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Redefining Government's Role in Health Care: Is a Dose of Competition What the Doctor Should Order?

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I. INTRODUCTION

Active political debate about the proper role of government in the health sector is nothing new. For almost seventy years, the question of the federal government's role in facilitating the public's access to medical services has been on the national political agenda. A major proposal for national health insurance, for example, was part of Theodore Roosevelt's Bull Moose platform in 1912.[1] Presidents Franklin D. Roosevelt and Harry S. Truman also promoted a form of comprehensive national health insurance. After a hiatus of about twenty years, the issue arose again during the New Frontier of President John F. Kennedy, albeit in revised and modified form, and in the Great Society of President Lyndon B. Johnson. Many proponents of national health insurance, however, considered the enactment of Medicare[2] and Medicaid[3] in 1965 only

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1. *See* Marmor, Feder & Holahan, *Introduction,* in NATIONAL HEALTH INSURANCE: CONFLICTING GOALS AND POLICY CHOICES 1 (J. Feder, J. Holahan & T. Marmor eds. 1980).

2. Social Security Amendments of 1965, Pub. L. No. 89-97, § 1801, 79 Stat 286 (codi-

a partial victory—a beginning and not a culmination. Federal financing of medical services for the poor and the elderly was viewed as a first step toward a strategic phase-in of broader comprehensive national health insurance coverage.[4]

Throughout the 1970s, the two major political parties espoused some form of national health insurance.[5] Faced with a fiscal squeeze, however, the Carter Administration gave national health insurance a relatively low priority.[6]

The political movement for comprehensive national health insurance rests on an ideological commitment that the federal government should underwrite the cost of providing universal access to medical services. The objective is essentially redistributive in nature: equitable concerns for the disadvantaged loom as the major focus. The selective expansion of coverage to encompass those identified as needy and worthy, but only those so identified, is anathema to those who traditionally support broad national health insurance. These proponents would contend that a universal and comprehensive program is necessary to avoid a dual system of medical care delivery—one for the poor and another for the nonpoor. Advocates of a universal program would, in effect, compel the nonpoor to fund and participate in a governmentally sponsored program designed to benefit the poor so that the medical care system operated under government auspices would not be confined to lower income persons and, implicitly, stigmatized as welfare medicine of lower quality and lower status.

The access gap between rich and poor—a disparity that underlay much of the political initiative for national health insurance—has been narrowed in recent years[7] at least partly because of Medicaid and Medicare. Overall expenditures on medical services have escalated dramatically during the past two decades and oc-

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fied at 42 U.S.C. § 1395 (1976)).

3. Social Security Amendments of 1965, Pub. L. No. 89-97, § 121, 79 Stat 286 (codified at 42 U.S.C. § 1396 (1976)).

4. *See generally* T. MARMOR & J. MARMOR, THE POLITICS OF MEDICARE (1973).

5. *See generally* Marmor, Feder & Holahan, *supra* note 1, at 2-7.

6. *See* CONGRESSIONAL QUARTERLY INC., HEALTH POLICY: THE LEGISLATIVE AGENDA 75A (1980).

7. *See* L. ADAY, R. ANDERSEN & G. FLEMING, HEALTH CARE IN THE U.S.: EQUITABLE FOR WHOM? (1980); K. DAVIS & C. SCHOEN, HEALTH AND THE WAR ON POVERTY: A TEN YEAR APPRAISAL 41 (1978); F. SLOAN & J. BENTKOVER, ACCESS TO AMBULATORY CARE AND THE U.S. ECONOMY 147 (1979); Davis & Reynolds, *The Impact of Medicare and Medicaid on Access to Medical Care*, in THE ROLE OF HEALTH INSURANCE IN THE HEALTH SERVICES SECTOR 391, 392 (R. Rosett ed. 1976).

cupy an increasingly large component of our national income.[8] Few people would now maintain that aggregate medical care spending is substantially too low.[9] To the contrary, skeptics point out that structural institutional relationships in the medical sector encourage ever-expanding medical expenditures.[10] Coupled with a growing awareness of the importance of nonmedical factors in the promotion of health,[11] this fact has led to general questioning whether individuals and society collectively are getting their money's worth from surging medical services expenditures. Pragmatically, factors such as lifestyle have assumed a more visible role in affecting health status.[12] Politically, the sense that illness is fortuitous has been challenged, which in turn has suggested a more tight-fisted response to claims for more munificent redistributive programs.[13] Moreover, other pressing claims on public budgets and cries for tax relief have recently emerged.[14] These nonhealth demands make less money available for public programs with strong redistributional orientations.

In the political arena, the result at both the state and the federal level has been to focus on problems of containing both the price of and aggregate expenditures on health services, adding a new perspective and a sense of balance to earlier public policy concerns that focused almost exclusively on the goals of access and quality. As the magnitude of federal[15] expenditures has come under scrutiny, and as the public has come to believe that the federal government must gain control over aggregate expenditure levels, those interested in the management of public funds have expressed concern about the so-called uncontrollable items in the

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8. *See* Gibson, *National Health Expenditures, 1979*, 2 HEALTH CARE FINANCING REV. 1 (1980).

9. *But see* Lunde, *Health in the United States*, 453 ANNALS 28, 29-30 (1981) (Survey shows that in 1977 over half the people in the United States thought the government "was spending too little on health," although the percentage of those who so believed fell between 1974 and 1977).

10. *See, e.g.*, Havighurst & Blumstein, *Coping with Quality/Cost Trade-offs in Medical Care: The Role of PSROs*, 70 NW. U.L. REV. 6, 13-30 (1975).

11. *See, e.g.*, Blumstein & Zubkoff, *Perspectives on Government Policy in the Health Sector*, 51 MILBANK MEMORIAL FUND Q.: HEALTH & SOC'Y 395, 399-400 (1973).

12. *See* Vaupel, *Early Death: An American Tragedy*, LAW & CONTEMP. PROB., Autumn 1976, at 73, 83-87, 97-110.

13. *See* Knowles, *The Responsibility of the Individual*, DAEDALUS, Winter 1977, at 57, 59-60.

14. The Reagan Administration's commitment to augment expenditures for national defense is perhaps the most signal example.

15. Although selected states have been active in cost containment, to a large degree the states are at the mercy of policies implemented at the federal level.

federal budget—the various government entitlement programs. These programs reduce governmental budgetary flexibility because by their nature they are not required to run the political gauntlet and compete for annual appropriations. By establishing broad programs of entitlements,[16] Congress imposes on itself the obligation to fund social welfare programs at levels that are beyond effective budgetary control. Because of the inflexibility and political isolation—even political untouchability—that these entitlement programs have enjoyed in the past, they are now subject to intensive review and reappraisal. In the health field, major and ever-escalating entitlement commitments in the Medicare and Medicaid programs have become focal points of controversy, suggesting that even more expansive national health insurance commitments would exacerbate the problem of uncontrollable federal expenditures.

As government's fiscal obligations under Medicare and Medicaid have increased, the perception that prices and aggregate costs in the health sector are a significant public policy problem has been reinforced. These perceptions, when coupled with a growing institutionalist critique[17] focusing on the lack of proper incentives in the health arena,[18] have prompted a new type of public policy awareness in the health field. While concerns about access still exist, the new focus seems to emphasize the establishment of proper market incentives with the dual objectives of conserving public funds and curbing inflation in health care costs. Prompted by general criticism of economic regulation,[19] health policy analysts have begun to think of the health sector more as an economic system, subject to economic principles.[20] The assumption that the laws of

16. Entitlements are built into statutory programs. Beneficiaries who qualify under program criteria are entitled to receive benefits, and Congress is obligated to appropriate adequate funding. As a result, the legislative branch makes no budgetary decision at the front end of the process; rather, funding levels are determined after the fact on the basis of how many individuals qualify under the statutory or regulatory provisions of the program. As a result of proliferating entitlement programs, Congress, through its budgetary authorization and appropriation process, loses considerable control over aggregate levels of expenditure.

17. *See* Blumstein, *The New Institutionalism*, N.Y. Times, Feb. 1, 1981, § E, at 21, col. 2.

18. *See* Havighurst, Blumstein & Bovbjerg, *Strategies in Underwriting the Costs of Catastrophic Disease*, LAW & CONTEMP. PROB., Autumn 1976, at 122, 188-95.

19. *See generally* Posner, *Regulatory Aspects of National Health Insurance Plans*, 39 U. CHI. L. REV. 1 (1971).

20. *See generally* J. NEWHOUSE, THE ECONOMICS OF MEDICAL CARE 49-66 (1978); COMPETITION IN THE HEALTH CARE SECTOR: PAST, PRESENT, AND FUTURE (W. Greenberg ed. 1978) [hereinafter cited as COMPETITION IN THE HEALTH CARE SECTOR]; *Report of the Task Force*

economics do not apply to the health arena is no longer blindly accepted.[21] Health policy analysts are now much more prone to shift the burden of proof to those who claim that the market does not, cannot, or should not function properly in the health sector.[22] With the 1979 amendments to the health planning legislation,[23] Congress took an important step toward accepting this new market-oriented approach, reflecting a major and fundamental turnabout in its way of thinking about health policy issues.[24]

Market-oriented critics focus on institutional reform and redesign as a means of restoring an appropriate incentive structure within the health sector.[25] Under that approach, governmental action follows from the identification of institutional misfunction,[26] and the preferred remedy is to perfect the institution by appropriately limited governmental intervention.[27] There is a normative sense that decentralized decisionmaking in a fair system is preferable to politically determined collective choice on the grounds of both individual freedom and allocative efficiency. There is also a prudential sense that government's direct allocative role in the health arena should be minimized because of the heavy overlay of symbolism involved in tradeoffs when life and health are at stake.[28] The risk of symbolic blackmail[29] is excessive; that is, government may find itself supporting expansive expenditures because it is unable to engage openly in tough interpersonal valuations.[30] Thus, for normative and prudential reasons, market proponents tend to be

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on the Marketplace, in 1 NATIONAL COMMISSION ON THE COST OF MEDICAL CARE, 1976-77, at 23-45 (1978).

21. *See, e.g.*, J. MEYER, HEALTH CARE COST INCREASES (1979); Havighurst & Hackbarth, *Competition and Health Care: Planning for Deregulation*, REGULATION, May/June 1980, at 39.

22. *See* Blumstein & Sloan, *Health Planning and Regulation Through Certificate of Need: An Overview*, 1978 UTAH L. REV. 3; Blumstein & Zubkoff, *supra* note 11, at 400-01; Blumstein & Zubkoff, *Public Choice in Health: Problems, Politics and Perspectives on Formulating National Health Policy*, 4 J. HEALTH POL., POL'Y & L. 382 (1979).

23. Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-79, 93 Stat. 592 (amending 42 U.S.C. § 300k-2(b) (1976)).

24. *See* Havighurst & Hackbarth, *supra* note 21, at 43-46.

25. *See generally* Havighurst, *Controlling Health Care Costs: Strengthening the Private Sector's Hand*, 1 J. HEALTH POL., POL'Y & L. 471 (1977).

26. *See* Blumstein & Zubkoff, *supra* note 22, at 383-84.

27. *Id. See also* Blumstein, *supra* note 17.

28. *See* Havigburst, Blumstein & Bovbjerg, *supra* note 18, at 129-31, 140-45.

29. Blumstein, *Constitutional Perspectives on Governmental Decisions Affecting Human Life and Health*, LAW & CONTEMP. PROB., Autumn 1976, at 231, 303. *See also id.* at 252 ("institutional blackmail").

30. *See* Havighurst, *supra* note 25, at 491.

cautious about new government initiatives, even those designed to contain costs. Instead, the focus is on procedural or institutional analysis, diagnosis, and redesign.[31]

This Article examines the market-oriented approach, describing what it is and what its rationale is. It then focuses on the problem of equity within the market system. In addition, the Article analyzes and evaluates prior regulatory experiences and examines the emerging directions of health policy. Finally, the Article considers selective developments from the perspective of the competitive alternative.

II. THE MARKET-ORIENTED APPROACH

The choice between competition and regulation is a choice between imperfect systems. It is not realistic to expect that the medical marketplace conforms to all the textbook preconditions for a perfectly competitive situation, and it is unreasonable to assume that abstract aspirations for a regulatory system can in practice be fully realized. Technical state-of-the-art limitations hamper regulation,[32] and because regulation is a political mode of social ordering, regulation and regulatory outcomes are to a considerable extent influenced by uncertain and sometimes unforeseeable political forces. In the real world, then, the choice is not between competition and regulation in either pure form.

Moreover, the realistic range of public choice does not reflect a total commitment to one or another system of social ordering. The regulatory environment virtually always allows for some forms of competition. Under certain circumstances, however, that type of competition may be counterproductive rather than constructive.[33] Similarly, the competitive approach does not rule out some forms of governmental intervention.[34] Indeed, certain forms of procompetitive regulation may be necessary for the proper functioning of

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31. *See, e.g.*, NATIONAL CHAMBER FOUNDATION, A NATIONAL HEALTH CARE STRATEGY: HOW BUSINESS CAN STIMULATE A COMPETITIVE HEALTH CARE SYSTEM (1978).

32. *See* Blumstein & Sloan, *supra* note 22, at 15-16; Bovbjerg, *Problems and Prospects for Health Planning: The Importance of Incentives, Standards, and Procedures in Certificate of Need*, 1978 UTAH L. REV. 83, 93-97. *See generally* Breyer, *Analyzing Regulatory Failure: Mismatches, Less Restrictive Alternatives, and Reform*, 92 HARV. L. REV. 549, 584-609 (1979); Schuck, *Regulation: Asking the Right Questions*, NAT'L J., April 28, 1979, at 711-17; Wolf, *A Theory of Nonmarket Failure: Framework for Implementation Analysis*, 22 J.L. & ECON. 107-39 (1979).

33. *See, e.g.*, Breyer, *supra* note 32, at 573-74.

34. *See, e.g.*, A. ENTHOVEN, HEALTH PLAN 78-82 (1980).

markets.[35] Truth-in-labeling regulation is an example. Other areas, such as emergency medicine, public health, and catastrophic illness, also suggest an appropriate and constructive governmental presence.[36] Under the competitive approach the government will continue to have a role in financing medical care for the needy, for persons who cannot reasonably be expected to bear the full cost of medical services, and for those for whom society feels a moral or political obligation and a financial responsibility.

In sum, the relevant public choice issues will concentrate on where to draw the line along a continuum of public-private responsibility. It is therefore not productive to think of the public policy issues in health as balancing one pristine world view against another equally pure approach. Rather, it is more useful to start from the proposition that there may well be deviations from the competitive model in the health sector, but that those who seek to involve government should bear the burden of establishing the existence of either an institutional misfunction or an equitable problem in need of redress.[37] Even then, proposed remedies should be aimed at perfecting the market before replacing it with a command-and-control regulatory apparatus.[38] When redistributive goals of access are pursued, they too should, to the extent possible, be promoted by an approach that builds on, not conflicts with, an unrestricted market emphasizing incentives and consumer choice.

A. The Market Approach: Economic Preconditions

The market system relies on decentralized, private decisionmakers—producers and consumers—for allocative choices.[39] When the parties to a transaction are the sole or primary interested persons, society in general can safely assume a noninterventionist "low profile" unless it has reason to believe that the transaction is unfairly structured.[40] Such unfairness could occur, for

35. *See, e.g.*, text accompanying notes 212-423 *infra*.

36. Blumstein & Zubkoff, *supra* note 11, at 421-26.

37. *See* Blumstein & Zubkoff, *supra* note 22, at 385-87, 403-05.

38. This terminology was introduced by Charles L. Schultze, the Chairman of the Council of Economic Advisors under President Carter. *See* C. SCHULTZE, THE PUBLIC USE OF PRIVATE INTEREST (1977).

39. *See* J. HIRSHLEIFER, PRICE THEORY AND APPLICATIONS (1980). For a discussion from a health care perspective, see P. FELDSTEIN, HEALTH CARE ECONOMICS 405-22 (1979). *See also* Zubkoff & Blumstein, *The Medical Marketplace: Health Policy Formulation in Consideration of Economic Structure*, in 2 NATIONAL COMMISSION ON THE COST OF MEDICAL CARE, 1976-77, at 73, 92-93 (1978).

40. The traditional grounds for governmental intervention in the market are: (1) ex-

example, if a consumer is improperly informed[41] or incapable of making an informed choice.[42] It could also occur when, for a number of reasons, a consumer's choice is artificially circumscribed by either public or private regulations that narrow the range of options[43]—for example, when a consumer would choose to engage a dental hygienist independently (and presumably at a price lower than that charged by a hygienist who works in a dentist's office) but a state's law prohibits consumer choice by barring that form of service delivery.

Since one justification for decentralized decisionmaking is the desirability of allowing private firms and households to choose among available alternatives, an essential precondition to the market approach is that the consumer's ability to choose exist in fact and without substantial distortion. A critical element of any market-oriented system is that private decisionmakers have some significant stake in forgoing consumption. One of the remarkable strengths of private marketplace choice is that decisionmakers select in an either/or rather than a yes/no context.[44] Given a budget constraint, a private decisionmaker knows that the choice of more of X inevitably means less of Y. Balancing present against future wants and needs, a private decisionmaker is well situated to make efficient tradeoff decisions based on a distinct set of preferences.

The widespread existence of third-party payment relieves patients and providers from the perceived constraint of scarce re-

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ternalities, (2) public goods, (3) monopoly, and (4) other market imperfections. *See* J. HIRSHLEIFER, *supra* note 39, at 520-51.

In the absence of significant externalities, government can usually rely on the parties to a transaction to take respousibility for the outcome of their own negotiations. Exceptions exist when the parties have grossly uneven bargaining leverage or when the outcomes are so one-sided that, because of notions of equity, government migbt step into the negotiation process.

41. *See* J. NEWHOUSE, *supra* note 20, at 54-55. *See generally* Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 YALE L.J. 1533, 1535-41 (1970).

42. *See generally* Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413, 415 & nn.10-11, 439-53. *See also* Ingelfinger, *Informed (but Uneducated) Consent*, 287 NEW ENG. J. MED. 465 (1972); Oppenheim, *Informed Consent to Medical Treatment*, 11 CLEV.-MAR. L. REV. 249, 261 (1962).

43. *See generally* Cohen, *Professional Licensure, Organizational Behavior, and the Public Interest*, 51 MILBANK MEMORIAL FUND Q.: HEALTH & SOC'Y 73 (1973); Kissam, *Physician's Assistant and Nurse Practitioner Laws: A Study of Health Law Reform*, 24 KAN. L. REV. 1 (1975).

44. *See* Havighurst & Blumstein, *supra* note 10, at 33-38, 52-58. *See generally* A. ALCHIAN & W. ALLEN, EXCHANGE AND PRODUCTION: COMPETITION, COORDINATION, AND CONTROL (1979).

sources.[45] At the physician-patient level of decisionmaking both parties face inexorable pressures toward a spare-no-expense approach to medical practice. Apprehensive and uncertain, patients seek and may well demand the best available care. This instinct can be indulged in a world of third-party coverage since patients' out-of-pocket expenses are kept relatively low and the potential effect of a single episode of illness on the overall experience of any group of insureds is minimal. Only in the aggregate do such individual decisions have an impact on group rates. The pool of insurance funds is much like a commons.[46] Individual decisionmakers suffer very directly when they decide not to use collectively pooled resources—for example, by forgoing an additional test or procedure—but the savings derived from that decision do not accrue specifically to the individual who made it. Rather, they are shared with all other users of the collective resource. As a result, the incentive to conserve is minimal.

A fee-for-service setting relieves providers of their fiduciary responsibility to weigh the cost effectiveness of any test or procedure they recommend.[47] Realizing their patients claim on a common insurance fund, providers can rationalize prescribing tests or procedures that, while somewhat beneficial, may be of low priority.[48] A prudent person, absent insurance, might elect to forgo these tests or procedures if he could recapture and reallocate the amount thereby saved. In short, circumstances in which a decisionmaker faces a choice of only yes or no—that is, to consume or not to consume medical services—and does not stand to benefit directly from a tough-minded decision to forgo some services reinforce the preexisting inclination to purchase the most elaborate services modern medicine has to offer.[49] Only when private decisionmakers—patients, providers, or institutions—can recapture and reallocate (R & R) resources derived from economizing can an

45. *See* McClure, *The Medical Care System Under National Health Insurance: Four Models*, 1 J. HEALTH POL., POL'Y & L. 22 (1976).

46. *See* Hardin, *The Tragedy of the Commons*, 162 SCIENCE 1243 (1968); Hiatt, *Protecting the Medical Commons: Who is Responsible?*, 293 NEW ENG. J. MED. 235 (1975).

47. *See* A. ENTHOVEN, *supra* note 34, at 10. *See also* Havighurst & Blumstein, *supra* note 10, at 13-15.

48. *See generally* Blumstein, *Inflation and Quality: The Case of PSROs*, in HEALTH: A VICTIM OR CAUSE OF INFLATION? 245, 270 (M. Zubkoff ed. 1976) [hereinafter cited as HEALTH]; Havighurst & Blumstein, *supra* note 10, at 15-20.

49. *See* M. PAULY, DOCTORS AND THEIR WORKSHOPS: ECONOMIC MODELS OF PHYSICIAN BEHAVIOR 1-15, 43-63 (1980).

effective decentralized system emerge.[50] In the absence of R & R, decisions will not be seen as either/or. Rather, they will be perceived as yes/no, and decisionmakers will follow their biases toward a higher style of care, which in turn will create a ready market for whatever new technology can make even a marginal contribution to improved diagnosis or treatment.

The R & R principle, which plays a crucial role in any responsible market-oriented system, conflicts with current modes of third-party payment plans and proposals. Developed as a means of alleviating uncertainty by pooling risks, health insurance plans, both private and public, solve the access problem by distorting the decisionmaking structure in the medical care marketplace. No serious proponent of a market-oriented strategy can, therefore, be unconcerned about the structure of public and private insurance programs, about the federal tax incentives that encourage broad and deep insurance coverage,[51] and about the lack of incentives for cost consciousness in the current system.[52]

The market-oriented strategy assumes that, given the opportunity to choose between alternatives and the ability to benefit tangibly from forgoing the consumption of medical services, many consumers (or, when appropriate, physicians on behalf of their patients)[53] will decide to forgo some medical services that would be marginally beneficial because other, nonmedical priorities will take precedence.[54] The market-oriented strategy views health as an instrnmental rather than an ultimate value—a means to an end, not an end itself.[55] Thus, the desirability of trading off health for other

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50. *See* A. ENTHOVEN, *supra* note 34, at 16; H. FRECH & P. GINSBURG, PUBLIC INSURANCE IN PRIVATE MEDICAL MARKETS: SOME PROBLEMS OF NATIONAL HEALTH INSURANCE 21-22 (1978).

