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MELODIC VARIATIONS, COUNTERPOINT, AND THE FUTURE ROLE OF PHYSICIANS

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It seems to me I've heard that song before
It's from an old familiar score
I know it well, that melody
— "I've Heard That Song Before" (1942)

It is conventional wisdom that the U.S. health care system is overly fragmented, and therefore should be consolidated or coordinated. In this symposium on the "patchwork" health care system, four leading health law scholars test the fragmentation hypothesis in different health policy domains: hospital pricing, data privacy, information technology, and provider competition. The description in each article is thick, and the insights rich. Each contribution, moreover, further illuminates the underlying questions: Is fragmentation problematic? Is defragmentation beneficial?

Ideals of Physician Control. The fragmentation hypothesis is a recent variation on an established theme of information and accountability in the health care system. The original rendition of the theme is familiar, and still makes for easy listening: Only physicians are sufficiently worthy and sufficiently responsible to run the health care system. Guided internally by ethical norms and externally by legal ones, the medical profession performs three essential functions. First is expertise. Physicians know what health care is needed and

how to deliver it. Second is loyalty. Physicians act in their patients' interests. Third is stewardship. Physicians honor the needs of society for charity, forbearance, and balance.

Whether or not these assertions are true is beside the point. They reasonably describe the initial conditions for U.S. health policy, and have been embodied in laws ranging from state professional licensing and hospital medical staff governance to Medicare reimbursement. Moreover, physician empowerment generally substitutes for more broadly accessible information that would enable individuals, corporations, or government to manage care and its associated expense. In Kenneth Arrow's famous account, information asymmetry is even regarded as both problem and solution, with ethical self-governance by the medical profession filling optimality gaps in market transactions and rendering direct control less necessary.[1]

Historically, believing in the medical profession meant embracing a physician yeomanry not unlike Jefferson's democratic ideal of small, independent farmers.[2] Norman Rockwell's family doctor was neither aristocrat nor wizard but someone with common sense and the common touch. Decentralized medical practice was also compatible with the practicalities as well as the mythos of the American frontier, including the 20th century version that emphasized the social and economic benefits of geographic mobility. As Paul Starr explained in his celebrated social history of American medicine, grassroots physicians repeatedly fought and usually defeated both corporate and governmental control, notwithstanding population growth, scientific advancement, and expanding public investment in health care.[3]

Admittedly, the theme of physician control generated variations

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[1] Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 Am. Econ. Rev. 141 (1963).

[2] Thomas Jefferson, Notes on the State of Virginia 179 (1784) ("Those who labour in the earth are the chosen people of God, if ever he had a chosen people, whose breasts he has made his peculiar deposit for substantial and genuine virtue.") (available at http://www.thefederalistpapers.org/wp-content/uploads/2012/12/Thomas-Jefferson-Notes-On-The-State-Of-Virginia.pdf

[3] PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982).

pretty much as soon as it was played. These offerings came from a range of policy-related academic disciplines, including ethics, administration, economics, sociology, political science, and law. However, most subsequent versions of the information and accountability theme disputed the real-world effectiveness of relying on physicians rather than its desirability as a normative matter. At an individual level, examples of both paternalism and self-dealing cast doubt on physicians' authenticity as agents for their patients. In the aggregate, professional market power, "moral hazard" from third-party payment, and substantial public subsidies for both coverage and care (e.g., non-taxability of employment-based health insurance) undermined confidence in the financial prudence of physician decision-making.

The Fragmentation Challenge. If physicians cannot fulfill our expectations of them perhaps our instincts about the desirability of independent physician practice are also misguided. This is one way to understand the fragmentation hypothesis – a variation with three distinct parts that match the trebly unrealistic responsibilities that the original theme placed on physicians.

The first part is personal fragmentation, meaning the health care system's failure to honor the totality of the people it serves. For several decades, advocates for a holistic approach to health have bemoaned the existing system's sub-specialization, its technical focus, its procedural intensity, its lack of cultural competence, and its tendency to construct the patient but neglect the whole person.

The second part is industrial fragmentation, meaning the health care system's failure to deliver services effectively and efficiently. Physicians practice habitually, typically in no more than loose association with hospitals and often with one another, and often feign or flaunt their ignorance of the associated costs. Systematic learning is rare, and what has been learned disseminates slowly. Technical innovations routinely increase expense but seldom improve performance. Over the past 25 years, moreover, extensive research has documented the system's unreliability, providing hard evidence of unwarranted clinical variation and pervasive, persistent lapses in quality and safety.

