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# HEALTH CARE LAW AND POLICY: WHENCE AND WHITHER?

*James F. Blumstein*<sup>†</sup>

**IN THE BEGINNING**, there was Law and Medicine. That was a course often taught in law schools and in schools of public health. It typically dealt with medical malpractice issues from a forensics perspective. Trial issues such as expert witnesses, evidence matters, etc., absorbed a lot of attention.

In the beginning, health law was not a field of study or of practice, at least under that terminology. One of my contributions to the discipline was that, during the time that I chaired the Law and Medicine section of the Association of American Law Schools, we succeeded in renaming the section Law, Medicine, and Health Care, a more inclusive nomenclature that reflected the broader set of issues taught in law school classes and practiced by the health law bar. Indeed, one of the most significant changes over the years has been the evolution of a discipline of health law, an area in which practitioners specialize and in which students can find employment. The American Bar Association now has a section on health law in recognition of its niche in law practice.

Yet, it is hard to make the case that health law, as a field of study or practice, fits into a neat, coherent, analytically discrete box. Professor Gregg Bloche has asserted that “[t]he law governing American health care arises from an unruly mix of state and federal agencies and from a jumble of statutes and common-law doctrines conceived, in the main, without medical care in mind.”<sup>1</sup> What gives health law its special character is its topical involvement with medical care. Health law encompasses how public policy should address matters related to individual and public health. And so, health lawyers must help clients and courts develop a way of thinking about medical care issues—a framework—to provide a context for the “doctrines conceived . . .

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<sup>1</sup> M. Gregg Bloche, *The Invention of Health Law*, 91 CAL. L. REV. 247, 249-50 (2003) [hereinafter Bloche, *The Invention of Health Law*].

without medical care in mind.”<sup>2</sup> Those doctrines must be adapted and fine-tuned to the particularized context of health care with special reference to the institutions, culture and values peculiarly related to that field. At the same time, the evolution of health law doctrine cannot be—and should not be—irrationally disconnected to those “doctrines conceived . . . without medical care in mind” when those doctrines and concepts have appropriate application to the health law and policy arena.

It is always important to bear in mind that “how one thinks about an issue and the way an issue is framed shape the way one analyzes it.”<sup>3</sup> In this regard, I would contend that the central issues with which health law and health lawyers have had to struggle are how to think about medical care issues, which principles from other areas of law and public policy have application to health law, and to what extent they should apply. Probably the most difficult problem that the field of health law and policy has had to confront is the appropriate role of economics in medical care decision-making.<sup>4</sup> A correlative has been to address the issue of who should be introducing economic considerations into the decision-making process (if one assumes that some role for economics is appropriate)<sup>5</sup> and under what circumstances.<sup>6</sup>

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<sup>2</sup> *Id.*

<sup>3</sup> James F. Blumstein, *Regulatory Review by the Executive Office of the President: An Overview and Policy Analysis of Current Issues*, 51 DUKE L.J. 851, 880 (2001) [hereinafter Blumstein, *Regulatory Review*].

<sup>4</sup> In this regard, Professor Clark C. Havighurst has been a pioneer. See, e.g., Clark C. Havighurst & James F. Blumstein, *Coping with Quality/Cost Trade-offs in Medical Care: The Role of PSROs*, 70 NW. U. L. REV. 6, 7, 9-20 (1975) (noting that allocation of resources to health care is a central policy issue); see also James F. Blumstein, *The Legal Liability Regime: How Well Is It Doing in Assuring Quality, Accounting for Costs, and Coping With an Evolving Reality in the Health Care Marketplace?*, 11 ANNALS OF HEALTH LAW 125, 125-30, 141-44 (2002) (raising question whether customary practice standard of liability appropriately takes cost factors into account); James F. Blumstein & Frank A. Sloan, *Health Care Reform Through Medicaid Managed Care: Tennessee (TennCare) as a Case Study and a Paradigm*, 53 VAND. L. REV. 125, 202-10 (2000) (noting significance of institutional design on cost-containment issues and observing that managed care was an effort to introduce economic considerations into medical care decision-making).