51. A. ENTHOVEN, *supra* note 34, at 19-21.

52. *See* H. FRECH & P. GINSBURG, *supra* note 50, at 17-33; J. KRIZAY & A. WILSON, THE PATIENT AS CONSUMER: HEALTH CARE FINANCING IN THE UNITED STATES 18 (1974).

53. Three actors can limit costs—consumers, providers, or government. *See* McClure, *supra* note 45, at 26. Proponents of regulatory approaches emphasize cost control by government. *See* text accompanying notes 93-211 *infra*. Proponents of market strategies disagree on whether primary reliance should be placed on consumers or providers. *Compare* Seidman, *Income-Related Consumer Cost Sharing: A Strategy for the Health Sector*, in NATIONAL HEALTH INSURANCE: WHAT NOW, WHAT LATER, WHAT NEVER? 307 (M. Pauly ed. 1980) [hereinafter cited as NATIONAL HEALTH INSURANCE: WHAT NOW] (advocating consumer cost sbaring) *with* A. ENTHOVEN, *supra* note 34, at 32-36 (advocating reliance on HMOs and physician cost consciousness). *See generally* Havighurst & Hackbarth, *Private Cost Containment*, 300 NEW ENG. J. MED. 1298 (1979).

54. *See* V. FUCHS, WHO SHALL LIVE? HEALTH, ECONOMICS, AND SOCIAL CHOICE 17-19 (1974).

55. *See* Zubkoff & Blumstein, *supra* note 39, at 73-74.

benefits is assumed and can be achieved only when the opportunity for R & R exists.

From this discussion, then, it should be apparent that the market-oriented strategy requires a reformist approach, a restructuring of institutions in the medical sector to restore health to that marketplace. It is inappropriate to consider this a "conservative" approach. Indeed, its threat to entrenched and concentrated structural medical interests[56] is its major political drawback. Rather, this approach is reformist and institutionalist, if not radical, in character; it is premised on the essential desirability of restoring proper private decisionmaking incentives to the medical marketplace.

B. The Market Approach: Political Pitfalls and Preconditions

The reformist agenda of the market-oriented strategy suffers from the lack of a discernible political constituency. For one set of proponents of comprehensive national health insurance, the use of financial disincentives as a mechanism for allocating medical care resources is ideologically anathema. To the extent that one believes that money should never matter in the health arena and that total equality in the utilization of medical services should exist, the market alternative is likely to be unacceptable. Choice and financial constraints inevitably mean that some persons with high incomes will be able to afford more health care than persons with lower incomes. This does not necessarily mean that all disparities must be permitted, however. Society could well decide that equal access should prevail with respect to certain basic services, allowing a disparity for only certain designated "extras" and ensuring a socially desirable, minimum level of care for low income groups. Finally, to the extent that one believes that income distribution should be unaffected by any illness—that is, *ex post* not just *ex ante* income should be a source of governmental concern[57]—the freedom of choice of the market will not be attractive.

These ideological positions, all too familiar a part of the health policy debate, make institutional redesign very difficult politically. If one believes in restoring incentives for economizing and in relying on private decisionmakers, one must assume the existence and

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56. *See generally* R. ALFORD, HEALTH CARE POLITICS: IDEOLOGICAL AND INTEREST GROUP BARRIERS TO REFORM 1-21 (1975).

57. *See* Fein, *On Achieving Access and Equity in Health Care*, in ECONOMIC ASPECTS OF HEALTH CARE 23 (J. McKinlay ed. 1973).

desirability of some differences in preferences; therefore, one can anticipate different decisions by similarly situated individuals about how much to spend on medical care. A political ideology that requires outcome equality and rejects as coercive the use of financial constraints on decisionmaking will not support a market strategy.

In addition to access egalitarians, providers and unions are likely political adversaries of a market strategy. Physicians do not necessarily welcome the prospects of competition and consumer choice. Although physician associations often support notions of competition, true reform would clearly leave some physicians substantially worse off financially. Moreover, certain market-oriented reforms threaten traditional prerogatives of the profession—in particular, pro-market reform would seriously undermine the physician's role as the benevolent father figure in control of the patient and his course of treatment.[58] A true competitive system would require physicians to disclose more information to patients and to acknowledge the patient as the ultimate decisionmaker. Such sharing of authority and responsibility, however, conflicts with traditional professional preferences for autonomy.[59]

Much of the medical profession's objection to commercialization of medical practice[60] will also reflect an instinctive, if often subconscious, concern about the effects of competition on style of practice and incomes. It is only reasonable that the profession prefers a situation in which medical judgments alone prevail and in which physicians feel at liberty to diagnose and treat on the basis of medical necessity, unsullied by the messy business of making treatment recommendations based at least in part on judgments of cost effectiveness. Certainly, economic considerations make an already taxing responsibility that much more complex. Any profession would prefer to have the authority to spend money from a

58. *See* Note, *supra* note 41, at 1535-41.

59. Under any competitive system, the consumer must make at least some choices in which extra quantity and/or quality involves an out-of-pocket outlay. *See, e.g.*, Evans, *Physician Based Group Insurance: A Proposal for Medical Cost Control*, 302 NEW ENG. J. MED. 1280 (1980).

60. As the medical marketplace is permitted or encouraged to emulate other economic sectors, the charge of commercialism is inevitable. This charge was the fear of professionals who sought to retain the ban on professional advertising. *See* Bates v. State Bar, 433 U.S. 350 (1977); Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council, Inc., 425 U.S. 748 (1976). Some manifestations of a freer market system in medical services will undoubtedly appear unprofessional and exploitative, especially at the outset, but standards of taste and decency may well emerge as excesses of the hard-sell turn away prospective consumers.

common fund for its patients' well-being; the incidental aggrandizement of its own members' incomes is an added, if unspoken, consideration. Surely, then, physicians are not natural political allies for those promoting competition.[61]

For physicians to feel comfortable with the competitive approach, they must believe that the alternatives are less acceptable. Physicians must be persuaded that they cannot have it both ways; comprehensive third-party financing cannot exist without concomitant oversight or control. Increasing public cost consciousness may lead to cutbacks in publicly financed programs such as Medicaid and Medicare. During the 1970s some states instituted a variety of cutbacks in Medicaid programs,[62] and similar efforts with respect to Medicare are foreseeable. State regulatory efforts now aimed at institutional capital investments and hospital rate-setting might, in the future, be focused more directly on physician fees, modes of practice, recertification, and the like.

The competitive approach, on the other hand, is ideologically compatible with physicians' traditional commitment to an entrepreneurial, pluralistic health care delivery system.[63] Direct government intervention is less likely to occur, or, if it does occur, it probably would be less intrusive in a competitive system. Moreover, increased sharing of information and responsibility for decisionmaking with patients could well have a salutary effect on a physician's malpractice liability.[64] If a properly informed patient takes or shares responsibility for a decision, courts may be more willing to impose an added measure of risk on the patient. This doctrinal development in the malpractice field would likely be favorably received by those doctors who may now practice medicine defensively out of apprehensiveness about malpractice liability.

Institutional providers also are unlikely political allies of the market advocates[65]—first, because they fear competition; and sec-

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61. *See* R. ALFORD, *supra* note 56, at 13-17, 191, 194-200.

62. On the general question of Medicaid cutbacks, see Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 YALE L.J. 243, 286-303 (1978).

63. *See* Enthoven, *Health Care Cost Control Through Incentives and Competition: Consumer-Choice Health Plan*, in SOCIO-ECONOMIC ISSUES OF HEALTH 1979, at 23, 35 (G. Misek ed. 1979).

64. Richard Epstein's skepticism about the usefulness of the doctrine of informed consent rests on his belief that patient participation in decisionmaking will not have a significant effect on the judicially established standard of care. Presumably, should the courts give weight to the element of patient participation, that would be a step in the right direction from Epstein's perspective. *See* Epstein, *Medical Malpractice: The Case for Contract*, 1976 AM. B. FOUNDATION RES. J. 87, 119-28, 126 n.80.

65. R. ALFORD, *supra* note 56, at 191, 200-09. *See also* Havighurst, *Regulation of*

ond, because competitive pricing will prevent them from subsidizing programs they regard as worthwhile.

Nonprofit corporations dominate the institutional sector, and, at the same time, fear competition from for-profit entities—in the hospital and nursing home fields and from emerging prepaid-group practices. Thus, it is hardly likely that these institutions will embrace the competitive alternative. Indeed, the nonprofit hospital industry took the initiative in seeking regulation, always a warning signal that an entrenched industry is seeking government support in its effort to exclude competitors.

A complicating factor is the close link between teaching and patient care functions.[66] This problem is particularly acute with regard to hospitals that are affiliated with medical schools, institutions with considerable influence in medical politics. Flexibility to cross-subsidize helps administrators to make ends meet and still allow "unprofitable" services to flourish if "interesting" for teaching or research purposes or if otherwise in the institution's or the public's general interest. In a competitive world, the market will make it more difficult for administrators to use cross-subsidization to achieve policy goals that are usually unarticulated and developed without any clear pattern of accountability.[67] The prospect of diminishing opportunities for cross-subsidization makes the procompetitive approach even less attractive to nonprofit institutions than would otherwise be the case.[68]

Because cross-subsidization might well be substantially eliminated by competition,[69] the perspective of provider institutions will likely depend on their perception of political reality.[70] A cap on

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Health Facilities and Services by "Certificate of Need", 59 VA. L. REV. 1143, 1148-51, 1153-55, 1178-88 (1973).

66. *See* J. NEWHOUSE, *supra* note 20, at 26-32; Zubkoff & Blumstein, *supra* note 40, at 109. *See also* Sloan, *Patient Care Reimbursement: Implications for Medical Education and Physician Distribution*, in MEDICAL EDUCATION FINANCING: POLICY ANALYSES AND OPTIONS FOR THE 1980'S, at 57, 73-81 (J. Hadley ed. 1980).

67. *See* Havighurst, *supra* note 65, at 1188-94; Posner, *Taxation by Regulation*, 2 BELL J. ECON. & MGMT. SCI. 22 (1971). *See also* Clark, *Does the Nonprofit Form Fit the Hospital Industry?*, 93 HARV. L. REV. 1416, 1437-41, 1465-71 (1980) (describing and criticizing the "elitist" role of nonprofit hospitals when engaging in cross-subsidization).

68. Proponents of competition must also address the problem of financing medical education in teaching hospitals—institutions that engage in the "joint production" of patient care and physician training. *See* J. NEWHOUSE, *supra* note 20, at 26-32.

69. *Cf.* Clark, *supra* note 67, at 1471-87 (suggesting legal changes to reduce "undesirable cross-subsidization [that] permeates nonprofit hospitals," *id.* at 1480).

70. For example, the American Hospital Association in 1968 supported certificate-of-need regulation in response to concerns about escalating hospital costs. *See* Havighurst, *supra* note 65, at 1151. One surmises that industry support for regulation stemmed in part

revenues, such as that which the Carter Administration's cost containment proposal had embodied,[71] would be less attractive to provider institutions as a long-run solution than the introduction of a more competitive system. If escalating hospital prices and aggregate costs continue to provoke investigation by policymakers into potentially harsh regulatory approaches, institutional providers may well conclude they can live with a decentralized competitive system in which the threat of direct governmental restrictions would be somewhat reduced.

A third group involved in the health care system—unions and other representatives of employees—is also unlikely to support the competitive approach unless certain concerns are addressed. After all, one of the major structural biases that marketeers typically target is the existing tax subsidy for employer-financed health insurance coverage.[72] Unions may well smell a "take away" in the move to rescind or modify current tax subsidies that support important components of hard-won fringe benefit packages.[73]

For unions and employee representatives to acquiesce to the competitive approach, they must be assured that reintroduction of incentives for economizing will not result in an overall reduction of their net welfare.[74] Thus, it seems clear that employee representatives will not embrace any proposal that merely takes away an existing tax inducement for purchasing high style medical insurance. Such a move would have significant distributive consequences, and one can safely assume that those whose tax benefit is at risk would vigorously oppose withdrawal of that benefit. Reform of the system in order to restore proper incentives and to achieve improved efficiency can be made more attractive to employee groups if there are no negative distributive consequences. Once that issue is eliminated, the incentives technique could be made to appeal to unions and engender their support.

At present, a union and a company typically negotiate an overall medical insurance package. Federal tax law allows an em-

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from its confidence that the result of regulation would not be unfavorable for the regulated hospitals. *See id.* at 1178-88.

71. *See* Blumstein & Sloan, *supra* note 22, at 30-32; Dunn & Lefkowitz, *The Hospital Cost Containment Act of 1977: An Analysis of the Administration's Proposal*, in HOSPITAL COST CONTAINMENT: SELECTED NOTES FOR FUTURE POLICY 166 (M. Zubkoff, I. Raskin & R. Hanft eds. 1978).

72. *See, e.g.*, Havighurst, Blumstein & Bovbjerg, *supra* note 18, at 189-90.

73. *See* Ginzberg, *Competition and Cost Containment*, 303 NEW ENG. J. MED. 1112, 1113 (1980).

74. *See id.*

ployer to deduct all insurance costs, but income is not imputed to employees for this benefit.[75] The tax law thus creates a clear incentive for the union to seek a broad and deep insurance policy, which minimizes out-of-pocket expenditures of employees, paid in after-tax dollars.[76] For the union leader, a political official, the elimination or reduction of irritating copayments, deductibles, or other internal limits is a distinct political plus. In turn, the employee likely faces very little financial constraint up to a certain maximum when illness occurs. Moreover, if the administration of a plan is rigorous, with claims reduced or disallowed, employees direct their hostility at the company, which is perceived as trying to save money at the worker's expense.

One way to secure political support from employee groups is to assure those groups a central role in purchasing medical insurance plans for their members. No cutback in tax subsidy is necessary, but the business expense deduction for the purchase of medical insurance could be limited to situations in which the employer specified in advance a fixed sum per employee up to a certain maximum as the employer's contribution to the health package and an employee group or employees individually selected a particular insurance plan and oversaw its administration. Under that arrangement, the union would decide whether to allocate the entire per employee sum to medical insurance or whether to economize by purchasing a less generous plan and to use the residual funds, not subject to full taxation, for some other worthy union activity. Acting as surrogate for its membership, a union would have an incentive to economize because the R & R principle[77] obtains. Union members, through internal politically representative procedures, could influence union decisionmaking about priorities. Since union members would benefit from tight-fisted administration, the union would be encouraged to manage the plan prudently, but not excessively niggardly, because of the its accountability to its membership.

Finally, it is important to realize that, even if the specific concerns of particular interest groups can be allayed, the most fundamental political barrier to competition is ideological. The belief

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75. *See* A. ENTHOVEN, *supra* note 34, at 19-21.

76. Unions have shown an unmistakable preference for complete coverage and for the Blues, which, at least traditionally, have been more likely to offer such coverage. *See, e.g.*, R. MUNTS, BARGAINING FOR HEALTH: LABOR UNIONS, HEALTH INSURANCE, AND MEDICAL CARE 131-43 (1967).

77. *See* text accompanying notes 47-55 *supra*.

that money should not matter in allocating medical resources is not uncommon in our society. Its corollary that people and institutions should not profit from illness reflects the queasiness many observers feel at what they decry as the emerging "medical-industrial complex."[78] This uneasiness about money and profit is perpetuated by our use of language.[79] In the medical sector physicians typically are not "compensated" or "paid" by the third-party carriers; rather, they are "reimbursed," a misnomer if one ever existed. Reimbursement suggests repayment or restitution for an expenditure or a loss incurred. It denies the obvious, that money is being earned for providing a service. Someone is indeed earning an income, and probably a handsome one, for performing a highly valued service that requires skill. The reimbursement terminology, however, dulls our sensitivity to what is for some an indelicate reality—namely, that in medical care, as elsewhere, priorities must be established, choices made, and, at times, increments of quality forgone because of resource constraints.[80]

The ideological position is difficult to overcome directly. Perhaps an indirect approach, however, can succeed. There does seem to be a growing awareness that equality of access may be an unattainable and even an undesirable goal.[81] Leveling up would require such a staggering commitment of resources that other public priorities would unduly suffer; leveling down would promote gross inefficiency, lower quality, achieve a dubious sort of equity in which waiting time would be the main resource allocator, and threaten fundamental precepts of freedom by barring individual expenditures for health above some arbitrary limit set by government. Indeed, as a practical matter, it is doubtful that any such governmental program could be enforced at all. As in the case of Prohibition, respect for law would diminish, and physician moonlighting would substitute for the rural moonshining of the Prohibition era.

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78. *See* Relman, *The New Medical-Industrial Complex*, 303 NEW ENG. J. MED. 963 (1980).

79. For discussions of the importance of language in shaping health policy issues, see Blumstein & Zubkoff, *supra* note 22, at 385-86 (distinguishing between "maldistribution" and "disparity"); Havighurst, Blumstein & Bovbjerg, *supra* note 18, at 158-62 (discussing the definition of death); Havighurst & Blumstein, *supra* note 10, at 31-33 (suggesting an economic dimension to the concept of overutilization).

80. *See* R. ANDREANO & B. WEISBROD, AMERICAN HEALTH POLICY: PERSPECTIVES AND CHOICES (1974); V. FUCHS, *supra* note 54, at 3-29.

81. *See, e.g.*, V. FUCHS, *supra* note 54, at 7 (" 'Highest quality care for all' is 'pie in the sky.' "). *See also* Blumstein & Zubkoff, *supra* note 11, at 407-12.

It does seem self-evident by now that the goal of equal utilization of medical services is an unrealistic and probably unwarranted policy aspiration.[82] It serves more as a symbolic myth founded in the "right to health" rhetoric of the 1960s.[83] Once it is accepted that some disparities are inevitable and even desirable, the purely ideological position should be defused. If the notion of "adequacy" can be substituted for "equality,"[84] the toughest ideological hurdle will have been leapt. This is not to say that consensus will miraculously emerge about what constitutes an acceptable level of "adequacy," but at least the more versus less debate can proceed along customary political lines without the inhibiting intrusion of rigid ideology. Unless and until adequacy or some similar notion is accepted and equal utilization is no longer an ideological precondition to acceptability, a market-oriented strategy will not be politically viable. Similarly, unless health is perceived as an instrumental, not an ultimate, value,[85] the possibility of tradeoffs is remote. Without acceptance of the need for and desirability of tradeoffs, the market-oriented approach is not likely to succeed.[86]

C. *The Market Approach: The Issue of Equity*

The above discussion of economic and political preconditions for a market-oriented strategy did not directly consider a traditionally major health policy issue—the problem of equity.[87] The introductory discussion noted that issues of access and quality dominated the health policy dialogue until the 1970s. The current emphasis on constraining rising prices and aggregate costs reflects a basic modification in the political agenda in the health field.

The procompetitive critique of the health sector stresses the bias toward overutilization of services and excessive commitment of resources characteristic of the equality of access approach.[88] The goal is to restore a system in which decisionmakers face appropriate incentives and share in the benefits and burdens that arise

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82. *See* Havighurst, *supra* note 25, at 491.

83. *See* Havighurst & Blumstein, *supra* note 10, at 6-7.

84. *See* Blumstein & Zubkoff, *supra* note 11, at 411; Blumstein & Zuhkoff, *supra* note 22, at 405. *See generally* Michelman, *On Protecting the Poor Through the Fourteenth Amendment*, 83 HARV. L. REV. 7 (1969).

85. *See* Zubkoff & Blumstein, *supra* note 39, at 73-74.

86. *See* H. FRECH & P. GINSBURG, *supra* note 50, at 21-22.

87. *See* Callahan, *Health and Society: Some Ethical Imperatives*, DAEDALUS, Winter 1977, at 23. *See also* Blumstein & Zubkoff, *supra* note 11, at 407-12; Blumstein & Zubkoff, *supra* note 22, at 384-87, 403-05.

88. *See* Havighurst & Blumstein, *supra* note 10, at 9-20.

from their own choices.

The competitive approach, therefore, is designed to improve efficiency in the allocation of resources. It does not directly address the question of equity of access,[89] except that it rejects the ideological stances that (1) health is an ultimate good and therefore not subject to tradeoffs[90] and (2) equal utilization of medical services is an absolute equitable imperative,[91] unrelated to private preferences and different private resource constraints. Beyond that, the market-oriented strategy makes no specific claim about the proper eligibility criteria or level of medical services that society should provide to worthy and needy persons. It takes no position on what degree of redistributive munificence is proper in the medical services field,[92] although it assumes that an adequate level of services will be provided for those who cannot otherwise afford to pay for care from their own resources.

Given the magnitude of overall expenditures for medical care, the system cannot be designed solely, or even primarily, to solve the access problem of indigents. The structure established must set in place a well-designed system, including proper incentives for the various decisionmakers. Instead of piggybacking the nonpoor onto a plan designed to care for the needy, the competitive approach provides resources for the needy to enable them to participate responsibly in a system designed for everyone.

III. The Regulatory Approach

Ironically, the market approach in the health field requires a reformist political agenda because the predominant mode of governmental intervention in this sector has been government regulation. The market-oriented strategy therefore must undo and redo a great deal of existing governmental intervention if it is to be fairly tried.

Traditionally, intervention is justified as a means of overcoming some form of market failure or of achieving some set of equita-

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89. *See* Blumstein & Zubkoff, *supra* note 22, at 387. *See generally* V. Fuchs, *supra* note 54, at 14, 22-23, 127-42.

90. *See* Callahan, *supra* note 87, at 25-26; Zubkoff & Blumstein, *supra* note 39, at 73-74.

91. *See* Havighurst, *supra* note 25, at 491.

