the National Health Service (make). Other countries, like the United States, provide public benefits largely through private facilities (buy). One solution to the problem of the uninsured would be government funded universal coverage provided through public facilities. For complicated social and political reasons, the United States has consistently rejected this option. The following discussion, therefore, assumes that universal coverage is not politically feasible. Rather, it will examine what can be done within a context where the United States continues its market-based experiment for meeting health care needs.

There is great irony in the assertion that the American health care system is “private.” The truth is that it is an often dysfunctional public-private hybrid. The analysis of Part II is straightforward: The rise of competition has led to the demise of cross-subsidies. In the absence of cross-subsidies, there are two basic alternatives for providing care to poor and indigent patients. The first is to provide direct subsidies. If society values the ability of the poor and indigent to access the health care system, then it should go to the market, pony-up the cash and buy the desired services. The viability of this option is largely a political question. Alternatively, if the political will does not exist to provide direct subsidies, policy makers could remove existing constraints on the market’s ability to solve the problem itself. This alternative takes the market-based approach to its logical conclusion. Unconstrained markets will typically provide differentiated products in response to differential consumer demand. The existence of 45 million uninsured individuals indicates a serious unmet demand for lower cost and lower quality care. The second alternative, therefore, is to permit the markets to provide low-end, WalMart-style medicine.<sup>23</sup> Each of these options will be considered in turn.

In America it is a truism that “you get what you pay for.” Conversely, if you do not pay for it, you do not get it. In the absence of the willingness to engage in structural reform, the problem of medical access for the poor and uninsured must be met through the provision of greater public resources: direct subsidies for care. Marshaling public resources requires successful political action, raising the question as to whether the political will exists to support

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<sup>23</sup> While not guilty of mixing metaphors, by conflating K-Mart’s “blue light special” with WalMart-styled medicine, I am guilty of mixing big-box, low-end retailers.

such an effort. If history is any guide, the answer is no. The continued plight of the millions of uninsured stands in quiet condemnation of the lack of political willingness to address the problem. The reasons for this inaction are easy to discern. One need only recall the socioeconomic breakdown of the uninsured. The uninsured consist mostly of poor white people, along with disproportionately represented numbers of poor Hispanics, Blacks and Native Americans. These are not constituents with substantial economic resources to influence government. Moreover, in contrast to the politically active beneficiaries of the Medicare program, the ranks of the uninsured are not filled with individuals who are traditionally active in the political process. None of the dynamics necessary for a successful political movement are present.

This suggests an underappreciated truth. The existence of cross-subsidies in the first instance is likely to be correlated with types of assistance that most people would agree is something society should provide, in conjunction with the absence of the political dynamics necessary to make direct subsidies feasible. Traditional cross-subsidies for indigent care may well have come into being exactly because of the lack of political ability to marshal resources directly. If this is the case, then the typical economist's prescription to simply replace cross-subsidies with direct subsidies sounds hollow and politically naive. Political markets can fail just as easily as economic markets.

In the absence of the political will to provide direct subsidies for the uninsured, can the market heal itself? Fundamentally, the uninsured need basic, low cost medical care. Markets are usually good at responding to unmet consumer demand. Can markets independently provide low cost (and presumptively lower quality) care?<sup>24</sup> As I frequently ask my students, "why don't we see WalMart

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28. What lower quality means in this setting needs to be spelled out. Lower quality means relatively greater reliance on certified nurse practitioners and physician assistants, rather than physicians themselves. It means a focus on primary and preventative care. It means restrictions on the ability of individuals to choose their own providers. It also means strong restrictions on high-end, tertiary services (limitations on the scope of coverage). Lower quality as used in this article does not mean a willingness to subject persons to unsafe practices or a willingness to sanction malpractice. It simply means that people would be permitted to knowingly purchase

medicine?” Framed as such, one can begin to identify a number of legal (and political) barriers to WalMart-styled medicine.

To begin with, state licensing laws and scope of practice limitations implicitly define and limit the type of medical “products” that can be sold. In the name of ensuring minimum levels of quality (and protecting provider incomes) licensing laws operate to chop off the low-end tail of the market. One of the invisible costs of licensing, therefore, is to deny consumers a range of choices that might otherwise exist. Another invisible cost is how licensing laws prohibit what might otherwise be quite rational substitutions of supply-side labor inputs. The legal barriers to WalMart medicine, however, go far beyond licensing laws. As argued for many years by Clark Havighurst, complicated interactions between tort and contract law seriously constrain the ability of health care to be privately rationed by conscious *ex ante* consumer choices.<sup>25</sup> Tort law often imposes categorically determined, national standards of care. Courts are reluctant to honor contracts that might limit the potential tort liability of medical providers. Finally, biases deeply embedded in insurance law make it very difficult to draft and enforce the type of contracts that would be necessary for developing the business infrastructure underlying WalMart medicine.