The third part is public fragmentation, meaning the health care system's failure to act with social purpose. The United States tolerates profound and unjust racial, ethnic, and socioeconomic disparities in both treatment and outcomes; wastes scarce public resources on overpriced, ineffective medical care; and under-invests in other sectors, such as education, which are powerful social determinants of health. As with public shareholders, listed companies, and the financial markets, health care has become so interconnected with the broader economy that proper governance requires more than loyal and capable private agents for patients. It requires explicit public responsibilities as well.

Four Patches in the Patchwork. Each of the four contributing authors sheds light on these fragmentation problems. One question readers of the articles might ask themselves is whether each author's take on fragmentation tends to reprise the original theme of physician empowerment or whether it composes a counterpoint that moves the music in a new direction—one in which physicians no longer play all of the principal parts.

Professor Tim Greaney, an authority on antitrust law in the health care sector, examines the competitive implications of "physician integration." His analysis is firmly grounded in the legal framework of competition oversight, including case law interpreting the principal federal antitrust statutes and the guidance and enforcement practices of the Federal Trade Commission and the U.S. Department of Justice. He offers a lukewarm endorsement of the agencies' current approach, which he describes as deferential to the methods by which physicians choose to combine their clinical practices, on condition that those combinations are non-exclusive and therefore do not confer market power on a few purveyors of particular physician services. By using the neutral term "network," Greaney tends to finesse the question of whether physicians are the principal entrepreneurs in these business ventures, represent necessary partners in activities initiated by other parties, or form groups only reactively as a defensive strategy. Overall, he seems less concerned about physicians themselves misbehaving, and more concerned about dominant hospitals locking up physicians in order to gain economic power over health insurers or dominant health insurers locking up physicians in order to exclude competing health

insurers from the market.

However, Greaney also points out inconsistencies in the agencies' approach that suggest uncertainty regarding the relationship between physician empowerment and defragmentation. For example, it is not clear whether the antitrust enforcement agencies view physicians as potential leaders of integrated organizations or merely as valuable inputs into insurance benefit packages and other products assembled elsewhere. If the former, exclusivity would seem necessary for efficient physician integration; if the latter, physician integration would seem unnecessary regardless of exclusivity. Relatedly, he notes that the agencies seem unable to articulate a structural description of a competitive market composed of integrated physicians, and rely instead on "conduct remedies" that require promises of good behavior as integration proceeds. He also supports stricter requirements for antitrust pre-clearance of physician integration transactions because it would force physicians to make a procompetitive case for their proposals and help the agencies improve their understanding of the markets at issue.

Professor Nicolas Terry, an expert on health information technology, looks dispassionately at efforts to remedy fragmentation in the health care system through improvements in electronic record-keeping and communication. He demonstrates that even after roughly twenty years of efforts to jumpstart HIT, we have not advanced much beyond wishful thinking. The mid-1990s decision to require "administrative simplification" through regulatory diktat without federal funding failed miserably, but subsidy-based strategies have not done much better. Those include relatively modest push approaches in the 2000s to incentivize the development of new technologies, and much more sweeping pull approaches following the Great Recession that offered economic stimulus funds to health care providers in exchange for "meaningful use" of HIT.

Terry asks whether the bigger problem is that HIT suppliers cannot seem to understand health care well enough to make decent products, or that health care providers simply cannot use HIT productively regardless of its quality. He concludes that both sides of the HIT market should share the blame, citing perverse financial incentives, poor provider organization, lack of interoperability

among electronic health record systems and various "smart" devices, and a slew of regulatory barriers to efficient adoption and use of HIT. Terry's most provocative suggestion is that "IT-enabled outside attackers"—not established providers, insurers, or even pharmaceutical companies—may be the entities that finally succeed in improving efficiency and performance in health care. Pushing hospitals and even physicians to the periphery, these disruptive innovators might well equip each of us with our own Star Trek tricorder, mooting much of the current debate over fragmentation and its remedies.