92. The following has been suggested as a normative benchmark: "[W]hat provident individuals would choose to spend if they knew the value of each service and could design their own insurance coverage, carefully balancing the benefits and costs against other uses for their money." Havighurst & Blumstein, *supra* note 10, at 15.

ble objectives.[93] Existing governmental regulatory and financial support programs are supported on one or both of these bases. For example, the Hill-Burton program, enacted in 1946 and designed to promote hospital construction, was the federal government's first major health initiative.[94] The program's rationale, as expressed in the legislation itself and in the hearings, was that existing hospital facilities were inadequate. Additionally, there was the implicit belief that the private sector would not generate sufficient new facilities unless the federal government directly subsidized the growth. By 1974, Congress had concluded that there was an oversupply of hospital beds and other hospital-based capital facilities and equipment. It responded by requiring states to develop certificate-of-need (CON) programs that scrutinize the necessity for all bospital capital expenditures above a certain level, even when no direct support is involved.[95] Indeed, in the same legislation Congress enacted a new hospital construction program. No funds have been appropriated under it, bowever, or under Hill-Burton, its predecessor, since its enactment.

Similarly, in 1965 Congress enacted the Medicare and Medicaid programs, providing medical care for the elderly and the categorically needy. Unlike the Hill-Burton approach, which relied on direct support for hospital supply expansion, Medicare and Medicaid provide financial support on the demand side. Federal dollars allow the needy and the elderly to purchase medical services in an existing system.

The increase in overall demand for medical services caused by Medicare and Medicaid was not only predictable, but was the very objective of the legislation. The magnitude of the increase was underestimated, however, and by 1972 conflicting pressures emerged. In that year Medicare eligibility was significantly expanded to include kidney patients and the disabled.[96] At the same time,

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93. *See, e.g.*, Davis, *The Federal Role in the Health Care Market*, in 2 NATIONAL COMMISSION ON THE COST OF MEDICAL CARE, 1976-77, at 201-05 (1978). More recently, commentators have viewed regulation as providing a mechanism for reorienting provider incentives in ways consistent with cost containment. *See* Altman & Weiner, *Regulation as Second Best*, in COMPETITION IN THE HEALTH CARE SECTOR, *supra* note 20, at 339.

94. *See generally* Rose, *Federal Regulation of Services to the Poor under the Hill-Burton Act: Realities and Pitfalls*, 70 NW. U.L. REV. 168 (1975); Note, *The Hill-Burton Act, 1946-1980: Asynchrony in the Delivery of Health Care to the Poor*, 39 MD. L. REV. 316 (1979); Note, *Due Process for Hill-Burton Assisted Facilities*, 32 VAND. L. REV. 1469 (1979).

95. Blumstein & Sloan, *supra* noto 22, at 19-23.

96. *See* Rettig, *The Policy Debate on Patient Care Financing for Victims of End-Stage Renal Disease*, LAW & CONTEMP. PROB., Autumn 1976, at 196.

though, Congress enacted a number of cost-containment programs, including the Professional Standards Review Organization (PSRO) program designed to review the necessity of medical services provided by or in institutions.[97] The story of the PSRO program's legislative history and postenactment interpretation is told elsewhere;[98] what is germane here is that, seven years after expanding demand by enacting Medicare and Medicaid, Congress intervened again to combat the unintended consequences of its munificence.

Thus, governmental intervention to satisfy certain equity or access objectives can create market imperfections that in turn justify further intervention. CON legislation, designed to forestall wasteful duplication, is deemed necessary because of the prevalence of third-party financing and the dominance of nonprofit institutions in the hospital industry, two distinctive characteristics of the health care marketplace. Governmental programs have helped shape that marketplace. Tax subsidies encourage broad and deep private medical insurance coverage, major third-party government insurance programs (Medicare and Medicaid) account for nearly fifty percent[99] of third-party payments for hospital services, and major federal subsidies for the construction of nonprofit hospitals (Hill-Burton) give nonprofits a competitive edge in the hospital industry.

Not all deviations from the competitive model are governmentally inspired, of course. Genuine problems exist with respect to consumer information and understanding. In some situations, especially in the case of emergency care, it is not realistic to expect patients to make careful on-the-spot medical judgments and sound economic tradeoffs.[100] The traditional assumptions, however, that have justified governmental intervention are no longer accepted uncritically. It is still true that providers exercise great influence over patients' utilization decisions and that patients often are uninterested in or incapable of being educated about qualitative matters and risk factors, but this does not necessarily mean that regulatory control is therefore required. These inadequacies could easily be corrected by educating patients or providing them with some form of informational intermediary, rather than using them

97. *See* Blumstein, *The Role of PSROs in Hospital Cost Containment*, in HOSPITAL COST CONTAINMENT, *supra* note 71, at 461.

98. Havighurst & Blumstein, *supra* note 10, at 38-45.

99. *See* Gibson, *supra* note 8, at 25.

100. *See* R. CAMPBELL, ECONOMICS OF HEALTH AND PUBLIC POLICY 53-54 (1971); Blumstein & Zubkoff, *supra* note 11, at 421-23.

as an excuse for rejecting the market altogether.

Nonetheless, the perceived existence of irremediable market imperfections, irrespective of their source, has been the justification for governmental intervention. Much regulation now exists as a result, and it is appropriate to consider what the experience has been in those regulatory programs. This review will focus on regulatory activity centered on the hospital, the hub of the modern medical care delivery system.

Expenditures on hospital services represent the largest single component of health care expenditures. In 1979, for example, about forty percent[101] of total expenditures on personal health services went to hospitals. Both expenditures per unit and total expenditures per hospital service have escalated more dramatically than any other major category of health services. For over a decade third-party coverage has almost completely funded hospital care.[102] Regulation is seen as a method of offsetting overutilization and excess capacity, attributable to insurance and physician generated demand.[103]

The major hospital regulatory efforts have been the following: (1) controls over hospital facilities and services through health planning and CON; (2) utilization controls, accompanied by concerns for quality assurance, under the PSRO program; and (3) at the state level, direct regulation of hospital rates and/or revenues. Each will be considered in turn.

A. Facilities and Services Regulation

1. The Regulatory Programs

State CON laws, federally mandated since 1974, and the section 1122 review program are the major forms of hospital facilities and services regulation. Section 1122 is a federal program adopted by states on a voluntary basis.[104] It seeks to limit hospital capital expenditures by withdrawing Medicare and Medicaid reimbursements for nonapproved capital outlays. Under the program, state-designated planning agencies review capital expenditures exceeding federally-set guidelines, as well as changes in bed census and changes in services offered. Absent regulatory approval, hospital

101. *See* Gibson, *supra* note 8, at 13.

102. *See id.* at 25 (over 90% of hospital care is financed by third parties).

103. *See* Altman & Weiner, *supra* note 93, at 341.

104. Social Security Amendments of 1972, Pub. L. No. 93-603, 86 Stat. 1453 (codified at 42 U.S.C. § 1320a-1 (1976 & Supp. II 1978)).

expenditures attributable to unapproved capital projects are not considered legitimate costs for reimbursement under Medicare and Medicaid.[105]

Section 1122 operates by establishing a financial disincentive for unapproved hospital capital spending. Hospitals can, however, proceed with construction if they can secure reimbursement from nonfederal sources. The CON program, on the other hand, is a command-and-control regulatory program that is intended to stop duplication of hospital facilities and services. Under CON, state-designated agencies applying federally-established minimum standards must approve entry of new hospitals, expansion and/or modernization of existing hospital plants, and, in certain cases, provision of new services or termination of existing services.

Under the mandate of the federal health planning legislation, virtually all states have enacted CON laws.[106] Although federal guidelines establish parameters for state CON legislation, states vary in such matters as comprehensiveness and review and appeals procedures.[107] Coverage must extend to health care facilities, including both hospitals and nursing homes, but not to doctors' offices. Under revised federal regulations, state CON programs must review the addition by a health care facility of a health service if it is either "associated with" a capital expenditure of any amount or if it "entails annual operating costs" of at least $75,000. In addition, a CON agency must review a facility's decision to terminate a health service if that termination is "associated" with a capital expenditure in any amount.[108]

CON is a reactive form of regulation; the regulated institution, rather than the agency, takes the initiative in proposing a particular capital expenditure.[109] With very few exceptions, state CON programs lack the authority to require decertification of existing

105. *See generally* H. HYMAN, HEALTH REGULATION: CERTIFICATE OF NEED AND 1122 (1977).

106. *See* U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, BUREAU OF HEALTH PLANNING, DATES OF CERTIFICATE OF NEED ENACTMENT AND 1122 AGREEMENT (1980) [hereinafter cited as DATES OF CON ENACTMENT AND 1122 AGREEMENT].

107. *See* CHAYET & SONNENREICH, P.C., CERTIFICATE OF NEED: AN EXPANDING REGULATORY CONCEPT, SUPPLEMENT, FALL 1978, at 30-274 (1978). For a discussion of distributional objectives and accomplishments in the context of CON programs, see POLICY ANALYSIS INC. & URBAN SYSTEMS RESEARCH AND ENGINEERING, INC., EVALUATION OF THE EFFECTS OF CERTIFICATE OF NEED PROGRAMS: FINAL REPORT (1980) (prepared for the U.S. Department of Health & Human Services under Contract No. 231-77-0114).

108. 45 Fed. Reg. 69,740, 69,747 (1980) (to be codified in 42 C.F.R. § 123.404(a)(3)).

109. *See generally* Bovbjerg, *supra* note 32; Kopit, Krill & Bonnie, *Hospital Decertification: Legitimate Regulation or a Taking of Private Property?*, 1978 UTAH L. REV. 179.

facilities and services. In fact, the revised federal regulations actually constrain hospitals' ability to terminate a service, to redistribute beds among categories, or to relocate beds from one site to another.[110]

Areawide planning agencies (health systems agencies or HSAs) do have authority to develop a health systems plan (HSP), which may influence providers who propose new construction or modernization. The agencies, however, lack enforcement tools; all they can do is refuse to approve projects that do not comply with the HSP. Even then areawide agencies only recommend decisions to statewide agencies, which make the ultimate decision and may respond to a political constituency beyond the purview of the areawide agency.

Although CON does not explicitly repeal the section 1122 program, CON review makes separate review under section 1122 redundant. Theoretically, CON review could authorize an institution to expand or modernize while section 1122 review refused federal reimbursement under Medicare or Medicaid for that capital expenditure. As a practical matter, however, both decisions are likely to be the same because they are based on the same factors of need. As a result, many states have now dropped their section 1122 programs.[111] Accordingly, this consideration of the effectiveness of facilities and services regulation will concentrate on the state CON programs.

2. The Effectiveness of the Certificate-of-Need Program

A major study of CON programs covering the years 1968-1972 concluded that they reduced bed expansion.[112] Despite this reduction plant assets per bed increased during the study period, apparently because controls on fixed equipment other than beds were less stringent.[113] Coupled with the findings of another inquiry,[114] this study indicates that the CON program has had no net impact on total hospital investment (plant assets). Although these studies

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110. 45 Fed. Reg. 69,740, 69,747 (1980) (to be codified in 42 C.F.R. § 123.404(a)(2)).

111. All except 9 states had adopted a § 1122 program at one time or another by 1979. By late 1979, however, 15 states had terminated or were terminating their programs. *See* DATES OF CON ENACTMENT AND 1122 AGREEMENT, *supra* note 106, at 4.

112. *See* D. SALKEVER & T. BICE, HOSPITAL CERTIFICATE OF NEED CONTROLS: IMPACT ON INVESTMENT, COSTS, AND USE 53-73 (1979).

113. *Id.*

114. *See* Hellinger, *Prospective Reimbursement through Budget Review: New Jersey, Rhode Island, and Western Pennsylvania*, 13 INQUIRY 309 (1976).

of early CON efforts may be criticized because they sought to measure impact before implementation efforts could realistically be evaluated, a more recent study of hospital regulation supports these findings.[115] Distinguishing CON programs on the basis of program age, this recent study found that in the year preceding the introduction of the CON program, a 1.4 percent increase occurred in bed growth, due greatly to anticipation that such growth would be restricted in the future by CON.[116] This increase was not offset on average by reductions in bed growth as the program matured. In addition, CON seemed to increase aggregate expenditure levels by raising hospital demand for labor inputs, which are beyond the direct control of CON programs. Other research, using data as recent as 1978, has confirmed this study.[117] Overall, those who have investigated the effectiveness of mature CON efforts conclude that the program's vintage has no measurable effect on hospital costs. Even with regard to bed growth alone, the program seems only marginally effective. In sum, the consensus in the research community is that CON has not succeeded in cost containment.

B. Utilization-Quality Regulation

1. The PSRO Program

Hospital certification has long required utilization review (UR), a self-policing mechanism by which hospitals gauge both the technical quality and the medical necessity of services delivered by their medical staff. UR encompasses a broad range of activities, including review of the necessity for admission, periodic recertification of the necessity for continuation of a stay, and review of specific services delivered.[118]

In 1972, Congress mandated the establishment of PSROs as a mechanism for requiring peer review of utilization of hospital services paid for by Medicare and Medicaid.[119] Congress enacted the

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115. *See* F. SLOAN & B. STEINWALD, INSURANCE, REGULATION, AND HOSPITAL COSTS 91-121 (1980).

116. *Id.* at 169.

117. *See* POLICY ANALYSIS INC. & URBAN SYSTEMS RESEARCH AND ENGINEERING, INC., *supra* note 107. *See also* Sloan, *Regulation and the Rising Cost of Hospital Care*, in REV. ECON. & STATISTICS (forthcoming).

118. On the origins and rationale of utilization control, see TECHNICAL WORK GROUP ON HEALTH CARE COSTS, RISING MEDICAL COSTS IN MICHIGAN: THE SCOPE OF THE PROBLEM AND THE EFFECTIVENESS OF CURRENT CONTROLS 340-42 (1973).

119. *See* J. BLUM, P. GERTMAN & J. RABINOW, PSROs AND THE LAW 12-17 (1977); U.S. HEALTH CARE FINANCING ADMINISTRATION, PROFESSIONAL STANDARDS REVIEW ORGANIZATION 1979 PROGRAM EVALUATION (1979).

PSRO program out of its belief that traditional UR programs then existing under Medicare and Medicaid were ineffective in curtailing the unnecessary use of services provided by or in institutions.

Under the PSRO legislation, no Medicare or Medicaid funds can be disbursed if a PSRO disapproves the provision of service. PSROs are organized geographically, covering areas as large as an entire state or as small as a few zip codes within a single city. They are composed of physicians practicing in the area and are open to any physician who seeks membership.

By establishing guidelines for practice, including ranges of acceptable variance around specified norms—for example, a range of permitted lengths of stay for a given illness—a PSRO engages in a form of rulemaking or standard setting. In addition, the PSRO has ultimate responsibility for applying those guidelines in specific cases, an essentially adjudicatory function. In practice, the PSRO delegates much adjudicatory review to the hospital itself under terms set out in the statute. Thus, it is somewhat misleading to consider a PSRO as an external peer review entity.

The PSRO delegation of responsibility for UR back to the institution suggests that hospitals have much the same autonomy they had under UR prior to enactment of the PSRO program. PSROs do oversee delegated hospital review, however, and can revoke a hospital's delegated reviewer status if the institution does not perform its review function satisfactorily. Moreover, the practice guidelines established by PSROs are likely to be influenced by physicians' sense that the PSRO program should deemphasize cost containment and emphasize quality assurance as the overriding goal. The prevalence of delegated review and the physicians' success in turning PSRO into primarily a quality assurance program led to rather accurate early predictions that PSRO would not be a cost-containment program at all but rather would be an "effective . . . political instrument for increasing, not reducing, health expenditures."[120]

2. The Effectiveness of the PSRO Program

Very few large-scale studies have been conducted on the effects of UR on hospital expenditures. A thorough evaluation of the Experimental Medical Care Review Organization (EMCRO) program in New Mexico during 1971-1975, a PSRO prototype, yielded

120. *See* Blumstein, *supra* note 48, at 286.

no significant evidence that EMCRO reduced rates of hospital admission, length of stay, or hospital days of care of the Medicaid population.[121] One subsequent analysis of the effects of UR and PSRO activities nationwide found no effect on levels of, or changes in, Medicare utilization rates.[122] A federal government study, however, did find that PSROs have reduced hospitalized days of Medicare beneficiaries by 1.7 percent.[123] The study showed wide regional disparities in PSRO effectiveness. In the South, for example, the statistical analysis suggests that PSROs have raised levels of hospital utilization by Medicare beneficiaries by more than a trivial amount.[124] In the West, on the other hand, no effect was detected. If PSRO effectiveness is region-specific, it would be useful to know why.[125]

The ultimate conclusion about the effectiveness of PSROs seems to be that, if they have any effect at all, they may cut hospitalized days by a very modest amount in some areas of the country. PSROs do not, on the other hand, measurably affect hospital costs per admission or per diem. Moreover, the program itself creates costs. Thus, any cost savings are outweighed by the costs of administration.[126] The Reagan Administration seems to have concluded that the PSRO program is a likely target for extinction because it is not justified on cost effectiveness grounds.[127] Of course, PSROs do have a quality assurance mission, and undoubtedly some would attempt to justify their continued existence on that basis. Evidence on that claim, however, is speculative, and there is indeed a basis for questioning whether the quality assurance objective should serve as the saving rationale for continued support of the PSRO program.

C. *Rate-Revenue Regulation*

A final type of hospital regulatory effort involves direct control of hospital charges and revenues. Regulatory bodies may place lim-

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121. Steinwald & Sloan, *Regulatory Approaches to Hospital Cost Containment: A Synthesis of the Empirical Evidence*, in HEALTH CARE—PROFESSIONAL ETHICS, GOVERNMENT REGULATION, OR MARKETS (M. Olson ed.) (forthcoming) [hereinafter cited as HEALTH CARE].

122. *Id.*

123. *See* U.S. HEALTH CARE FINANCING ADMINISTRATION, *supra* note 119, at xii.

124. *Id.*

125. For a comprehensive review of an earlier Health Care Financing Administration study of PSROs, see CONGRESSIONAL BUDGET OFFICE, THE EFFECT OF PSROS ON HEALTH CARE COSTS: CURRENT FINDINGS AND FUTURE EVALUATION (1979).

126. *Id.*

127. *See* [1981] 4 MEDICARE & MEDICAID GUIDE (CCH), Report Letter #318, at 1.

its on levels and rates of increase in charges; they may also set limits on levels and rates of increase in revenues (input expenditures). The most important such program attempted to date by the federal government was the wage and price controls of the Nixon Administration's Economic Stabilization Program (ESP). At the state level, prospective reimbursement (PR) programs, which establish ceilings on amounts hospitals receive from participating third-party payors, have been the most important initiative.

1. The Economic Stabilization Program

Under ESP the federal government controlled wages and prices. Somewhat later, the federal government also restricted reimbursement costs by third-party payors. Annual growth of hospital revenues because of price was limited to a maximum of six percent, based on "allowable" increases in costs. Thus, certain cost increases were "nonallowable" and could not justify an increase in prices.[128] "In practice . . . the effective limitation on price increases was nearer to 4.3 percent"[129] because of a very low level of allowable nonlabor cost increases. The emphasis of ESP on price rather than expenditure increases was not what many health care experts would have preferred.

Descriptive studies show that hospital cost increases were reduced several percentage points during the ESP period.[130] Although early analytical studies of the ESP show little or no effect on hospital costs,[131] a more recent analytical study is consistent with the descriptive evidence.[132] Overall, it appears that ESP did reduce hospital costs. It is somewhat risky, however, to project future effectiveness on the basis of ESP because of the program's brief existence and because of the many political and administrative problems that beset it.

2. Prospective Reimbursement

Several states have initiated PR programs. Under PR an ex-

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128. *See* Ginsburg, *Inflation and the Economic Stabilization Program*, in HEALTH, *supra* note 48, at 31, 38.

129. *Id.* at 38.

130. *See* Altman & Eichenholz, *Inflation in the Health Industry—Causes and Cures*, in HEALTH, *supra* note 48, at 7, 20-22. *See also* F. SLOAN & B. STEINWALD, *supra* note 115.

131. *See* Ginsburg, *Impact of the Economic Stabilization Program on Hospitals: An Analysis with Aggregate Data*, in HOSPITAL COST CONTAINMENT, *supra* note 71, at 293. *See also* F. SLOAN & B. STEINWALD, *supra* note 115, at 105-07.

132. *See* Sloan, *supra* note 117.

ternal authority sets or approves hospital charges, third-party payment rates, and total hospital revenue. Decisions are made in advance of the year to which they apply. Hospitals are paid according to these prospectively determined rates rather than on the basis of actual costs incurred. Moreover, hospitals are placed at risk for differences between prospectively determined revenues and actual costs.[133] Unlike cost-based reimbursement in which costs at least theoretically generate revenue,[134] PR theoretically encourages hospitals to be concerned with the cost implication of changes in quantity, quality, style of care, scope of services, and efficiency because third-party payors under PR do not cover overruns.[135]

While the various state PR programs share many elements, two major differences are notable: (1) type of review (formula or budget-review method); (2) rate versus total revenue regulation. Formula review involves periodic recomputation of new prospective rates on the basis of such factors as the general inflation rate and the type of hospital.[136] Formula PR involves little direct interaction between hospitals and the rate-setting authority.[137] Although a formula may be arbitrary in some circumstances, the distancing of agency from hospital suggests that the agency's formula can be viewed abstractly, in statistical terms, and therefore has some prospect for success in containing costs.

Under budget review PR, the hospital develops a budget for the prospective year, which is reviewed by the PR authority. Items in the budget deemed unnecessary or excessive by the agency are eliminated or reduced. Hospitals are generally given the opportunity to negotiate and appeal budget-reducing decisions. Once the final budget has been approved, the PR authority establishes a payment rate covering the hospital's budgeted costs. Because this method permits maximum recognition of individual hospital characteristics, hospitals often prefer it to the formula method.[138] By

133. *See* Dowling, *Prospective Reimbursement of Hospitals*, 11 INQUIRY 163, 163-64 (1974).

134. For descriptions of cost and charge-based reimbursement, see Tekolste & Sigmond, *How Should Blue Cross Reimburse Hospitals?*, MOD. HOSPITALS, July 1963, at 90. For a concise legal history of reimbursement trends, see Weiner, *"Reasonable Cost" Reimbursement for Inpatient Hospital Services Under Medicare and Medicaid: The Emergence of Public Control*, 3 AM. J.L. & MED. 1 (1977).