<sup>5</sup> See generally Mark A. Hall, *Rationing Care at the Bedside*, 69 N.Y.U. L. REV. 693, 764-68 (1994) (arguing that physicians should make health care rationing decisions because they are more trustworthy than insurers or government); M. Gregg Bloche, *Trust and Betrayal in the Medical Marketplace*, 55 STAN. L. REV. 919, 924 (2002) [hereinafter Bloche, *Trust and Betrayal*] (explaining the historical rejection of economic competition in health care as “beneath professional dignity”). See also James F. Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis*, 59 TEX. L. REV. 1345, 1392-95 (1981) [hereinafter Blumstein, *Rationing Medical Resources*] (discussing how the standards for informed consent in different jurisdictions might be affected by government rationing decisions).

“In a nation whose institutions have relied on market mechanisms for making basic economic choices, governmental imposition [of non-market mechanisms of resource allocation] bears a burden of persuasion.”<sup>7</sup> Yet, the tradition in health care has started from the opposite assumption—an “assumption that the laws of economics do not apply to the health arena.”<sup>8</sup> For years, those who thought that market-based approaches have an appropriate and important role to play in institutional design had to overcome a presumptive skepticism toward that belief. Over time, many health policy analysts became “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.”<sup>9</sup>

Advocates for market-oriented policies in health care recognized that “[t]he choice between competition and regulation is a choice between imperfect systems,” as it is “not realistic to expect that the medical marketplace conform[] to all the textbook preconditions for a perfectly competitive situation.”<sup>10</sup> At the same time, “it is unreasonable to assume that abstract aspirations for a regulatory system can in practice be fully realized.”<sup>11</sup> That is, “[i]n the real world . . . the choice is not between competition and regulation in either pure form.”<sup>12</sup> Rather, “the realistic range of public choice does not reflect a total commitment to one or another system of social ordering.”<sup>13</sup> The issue for public policy is “where to draw the line along a continuum of public-private responsibility,”<sup>14</sup> with pro-market advocates asserting “that those who seek to involve government should bear the burden of establishing the existence of either an institutional malfunction or an equitable problem in need of redress.”<sup>15</sup>

<sup>6</sup> See, e.g., William M. Sage, *Regulating Through Information: Disclosure Laws and American Health Care*, 99 COLUM. L. REV. 1701, 1713-43 (1999) (analyzing the rationales for regulation of disclosure in health care, including the “competition rationale,” which attempts to balance the market by giving patients and purchasers increased access to information).

<sup>7</sup> James F. Blumstein & Frank A. Sloan, *Health Planning and Regulation Through Certificate of Need: An Overview*, 1978 UTAH L. REV. 3, 3.

<sup>8</sup> See James F. Blumstein & Frank A. Sloan, *Redefining Government's Role in Health Care: Is a Dose of Competition What the Doctor Should Order?*, 34 VAND. L. REV. 849, 852-53 (1981) [hereinafter Blumstein & Sloan] (noting that health policy analysts had just begun “to think of the health sector . . . as an economic system, subject to economic principles” at the time the article was written).

<sup>9</sup> *Id.* at 853.

<sup>10</sup> *Id.* at 854.

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

<sup>13</sup> *Id.*

<sup>14</sup> *Id.* at 855.

<sup>15</sup> *Id.* See also Blumstein, *Rationing Medical Resources*, *supra* note 5, at

The culture of medicine, traditionally, has been steeped in professional values.<sup>16</sup> The professional model takes as its premise that, empirically, the economic marketplace does not and cannot function properly in the healthcare field, and, normatively, that it should not so function.<sup>17</sup> Thus, “[m]arket factors such as cost-benefit trade-offs are not only seen as irrelevant, but as corruptive of medical judgments.”<sup>18</sup> This challenges the general belief that, presumptively, institutions should be structured according to the dictates of the market, by allocating resources based on price and consumer preferences and choices.

“The professional paradigm places power paternalistically in physician hands,” with physicians “perceiv[ing] themselves as controlling decision-making.”<sup>19</sup> Medical decision-making is viewed as “technical and scientific,” with “[q]uality-cost trade offs [being] attenuated.”<sup>20</sup> The result is that “economics and trade offs become marginalized in the policy debate,” since medical care is seen as an “exclusively technical-scientific enterprise.”<sup>21</sup> Thus, “[u]nder the professional paradigm, economic considerations undermine and corrode what are and should be technical scientific judgments.”<sup>22</sup>

The professional model reflects an approach to market failure that substitutes professional decision-making for that of consumers, who are sovereign in the economic marketplace. The market failure that underlies the claim for professional control is the asymmetry of information between physicians and patients.<sup>23</sup> Doctors are highly

1349 (observing that “[o]ne clear justification for some form of governmental involvement in the medical care marketplace stems from widespread acceptance of the view that society has some responsibility to help needy and worthy persons secure access to medical services”).