Professor Erin Fuse Brown contributes the first comprehensive analysis of US hospital pricing by a legal academic. Pulling no punches, she characterizes hospital prices as "irrational," by which she means high, arbitrary, and variable. Drawing on her own investigations as well as recent exposés in the popular press, she describes how hospitals assemble phonebook-sized "ChargeMasters" of list prices for their services and then differentially attempt to impose those prices on patients, health insurers, and other buyers. Fuse Brown attributes a range of individual and collective harms to these practices, refuting the hospitals' arguments that list prices are economically irrelevant. The problems she identifies include discriminatory effects on patients without insurance, misrepresentation of charitable contributions, and gaming of government payment systems. More generally, she argues, hospital price irrationality breeds inefficiency and perpetuates waste. In his explanation of why market capitalism is superior to centralized economic planning, Hayek focused on the "marvel" of accurate prices in conveying quickly and inexpensively a huge amount of granular information about production options and their associated costs.[4] Fuse Brown offers similar conclusions about the anti-competitive and anti-innovative effects of false prices in American hospitals.

[4] Friedrich A. Hayek, *The Use of Knowledge in Society*, 35 AM. ECON. REV. 519 (1945).

Fuse Brown says less about the causes of price irrationality, and she seems of two minds regarding the role of hospital regulation. On one hand, she suggests that solving the problems of unreasonable and discriminatory pricing may require regulatory intervention. On the other hand, she acknowledges that the accumulation of well-intentioned but counterproductive regulation is largely responsible for the current mess.

Historically, one of the most pernicious aspects of the regulatory environment for hospital pricing has been the independent status of physicians who constitute the "voluntary," self-governing medical staff of the typical community hospital. This legally enforced structural separation of clinically interdependent actors has significant economic consequences, both directly and by partitioning health coverage into hospital insurance for facility fees (the original Blue Cross and Medicare Part A) and supplemental medical insurance for professional fees (the original Blue Shield and Medicare Part B), including professional fees for services delivered to hospitalized patients. The "irrational" fees that Fuse Brown criticizes therefore result from a payment model that allows and encourages physicians to free-ride on resources such as facilities, staff, and technology that hospitals then bill to patients and their insurers.

Professor Frank Pasquale, like Terry a guru of technology, explores the relationship between health system defragmentation and patient privacy. He begins by restating three assertions that have often been made by commentators. First, that privacy is a substantial barrier to health system learning and therefore accelerated improvements in quality and efficiency. Second, that data aggregation—combining many sources of information about an individual—represents a significant incremental threat to privacy. Third, that individual patient control, through notice and consent requirements for each disclosure or use of protected health information, is an effective privacy safeguard. He concludes that many situations presenting serious privacy risks are orthogonal to these considerations, and instead urges the strengthening of substantive legal prohibitions on using health information to engage in specific discriminatory or improper conduct. For example, the prohibitions on medical underwriting and pricing to risk in the Affordable Care Act have greatly reduced, though not completely

eliminated, the potential for insurance discrimination based on personal health information.

Pasquale's examples of privacy violations come from both within and outside the health care system. Pharmaceutical marketing is a common example of the former, while employment and credit decisions involve parties without direct connections to the health care system. On the whole, misappropriation by non-health entities seems more worrisome. Physicians are not major players in Pasquale's analysis, even though they originate many of the data entries that can compromise privacy. An interesting question is whether the information that poses the highest privacy risk is created and exchanged for clinical purposes or mainly for payment and administration. If the latter, provider fragmentation that turns nearly every measurement into a reimbursable claim likely exacerbates the problem, compared with integrated risk-bearing organizations such as Kaiser.

Ambiguity and Ambivalence. Overall, the articles in this symposium are insightful and original, but light on prescription and not notably optimistic in tone. That combination of attributes seems well-suited to the national mood in health law and policy. We have embarked on an ambitious program of health reform, but its effects have varied widely from person to person and place to place because so little consensus exists around either its necessity or its goals. One can almost forgive the skeptics for concluding that a system in perpetual crisis may not be in crisis at all.

It is likely that the United States will vigorously pursue only two incremental remedies for fragmentation: new payment models that reward health care providers for bundled, episodic care, and transparency initiatives that focus on measurable clinical outcomes. These are melodic variations on the theme of independent physician control, not counterpoint. More radical changes, especially ones that would create a less physician-centric system, still seem dissonant and unattractive.

Most people continue to search for perfect doctors, and force themselves to believe that each physician they find is in fact an all-knowing, benevolent presence. At a policy level, we still view physicians as the cavalry riding over the hill to save us from insurance companies, drug companies, malpractice lawyers, and/or

the government. For example, physicians are seen as leaders of the movement toward "accountable care." It is a new variation, but it is indeed a familiar song.