135. *See* Dowling, *supra* note 133, at 164.

136. New York relies most extensively on this method. *See* U.S. HEALTH CARE FINANCING ADMINISTRATION, VII HEALTH CARE FINANCING GRANTS AND CONTRACTS REPORT: NATIONAL HOSPITAL RATE-SETTING STUDY 1-2 (1980).

137. *Id.*

138. *See* Worthington, *Prospective Reimbursement of Hospitals to Promote Effi-*

focusing attention on the fine detail of hospital management, the budget-review approach seems to give hospitals an advantage in the negotiation process since it is difficult for the PR agency to demand cuts that affect identifiable services and possibly identifiable individuals.

To date, only two of the eight mandatory state PR programs regulate hospital revenue.[139] Setting prices for particular hospital services is more popular. To the extent that hospitals can generate extra units of service to compensate for low, regulated prices, the latter approach is less constraining.

The mandatory rate-setting programs of eight states represent the most stringent rate-revenue efforts at the state or local levels. Descriptive evidence suggests that increases in expense per admission, expense per patient day, and total expenses were considerably lower in 1977 and 1978 in states with mandated rate-setting than for the rest of the United States. Total hospital expenses in the eight "mandatory" states increased 9.7 and 8.6 percent for 1976-1977 and 1977-1978, respectively, in contrast with increases of 15.8 and 14.0 percent for the other states and the District of Columbia.[140] Because these patterns are only evident for 1976-1978, and not for earlier years, the authors of one study concluded that these programs first became effective several years after initial implementation.[141]

More comprehensive hospital cost studies, using regression analysis on state-by-state aggregates of hospital data, reach nearly the same conclusion. The Congressional Budget Office found that mandatory state rate-setting reduced hospital expenditures per capita by about three percentage points over the period 1976-1978.[142] A study by one of the authors of this Article distinguished new state programs, those less than three years old, from mature ones, those three or more years old. The study found that new

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ciency: New Jersey, 13 INQUIRY 302 (1976). Sometimes budget and formula approaches are combined. A hospital's rate may initially be set by budget review and be updated by formula. Likewise, with a formula, a hospital seeking legal remedy may be subject to budget review.

139. Maryland and Washington regulate hospital revenue. *See* U.S. HEALTH CARE FINANCING ADMINISTRATION, III & VIII HEALTH CARE FINANCING GRANTS AND CONTRACTS REPORT: NATIONAL HOSPITAL RATE-SETTING STUDY (1980).

140. *See* U.S. HEALTH CARE FINANCING ADMINISTRATION, RESEARCH AND DEMONSTRATIONS IN HEALTH CARE FINANCING 1978-1979, at 26 (1979).

141. *See* Biles, Schramm & Atkinson, *Hospital Cost Inflation Under State Rate-Setting Programs*, 303 NEW ENG. J. MED. 664 (1980).

142. *See* CONGRESSIONAL BUDGET OFFICE, CONTROLLING RISING HOSPITAL COSTS 94-96 (1979).

state rate-setting programs did not affect hospital costs, but that mature programs lowered both levels and growth rates of hospital costs per admission and per diem. These estimates imply that if all payors were subject to mature state rate-setting, equilibrium cost reductions would range from seven to twenty percent.[143] Coelen and Sullivan have reported somewhat smaller statistically significant negative effects.[144] Their study, like other recent analyses of hospital rate-setting, found that program effectiveness is evident only for the late 1970s. Earlier research extending through only 1975 found little or no rate-setting program impact on hospital cost dependent variables.[145]

Although research results support the notion that mandatory rate-setting has achieved its objective, for several reasons these results should not be viewed uncritically. First, programs may have produced certain wasteful distortions as hospitals have looked for ways to circumvent binding regulatory constraints. For example, hospitals under ESP or tough PR programs may admit more patients whose conditions require relatively short stays and/or relatively few resources per patient-day. Second, the apparent failure of some regulatory programs and the at best limited success of others raise a political bureaucratic question about why and how some states are able to develop cost-reducing programs. Mandatory PR programs are overrepresented in the Northeast. One Western state, Colorado, eliminated PR in early 1980 because of industry opposition and a general antiregulatory environment. This raises a question whether the experiences of such states as Maryland, Massachusetts, New Jersey, and New York can be replicated elsewhere. Third, even in states in which rate-setting programs eventually have controlled hospital costs, no effects were evident on average within the first two or three years. In this sense, tough rate-setting programs are not a short-run panacea. Fourth, controls that successfully curb hospital costs may also eventually force certain hospitals into bankruptcy. If they do, one must wonder how this will affect such other goals as access and how the regulatory and political processes will respond. For this reason, very mature revenue-cost programs, which are not yet possible to assess, may have a smaller impact on cost than mature ones, which can be evaluated at this time.

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143. *See* Sloan, *supra* note 117.

144. *See* Coelen & Sullivan, *An Analysis of the Effects of Prospective Reimbursement Programs on Hospital Expenditures*, 2 HEALTH CARE FINANCING REV. 1 (Winter 1981).

145. For further discussion, see F. SLOAN & B. STEINWALD, *supra* note 115, at 134-35.

D. Regulatory Programs in Policy Perspective

While empirical evidence from statistical studies provides an extremely important basis for evaluating regulatory programs, a comprehensive analysis of regulatory policy should also include consideration of normative, procedural, structural, and institutional factors. Examination of these factors is useful when empirical evidence is lacking and helps to interpret otherwise sterile statistical findings. Thus, despite the absence of conclusive statistical findings on outcomes of competitive approaches, these approaches are gaining support as alternatives to regulation, primarily on normative and institutional grounds.

1. Technical Limitations

Both facilities-services and utilization-quality regulation require that decisions be made with reference to a well-defined standard of patient and/or community need. Facilities-services health planners assigu numerical benchmarks as part of their regulation writing. Unfortunately, no single number adequately serves as an indicator of need. The adopted ratio of four beds per thousand population has little or no empirical basis.[146] Even if it did, it is unclear how levels of care and cost are affected by ratios of 3.8 or 4.2.[147] Although a continuum is more appealing conceptually than a point estimate, health planners are ill-equipped to identify what tradeoffs must be made at any single point, whether it be a fixed criterion or a point within a range of acceptability. When, in addition, one considers matters such as travel time, population health

146. For policy studies that assume an important relationship between bed capacity and utilization of hospital services, see INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, CONTROLLING THE SUPPLY OF HOSPITAL BEDS (1976); W. MCCLURE, REDUCING EXCESS HOSPITAL CAPACITY (1976).

147. For early studies that associate increased bed supply with increased hospital use, see Shain & Roemer, *Hospital Costs Relate to the Supply of Beds*, 92 MOD. HOSPITAL, Apr. 1959, at 71; Wennherg & Gittelsohn, *Small Area Variations in Health Care Delivery*, 182 SCIENCE 1102 (1973). These studies show two-way relationships between beds and use. Methodologically, such studies tend to be inferior to multivariate studies that take into account, in addition to beds, a number of possible determinants of utilization. For full scale (multivariate) studies of the beds-hospital utilization relationships, see G. ROSENTHAL, THE DEMAND FOR GENERAL HOSPITAL FACILITIES (1964); Feldstein, *Hospital Cost Inflation: A Study of Nonprofit Price Dynamics*, 61 AM. ECON. REV. 853, 870 (1971); May, *Utilization of Health Services and the Availability of Resources*, in EQUITY IN HEALTH SERVICES: EMPIRICAL ANALYSIS IN SOCIAL POLICY 131 (R. Anderson, J. Kravits & O. Anderson eds. 1975). Professor Rosenthal's research suggests that the supply of hospital beds has virtually no effect on hospital utilization. Professor Feldstein reports beds-admissions and heds-length of stay elasticities in the 0.25 to 0.4 range. Professor May's estimated elasticities were 0.2 and lower.

status, variations in patients' taste for health in comparison to other aspects of quality of life, and ability-to-pay, numerically specified regulatory norms assume an unreal aura of definitiveness. Numbers can easily be specified but are inherently arbitrary; consensus is, for good reasons, difficult to achieve.

2. Program Composition

An important justification for UR is the alleged ability of physicians to generate demand for their services. Presumably, review of utilization levels provides a mechanism for curbing services of greater benefit to the physician's pocketbooks than to the patient's health. One questions whether the structure of a UR program such as PSRO facilitates this goal in a world of substantial physician-created demand.[148]

By statute, PSROs are operated by local practicing physicians.[149] Suppose that a PSRO is placed in a town with a surfeit of doctors. To earn a "decent living" each doctor must boost utilization over what it would otherwise be. The PSRO provides an excellent vehicle for increasing aggregate levels of utilization since it, in effect, determines the controlling standard of medical practice in its region. The PSRO-established standard will govern federal reimbursement decisions even if the local standard reflects supplier-created demand.[150] Moreover, since compliance with PSRO-established norms results in malpractice liability immunity for providers,[151] doctors who do not adhere to PSRO norms are encouraged to shift their level of practice up to PSRO levels. Otherwise, a noncomplying physician risks malpractice exposure, and counsel for plaintiffs will point to PSRO-established norms as the appropriate standard of practice in the community. Although national oversight of local PSRO norms is possible, federal administrators apparently renounced the exercise of that authority in order to win physicians' support for the PSRO program.[152]

In sum, then, rather than police supplier-created demand,

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148. *See* Sloan & Feldman, *Competition Among Physicians*, in COMPETITION IN THE HEALTH CARE SECTOR, *supra* note 20, at 81-85.

149. 42 U.S.C. § 1320c-1(b)(1)(A) (1976 & Supp. I 1977).

150. *See* Havighurst & Blumstein, *supra* note 10, at 47-51.

151. 42 U.S.C. § 1320c-16(c) (1976). *See* Note, *Federally Imposed Self-Regulation of Medical Practice: A Critique of the Professional Standards Review Organization*, 42 GEO. WASH. L. REV. 822, 838-42 (1974); Comment, *PSRO: Malpractice Liability and the Impact of the Civil Immunity Clause*, 62 GEO. L.J. 1499 (1974).

152. *See* Havighurst & Blumstein, *supra* note 10, at 47-51.

PSROs may legitimize community practice. Even worse, PSROs may serve as a convenient forum, probably immune from antitrust liability, in which physicians acting collectively may increase rather than reduce levels of utilization.[153] All the while, the PSRO can camouflage this type of economic collusion under the guise of quality assurance. It is no wonder that the PSRO program is seriously being considered for elimination.[154]

3. Lack of Proper Institutional Incentives

Three types of limitations are common to existing federal regulatory programs—geographical orientation, limited regulatory jurisdiction, and lack of a predetermined budget.

(a) Geographical Orientation

Although the geographical approach to jurisdiction of regulatory agencies serves valid policy objectives, it also has serious drawbacks. A regional regulatory body, such as a PSRO or an HSA, has no institutional reason to act in a tight-fisted manner. Since third parties pay for nearly all hospital expenses and since most of those payments come from the federal treasury, a regional regulatory body will aggressively pursue cost containment only out of an abstract commitment to the goal. It is all too easy to rationalize permissive regulatory policies as promoting improved quality of or access to care. The agency will be particularly reluctant to take a tight-fisted approach when its own constituents bear the adverse effect of an aggressive cost-containment strategy and the benefits of reducing costs are spread widely, among all federal taxpayers in the case of Medicare.

In order for the system to function properly, therefore, regional agencies must rely on an implicit reciprocity of regulatory philosophy among regulatory bodies across regions and states. Even assuming agreement on philosophy, however, the absence of an enforcement mechanism and the varying political viewpoints in different parts of the nation make it difficult to enforce any understandings. Thus, when a tight-fisted local PSRO causes the community to lose federal health dollars, neither the PSRO itself, the deprived patient, nor the individual provider receives any apparent reward.[155] Indeed, the physician members of the PSRO may face

153. *Id.* at 53-54, 66-67.

154. *See* [1981] 4 MEDICARE & MEDICAID GUIDE (CCH), Report Letter #318, at 1.

155. *See* Blumstein, *supra* note 48, at 283-85. *See also* note 46 *supra* and accompany-

the wrath of colleagues angry with negative PSRO decisions since the benefit looms as abstract, hypothetical, and widely dispersed and the real harm is localized, identifiable, and concentrated.[156] Inevitably, the PSRO will back away from a serious effort against escalating costs. Absent institutionalized incentives for minimizing costs, such nonfeasance is all too easily rationalized as a means for improving quality and access.

(b) Limited Jurisdiction

Health planning and CON agencies, rate review bodies, and PSROs exercise very circumscribed substantive jurisdiction. Planning and CON agencies have no authority over utilization. PSROs do not influence capital expenditures or other such cost-generating elements. Neither PSROs nor CON agencies control utilization or capital expenditures in noninstitutional settings; they also exercise no authority over individual or institutional pricing decisions, or federal or private third-party reimbursement schedules. Rate review commissions affect prices or revenues, but they exercise only indirect jurisdiction over utilization and virtually none over capital expenditures. The limited substantive jurisdiction of these regulatory agencies also leads to regulatory fragmentation and problems in interagency cooperation, and the differences in agency composition exacerbate these potential bureaucratic conflicts.

No single agency can predict how its regulatees will respond to regulatory decisions. Because of the lack of consensus on a model of hospital behavior, one cannot accurately predict side effects of specific regulatory decisions.[157] For example, if a capital project is disallowed, will the hospital compensate by hiring additional nurses?[158] If an external authority constrains prices, will the hospital seek to lengthen stays or reduce its teaching and community outreach efforts? What side effects actually occur in response to particular regulatory activities must be determined by statistical analysis. The state of the theory, however, prevents ruling out undesirable side effects in advance.

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156. *See* Blumstein, *supra* note 48.

157. For a review of alternative theories of hospital behavior, see P. FELDSTEIN, *supra* note 39, at 186; J. NEWHOUSE, *supra* note 20, at 69; Sloan, *The Internal Organization of Hospitals: A Descriptive Study*, 15 HEALTH SERVICES RESEARCH 203 (1980).

158. CON appears to increase hospital demand for labor inputs, including RNs, as a compensatory response to capital regulation. F. SLOAN & B. STEINWALD, *supra* note 115, at 168-70.

The problem of unintended side effects largely reflects the fact that hospital outputs defy measurement in standard units. Although numbers of inpatient days, outpatient visits, and X-rays can be counted, tremendous room exists for variation in the nature of the product in terms of accessibility and convenience, as well as effectiveness. Recent experience with prospective payment on a per case basis demonstrates hospitals' ingenuity in classifying patients to increase allowable reimbursements.[159]

The responses of regulatees to regulatory behavior may well fall outside the purview of the agency in question. Thus, a regulatee might play off one agency against another. Moreover, because the regulatory bodies have different compositions, they will not all have uniform or even similar value preferences in terms of overall regulatory objectives.[160] Overall costs of regulation should include the private sector resources allocated to "beating the system" and the program distortions that arise from a form of regulatory whipsawing.

(c) Lack of Predetermined Budget

Because of the absence of any ceiling on capital expenditures for an area, a capital-facilities regulator faces asymmetric gains and losses. Approval of a project at Hospital *A* does not affect funds available for a project at Hospital *B*. Moreover, the agency is not explicitly rewarded for policing a "wasteful" outlay of public funds at Hospital *A*.[161] The agency does, however, face potential political pressure from *A*, which is difficult to resist in view of the amorphous concept of need on which the adverse decision was probably based and the speculative nature of the local benefits that accrue from a tough-minded, cost-conscious decision. A similar phenomenon occurs for PSROs that establish norms of care and apply those norms without any predetermined budget. As a consequence, the PSRO need not directly confront quality/cost tradeoffs. With open-ended funding, a PSRO can approve medical services without perceiving a direct, negative consequence to any other potential beneficiary within its jurisdiction.

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159. For a discussion of recent experience in New Jersey with Diagnosis Related Groups (DRGs) and per case payment, see Larson, *Hospital Program to Charge by the Ailment Raises Questions of Health Care Quality*, Wall St. J., Nov. 4, 1980, at 23, col. 3.

160. *See* Blumstein & Sloan, *supra* note 22, at 15-16.

161. In response to this problem, the Carter Administration proposed hospital capital expenditure limits. *See* Blumstein & Sloan, *supra* note 22; Dunn & Lefkowitz, *supra* note 71.

The lack of a predetermined budget suggests that neither CON agencies nor PSROs will perceive allocation decisions in either/or terms. Rather, they will typically view them in yes/no terms, because it is easier to say "yes" when to say "no" results in no visible or discernible benefit to anyone in the agency's jurisdiction.

The cost effectiveness of health maintenance organizations (HMOs), which live within predetermined budgets, is the conceptual paradigm for PR regulatory programs.[162] The goal of the HMO is to place providers "at risk," so that they will have an incentive to count costs while presumably delivering care to a covered population that is in its collective best interest. The objective is to have a provider institution look at quality in macro terms for an entire group, not to focus exclusively on micro quality—that is, the individual physician-patient encounter.

PR agencies administering "mature" programs have had some success in restraining cost escalation by negotiating a predetermined level of prices or, as in two states, revenues.[163] The principle of holding provider institutions at risk seems successful when transferred from the HMO to the regulatory arena. Most state PR agencies, however, cannot control total levels of utilization, and in a political climate the negotiated levels of prospective budgets may be subject to manipulation absent market-generated pressures for keeping prices and costs under control.

4. Equity

Several considerations relating to equity in the health care system must be kept in mind when reviewing the regulatory efforts. First, because facilities-services regulators lack decertification powers, the burden of adjusting to the need standard falls on prospective entrants. To the extent that the new entrant would provide more efficient and effective services, this type of regulation has efficiency as well as equity implications. The 1979 amendments

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162. HMOs are a form of prepaid group practice. Consumers pay a specified fee negotiated in advance, and providers are obligated to provide an agreed upon range of services for that fee. Providers, thus, must live within a fixed budget in delivering care to a defined population. Since they are responsible for cost overruns, the providers are "at risk" financially. *See generally* Luft, *Assessing the Evidence in HMO Performance*, 58 MILBANK MEMORIAL FUND Q.: HEALTH & SOC'Y 501 (1980); Wolinsky, *The Performance of Health Maintenance Organizations: An Analytic Review*, 58 MILBANK MEMORIAL FUND Q.: HEALTH & SOC'Y 537 (1980).

163. *See* Sloan, *supra* note 117.

to the federal health planning act, which largely exempt HMOs from coverage under CON,[164] ameliorated some of the most pernicious consequences of this phenomenon. Second, as a practical matter, prospective rates or budgets are typically set with reference to levels of cost in a base period. This rewards the profligate hospital for its waste and at the same time penalizes the efficient hospital for its efficiency. Any other reference standard for rate-revenue setting, however, would probably be seen as potentially too disruptive. Third, price regulation "with teeth" contains cost by creating a contrived scarcity of supply and thus an excess in demand. In contrast, various nonprice mechanisms—for example, lengthening queues and deterioration in quality and amenities—are used to balance supply and demand. Nonprice rationing imposes high costs on consumers that do not appear in public budgets, but are very real and not necessarily fairly or efficiently distributed.

5. Other Practical and Political Considerations

A real question exists whether citizen participation can be of value in providing a balanced perspective in regulatory bodies.[165] PSROs have only physician membership, but HSAs must be composed of a majority of nonproviders.[166] Providers and consumers as a group are likely to have similar views on the overriding issues of cost containment and balancing the goals of quality, cost, and access. Given the structure and institutional incentives, all participants have a stake in more and better services.

Disputes may arise, however, between different groups of consumers. A typical debate concerns the relative importance to be attached to the needs of underserved populations as weighed against the desires of other groups for even higher quality services.[167] Recent federal CON regulations, by establishing result-oriented provisions about adverse effects on underserved populations,[168] appear to recognize that consumer representation alone

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164. 42 U.S.C. § 300m-6(b) (Supp. III 1979); *see* 45 Fed. Reg. 69,740, 69,748 (1980) (to be codified at 42 C.F.R. § 123.405); Havighurst, *Prospects for Competition under Health Planning-cum-Regulation,* in NATIONAL HEALTH INSURANCE: WHAT NOW, *supra* note 53, at 329.

165. *See* Marmor & Morone, *Representing Consumer Interests: Imbalanced Markets, Health Planning, and the HSAs,* 58 MILBANK MEMORIAL FUND Q.: HEALTH & SOC'Y 125 (1980).

166. *Id.* at 131.

167. *See generally* Marmor & Morone, *supra* note 165.

168. 45 Fed. Reg. 69,740, 69,741, 69,752-54 (1980) (to be codified at 42 C.F.R. §§

will not assure a legitimate airing of these distributive issues or ensure an outcome favorable to underserved groups. Moreover, because of the highly technical nature of many regulatory decisions, providers strongly influence agencies even when consumers are present. Overall, consumer representation in the regulatory process is unlikely to constrain the allocative process, though it may affect the distribution of health care resources.

Additionally, some question exists whether a form of regulation that is truly successful in containing costs will be allowed to function without externally imposed constraints. For example, New York's rate regulation program, which may have reduced hospital costs below what they otherwise might have been, apparently adversely affected some hospitals servicing low-income populations.[169] A major political flap ensued, and the prospective closing of at least one hospital was challenged in federal court[170] on the ground that any such action having a disproportionate impact on a minority group was illegal under Title VI of the 1964 Civil Rights Act.[171] Although that particular lawsuit was unsuccessful, the federal Department of Health and Human Services (HHS) supported plaintiffs' legal position.[172]

Adoption of a disproportionate impact theory could have far-reaching consequences for programs designed to contain costs. While the Second Circuit declined to adopt the effects test of dis-

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123.412(a)(5)-(6), .413).

The former administrator of the Health Resources Administration of the Department of Health and Human Services, Henry A. Foley, acknowledges that consumers in the planning process are typically most interested in access issues and that providers are most concerned with questions of quality. He views health planning as a "mechanism for promoting pragmatic bargaining about the development of community resources to meet problems of access . . . ." Foley, *Health Planning—Demise or Reformation,* 304 NEW ENG. J. MED. 969, 970 (1981). Foley does not see health planning as a strong tool for cost containment ("the government oversold the cost-containment aspects of health planning," *id.* at 972.); he advocates recognition that the planning process provides "a forum for negotiation about the allocation of resources at the local level, and a mechanism for educating the public about the health-care system." *Id.* at 972. Foley assumes, apparently, that the overall level of resources will he set by some other device, but he does not specify what method is to be used.