<sup>16</sup> See, e.g., James F. Blumstein, *Health Care Reform and Competing Visions of Medical Care: Antitrust and State Provider Cooperation Legislation*, 79 CORNELL L. REV. 1459, 1463 (1994) [hereinafter Blumstein, *Competing Visions*].

<sup>17</sup> See Blumstein, *Regulatory Review*, *supra* note 3, at 881.

<sup>18</sup> James F. Blumstein, *Medicine Isn't an Economics-Free Zone*, WALL ST. J., June 22, 2001, at A14.

<sup>19</sup> Blumstein, *Competing Visions*, *supra* note 16, at 1465.

<sup>20</sup> *Id.* at 1466.

<sup>21</sup> *Id.*

<sup>22</sup> Blumstein, *Regulatory Review*, *supra* note 3, at 881.

<sup>23</sup> E.g., Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 946 (1963) (observing that “[w]hen there is uncertainty,” knowledge tends to become “concentrated among those who can profit most from it”). Cf. James C. Robinson, *The End of Asymmetric Information*, 26 J. HEALTH POL. POL'Y & L. 1045, 1051-52 (2001) (noting the potential impact of patients' increasing access to information, for example, via the internet); Frank A. Sloan, *Arrow's Concept of the Health Care Consumer: A Forty-Year Retrospective*, 26 J. HEALTH POL. POL'Y & L. 899, 900, 909 (2001) (suggesting that health care consumers

trained scientists who make scientifically-based professional judgments based on medical criteria; patients are not well informed about the technically complex dimensions of medical care and are not really capable of becoming adequately informed so as to exercise control as they would in a typical market-based context.

Professionals self-regulate as a means of restraining self-interest, a necessary concomitant of placing decision-making authority in the hands of the professional.<sup>24</sup> And the professional paradigm assumes that financial incentives do not and should not affect professional judgment.<sup>25</sup> That claim facilitated the growth of third-party medical insurance; the normal economic considerations of moral hazard—that a person will consume more when the cost is borne by someone else—were, it was contended, inapplicable to the professional setting of medical care. As one can see from the third-party insurance example, much institutional design in medical care was driven by the assumptions underlying the professional paradigm, namely, that economic considerations do not and should not influence medical decision-making.

A similar policy example is the on-going debate over the issue of rationing in medical care.<sup>26</sup> In economic terms, resources are “allocated” in any market-based system to their most efficient and highly preferred use. Since human wants far exceed the availability of resources, there is always a need to allocate, to prioritize. The conventional professional paradigm contests the economics-based vision—the need to array economic resources “so as to maximize the medical benefits that every dollar buys.”<sup>27</sup> That is, the professional model rejects the economic insight that medical resources (like all economic resources) are scarce, and that “withholding of beneficial care” might be appropriate in circumstances where the value of that care is ex-

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can be educated to overcome their lack of knowledge).

<sup>24</sup> See Bloche, *Trust and Betrayal*, *supra* note 5, at 924 (discussing Kenneth Arrow’s argument that “[t]he ethic of self-sacrificing fidelity [of physician to patient] reduced the risk of opportunistic exploitation of this knowledge asymmetry” and “assuaged patients’ fears of being exploited”).

<sup>25</sup> See *id.* (emphasizing the historic insistence on insulating professionals from public or private influences on clinical judgment). See also Blumstein, *supra* note 18, at A14 (highlighting this assumption).

<sup>26</sup> E.g., Blumstein, *Competing Visions*, *supra* note 16, at 1467-68 (“The rhetoric of rationing and denigration of its use suggest that economic trade-offs are inappropriate when it comes to health care.”). For a thoughtful and comprehensive consideration of rationing issues, see MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS: THE LAW, ETHICS, AND ECONOMICS OF RATIONING MECHANISMS (1997). For a discussion of rationing as a current policy matter, see Geeta Anand, *The Big Secret in Health Care: Rationing Is Here*, WALL ST. J., Sept. 12, 2003, at A1.