Obviously, the laws and public policies preventing WalMart medicine could be changed. Here, one confronts an almost visceral opposition to the very idea of letting people choose lower cost, lower quality health care. The myth that all people should receive the same quality of care is very powerful. Unfortunately, this instinct is not politically powerful enough to build a coalition for universal coverage, or to support direct subsidies to provide higher quality care to the poor and uninsured. Cognitive dissonance, however, is nothing new in politics. We collectively think that the uninsured are entitled to the best quality of care that money can provide. We are just collectively unwilling to pay for it. The price of this hypocrisy is the maintenance

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a package of services that provided substantially less coverage at substantially lower costs than the standard insurance package.

29. Clark C. Havighurst, *HEALTH CARE CHOICES: PRIVATE CONTACTS AS INSTRUMENTS OF HEALTH CARE REFORM* (1994).

of a myth of equality in the face of a demonstrably unequal system of health care access.

Is the visceral reaction that most people feel to WalMart medicine justified? Most markets, even those for things that are necessary for life itself are segmented and differentiated. Wealthier people live in nicer houses and eat better food than those with less income. Some intuition can be gained from thinking about the market for automobiles. In the market for cars, there is a full menu of choices reflecting the heterogeneous nature of consumer demand. Some of these differences are driven purely by different preferences for style or color. Other preferences are driven by concerns for safety or economy. Other differences are driven primarily by differences in income. Some people buy a Hyundai because it is all they can afford. Others buy a Lexus, because they can. There is no doubt that smaller, compact cars are less safe and have higher relative rates of injuries and fatalities than safer, more expensive models. Nevertheless, people with lower incomes are permitted to purchase less safe cars. Moreover, competition is a powerful force that progressively fractures and segments automobile markets in response to differences in consumer demand, and provides low income consumers products that match their preferences and ability to pay. Similar competitive forces have been unleashed in medical markets in the past twenty years, but they have not been unleashed to their full potential, and have not been permitted to fill in gaps at the low-end of the market.

Most questions about fairness and equity can be reduced to debates over what is the relevant baseline. This is why it is useful to juxtapose the question of direct subsidies with the question of WalMart medicine. If the relevant baseline is high, uniform quality for all, WalMart medicine appears unjust. It forces poorer persons to have lower quality care (even if it is at a lower price). This baseline, however, is only realistic if there is the political will to directly subsidize care for all. If the relevant baseline is the current political reality, where 45 million people are denied any meaningful access to care, then WalMart medicine does not look that unfair after all. Lower cost and lower quality care compared to a baseline of no meaningful access to services is at least a step in the right direction.

#### IV. CONCLUSION

So, what is to be done? Ross Perot used to be fond of saying that there were plans laying everywhere around Washington D.C. All we have to do is bend down, pick one up, and implement it. Unfortunately, the bad news is that there really aren't many clear answers for how to address Detroit's health care needs. This is not just a problem for Detroit. It is a national problem. Health care markets have experienced tumultuous changes in the past two decades. Large urban hospitals like the DMC face complicated and nearly insurmountable challenges, with few successful models to build upon. New leadership at the DMC appears to have at least stopped the financial hemorrhaging and have started to put the financial house in better order. Sadly, the direction of sound financial management of the hospital will likely lead the institution further away from addressing the needs of the poor and uninsured. It is the nature of the competitive market.

The needs of the uninsured must be addressed largely through political processes. Steps have been taken in this direction through the formation of the Detroit-Wayne County Public Health authority. But the concept of a public authority simply raises other difficult questions. Who is going to pay for the care? How will the care be managed? Will the public authority own their own facilities (make) or simply be a financier of care (buy)? There are no simple answers to these questions and, again, few successful domestic models to build upon. Historically, the State of Michigan has had an embarrassingly poor record in experimenting with Medicaid managed care to provide health services for vulnerable populations.<sup>26</sup> This should make City and County officials somewhat nervous about rushing in to participate in the market for indigent care. We are left with far more questions than answers. All we know for certain is that there is a blue light on the horizon.

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30. See Carol S. Weissert & Malcom L. Goggin, *Nonincremental Policy Change: Lessons from Michigan's Medicaid Managed Care Initiative*, 62 PUB. ADMIN. REV. 206, 207 (2002).