169. For a general discussion of hospital closures in New York City, see UNITED HOSPITAL FUND, 2 PROCEEDINGS OF THE HEALTH POLICY FORUM ON HOSPITAL CLOSURES IN NEW YORK CITY, OCTOBER 26-27, 1978 (1980).

170. *See* Bryan v. Koch, 492 F. Supp. 212 (S.D.N.Y.), *aff'd,* 627 F.2d 612 (2d Cir. 1980).

171. Section 601 of the 1964 Civil Rights Act provides as follows: "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." 42 U.S.C. § 2000d (1976).

172. 627 F.2d at 615 n.1.

crimination under Title VI in the Sydenham Hospital litigation,[173] HHS seems to have imposed that standard in its most recent CON regulations.[174] Thus, when a health care facility seeks to reduce or eliminate a service, CON agency review is triggered.[175] One of the factors the reviewing agency must consider is the effect of the reduction, elimination, or relocation of services on the ability of underserved groups to obtain health care.[176] Of all the criteria specified in the regulations,[177] only the effect that an agency determination will have on access to care by underserved groups must be the basis of a specific agency finding.[178]

This access provision raises weighty political issues for any serious regulatory cost containment strategy. Given the requirement for specific access findings, it is more difficult for a regulatory agency to withstand the political pressure that surely will come from the termination of a service or the closing or even bankruptcy of a hospital as part of a policy of fiscal stringency. One of the serious risks of a successful rate-revenue control program is that it will result in hospital failure and that the failure rates will have a disproportionate impact on underserved populations. If the affected groups are able to offset those consequences either in court or in the political arena, the cost-reducing effects of the rate-revenue programs will be vitiated.

E. Planning for Competition

Largely in response to the general political climate in the United States favoring deregulation of certain key sectors, the paucity of demonstrated successes of health planning in particular, and the overall institutional critique of existing health regulation

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173. The court declined to rule on whether a finding of a Title VI violation requires a showing of discriminatory intent or racially disproportionate impact. *Id.* at 615. At least one panel of the Second Circuit, however, has concluded that discriminatory purpose is the proper standard under Title VI. Lora v. Board of Educ., 623 F.2d 248, 250 (2d Cir. 1980); *accord*, Bryan v. Koch, 492 F. Supp. 212 (S.D.N.Y. 1980).

174. *See* 45 Fed. Reg. 69,740, 69,752-53 (1980) (to be codified at 42 C.F.R. § 123.412(5)(ii)). These regulations are consistent with the federal government's Title VI regulations. *See* 45 C.F.R. § 80.3(b)(2) (1980). *See generally* Bryan v. Koch, 627 F.2d 612, 621-23 (2d Cir. 1980) (Kearse, J., dissenting).

175. 45 Fed. Reg. 69,740-41, 69,747, 69,752 (1980) (to be codified at 42 C.F.R. §§ 123.404(a)(i)(B), .412(a)(5)(ii)).

176. 45 Fed. Reg. 69,740, 69,752 (1980) (to be codified at 42 C.F.R. § 123.412(a)(5)(ii)).

177. The CON regulations specify 21 criteria. 45 Fed. Reg. 69,740, 69,752-53 (1980) (to be codified at 42 C.F.R. § 123.412).

178. 45 Fed. Reg. 69,740, 69,745, 69,753-54 (1980) (to be codified at 42 C.F.R. §§ 122.311, 123.413). *See also* 45 Fed. Reg. 69,772-73 (1980).

programs, there has been a growing sentiment for using health planning and regulation to promote competition.[179] Although this may seem a contradiction in terms, proponents of this strategy have offered specifics. For example, the National Chamber Foundation has suggested that planners might develop a climate that fosters competition by doing some or all of the following: (1) developing constituencies for market-oriented approaches to health care in the local business community, among consumers, labor, health insurers, government, and other potentially interested parties; (2) promoting the development of alternative delivery systems (ADS), including prepaid group practices, independent practice associations (IPA), health care alliances, and HMOs; (3) assisting in recruiting enrollees for alternatives to the fee-for-service system; (4) easing regulatory restrictions that impede entry of ADS; (5) enforcing antitrust measures to eliminate anticompetitive collective actions by providers; (6) encouraging businesses, unions, and insurers to offer multiple-choice benefit plans to employees and facilitating informed choices among the options by encouraging health-education campaigns, physician directories, and the like; (7) promoting enrollment of Medicare and Medicaid eligibles in efficient delivery systems; and (8) serving as an independent source of information on the quality of care provided in the area.[180]

Most of these activities represent a dramatic departure from past and present planning-regulatory agency practices. The agenda for planner-regulators proposed by the National Chamber Foundation raises a number of interesting questions. To date, the principal role of health planning has been to develop health plans for geographic areas and evaluate the merits of specific proposals by institutions that are contemplating specific investments and/or service changes.[181] At the same time, planners have functioned under rather severe budget limitations. Thus, it is questionable whether planning agencies have the resources, the know-how, the inclination, or the incentives to accept these new responsibilities. Despite the hopeful comments of some market proponents who wish to

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179. *See* Havighurst, *supra* note 164.

180. NATIONAL CHAMBER FOUNDATION, A NATIONAL HEALTH CARE STRATEGY: HOW BUSINESS CAN IMPROVE HEALTH AND REGULATION 17-18 (1978).

181. *See* Atkisson & Grimes, *Health Planning in the United States: An Old Idea with a New Significance*, 1 J. HEALTH POL., POL'Y & L. 295 (1976); Blumstein & Sloan, *supra* note 22; Bovbjerg, *supra* note 32; O'Connor, *Comprehensive Health Planning: Dreams and Realities*, 52 MILBANK MEMORIAL FUND Q.: HEALTH & SOC'Y 391 (1974); West & Stevens, *Comparative Analysis of Community Health Planning: Transition from CHPs to HSAs*, 1 J. HEALTH POL., POL'Y & L. 173 (1976).

take advantage of the enthusiasm of a closet Alfred Kahn here or there on an HSA staff,[182] a very serious question exists about whether HSAs or other health planning units have a comparative advantage in or an adequate legal mandate for spearheading deregulation or promoting alternative delivery systems. More fundamentally, if the failure of market forces in health care is attributable to current methods of paying for health services,[183] it would seem essential that a viable competitive alternative address this basic source of the problem rather than become distracted with potentially time-consuming but eventually meaningless regulatory tinkering. The issue, in sum, is whether proposals for a procompetitive planning-regulation strategy truly represent a constructive alternative course of action or whether they are merely diversionary "makework" for an institutional apparatus whose time has passed.

The federal Health Planning and Resources Development Amendments of 1979[184] embody an important recent example of the application of the procompetitive approach to planning and regulation. Although the federal legislation is much more modest than the changes suggested by the National Chamber Foundation, it nevertheless represents a dramatic departure from past legislative attitudes toward planning-regulation. The 1979 health planning amendments explicitly recognize the promotion of competition as a desired goal of federal health policy.[185] This is quite a change from the attitude evidenced in the legislative history of the 1974 health planning act when the Senate report stated, "[T]he health services industry does not respond to classic market forces."[186] The 1979 report observed that the industry "has not to date responded"[187] to market forces but implicitly expressed the hope that competition and the market could be put to productive

182. *See* Havighurst, *supra* note 164, at 351.

183. *See* H. FRECH & P. GINSBURG, *supra* note 50, at 21-22; J. KRIZAY & A. WILSON, *supra* note 52, at 30-31.

184. Pub. L. No. 96-79, 93 Stat. 592 (1979). Utah's procompetitive CON legislation, enacted in March 1979, is discussed below at note 213. *See also* Havighurst, *supra* note 164, at 338-39.

185. 42 U.S.C. § 300k-2(a)(17),-(b)(3) (Supp. III 1979).

186. SENATE COMM. ON LABOR AND PUBLIC WELFARE, NATIONAL HEALTH PLANNING AND DEVELOPMENT AND HEALTH FACILITIES ASSISTANCE ACT OF 1974, S. REP. No. 93-1285, 93d Cong., 2d Sess. (1974) (to accompany S. 2994), *reprinted in* [1974] U.S. CODE CONG. & AD. NEWS 7842.

187. SENATE COMM. ON LABOR AND HUMAN RESOURCES, HEALTH PLANNING AMENDMENTS OF 1979, S. REP. No. 96-96, 96th Cong., 1st Sess. 52 (1979) (to accompany S. 544).

use in the health sector.[188]

The 1979 legislation appears to have adopted the view that regulation is appropriate as an antidote for existing or inherent market failure. Legislative findings noted that the effect of competition on the supply of health facilities and services is presently diminished because of "prevailing methods of paying for health services by public and private insurers, particularly for inpatient health services and other institutional health services."[189] When competition "does not or will not appropriately allocate supply,"[190] the amendments provide that planning agencies should "give priority . . . to actions which would strengthen the effect of competition on the supply of such services."[191]

These modest procompetition goals, while representing a considerable change of attitude from the 1974 health planning legislation, suffer from the same deficiencies as the other planning goals: they are long on aspiration but short on implementation.[192] On the other hand, the 1979 legislation does mandate the virtual exemption of HMOs from coverage under CON.[193] Critics had argued that given the fact that HMOs already face sufficient cost-containment incentives, they should not be required to undergo the CON process.[194] If anything, CON, as applied to HMOs, could prevent the entry of a major source of competition to traditional fee-for-service providers.[195] The mandatory HMO exemption from CON is a legitimate step toward recognizing, in a substantive way, the desirability of allowing market forces to operate where they can.

Despite their hope that regulations implementing the amendments' procompetition sections would be developed imaginatively,[196] Havighurst and Hackbarth, writing in May 1980, were realistically sober in recognizing that the HHS "record of hostility to the market . . . cast[s] doubt on its willingness to take the new mandate seriously."[197] Unfortunately, the skepticism about HHS's

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188. *See* Havighurst & Hackharth, *supra* note 21.

189. 42 U.S.C. § 300k-2(b)(1) (Supp. III 1979).

190. 42 U.S.C. § 300k-2(b)(2) (Supp. III 1979).

191. 42 U.S.C. § 300k-2(b)(3) (Supp. III 1979).

192. *See* Blumstein & Sloan, *supra* note 22, at 17-19.

193. 42 U.S.C. § 300m-6(b) (Supp. III 1979).

194. *See* Havighurst, *Health Maintenance Organizations and Health Planners*, 1978 UTAH L. REV. 123, 140-54.

195. *Id.*

196. For example, the regulations might have required findings on the impact of proposals on competition.

197. Havighurst & Hackbarth, *supra* note 21, at 46.

intentions was well founded. The regulations, published in October 1980, make only a token response to the statutory competitive initiative. Sections 123.412(a)(17) and (18),[198] which establish the competitive review criteria, border on unintelligibility,[199] and the HHS explanation of its competition criteria is hardly more enlightening.[200] The Department promised a monograph on how competition should be included in health plans, but it declined to permit exemptions from CON review or to require "individual determinations [of competitive impact] as applications are being reviewed."[201]

On the other hand, HHS felt perfectly at ease in imposing even greater regulatory control on facilities and equipment decisions, expanding CON review to encompass termination as well as expansion, and making its replacement decisions in the name of access equity.[202] Although the regulations require no findings on competitive effect, they do mandate specific findings on access for underserved populations.[203] Apparently, the portion of the regulations implementing the HMO exemption provisions was adopted[204] only because the statute commanded an exemption.[205]

Thus, HHS hostility to the role of competition, as reflected in its October 1980 CON regulations, has short-circuited the procompetitive initiative, except for the HMO exemption, at least for the time being. Even if HHS suddenly has a change of heart under the stewardship of Secretary Richard Schweiker,[206] it is doubtful that

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198. 45 Fed. Reg. 69,740, 69,753 (1980) (to be codified in 42 C.F.R. § 123.412(a)(17) - (18)).

199. For example, the regulations provide that state planning agencies conducting CON reviews must consider "the factors which affect the effect of competition on the supply of health services being reviewed." *Id.*

200. *Id.* at 69,771.

201. *Id.*

202. *See id.* at 69,740-41, 69,757-58, 69,768-70, 69,772-73.

203. *Id.* at 69,753-54 (to be codified in 42 C.F.R. § 123.413).

204. *Id.* at 69,748-49 (to he codified in 42 C.F.R. § 123.405).

205. In explaining its CON regulations on HMOs, HHS noted some dissatisfaction with the exemption of HMOs from CON. HHS observed that the statute, not the "Department's interpretation" of the statute, "required" special consideration be given to HMOs. "In general," noted HHS, it has "little latitude in setting forth the certificate of need requirements for HMOs . . . ." *Id.* at 69,760.

206. Early indications have not been as promising as one might have hoped. For example, Secretary Schweiker at one point prohibited Food and Drug Administration approval of generic prescription drugs unless the drugs undergo independent testing, which is costly and time consuming. The extra testing, which would slow competition with brand drugs whose patents expire, would have been required even though the generic drugs duplicate drugs sold under patent for seventeen years. *See* Mecham, *Reagan, Big Drug Firms Said Linked,* Nashville Tennessean, March 11, 1981, at 2, col. 6.

the change per se could have a dramatic impact on health care markets.

First, changes in health care financing are beyond the scope of health planning legislation, and, as Congress acknowledged in the 1979 amendments, health care market failure is largely attributable to current payment practices.[207] Second, while as Congress has recognized,[208] insurance is the dominant source of payment for inpatient care, a sizeable portion of the health system is not dominated by insurance. The Congress, however, has not granted planning agencies jurisdiction over parts of the health system in which insurance is less dominant, such as offices of physicians and dentists. Thus, even if HHS aggressively committed itself to competition, it is not clear that it could implement subsection 1502(b)(3)[209] in a meaningful or effective manner. Third, the 1979 amendments do not change important features of state CON laws that have contributed to past regulatory failures. Importantly, planner-regulators are not explicitly rewarded for fostering efficiency. Even if the planners had jurisdiction over noninstitutional providers, they have no incentive to undertake actions that, while procompetitive, may be strenuously opposed by existing providers.[210]

In sum, the 1979 health planning amendments may have reopened the debate about the possible role of competition in health care. HHS's implementing regulations, however, do not pick up on this opportunity to promote competition by planning and regulation. Some question exists whether even a willing HHS could make much of an impact, although the HMO exemption probably is an experiment worth monitoring. Since the present planning-for-competition approach is so narrowly focused—without jurisdiction, for example, over reimbursement, revenues, or levels of utilization—it falls far short of the reformist agenda necessary for a fair market test of competition in the health sector. It is too soon to tell

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After considerable political pressure from Representative Albert Gore, Jr., among others, Secretary Schweiker apparently reversed his initial decision. *See* Wall St. J., April 17, 1981, at 1, col. 3. For a fuller story, see *Reversing Policy, U.S. Eases Path to Generic Drugs*, Nashville Tennessean, April 17, 1981, at 1, col. 6.

207. 42 U.S.C. § 300k-2(b)(1) (Supp. III 1979).

208. *Id. See also* 42 U.S.C. § 300k-2(b)(2) (Supp. III 1979).

209. 42 U.S.C. § 300k-3(b)(3) (Supp. III 1979). *See* text accompanying note 191 *supra.*

210. A recent proposal by Walter McClure for a local incentive health care surtax, which explicitly rewards cost saving actions undertaken at the local level by area HSAs and other parties, may be a step toward correcting this problem. *See* McClure, *An Incentive Tax in Medicare, Medicaid, and National Health Insurance*, 5 J. HEALTH POL., POL'Y & L. 10 (1980).

whether the amendments are worthwhile as a tactical move in the right direction, a bellwether.[211]

IV. Emergent Directions in Health Policy

Whereas procompetitive regulation engrafts concepts of competition onto a framework of controls over health care suppliers, market-perfecting or incentive approaches to reform start from the opposite direction. The regulatory strategy focuses on the need to limit hospital prices, utilization, revenues and capital expenditures, and physicians' fees; the market-perfecting approaches seek to achieve cost containment by enabling consumers to make choices in the health care marketplace and by providing them with appropriate incentives. While a role for some regulation is acknowledged, incentives approaches emphasize rules that are designed principally to improve consumer decisionmaking or otherwise nurture the institutional structure of the competitive marketplace.[212]

Advocates of market-oriented approaches fall into two camps. The first emphasizes consumer cost-consciousness by advocating the introduction of deductibles and coinsurance, perhaps with a

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211. In 1979 Utah enacted a CON law which recognizes in its statement of purpose that "the degree to which competition and consumer choice can constructively serve the public purposes of quality assurance, cost containment and responsiveness to consumers' preferences varies from service to service and place to place." Utah Code Ann. § 26-34-2(2) (Supp. 1979). The Act requires that the state planning apparatus consider as part of the CON review of a specific project:

> The relationship of the project proposed to be provided to the existing health care system of the area in which such project is proposed to be provided, including the effect of the proposed facility or service on the maintenance of competitive conditions in the local market; in assessing the relationship of proposed services to the existing health care system, any consideration given to the ability of an existing provider to continue to offer service of this or a similar type shall be contained in the findings required . . . .

Id. at § 26-34-11(f).

The Utah CON law recognizes, as do the 1979 Amendments enacted at the federal level, the potential benefits which derive from competition in the health care market. The law, however, applies only to health care facilities, a term that encompasses hospitals, nursing homes, ambulatory surgical units, HMOs (specificially excluded by the federal 1979 Amendments), and home health agencies, excluding physicians' offices. Under the Utah law, planners still react to proposed projects rather than initiating them. Thus, the planner has no incentives to promote competition. Furthermore, planners may interpret the Utah CON law's statement of purpose as a license to protect the "ins" against potential efficient competitors.

The Utah law is still new, and it is too early to assess this marriage of the planning-regulation and market-oriented approaches. Utah's recognition that competition provides an alternative worth trying is commendable. Yet, it would appear, especially when one considers previous evidence with CON, that circumstances warrant a more radical solution.

212. *See, e.g.*, Blumstein & Zubkoff, *supra* note 22, at 382-87.

ceiling on patient out-of-pocket payments that may vary directly with household income. This strategy preserves the fee-for-service payment system. Underlying this approach is the notion that consumers will learn to choose among alternatives since they are likely to pay out of their own pockets for a proportion of any extra expenses. Furthermore, this approach assumes cost-conscious consumers or their information intermediaries will encourage providers to conserve scarce health care resources.[213]

The second strategy emphasizes the role of competition between various types of ADSs and the fee-for-service system.[214] Proponents of this strategy contend that, if presented with alternative sets of "prepackaged" services, consumers can make informed decisions about quantity, quality, and price embodied in the alternative packages. When they are well, consumers are in a position to seek out information and to make a sensible selection. When patients are confronted with illness and a potentially major expense, rational consumer choice may be more difficult.

Although they agree that the most desirable road to cost containment is through strengthening the hand of the consumer, advocates of each approach find deficiencies in the other. Proponents of the copayment strategy are skeptical about ADSs for three reasons. First, although some types of ADSs have been devised rather recently, the concept underlying the major ADS, prepaid group practice, has been around for years. Proponents of copayment wonder why, if this concept is so attractive to consumers and providers, the growth of prepaid groups has been so slow.[215] They contend that it is imprudent to design health policy strategy around systems that currently account for an insignificant share of the total health care sector.[216] Second, they wonder to what extent the cost savings attributable to ADSs are real. A substantial proportion of the savings may be due to preferred case selection[217] and out-of-

213. *See* Seidman, *supra* note 53.

214. *See, e.g.*, A. ENTHOVEN, *supra* note 34; McClure, *On Broadening the Definition of and Removing Regulatory Barriers to a Competitive Health Care System*, 3 J. HEALTH POL., POL'Y & L. 303 (1978).

215. *See generally* McNeil & Schlenker, *HMOs, Competition, and Government*, 53 MILBANK MEMORIAL FUND Q.: HEALTH & SOC'Y 195 (1975).

216. Eli Ginzberg and others have made this point in discussions of competitive alternatives to health care delivery. *See* Ginzberg, *supra* note 73, at 1112-13.

217. Empirical analysis of patient choices between HMO and traditional fee-for-service plans reveals no differences in health status between persons who select HMOs and those who select fee-for-service plans. *See* Berki & Ashcraft, *HMO Enrollment: Who Joins and Why: A Review of the Literature*, 58 MILBANK MEMORIAL FUND Q.: HEALTH & SOC'Y 588, 626 (1980). Past studies have focused on employed persons' choices of plans. Evidence

plan use may not be recorded as an ADS expense.[218] If ADSs' market share were expanded from less than ten percent to, say, fifty percent or more of the market, would the reported cost savings persist? Payments to providers—for example, compensation for loss of professional independence—might have to rise to recruit providers not otherwise inclined to join ADS plans. These latter-day recruits may not be as cost-conscious as their colleagues who, perhaps out of a sense of predisposition or commitment, joined ADS plans initially.[219] Last, an ADS is fine so long as the patient is healthy. One wonders, however, whether, when serious illness strikes, the patient will be satisfied with ADS providers' choices of doctors and modes of treatment. For this reason alone, patients with relatively high probabilities of serious illness may eschew ADSs.

Similarly, proponents of the ADS-oriented approach find various deficiencies in the cost-sharing strategy. First, they reason that physicians have the capacity to control demand for their services. Under fee-for-service systems, each extra service generated is a source of extra revenue for the provider. The copayment approach may reduce supplier-induced demand, but not by much because political considerations narrow the range of acceptable coinsurance rates. With ADS sytems, however, extra service means a lower profit. Thus, even if the provider had demand-generating power, he would not exercise it if part of an ADS.[220] Second, copayment is unrealistic for inpatient services, which are the source of much of the cost problem.[221] After all, the patient's expense is likely to ex-

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on choices by the aged and unemployed is needed.

218. According to Professor Luft, *supra* note 162, at 511, 519, outside use of prepaid group practice plans accounts for 7% to 14% of all services that members receive. Therefore, out-of-plan use does not offset the estimated cost saving of 10% to 40% attributed to prepaid group practice over conventional fee-for-service.