<sup>27</sup> Bloche, *The Invention of Health Law*, *supra* note 1, at 252.

ceeded by its cost. The professional model reflects “physician conceptions of medical need that call for provision of care regardless of cost when expected clinical benefits outweigh potential clinical harms.”<sup>28</sup>

Use of the term “rationing” is a “rhetorical ploy” to advance the anti-economic perspective of the professional paradigm by focusing on a particular, centralized form of resource allocation.<sup>29</sup> But, as Professor Bloche candidly acknowledges in his recent defense of the professional paradigm and critique of economically-driven health care policy,<sup>30</sup> the agenda is much broader: There is opposition not just to a particular form of resource allocation, but resistance to consideration of economic trade-offs as “inappropriate when it comes to health care.”<sup>31</sup>

The competing visions of medical care underlie the different critiques of various cases and doctrines that have evolved in health care. Should economics influence medical decision-making at all or just not unduly (however one might define the point at which medical judgment is “corrupted”)? The North Carolina decision in *Muse v. Charter Hospital of Winston-Salem, Inc.*<sup>32</sup> provides a good vehicle for discussing these issues and for framing much of the debate in health law and policy.

Although the precise contours of the doctrine in *Muse* leave room for debate, a broad reading of the case suggests that any hospital policy or practice designed to influence medical decision-making on account of economic considerations (e.g., the expiration of coverage under an insurance policy) is improper as wanton and wilful conduct subject to punitive damages.<sup>33</sup> A nice contrast with the approach in *Muse* is the Supreme Court’s decision in *Pegram v. Herdrich*,<sup>34</sup> holding that physician health-plan coverage decisions, which mix clinical judgments with scope-of-benefits determinations, are not “fiduciary” in nature under the federal ERISA law.<sup>35</sup> The Court noted that when physicians make mixed clinical-coverage determinations, they are not acting solely in the interest of their individual patients and therefore

<sup>28</sup> *Id.*

<sup>29</sup> Blumstein, *Competing Visions*, *supra* note 16, at 1467.

<sup>30</sup> Bloche, *The Invention of Health Law*, *supra* note 1, at 253-55 (rejecting the policy of maximizing social welfare without acknowledging the complexity of values involved in health law disputes).

<sup>31</sup> Blumstein, *Competing Visions*, *supra* note 16, at 1467.

<sup>32</sup> 452 S.E.2d 589 (N.C. Ct. App. 1995), *aff’d*, 464 S.E.2d 44 (N.C. 1995).

<sup>33</sup> *Id.* at 594 (“[A] hospital has the duty not to institute policies or practices which interfere with the doctor’s medical judgment.”).

<sup>34</sup> 530 U.S. 211 (2000).

<sup>35</sup> *Id.* at 237.

cannot properly be deemed fiduciaries, since fiduciaries must act exclusively in the interest of their principals.<sup>36</sup> The *Pegram* Court considered it self-evident that physicians would take into account economic factors,<sup>37</sup> whereas the *Muse* Court deemed such considerations antithetical to medical practice.

The evolution of policy and doctrine in health law will continue to reflect the tension between the professional and the market-oriented paradigms. It will also continue to reflect the rich normative overlay of policy concern with individuals' access to medical care.<sup>38</sup> These pivotal underlying issues remain unresolved, and that continued debate leaves the development of policy and legal doctrine under contention since policy and legal doctrine implement the underlying principles. The result is likely to be the continued presence of doctrines and policies in tension with one another; landmines that health lawyers and teachers must carefully identify and skillfully navigate. These tensions mirror the underlying disagreements on core issues related to normative premises (e.g., related to access issues) and to the appropriate role of economics in medical decision-making.

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<sup>36</sup> *Id.* at 234-35.

<sup>37</sup> Compare *Pegram*, 520 U.S. at 234-35 ("It would be so easy to allege, and to find, an economic influence when sparing care did not lead to a well patient, that any such standard in practice would allow a factfinder to convert an HMO into a guarantor of recovery.") with *Herdrich v. Pegram*, 154 F.3d 362, 374-80 (7<sup>th</sup> Cir. 1998) (decrying the evils of allowing economic considerations to play a role in medical decision-making).

<sup>38</sup> For a discussion of these issues, see James F. Blumstein, *Health Care Reform: The Policy Context*, 29 WAKE FOREST L. REV. 15, 29-38 (1994).