219. The body of empirical research on physician satisfaction with prepaid group practice, the only ADS with a long history, is still rather meager. *See, e.g.*, R. HETHERINGTON, C. HOPKINS & M. ROEMER, HEALTH INSURANCE PLANS: PROMISE AND PERFORMANCE (1975); D. MECHANIC, THE GROWTH OF BUREAUCRATIC MEDICINE (1975); Freidson, *Prepaid Group Practice and the New "Demanding Patient,"* 51 MILBANK MEMORIAL FUND Q.: HEALTH & SOC'Y 473 (1973); Mechanic, *The Organization of Medical Practice and Practice Orientation Among Physicians in Prepaid and Nonprepaid Primary Care Settings*, 13 MED. CARE 189 (1975).

220. Economists have debated the issue of physician-induced demand at length. *See, e.g.*, Reinhardt, *Comment*, in COMPETITION IN THE HEALTH CARE SECTOR, *supra* note 20, at 121; Sloan & Feldman, *Competition Among Physicians*, in COMPETITION IN THE HEALTH CARE SECTOR, *supra* note 20, at 45.

221. *See* Newhouse, *Commentary*, in NATIONAL HEALTH INSURANCE: WHAT NOW, *supra* note 53, at 371.

ceed any politically palatable deductible on the first inpatient day. If the plan's out-of-pocket ceiling is set at a level consistent with moderate risk protection, the expense will soon reach the region of full insurance coverage, at which point neither the patient nor his physician-agent has any incentive to conserve hospital resources. On the other hand, if the ceiling is raised for efficiency reasons, the patient assumes a high degree of risk. Third, with an ADS, consumers make decisions about care before they are confronted with an illness. The copayment strategy, however, if it is to succeed, requires patients to make tough choices among providers at a time when they are ill-equipped to do so.

Fortunately, the incentive approach does not require that society act collectively to choose between the two strategies. Rather, once a set of incentives has been established, market forces can decide.

The questions raised by the two camps, however, do suggest a need for considerably more thought as well as further empirical research on both of these competitive strategies. Further research is especially important because the normative and prudential attractiveness of competitive alternatives, in combination with the empirical and structural critiques of the regulatory approach, have led to active examination of market-perfecting strategies.[222]

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222. During the 96th Congress, a numher of bills incorporating the incentive approach were introduced by Senators Durenherger (S. 1968, 96th Cong., 1st Sess. (1979)), and Schweiker (S. 1590, 96th Cong., 1st Sess. (1979)), and Representatives Jones (H.R. 7528, 96th Cong., 2d Sess. (1980)), Martin (H.R. 6405, 96th Cong., 2d Sess. (1980)), Gephardt and Stockman (H.R. 7527, 96th Cong., 2d Sess. (1980)), and Ullman (H.R. 5740, 96th Cong., 1st Sess. (1979)). Although each differs in details, the essence of each bill is to eschew the regulatory approach in favor of (1) limits on the tax-free premium an employer may contribute to a health plan; (2) requirements that employers offer employees choices among health plans; and (3) incentives for consumer cost consciousness—for example, employees who select a lower cost health plan would be allowed to retain the savings in premiums or, if a more costly alternative is selected, to pay out of pocket the excess premium over the fixed employer health plan contribution. Even though the plans taken as a group are more in accord with the market-oriented strategy that relies on provider cost consciousness, they do not eliminate fee-for-service.

The desigu of market-oriented health legislation is by no means straightforward. These are some of the thorny issues that should be considered. Their complexity, and the controversy among market-oriented proponents about provider versus consumer-based approaches, explain in part why the 96th Congress enacted none of the above bills into law.

First, although the fee-for-service system has often been defended on the ground that it provides "freedom of choice," there is a valid question whether this is in fact so, since employers seldom offer employees a range of options from which to choose. And, if given a choice, the employee rarely reaps all or even part of the savings from selecting an option with a lower premium. *See* A. ENTHOVEN, *supra* note 34, at 72. For competition to work, employees must have both choices and explicit incentives. But employers and/or labor un-

The developments to be considered next in this section either are aimed at or may have the effect of restoring a system of decentralized decisionmaking by overcoming market imperfections or otherwise reestablishing incentives for private choice. In short, when there are deviations from ideal market conditions, these approaches seek to alleviate the problem rather than substitute a regulatory for a competitive system.

A. *The Commercial Speech Doctrine*

In 1976 the Supreme Court gave impetus to the competitive alternative, albeit in a perhaps unintended manner. Prior to the decision in *Virginia State Board of Pharmacy v. Virginia Citizens*

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ions can claim that offering options is costly. The extent to which mandatory choice will raise administrative costs to employers is unknown; hut the fact that few employers have offered it historically at least suggests that tlie cost may not be negligible.

Second, if a tax credit is to be granted for the purchase of insurance, which plans are to qualify for the credit? Presumably, Congress could decide to eliminate all current preferential treatment of health insurance purchases under the current U.S. tax code and return tlie extra tax revenue gained thereby in tlie form of tax credits, lower marginal rates on personal and/or corporate incomė taxes, public expenditures on otlier programs or combinations thereof. Society, however, appears to liave a special concern for health care, and tliis option has not yet been politically viable. Therefore, a qualified plan must be defined by statute and/or regulation. If the standard is set too low, a potential adverse selection problem may arise. A healtliy person might select a low option plan, at least while healthy. When illness strikes, he may decide to join liis sicker compatriots in the high option plan. But if tlie high option plan contains a disproportionate number of sick persons, however, its premium will be unduly high. *See* Enthoven, *Supply Side Economics of Health Care and Consumer Choice Health Plan,* in HEALTH CARE, *supra* note 121. Some experts, such as Jack Meyer, liave argued tliat this is not a serious problem since most insurance under these proposals would remain employer-based and experience-rating would be by firm or plant ratlier tliaп by individual. *See* Meyer, *Health Care Competition: Are Tax Incentives Enough?,* in HEALTH CARE, *supra* note 121. Meyer's comment implicitly assumes that employee liealth status within a group is reasonably liomogenous. In any event, this problem does not exist if high minimum standards are set in order for the plan to qualify for tax credits. High standards may, liowever, (1) force some persons to purcliase much more insurance tliaп their tastes and financial resources dictate, (2) encourage some employers to drop liealth insurance altogetlier, a response to the 1974 federal pension reform, (3) cause endless liaggling on tlie part of certain professional groups not currently covered by insurance to be included under the umbrella of liigh minimum standards, and (4) in the final analysis, could possibly raise rather tliaп lower the proportion of gross national product devoted to liealtli care.

Last, proponents of regulation are very concerned about asymmetric information between providers and consumers. If providers currently use their dominant positions in tlie liealth care market to generate unnecessary utilization, will they not underproduce wlien tlieir incentives are reversed? Although economists bave shown tlie welfare loss associated with overuse, *see* Feldstein, *The Welfare Loss of Excess Health Insurance,* 81 J. POLITICAL ECON. 251 (1973), a welfare loss may also be associated with underuse. To guard against such abuses, will regulation against false advertising suffice? Or are more extensive controls on quality needed?

Consumer Council, Inc.,[223] commercial speech by professionals—for example, advertising—was widely prohibited,[224] usually on grounds of professionalism. Although the first amendment bars government from suppressing expression,[225] the generally accepted view, based on Supreme Court decisions, was that commercial speech, which "did no more than propose a commercial transaction,"[226] was so far removed from any "exposition of ideas"[227] that it was not covered by the first amendment at all.[228]

In the *Virginia Board of Pharmacy* decision, the Supreme Court reviewed a Virginia law that prohibited a licensed pharmacist from advertising prices for prescription drugs. The evidence showed that prices of both prescription and nonprescription drugs varied considerably from store to store, even within the same locality.[229] Thus, for example, in Richmond the price of forty Achromycin tablets ranged from $2.59 to $6.00, while elsewhere in the state the price of a given amount of tetracycline ranged from $1.20 to $9.00.[230] The ban on advertising meant that consumers had great difficulty in comparison shopping. As a result, pharmacies that charged high prices were not subject to the constraints of the market because price information was either unobtainable or obtainable only at very high transactions costs.

In rejecting the claim that commercial speech is beyond the purview of the first amendment, the Court noted the importance of "the free flow of commercial information"[231] in the economic marketplace, especially for "the poor, the sick, and . . . the aged" whom the "suppression of . . . drug price information hits the hardest."[232] Indeed, a consumer's interest in commercial messages may well be keener than his interest in the political discourse usually accorded the highest degree of first amendment protection.[233]

The Court's rationale in holding that commercial speech is a form of expression protected under the first amendment rested

223. 425 U.S. 748 (1976).

224. *See* Valentine v. Chrestensen, 316 U.S. 52 (1942).

225. U.S. CONST. amend. I.

226. Pittsburgh Press Co. v. Pittsburgh Comm'n on Human Relations, 413 U.S. 376, 385 (1973).

227. Chaplinksy v. New Hampshire, 315 U.S. 568, 572 (1942).

228. *See* Valentine v. Chrestensen, 316 U.S. 52 (1942).

229. 425 U.S. at 754.

230. *Id.*

231. *Id.* at 763.

232. *Id.*

233. *See generally* Consolidated Edison Co. v. Public Serv. Comm'n, 447 U.S. 530 (1980).

squarely on the vital role that consumer information plays in the economic marketplace. No matter how "tasteless or excessive,"[234] advertising does "disseminat[e] . . . information as to who is producing and selling what product, for what reason, and at what price."[235] In a "free enterprise economy" resources are allocated by "numerous private economic decisions" that should be based on ample information. By facilitating informed decisionmaking, the communication of commercial information serves a societal interest. It improves the functioning of the free market system and thereby increases the likelihood that economic resources will be allocated intelligently. "To this end, the free flow of commercial information is indispensable."[236]

The Court did not accept the state's essentially paternalistic justifications for limiting advertising. The Court observed that "the State's protectiveness of its citizens rests in large measure on the advantages of their being kept in ignorance."[237] The state was concerned that price competition would lower the quality of service and undermine the professional relationship between pharmacist and patient. The Court responded that the first amendment commanded "an alternative to this highly paternalistic approach."[238] Government must assume that information "is not itself harmful, that people will perceive their own best interest if only they are well enough informed, and that the best means to that end is to open the channels of communication rather than to close them."[239] In sum, a state may not protect consumers from themselves by keeping them in ignorance of competitive opportunities in the marketplace, even if those consumers eventually choose to prefer lower quality goods or services at lower prices in preference to goods or services delivered according to professionally determined standards of quality. Provided the choices advertised are legal[240] and the terms of the advertising accurate (*i.e.*, not false, deceptive, or misleading),[241] commercial messages are protected forms of expression under the first amendment.

After the *Virginia Board of Pharmacy* decision, the Court in

234. 425 U.S. at 765.
235. *Id.*
236. *Id.*
237. *Id.* at 769.
238. *Id.* at 770.
239. *Id.*
240. *Id.* at 772.
241. *Id.* at 771 & n.24.

Bates v. State Bar faced the question whether states could prohibit lawyers from advertising the prices at which they perform specified routine services.[242] The Court in *Bates* upheld the first amendment right of lawyers to advertise, rejecting many of the same paternalistic arguments advanced in the pharmacists' case. Thus, the Court was unpersuaded by defendants' argument that advertising, because it is a candid acknowledgement of the fact that lawyers work for money, would adversely affect the professionalism of lawyers.[243] It also rejected the view that attorney advertising was inherently misleading. Although advertising claims may be incomplete, the assumption that consumers will necessarily be misled rests on the proposition that "the public is not sophisticated enough to realize the limitations of advertising, and that the public is better kept in ignorance than trusted with correct but incomplete information."[244] The Court believed that that proposition underestimated the ability of the public and expressed its dubiety about "any justification that is based on the benefits of public ignorance."[245] In the Court's opinion, the way to offset consumer ignorance is "more disclosure, rather than less."[246]

The Court in *Bates*, as it had in *Virginia Board of Pharmacy*, made it clear that government may regulate false, deceptive, or misleading advertising.[247] Given the public's lack of sophistication in areas of professional services, some forms of advertising might be inappropriate because they are so susceptible to misinterpretation and so difficult to measure or verify. For example, claims as to *quality* of professional services, not adjudicated in *Bates*, might be "so likely to be misleading as to warrant restriction."[248] Thus, the Court recognized the difficulty of drawing lines between deceptive and nondeceptive advertising; but because of the importance of commercial information to the proper functioning of the market system, the Court required that such lines be drawn on a case-by-case basis over time.[249]

After *Virginia Board of Pharmacy* and *Bates* no outright ban on professional price advertising for routine services can be toler-

242. Bates v. State Bar, 433 U.S. 350, 367-68 (1977). *See generally* Canby & Gellhorn, *Physician Advertising: The First Amendment and the Sherman Act*, 1978 DUKE L.J. 543.
243. 433 U.S. at 371-72.
244. *Id.* at 374-75.
245. *Id.* at 375.
246. *Id.*
247. *Id.* at 383.
248. *Id.* at 383-84.
249. *Id.* at 384.

ated under the first amendment. Not all commercial expression, however, will be immune from governmental regulation. If a particular form of advertising does not mislead or is not related to an unlawful activity, it is within the ambit of protected expression. In order to justify regulation of advertising, the state must show that it has a substantial interest at stake. In addition, it must demonstrate that the regulation directly furthers that substantial interest and does so in a way that is least intrusive on the right of free expression.[250]

What the commercial speech cases establish, on a constitutional foundation, is the principle that professionals have a right to promote and advertise the prices of their services and that consumers have a derivative right to receive that information in order to make intelligent choices in the economic marketplace.[251] The first amendment protects, as a fundamental principle, the right of market participants—both providers and consumers—to disseminate and receive commercial information. The paternalistic view that quality will be compromised or that unsophisticated consumers will be unduly confused is rejected as at odds with the precepts of the first amendment. These commercial speech cases provide an important constitutional foundation upon which to build further market-perfecting policies in the health sector, aimed at promoting competition among providers and providing consumers with a better understanding of the array of choices available in the medical marketplace.

B. The Doctrine of Informed Consent

Informed consumer choice is a cornerstone of any market-oriented strategy. In the health area, the dogma has been that patients do not and cannot understand enough about medical matters to make informed choices. Also the implicit assumption is made that, when seeking medical assistance, patients are not inclined to shop around in a market. In short, patients are and want

250. Central Hudson Gas Co. v. Public Serv. Comm'n, 100 S. Ct. 2343, 2354 (1980).

251. The *Virginia Board of Pharmacy* case was brought by consumers, not providers. The first amendment right recognized in the case, therefore, was the derivative right of consumers to receive information that providers, who were not parties to the lawsuit, might wish to furnish. 425 U.S. at 754. For a discussion of the Federal Trade Commissions antitrust action against the American Medical Association's restrictions on solicitation and advertising, see Costillo, *Competition Policy and the Medical Profession*, 304 NEW ENG. J. MED. 1099 (1981).

to be dependent, even helpless.[252]

The evolution of the commercial speech doctrine, as applied in the medical context,[253] suggests a very different model of patient decisionmaking. It relies on the ability of patients or their intermediaries to seek out and act on information about the range of choices in the marketplace.[254] By encouraging discussion and dialogue about price information, the commercial speech doctrine facilitates the process of patient awareness and ultimately, patient responsibility.

Although economic considerations are not the primary rationale for informed consent,[255] the common law doctrine of informed consent may perform much the same function as the commercial speech doctrine in improving the flow of medical information to patients.[256] It could therefore facilitate more rational patient choice and participation in medical decisionmaking.

The doctrine of informed consent[257] is founded on the principle, articulated by Judge Cardozo, that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body . . . ."[258] The fundamental value protected by informed consent is individual autonomy.[259] Protection of that value in turn has two components—the actual agreement by a person to a particular form of treatment and the disclosure of sufficient information to allow informed decisionmaking.[260]

Consent, when a patient can give it,[261] has long been an essen-

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252. *See generally* Meisel, *supra* note 42, at 415-16 & nn.11 & 12.

253. *See* Canby & Gellhorn, *supra* note 242, at 546-64.

254. *See* Bates v. State Bar, 433 U.S. 350, 374-75 (1977); Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council, Inc., 425 U.S. 748, 770 (1976).

255. *See generally* Capron, *Informed Consent in Catastrophic Disease Research and Treatment*, 123 U. PA. L. REV. 340, 364-76 (1974); Meisel, *The Expansion of Liability for Medical Accidents: From Negligence to Strict Liability by Way of Informed Consent*, 56 NEB. L. REV. 51, 77-86 (1977).

256. Actual empirical evidence on how the doctrine of informed consent affects physician disclosure and patient understanding is inconclusive. *See generally* A. ROSOFF, INFORMED CONSENT: A GUIDE FOR HEALTH CARE PROVIDERS 313-85 (1981); Meisel, *supra* note 42, at 427 n.61.

257. For a discussion of the statutory responses to court-created common law, see Miller, *Informed Consent: III*, 244 J.A.M.A. 2556 (1980).

258. Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914), *overruled on other grounds*, Bing v. Thunig, 2 N.Y.2d 656, 143 N.E.2d 3, 163 N.Y.S.2d 3 (1957).

259. Capron, *supra* note 255, at 364-65.

260. *Id.*

261. *See* Meisel, *supra* note 42.

tial precondition to medical intervention.[262] The requirement of consent provides a form of operational protection to the patient's right of bodily integrity.[263] The doctrine of informed consent requires that the consent be based on adequate information.[264]

Since patients are typically not medical experts, they must rely on their physicians for the information upon which to base their decisions. Because of the nature of the doctor-patient relationship, in which the physician serves the patient in a fiduciary capacity, the responsibility for informing the patient rests with the physician. Otherwise, without knowledge of therapeutic alternatives and their risks, patients cannot exercise their right of choice in an intelligent manner. The assumption is that a properly informed patient will be able to exercise a reasoned judgment, evaluating risks and benefits in consultation with the physician.[265]

The development of doctrine in the law of informed consent has focused on the scope of the physician's obligation of disclosure. The Kansas Supreme Court's formulation of the traditional rule is still widely cited: "The duty of the physician to disclose . . . is limited to those disclosures which a reasonable medical practitioner would make under the same or similar circumstances."[266] This so-called professional standard of disclosure, which apparently is still the majority rule,[267] is premised on the view that "[h]ow the physician may best discharge his obligation to the patient . . . involves primarily a question of medical judgment."[268] In other words, professionals, not patients, determine what risks should be disclosed.

The professional standard of disclosure requires a plaintiff to establish, by expert medical evidence, the existence of a duty to disclose.[269] Under the professional standard, whether the duty exists at all depends on what similarly situated physicians would do in like circumstances. This approach perpetuates the common paternalistic judgment that patients are unable or unwilling to become active participants in the medical decisionmaking process. By

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262. *See* J. KING, THE LAW OF MEDICAL MALPRACTICE 136 (1977); J. LUDLAM, INFORMED CONSENT 19 (1978).

263. Pratt v. Davis, 118 Ill. App. 161, 166 (1905), *aff'd*, 244 Ill. 300, 79 N.E. 562 (1906).

264. *See* J. KING, *supra* note 262, at 152.

265. Canterbury v. Spence, 464 F.2d 772, 782 n.27 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

266. Natanson v. Kline, 186 Kan. 393, 409, 350 P.2d 1093, 1106 (1960).

267. *See* J. KING, *supra* note 262, at 155.

268. 186 Kan. at 409, 350 P.2d at 1106.

269. *See* A. ROSOFF, *supra* note 256, at 35.

allowing providers to set the standard, this traditional view encourages provider paternalism and does nothing to lessen the inherent leverage providers have by virtue of their greater knowledge and relative noninvolvement in a patient's medical problem. A provider's disinclination to share information, and thus, presumably, power and responsibility, with a patient is reinforced; lack of information impairs patient participation in decisionmaking and helps to establish provider dominance. At the same time, by inhibiting rather than nurturing active patient involvement, the traditional approach undermines the societal interest in increased patient understanding, a precondition to a more effectively functioning market in the health sector.[270]

In 1972, the seminal decision in *Canterbury v. Spence*[271] rejected the professional standard as the basis for disclosure to patients. The *Canterbury* court refused to accept the position that "the physician's obligation to disclose is either germinated or limited by medical practice."[272] Recognizing that tying the duty to disclose to medical custom "arrogate[s] the decision . . . to the physician alone,"[273] the court held that "[r]espect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose on themselves."[274]

In short, under *Canterbury* the physician's duty to disclose stems from the "patient's right of self-decision."[275] Since "ofttimes a nonmedical judgment"[276] is involved in determining what matters to disclose, "medical custom cannot furnish the test of its propriety."[277] The basis for disclosure, therefore, must be what information a reasonable patient needs in order to make an intelligent choice, not what professional practice would command or allow.

The *Canterbury* approach, though still a minority rule, was followed in the same year by the Supreme Court of California in *Cobbs v. Grant*[278] and by the Rhode Island Supreme Court in *Wil-*

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270. *See generally* Meisel, *supra* note 42, at 418-29; Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628 (1970); Note, *supra* note 41, at 1535-55.

271. 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

272. *Id.* at 783.

273. *Id.* at 784.

274. *Id. Accord*, Cobbs v. Grant, 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972); Wilkinson v. Vesey, 110 R.I. 606, 625, 295 A.2d 676, 688 (1972).

275. 464 F.2d at 786.

276. *Id.* at 785.

277. *Id.*

278. 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972).

kinson v. Vesey.[279] In *Cobbs* the California court noted that patients generally are not knowledgeable about medical matters and accordingly depend on physicians for information. Since patients have the right to control their bodily integrity—"to determine whether or not to submit to lawful medical treatment"—patient consent is necessary. For that consent to be effective, it must be based on adequate information.[280] The duty under *Cobbs* to disclose "all information relevant to a meaningful decisional process"[281] follows from those premises.

In *Wilkinson* the Rhode Island court recognized that the "keystone" of informed consent doctrine is the right of every competent adult "to forego treatment, or even cure, if it entails what for him are intolerable consequences or risks however unwise his sense of values may be in the eyes of the medical profession, or even the community."[282] Protection of the right requires that a patient be able to make a rational decision in light of his "individual value judgment,"[283] and that the decision about disclosure not be left to a professional standard. Rather, the physician bears the burden of proving that nondisclosure is in the best interest of the patient.[284]

Under the *Canterbury-Cobbs-Wilkinson* approach, then, the patient's need for disclosure controls. The duty to disclose encompasses all "material" information, including "all risks potentially affecting the decision."[285] The nature and extent of information deemed "material" is determined under *Canterbury* by an objective standard: what risks "a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to . . . in deciding whether or not to forego the proposed therapy."[286] In *Cobbs* the court argnably suggested a subjective standard to determine materiality:[287] "The scope of the physician's communications to the patient . . . must be measured by the patient's need . . . ."[288] Although *Cobbs* cited

279. 110 R.I. 606, 295 A.2d 676 (1972).
280. 8 Cal. 3d at 242, 502 P.2d at 9, 104 Cal. Rptr. at 513.
281. *Id.* at 242, 502 P.2d at 10, 104 Cal. Rptr. at 513.
282. 110 R.I. at 624, 295 A.2d at 687.
283. *Id.*
284. *Id.* at 624, 295 A.2d at 687-88.
285. Canterbury v. Spence, 464 F.2d 772, 786-87 (D.C. Cir.), *cert. denied,* 409 U.S. 1064 (1972).
286. *Id.* at 787 (quoting Waltz & Scheuneman, *supra* note 270, at 640).
287. *See* Capron, *supra* note 255, at 407.
288. 8 Cal. 3d at 245, 502 P.2d at 11, 104 Cal. Rptr. at 515.

Canterbury for this view, the *Cobbs* formulation, unlike that of *Canterbury,* can be read as focusing more clearly on the individual patient's needs in a particular circumstance. The court in *Wilkinson* appeared to embrace *Canterbury*'s objective standard.[289] It also recognized, however, the individual patient's right to make a decision even if the patient's own values are at odds with those of the medical or general community. That right suggests that subjective considerations are not irrelevant under *Wilkinson.*

Although there are still unresolved doctrinal issues with the "reasonable person" approach to informed consent, and apparently some question about its empirical effect,[290] the emerging formulation has extremely important potential significance for the market strategy. On a normative basis, the approach thrusts more responsibility for decisionmaking on the patient-consumer, suggesting greater individual responsibility for the making of choices in health matters. Also, it provides an incentive for providers to share more authority and information with consumers. This increased sharing could help restore balance to the doctor-patient relationship and encourage patients to become more active and knowledgeable as consumers. The reasonable person approach could also diminish the "shamanism"[291] aspect of medical practice by requiring doctors to have a sound basis for their treatment recommendations.[292] In any event, it vests ultimate authority in the patient and thus helps restructure the doctor-patient relationship by giving the patient added information and thus the capacity to exercise more authority.

In practice, some may object to the requirement for additional disclosure because of its potential cost. The communication of information is time-consuming and could mean lower productivity for physicians. At least three responses to this concern are possible. First, the extra cost may be wortbwhile. This is difficult to assess at this stage, however, and we would be hesitant to endorse the *Canterbury* approach on tbat basis. Second, cost-reducing possibilities exist. A patient who feels no need or desire for more in-

289. 110 R.I. at 627-28, 295 A.2d at 689.

290. *See* Meisel, *supra* note 42, at 427 n.61; A. ROSOFF, *supra* note 256, at 313. For an argument that there should be an obligation of patient comprehension as well as disclosure, see Capron, *supra* note 255, at 410-18. *But see* Meisel, Letter to the Editor, 245 J.A.M.A. 921-22 (1981).

291. *See* Avorn, *The Future of Doctoring,* THE ATLANTIC MONTHLY, Nov. 1974, at 71-79.

292. Note, *supra* note 41, at 1541-55. *See generally* A. COCHRANE, EFFECTIVENESS AND EFFICIENCY: RANDOM REFLECTIONS ON HEALTH SERVICES (1972).

volvement in decisionmaking and who wishes to remain dependent can waive his *Canterbury*-type rights to disclosure.[293] The physician's information costs would decrease, and he might well be persuaded to lower his fee for such a patient. Additionally, physicians can delegate the information-conveying function to allied health professionals, whose time would be less expensive. Indeed, we see this as an extremely valuable task for expanded-role nurses to perform.[294] Use of physician-extenders in this manner could mitigate the cost implications of the *Canterbury* standard of informed consent.

Last, from a pragmatic perspective, expanding patient participation in medical decisionmaking could decrease malpractice claims. On one level, increased patient participation in decisionmaking may discourage lawsuits by disgruntled patients about application of an appropriate standard of care. The courts might be persuaded to develop a deferential attitude toward a particular standard of practice if a fully informed and knowledgeable patient has acquiesced to that standard.[295] If informed patients assume more responsibility in diagnosis and treatment decisionmaking, it is reasonable to assign more weight to decisions made jointly with their physician about a given course of treatment. In sum, the reasonable patient approach to informed consent is a promising common-law doctrinal development that complements and could facilitate and justify the establishment of a freer market in the health sector.

C. *Antitrust Doctrine*

The antitrust laws are a form of government intervention designed to promote, not forestall, competition. Properly implemented, they are an important procompetitive force in the economy—discouraging anticompetitive conduct, encouraging competitive behavior, and, institutionally, keeping the structure of the marketplace intact to enable the normal competitive process to operate.[296]

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293. *See* Meisel, *supra* note 42, at 453-60.

294. *See* Blumstein & Zubkoff, *supra* note 22, at 386.

295. *See generally* Epstein, *supra* note 64, at 87, 119-28 & 126-27 n.80.

296. *See generally* United States v. Topco Assocs., 405 U.S. 596, 610 (1972), which states,

> Antitrust laws in general, and the Sherman Act in particular, are the Magna Carta of free enterprise. They are as important to the preservation of economic freedom and our free-enterprise system as the Bill of Rights is to the protection of our fundamental

It would be unnecessarily duplicative to discuss in detail the emerging antitrust issues relating to the health field since that is done elsewhere in this Symposium[297] and in other fora.[298] Here the focus is on the erosion of three threshold barriers that at one time forestalled the development of antitrust doctrine in the health field: (1) the demise of the so-called "learned profession" exemption for medical practice and related services; (2) the expansion of the notion of interstate commerce, which has in effect broadened the Sherman Act's jurisdictional reach; and (3) the modification of the rule, first announced in *Parker v. Brown*,[299] that the Sherman Act barred private anticompetitive activity but not state regulatory action.

1. The Learned Professions Exemption

Antitrust doctrine has developed relatively slowly in the health services context. The sense that the medical sector somehow did not conform to normal economic market forces was reinforced by the assumption that the practice of medicine was a "learned profession" and as such was not covered by the federal antitrust laws, which apply to "trade or commerce."[300] The "learned profession" issue lingered for years,[301] but was not squarely faced by the Supreme Court until *Goldfarb v. Virginia State Bar*[302] was decided in 1975.

Goldfarb involved a challenge under the Sherman Act to a minimum fee schedule for lawyers promulgated by a county bar association and enforced by the Virginia State Bar.[303] The Bar

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personal freedoms. And the freedom guaranteed each and every business, no matter how small, is the freedom to compete—to assert with vigor, imagination, devotion, and ingenuity whatever economic muscle it can muster. Implicit in such freedom is the notion that it cannot be foreclosed with respect to one sector of the economy because certain private citizens or groups believe that such foreclosure might promote greater competition in a more important sector of the economy.

297. *See* Bovbjerg, *Competition Versus Regulation in Medical Care: An Overdrawn Dichotomy*, 34 VAND. L. REV. 965 (1981); Leibenluft & Pollard, *Antitrust Scrutiny of the Health Professions: Developing a Framework for Assessing Private Restraints*, 34 VAND. L. REV. 927 (1981).

298. *See generally* Symposium, 1978 DUKE L.J. 303-697.

299. 317 U.S. 341 (1943).

300. *See* Goldfarb v. Virginia State Bar, 497 F.2d 1 (4th Cir. 1974), *rev'd*, 421 U.S. 773 (1975).

301. *See* Blumstein & Calvani, *State Action as a Shield and a Sword in a Medical Services Antitrust Context*: Parker v. Brown *in Constitutional Perspective*, 1978 DUKE L.J. 389, 390 n.2.

302. 421 U.S. 773 (1975).

303. *Id.* at 775.

sought total exclusion from Sherman Act coverage on the ground that the practice of law, as a learned profession, was not "trade or commerce" under the Act.[304] The Fourth Circuit had accepted the Bar's defense, ostensibly because of the type of regulation states typically impose on the professions. The court reasoned that certain forms of competition are incompatible with professional regulation. Consequently the Fourth Circuit held that balancing the conflicting policies of competition and professional regulation required an exemption from the Sherman Act for the practice of law.[305]

In reversing, the Supreme Court rejected any "sweeping exclusion"[306] for learned professions from the coverage of the antitrust laws. Such a broad exemption would conflict with the congressional goal of legislating as extensively as it could against anticompetitive activities.[307] Moreover, the Court saw "no disparagement of the practice of law as a profession to acknowledge that it has . . . [a] business aspect,"[308] especially since "lawyers play an important part in commercial intercourse, and . . . anticompetitive activities by lawyers may exert a restraint on commerce."[309]

The emphasis on the role of lawyers in "commercial intercourse" suggested to some that a narrower exemption from the antitrust laws for selected learned professions might still be carved out, despite *Goldfarb*'s rejection of a sweeping exemption for all learned professions. A footnote to the *Goldfarb* opinion reinforced that belief.[310] In that footnote, Chief Justice Burger noted that professions should not be viewed as wholly interchangeable with other forms of business for purposes of the antitrust laws. Thus, antitrust concepts developed in a commercial context should not he applied by rote to all professional activities. The Court "intimate[d] no view on any other situation than the one with which [it was] confronted . . . ."[311] The Court did assert, however, that the differences between the professions and other commercial activities could affect the substantive application of antitrust doctrine in the different professional context; any differences, though, would not

304. *Id.* at 787.
305. *Id.* at 779-80.
306. *Id.* at 787.
307. *Id.*
308. *Id.* at 788.
309. *Id.*
310. *Id.* at 788 n.17.
311. *Id.*

serve as a basis for a threshold exemption for any particular profession because "[t]he nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act."[312]

The Court's subsequent decision in *National Society of Professional Engineers v. United States*[313] makes the meaning of the *Goldfarb* footnote clearer. Apparently no argument for a total exemption was even made in *Professional Engineers*; rather, the Society argued that its canon of ethics, which prohibited competitive bidding,[314] was reasonable under the Sherman Act.[315]

In holding the canon illegal, the Court rejected the position that "because of the special characteristics of a particular industry, monopolistic arrangements will better promote trade and commerce than competition."[316] If an exemption for specific industries is to exist, the Court felt, Congress must expressly confer it.[317] Thus, the antitrust Rule of Reason doctrine does not confer a special exemption on the professions; the validity of an act depends on its "impact on competitive conditions."[318] Promotion of competition is the policy of the Sherman Act, and an activity that suppresses competition violates the Act.

The Court in *Professional Engineers* made it clear that a restraint on commerce will be examined to determine its "competitive significance."[319] Even when professional activity is involved, however, the Court will not question "whether a policy favoring competition is in the public interest."[320] The antitrust laws, as applied in the professional as well as the commercial context, seek to promote competition. Accordingly, an anticompetitive professional restraint cannot be justified on the ground that competition poses a potential threat to public safety or to the ethics of the profession.[321] In reasoning closely parallel to that in the commercial expression cases,[322] the Court held that the Sherman Act adopted a competitive approach and to allow anticompetitive professional ac-

312. *Id.* at 787.
313. 435 U.S. 679 (1978).
314. *Id.* at 681.
315. *Id.* at 687.
316. *Id.* at 689.
317. *Id.* at 689-90.
318. *Id.* at 690.
319. *Id.* at 692.
320. *Id.*
321. *Id.* at 695.
322. *See* text accompanying notes 223-51 *supra.*

tivity as a "reasonable method of forestalling . . . public harm"[323] would constitute "nothing less than a frontal assault on the basic [procompetition] policy of the Sherman Act."[324]

After *Goldfarb* and *Professional Engineers,* then, it is clear that the practice of medicine is not totally exempt from the antitrust laws, and the Seventh Circuit has explicitly so held.[325] Moreover, in the commercial expression area, the Supreme Court has rejected the paternalistic view that people will be unable to make reasoned consumer judgments when provided with commercial information. This dual stance by the Court reflects the societal decision to rely on the right of consumers to make informed choices and of providers to compete in a free marketplace. The protection of commercial expression under the first amendment—the provider's right to advertise and the consumer's right to receive commercial information—assumes that consumers will be able to decide what is in their own best interests. The first amendment protects the system of free expression and allows outcomes to derive from private decentralized choices. Similarly, the decisions in *Goldfarb* and *Professional Engineers* adopt the view that under the Sherman Act competition is the norm in the economic marketplace. Arguments that anticompetitive professional conduct somehow promotes the public interest "by preventing . . . inferior work and by insuring ethical behavior"[326] are unacceptable. The Sherman Act protects the system of competition and, like the first amendment, allows outcomes to derive from private decentralized choices. As in the commercial speech context, however, regulations designed to facilitate competition might well pass muster. The peculiarities of professional activities might well play an important role in that type of a Rule of Reason analysis.

2. The Interstate Commerce Requirement

Since the constitutional source of authority underlying the Sherman Act is the commerce clause,[327] the Act's jurisdictional reach is confined to anticompetitive restraints "among the several states."[328] As the scope of federal power under the commerce clause has expanded, the Supreme Court has "permitted the reach

323. 435 U.S. at 687.
324. *Id.* at 695.
325. *See* Williams v. St. Joseph Hosp., 629 F.2d 448, 453 (7th Cir. 1980).
326. 435 U.S. at 693-94.
327. U.S. CONST. art. I, § 8, cl. 3.
328. 15 U.S.C. § 1 (1976).

of the Sherman Act to expand" as well,[329] largely out of a sense that Congress intended that the Sherman Act reach to the maximum extent of federal constitutional authority.[330]

Thus, the Sherman Act extends to activities that either are "in" interstate commerce or substantially "affect" interstate commerce.[331] *Goldfarb* was analyzed as an "in" commerce case.[332] The *Goldfarb* plaintiffs alleged anticompetitive conduct by lawyers whom they sought to employ to perform a title search necessary to obtain title insurance for a home.[333] The Court noted that a significant amount of home loan financing funds came from out-of-state sources and that federal government programs guaranteed a significant amount of loans on real estate in the area. Thus, home purchase transactions, which create the need for title searches, are in interstate commerce, and title searches themselves are an integral, necessary, and inseparable part of those real estate transactions.[334]

While the *Goldfarb* Court stated that the legal services involved in that case had a sufficient effect on interstate commerce to satisfy the Sherman Act's jurisdictional requirements, the Court subsequently held in *McLain v. Real Estate Board*[335] that *Goldfarb* was analyzed as an "in" commerce not an "effect on commerce" case.[336] By citing to *Wickard v. Filburn*,[337] one of the most far-reaching commerce clause cases, the Court in *McLain* made it clear that the jurisdictional reach of the Sherman Act would be as "correspondingly broad"[338] as Congress' constitutional power. *McLain* involved an allegation of price fixing and other anticompetitive practices on the part of New Orleans real estate brokers.[339] The evidence of the practices' effect on interstate commerce concerned out-of-state financing of real estate transactions, including raising funds from out-of-state investors, trading mortgages as financial instruments in the interstate market for secondary mort-

329. Hospital Bldg. Co. v. Rex Hosp. Trustees, 425 U.S. 739, 743 n.2 (1976).

330. *See* McLain v. Real Estate Bd., 444 U.S. 232, 241 (1980); Blumstein & Calvani, *supra* note 301, at 420.

331. McLain v. Real Estate Bd., 444 U.S. 232, 241-46 (1980); Gulf Oil Corp. v. Copp Paving Co., 419 U.S. 186, 195 (1974).

332. McLain v. Real Estate Bd., 444 U.S. 232, 243-44 (1980).

333. 421 U.S. at 775-76.

334. *Id.* at 783-85.

335. 444 U.S. 232 (1980).

336. *Id.* at 243-44.

337. 317 U.S. 111 (1942).

338. 444 U.S. at 241.

339. *Id.* at 235.

gages, and participating in federal lending programs "which entailed interstate transfers of premiums and settlements."[340] The Court also noted that a relationship with the "interstate movement of people"[341] would also suffice for purposes of applying the Sherman Act.

The decisions in *McLain* and *Hospital Building Co. v. Rex Hospital Trustees*[342] are the most important recent "effect on commerce" rulings for purposes of applying the Sherman Act to the health sector. In *Rex Hospital* defendants were charged with an unlawful conspiracy to restrain trade by furnishing medical and surgical hospital services and to monopolize the hospital business in Raleigh, North Carolina. Plaintiff, a for-profit hospital, alleged that defendant, a nonprofit hospital, illegally conspired to block plaintiff's plans for expansion and relocation. Defendant's alleged goal was to "monopolize the business of providing compensated medical and surgical services in the Raleigh area."[343] Reversing the Fourth Circuit, the Supreme Court held that plaintiff had stated a cause of action by alleging facts which, if proved, could have a substantial effect on interstate commerce.[344] Plaintiff alleged that it purchased medicines and supplies from out-of-state companies, derived revenues from out-of-state insurance companies and from Medicaid and Medicare, and received a large portion of its construction financing from out-of-state lenders.[345]

Reading *Goldfarb, Rex Hospital,* and *McLain* together, one can conclude that most anticompetitive hospital activities will pass the "effect on commerce" threshold test because at least some of the following factors exist in virtually all hospital construction or operation situations: (1) construction financing, which includes significant sums from out-of-state lenders; (2) purchases of equipment, medication, and other goods and services from out-of-state suppliers;[346] (3) third-party reimbursements for significant numbers of patients from private insurance carriers or from federal programs such as Medicaid or Medicare;[347] and (4) out-of-state pa-

340. *Id.* at 245.
341. *Id.*
342. 425 U.S. 738 (1976).
343. *Id.* at 741.
344. *Id.* at 743-44.
345. *Id.* at 741, 744.
346. *See* Katzenbach v. McClung, 379 U.S. 294 (1964).
347. The allegation about the third-party financing in *Rex Hospital* was not specifically mentioned by the Court in its discussion. *See* Feminist Women's Health Center, Inc. v. Mohammad, 586 F.2d 530, 540 n.2 (5th Cir. 1978). Both *McLain* and *Goldfarb,* however,

tient referrals both to and from a particular hospital.[348]

Similarly, one can safely predict that most anticompetitive activities by groups of doctors will be deemed to have a substantial effect on commerce for Sherman Act purposes.[349] Although physicians may not need large construction financing, *Goldfarb* and *McLain* suggest that borrowing in even moderate amounts can be sufficient to pass the necessary jurisdictional threshold under the Sherman Act, especially since the trading of financial instruments in an interstate secondary mortgage market is considered a practical economic effect on commerce under *McLain*.[350] As for the other factors, they will likely be present with respect to physicians as well as hospitals in varying degrees. Most physicians who utilize hospital facilities receive compensation from Medicaid, Medicare, or private insurers, receive or make patient referrals out of state, or purchase equipment, drugs, supplies, or services from out-of-state sources.

Thus, it now seems likely that the vast bulk of potentially illegal anticompetitive practices involving institutional and individual providers will fall within the purview of the federal antitrust laws.[351] This expansion of the antitrust laws' jurisdiction may curtail a good deal of anticompetitive conduct and may provide an avenue of redress for those whose competitive efforts are forestalled by collective action of entrenched provider interests.[352]

3. The Effect of State Action

Regulatory action by state, local, or regional governmental entities can affect antitrust liability in two quite different ways. In

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suggest that federal loan guarantee programs for real estate transactions constitute a substantial nexus to interstate commerce in the Sherman Act context. *See* McLain v. Real Estate Bd., 444 U.S. 232, 245 (1980); Goldfarb v. Virginia State Bar, 421 U.S. 773, 783 (1975).

348. Again, this factor was raised by plaintiff in *Rex Hospital*, 425 U.S. at 741, but not specifically discussed by the Court. *Id.* at 744. The Court in *McLain*, however, explicitly invited plaintiffs to offer evidence about "the interstate movement of people" as a basis for Sherman Act jurisdiction. 444 U.S. at 245. *See also* Heart of Atlanta Motel v. United States, 379 U.S. 241, 255-56 (1964); Feminist Women's Health Center, Inc. v. Mohammad, 586 F.2d 530, 540 (5th Cir. 1978).

349. *See* American Med. Ass'n v. United States, 317 U.S. 519, 528-33 (1943), which implicitly involved this issue.

350. 444 U.S. at 245.

351. *See* Williams v. St. Joseph Hosp., 629 F.2d 448, 453 (7th Cir. 1980).

352. *See generally* Goldberg & Greenberg, *The Effect of Physician-Controlled Health Insurance:* U.S. v. Oregon State Medical Society, 2 J. HEALTH POL., POL'Y & L. 48 (1977); Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303.

some circumstances, it can confer an exemption from the Sherman Act's coverage. In other situations, however, the state may confer market power on a group to such an extent that activity that is otherwise legal may be found illegal under the antitrust laws.[353]

(a) State Action as an Exemption

In *Parker v. Brown*[354] the Supreme Court held that the Sherman Act applied to "individual and not state action."[355] The Court assumed that the state regulatory program challenged in *Parker* would have been illegal under the antitrust laws if organized and enforced by private parties.[356] Because the state program "derived its authority and its efficacy from the legislative command of the state,"[357] however, and because the Sherman Act contained no express statement that it was designed "to restrain a state or its officers or agents from activities directed by its legislature,"[358] the Court declined to infer a congressional "purpose that the antitrust laws be used to strike down the State's regulatory program imposed as an act of government"[359] in the absence of a clear and manifest articulation of congressional intent.

In *Parker* cases, a basic distinction arises between situations "when private parties are sued" and those "when governmental programs or official conduct are challenged."[360] Interestingly, every case in which the Court has applied *Parker* immunity has involved a state defendant.[361] When a governmental official or agency is sued, the fundamental issue raised is the proper "relationship between the sovereign States and the antitrust laws."[362] In that context, the *Parker* issue raises concerns of federalism embodied in the eleventh amendment[363]—the susceptibility of states and state

353. Blumstein & Calvani, *supra* note 301, at 394-95. *See generally* Landes & Posner, *Market Power in Antitrust Cases*, 94 HARV. L. REV. 937, 956 n.35 (1981).

354. 317 U.S. 341 (1943).

355. *Id.* at 352.

356. *Id.* at 350.

357. *Id.*

358. *Id.* at 350-51.

359. City of Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 406 n.33 (1978).

360. Blumstein, *A Prolegomenon to Growth Management and Exclusionary Zoning Issues*, LAW & CONTEMP. PROB., Spring 1979, at 5, 101.

361. *Id.* at 102 n.722 and cases cited therein.

362. Cantor v. Detroit Edison Co., 428 U.S. 579, 587 (1976).

363. U.S. CONST. amend. XI provides that "[t]he Judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by Citizens of another State, or by Citizens or Subjects of any Foreign State."

officers acting in their official capacities to suit in federal court for possible federal antitrust liability.[364]

Although no Supreme Court case has held that private parties are exempt from the Sherman Act under *Parker*,[365] a bare majority of the Court does seem to accept the view that the state can confer *Parker* immunity on private parties.[366] Nevertheless, *Parker* makes it clear that "a state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or by declaring that their action is lawful . . . ."[367] Thus, not all state action can confer immunity or is itself immune from the federal antitrust laws.

A proper analysis in *Parker* cases, then, has two dimensions: it must account for eleventh amendment sovereign immunity concerns and tenth amendment federalism concerns centered on the integrity of state government. The first question in the analysis should be "whether the act of the political subdivision (or state agency) 'is that of the state as sovereign.' "[368] To determine the answer to that question, which is closely akin to an eleventh amendment analysis,[369] the Court will consider whether the anticompetitive restraint is "one clearly articulated and affirmatively expressed as state policy."[370] The second inquiry should focus on the nature and magnitude of the state's interest in its regulatory policy.[371] This aspect of *Parker* immunity is closely related to the tenth amendment[372] federalism concerns reflected in *National League of Cities v. Usery*.[373] The tenth amendment protects certain reserved powers of the states, and this component of *Parker* immunity seems designed to respect sovereign state regulatory functions. Three elements drawn from *Usery* should shape this

364. *See* 1 P. AREEDA & D. TURNER, ANTITRUST LAW ¶ 217a1 (1978); Blumstein & Calvani, *supra* note 301, at 414-15.

365. *See* Blumstein, *supra* note 360, at 102 n.722.

366. *See* Blumstein & Calvani, *supra* note 301, at 419.

367. 317 U.S. at 351. *See* California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 104 (1980).

368. Blumstein, *supra* note 360, at 107; *see* City of Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 410 (1978).

369. *E.g.*, Mt. Healthy City Bd. of Educ. v. Doyle, 429 U.S. 274, 280 (1977).

370. City of Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 410 (1978). *See also* California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980).

371. *See* Blumstein, *supra* note 360, at 103.

372. U.S. CONST. amend. X provides, "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."

373. 426 U.S. 833, 856 (1976).

part of the *Parker* analysis. "[F]irst, there must be an attribute of *sovereignty* involved; second, the state activity must be an essential government function; and third, there must be an impairment of that function."[374]

The Supreme Court's most recent *Parker* decision, *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*,[375] although not couched in constitutional terms, established a two-strand analysis similar to the one proposed. First, the Court required that the activity be a "clearly articulated and affirmatively expressed . . . state policy,"[376] implicitly an eleventh amendment standard. To qualify for *Parker* immunity, a political subdivision must show "that the legislature contemplated the kind of action complained of."[377] The essential point is that a municipality or other subdivision must show that it "acted as the agent of the state, effectuating state-initiated policies, in performing the challenged activities."[378]

Second, *Midcal* requires that the state policy be "actively supervised" by the state itself.[379] The active supervision provision ensures that state sovereignty interests are truly at stake, since *Parker* "exempts only anticompetitive conduct engaged in as an act of government by the State as sovereign."[380] The Court's approach in *Midcal,* then, is consistent with the proposed tenth amendment analysis. Under the proposed analysis, the Court would examine

> whether the exercise of governmental authority constituted an attribute of sovereignty and promoted an essential governmental function. Also, there must be a finding of an impairment of traditional governmental sovereign functions. Presumably, no such impairment exists unless the state can show that no reasonable, less anticompetitive alternative exists by which it can further its goals.[381]

Thus, *Parker* immunity for nongovernmental defendants could be justified if "necessary" to make a regulatory program function[382]—that is, if "essential to avoid an impairment of a tradi-

374. Blumstein & Calvani, *supra* note 301, at 424.

375. 445 U.S. 97 (1980).

376. *Id.* at 105.

377. City of Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 415 (1978) (quoting City of Lafayette v. Louisiana Power & Light Co., 532 F.2d 431, 434 (5th Cir. 1976)).

378. Blumstein, *supra* note 360, at 104.

379. 445 U.S. at 105.

380. 435 U.S. at 413.

381. Blumstein, *supra* note 360, at 107.

382. *See* Cantor v. Detroit Edison Co., 428 U.S. 579, 597 (1976).

tional sovereign function."[383]

Applying this analytical framework to the field of health facilities regulation, one immediately must draw a distinction based on the identity of the defendant. If a state agency CON decision is involved, no eleventh amendment problem exists because the agency is unquestionably acting on behalf of the state. To satisfy the tenth amendment element of *Parker* immunity, the state must be able to show that the CON program was intended and administered to promote an "attribute of sovereignty"—that is, a valid police power objective.[384] A challenging party could attempt to show that the alleged purpose of the program or of the agency's action was private protectionism, not a legitimate public purpose;[385] but that is an extremely difficult burden for a plaintiff to carry.[386]

If a legitimate police power goal—that is, an "attribute of sovereignty"—is demonstrated, then the regulatory scheme is exempt if it promotes a sufficiently important ("essential") state function. A state policy of displacing "unfettered business freedom in the matter of the establishment and relocation"[387] of hospital capital facilities and equipment clearly satisfies that criterion, especially when the strong federal CON policy is taken into consideration.

Finally, to justify *Parker* exemption, an impairment of a state's essential function must occur. Since states have a degree of freedom in establishing regulatory regimes,[388] it would seem that the very essence of *Parker* immunity is to preserve the integrity of state regulatory programs that carry out fundamental state policies. Thus, the conclusion of Professor Frances Miller seems correct: "As long as the State Agency continues to evaluate independently the merits of CON proposals and as long as those proposals reasonably further the state's legitimate regulatory objectives, the *Parker* doctrine should preclude antitrust liability" for the agency itself.[389] Furthermore, it seems that the regulatory program's proper functioning would be impaired if private parties could not obey determinations made by the state agency. Thus, private parties should likewise be exempt, if they also satisfied the require-

383. Blumstein, *supra* note 360, at 108.

384. Blumstein & Calvani, *supra* note 301, at 424.

385. *Id.*

386. *See* New Motor Vehicle Bd. v. Orrin W. Fox Co., 439 U.S. 96 (1978).

387. *Id.* at 109.

388. New Motor Vehicle Bd. v. Orrin W. Fox Co., 439 U.S. 96 (1978); Exxon Corp. v. Governor of Md., 437 U.S. 117 (1978).

389. Miller, *Antitrust and Certificates of Need: Health Systems Agencies, the Planning Act, and Regulatory Capture*, 68 GEO. L.J. 873, 898 (1980).

ment articulated in *Cantor v. Detroit Edison Co.*[390] that "the state's participation in a decision [must be] so dominant that it would be unfair to hold a private party responsible for his conduct implementing it."[391] As Professor Miller recognized,[392] the *Parker* issue is more difficult to resolve in the context of areawide programs like health systems agencies (HSAs) because both the tenth and eleventh amendment components of the analysis must be considered. Much will depend on the particular provisions of the state's CON legislation and the peculiar factual circumstances[393] in which alleged anticompetitive conduct arises.

(b) State Action as Conferring Market Power

Interestingly, the involvement of government action can make some private conduct more rather than less susceptible to an antitrust challenge. Governmental regulatory action—for example, CON programs—that creates artificial scarcity can result in added market power for some private interests. If that increased market control is used to restrain competition, antitrust liability could follow.[394]

Two situations illustrate the problem. The first involves tying arrangements;[395] the second concerns access to scarce "resource[s] necessary to success of a particular trade or business."[396]

"A tie-in is an attempt by a seller to link the sale of one item to the simultaneous sale of another, separate item."[397] A heuristic example is a hospital's hypothetical decision to limit flowers sent

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390. 428 U.S. 579 (1976).

391. *Id.* at 594-95.

392. Miller, *supra* note 389, at 898.

393. *Compare* National Gerimedical Hosp. and Gerontology Center v. Blue Cross, 628 F.2d 1050 (8th Cir. 1980), *rev'd*, 49 U.S.L.W. 4672 (1981) *and* Huron Valley Hosp., Inc. v. City of Pontiac, 466 F. Supp. 1301 (E.D. Mich. 1979) *with* Feminist Women's Health Center v. Mohammad, 586 F.2d 530 (5th Cir. 1978). The Supreme Court decision in *National Gerimedical* was not handed down until after this Article was printed and therefore is not discussed.

In May 1980, the United States Department of Justice indicated that, in exercising its prosecutorial discretion, it would view HSA decisions on CON, appropriateness review, and grant application review as valid. It would not express a definitive judgment with respect to HSA activities involved in seeking to implement a Health System Plan or an Annual Implementation Plan. *See* Letter of Sanford M. Litvack to William G. Kopit, Esq., (May 6, 1980).

394. *See* Blumstein & Calvani, *supra* note 301, at 431-37. For an interesting theoretical attempt to define market power as a concept, see Landes & Posner, *supra* note 353.

395. *See* Blumstein & Calvani, *supra* note 301, at 431-37.

396. Calvani & James, *Antitrust Law and the Practice of Medicine*, 2 J. LEGAL MED. 75, 81 (1980).

397. Blumstein & Calvani, *supra* note 301, at 432.

to inpatients to those purchased in the official hospital florist shop. Clearly, the goal of this tying arrangement is to use market power with respect to one transaction to increase sales for the tied product.

Existing antitrust doctrine bars tying arrangements provided a plaintiff can show three things: (1) an effect on commerce that is "not insubstantial;"[398] (2) the tying and tied goods are separate, distinct products;[399] and (3) market power in the tying product exists so that the seller has "some advantage not shared by . . . competitors in the market for the tying product."[400]

If one assumes that the first two necessary showings can be made,[401] the analytical issue of the existence of market power in the tying product remains; that is, a court must decide "whether the seller has the power, within the market for the tying product, to raise prices or to require purchasers to accept burdensome terms that could not be exacted in a completely competitive market."[402] The "uniqueness" of a product may create this type of market power if an element of exclusiveness exists: "[u]niqueness confers economic power only when other competitors are in some way prevented from offering the distinctive product themselves. Such barriers may be legal, as in the case of patented and copyrighted products, . . . or physical, as when the product is land . . . ."[403]

CON legislation, by restricting the opportunity for health care institutions to purchase equipment or expand facilities, may add to the market power of some providers. Thus, an institution with "either equipment or facilities for which others cannot obtain a certificate will have market power"[404] that might serve as a basis for an adverse finding of antitrust liability. In sum, a CON might be "sufficiently analogous to the patent and copyright laws to justify a finding of uniqueness that confers market power."[405]

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398. Northern Pac. Ry. v. United States, 356 U.S. 1, 6 (1958).

399. *See, e.g.*, Fortner Enterprises, Inc. v. United States Steel Corp., 394 U.S. 495 (1969) (*Fortner I*); Times-Picayune Publishing Co. v. United States, 345 U.S. 594 (1953).

400. United States Steel Corp. v. Fortner Enterprises, Inc., 429 U.S. 610, 620 (1977) (*Fortner II*).

401. *See* Blumstein & Calvani, *supra* note 301, at 433-35.

402. United States Steel Corp. v. Fortner Enterprises, Inc., 429 U.S. 610, 620 (1977) (*Fortner II*).

403. *Id.* at 621 (quoting Fortner Enterprises, Inc. v. United States Steel Corp., 394 U.S. 495, 505 n.2 (1969) (*Fortner I*)).

404. Blumstein & Calvani, *supra* note 301, at 435.

405. *Id.* at 436. *See* United States v. Loew's, Inc., 371 U.S. 38, 45 (1962) ("requisite economic power is presumed when the tying product is patented or copyrighted.") *See generally* Calvani & James, *supra* note 396, at 81-83, 85-89.

The problem of access to hospital privileges provides the other heuristic example of the potential antitrust effect of governmental regulatory action through CON. Although courts traditionally have not carefully scrutinized hospital decisions on staff privileges,[406] "[a] very respectable case can be made" that anticompetitive barriers to hospital staff privileges violate the antitrust laws when a doctor's practice requires access to hospital facilities or equipment.[407]

Three Supreme Court cases suggest a line of analysis. In *Otter Tail Power Co. v. United States*[408] a power company owned the only power subtransmission lines in an area. It refused to sell potential competitors power at wholesale prices and also declined to "wheel" power to its potential competitors from other suppliers of wholesale energy.[409] The Supreme Court upheld a district court decree that ordered Otter Tail either to sell power at wholesale prices or to "wheel" power from other sources to cities and towns that sought to supply their own power.[410] The Court noted that "Otter Tail's refusals to sell at wholesale or to wheel were solely to prevent municipal power systems from eroding its monopolistic position."[411] It declared that a company cannot use its monopoly power "to foreclose competition or gain a competitive advantage, or to destroy a competitor . . . ."[412]

Otter Tail involved the use by one company of its market power—control of a unique resource—to prevent competitive entry. To remedy the situation Otter Tail was required to allow use of its subtransmission lines by potential competitors for whom the use was necessary for entry into and participation in the market.

Otter Tail seemed to build on two earlier cases, both of which involved group activity. In *Associated Press v. United States*[413] the Supreme Court held that "the news-gathering organization, membership in which conferred a substantial competitive advantage, could not discriminate against those applicants for membership who competed with existing members."[414] The bylaws of the Associated Press (AP) prohibited AP members from selling news

406. *See* Calvani & James, *supra* note 396, at 77.
407. *Id.* at 81.
408. 410 U.S. 366 (1973).
409. *Id.* at 371.
410. *Id.* at 375.
411. *Id.* at 378.
412. *Id.* at 377.
413. 326 U.S. 1 (1945).
414. III P. AREEDA & D. TURNER, ANTITRUST LAW ¶ 729g, at 242-43 (1978).

to nonmembers and granted members the authority to block nonmember competitors from membership.[415] The purpose of the bylaw provision was anticompetitive.[416] Concluding that the actual effect of the bylaws was not controlling, the Court held them illegal on their face. While the AP could limit admission, it could not do so on a discriminatory or anticompetitive basis.[417] *United States v. Terminal Railroad Association*[418] also involved joint action by a group of competing railroads to control all economical access routes into St. Louis. The Court held that exclusion of some competitors from the group was illegal because of the critical importance of the facilities to the excluded competitors. Accordingly, it ordered that competing companies be allowed to join the group or otherwise to use the facilities on a nondiscriminatory basis.[419]

Otter Tail, Associated Press, and *Terminal Railroad* suggest that when, either individually or by group action, a competitor controls some unique resource, access to which is essential for other competitors, the controlling competitor must provide its rivals nondiscriminatory access to the resource. This principle may apply to the medical sector. Governmental regulation through CON is designed to avoid the proliferation of medical facilities and equipment. Rational resource allocation under CON may result in specialization, whereby one institution emphasizes one service and another a different service. When a "physician's practice requires access to facilities or equipment that has been limited to a particular institution by virtue of certificate of need, the uniqueness of the asset may underscore the necessity of open access to it by all firms in the market."[420]

In the hospital context, the principle of nondiscriminatory access need not require the granting of staff privileges to all practitioners. *Terminal Railroad* suggests the possibility of allowing competitors to use facilities in certain circumstances without granting general privileges. *Associated Press* suggests that a hospital can limit its staff size, provided that the criteria for membership are not discriminatory or anticompetitive. *Otter Tail* reinforces that idea, since the decree conferring access in that case included a provision that Otter Tail be allowed to charge "rates

415. 326 U.S. at 4.
416. *Id.* at 18.
417. *Id.* at 21.
418. 224 U.S. 383 (1912).
419. *Id.* at 408-09.
420. Calvani & James, *supra* note 396, at 83.

which are compensatory."[421] Thus, no institution will be obliged to open its doors to such an extent that it suffers economically from the proliferation of practitioners, provided that the resulting economic harm is not the result of normal competitive factors.

Finally, *Otter Tail, Associated Press,* and *Terminal Railroad* all involved findings of anticompetitive intent underlying the respective access restrictions. In the hospital context, such findings may be more difficult to make. More likely, restrictive access decisions will be couched in terms of quality assurance. For example, hospitals may specify criteria such as board certification or board eligibility as a basis for granting privileges. As hospitals face broadened institutional liability for malpractice by nonemployee providers who practice in the hospital,[422] their institutional claim for a role in quality control grows stronger. Eventually, the courts must determine how important the finding of purposeful anticompetitive conduct is. Absent overt anticompetitive behavior, the courts may well accommodate the competing interests by carefully scrutinizing the quality assurance argument[423] and, in considering the feasibility of less anticompetitive alternatives, balance quality considerations against the desirability of maintaining a competitive system.

V. *Conclusion*

Is a dose of competition what the doctor should order? From the above discussion, it should be clear that society has moved in the direction of seriously considering market-oriented alternatives to health care delivery, and we endorse this general change in policy orientation. In stating that a dose of competition is warranted, we accept the guiding principle that both physicians and patients should face meaningful financial incentives to make cost-effective purchases in the medical marketplace. To make such decisions, they must have adequate information. Although equality of access to health care services may be an unattainable and undesirable objective, the principle that every citizen is entitled to a minimum standard of care should be maintained.

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421. 410 U.S. at 375.

422. *E.g.,* Tucson Med. Center, Inc. v. Misevch, 113 Ariz. 34, 545 P.2d 958 (1976); Gridley v. Johnson, 476 S.W.2d 475 (Mo. 1972). *See also* Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied,* 383 U.S. 946 (1966).

423. *See* Blank v. Palo Alto-Stanford Hosp. Center, 234 Cal. App. 2d 377, 385, 44 Cal. Rptr. 572, 575 (1965). *See also* Dattilo v. Tucson Gen. Hosp., 23 Ariz. App. 392, 396-97, 533 P.2d 700, 704-05 (1975).

To foster competition does not mean to eliminate government's role in health care, but, again with reference to the Article's title, rather to redefine it. There is a role for the state in assuring that patients have ready access to truthful information about the array of choices they face in the medical marketplace. State action may be necessary to ensure that competitive efforts are not forestalled by collective actions of entrenched provider groups. Exercise of tax-transfer power is surely needed to assure all citizens access to a socially-desirable minimum level of health care services. Certain governmentally-enforced rules may be necessary to assure that the poor and the very sick are not placed at an undue disadvantage in a competitive environment.

At the same time, under competition, many governmental activities would be substantially reduced. There would be no reviews of individual providers' charges or utilization patterns. Nor would there be areawide expenditure ceilings. Investments in beds and/or other facilities and services would not be monitored by planning authorities. Empirical studies reveal that most of these regulatory activities have not succeeded in reducing the growth of health care costs. Yet, when they have succeeded in cost containment, there is serious question whether undesirable side effects have not (or will not) largely offset the beneficial effects on private and public budgets.

Although a few elements of the competitive approach have been put into practice in the last half decade or so and additional ones are being given serious consideration, it is extremely doubtful that a "let-er-rip" (LER) market-oriented approach will be politically viable in the foreseeable future. Likely opposition from both provider and consumer groups, such as trade unions, has been discussed above as have possible ways of overcoming such opposition. We do not wish to minimize political problems in implementing a market-oriented approach; certainly our concept of the market differs substantially from that traditionally espoused by provider groups. But even if LER were possible, would it be desirable to adopt a full-scale market-oriented approach at this time? A gradualist approach would be preferable to LER.

There is now plenty of empirical evidence documenting the failures of most forms of regulation in the health field. But although we find the market-oriented approach conceptually appealing, many of the reforms currently being considered are based primarily on knowledge of how markets function but with little empirical underpinning. Furthermore, there are a number of prac-

tical implementation questions that arise when one moves from the abstract concept to actual implementation of a program. There is a danger of repeating a major error of the past—program implementation on a national basis without either prior empirical evidence on program effectiveness, or without sufficient attention to complex implementation issues. For this reason, there should be experimentation with a variety of market-oriented approaches on a small scale. Outcomes should be evaluated, and practical implementation problems that arise documented.

We realize that it would take years before the results of such studies would be available. But it is unlikely that the LER approach can be implemented on a national basis within the next few years in any event. More feasible in the short run than LER is reform of Medicare and Medicaid and of existing federal tax subsidies for private health insurance. We strongly favor introducing market-oriented incentives into the private health insurance market, and the same applies to existing public programs of health care financing with the proviso that they apply to Medicare as well as to Medicaid. Applied to Medicaid patients alone, competitive reforms could be misinterpreted as inevitably disadvantaging low-income groups. Inclusion of Medicare, which covers the full socioeconomic spectrum, would avoid any possibility of misperception about class bias in the market-oriented reform approach. Moreover, on programmatic grounds, Medicaid's market share is typically too small to have a meaningful influence on decisions of private sector providers. Further, federal involvement in Medicare is much more substantial than it is in Medicaid, which is a federal-state financial and administrative partnership. Thus, at the federal level, it would seem appropriate and desirable to include Medicare with Medicaid reform.

At the state level, of course, Medicaid reform alone may well be justified because states have no financial involvement in Medicare while they have a substantial fiscal stake in Medicaid. In addition, states can serve as laboratories for experimentation as part of the gradualist approach we endorse. Consequently, our appeal for inclusion of Medicare with reform of Medicaid applies to formulation of federal policy; states should be free to experiment with incentives approaches to Medicaid.