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Rationing Access to Medical Care: Some Sober Second Thoughts

by

Richard A. Epstein

MARKETS IN THE FACE OF NEED

The subject of this essay is a familiar topic: to what extent should access to health care be determined by market mechanisms? Today there is so little support for the use of these mechanisms that it is all too easy to forget why markets work as well as they do in most situations. Markets are institutions with only one engine for improvement in social life: voluntary exchanges by self-interested parties for their mutual benefit. Let any set of initial endowments be well-defined, then the observed exchanges from those endowments must benefit all parties to them. When transactions do not take place, it is for one of two reasons: either the cost of transacting is sufficiently great to negate the potential gains from exchange,¹ or there is no price of exchange that

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allows both parties to be better off than they were before: at every point the seller's cost is greater than the buyer's gain. The market, while legal, closes down.

When transactions fail for the first reason, the result is unfortunate. When they fail for the second reason, the result is desirable. The reason for the difference

is this: in the first case, the deal that does not take place is one that would increase value. In the second, the deal that does not take place is one that would decrease value. In practice it is difficult to decide by observation which of these two reasons account for the failure of any particular transaction. But as a matter of social policy there is no reason to examine failed transactions on a case by case basis. The proper global strategy is to reduce the overall level of transaction costs so as to make it more probable that the transactions that abort are those that would not take place even in a zero transaction cost world. In some cases, such as sales of a business, that strategy calls for contracts to be put in writing; in some, as with trades on the futures market, it is to encourage informal dispute

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resolution by cooperatives and trade associations; and in some, such as real estate mortgages, it is to use systems of recordation that make property rights more definite. The use of one strategy to control transaction costs in any given setting does not preclude another. Whatever the set of appropriate responses in a particular setting, the overall strategy is clear: voluntary transactions that do occur are ordinarily welcome because everyone benefits. Transaction costs are unwelcome because of the barriers that they throw up to exchange.

This transactional model works well to explain what is good and bad in the organization of labor markets, housing markets, and financial markets—or so I would argue. But even the strongest defender of the market faith has to blanch visibly when the logic of voluntary exchanges is applied to a newborn infant left malnourished on the doorstep of a public hospital. Clearly there is no capacity for the archtypical voluntary exchange that drives the market. Yet deep in our bones we (and it is the primordial, collective “we”) are convinced that the benefits that can be conferred upon the child in distress far outweigh the costs, necessarily borne by others, that are necessary to respond to the particular case. No matter how powerful the analytical case for saying that comparisons of utility cannot be made between persons, virtually no one holds fast to that belief as an operating assumption when faced with the stark reality of vulnerable infants abandoned on the doorstep of a hospital on a cold winter day. This is not a case where the want of willingness or ability to pay—often the decisive market test²—marks a lack of value. On matters of health care, wealth maximization is a very bad proxy for utility maximization, and where the two diverge the former gives way to the latter.³ Judge Posner gives an illustration of a pituitary extract of modest use to the child of a rich family, but of great use to the child of a poor family, who without it will become a dwarf. He then concludes: “In the sense of value used in this book, the pituitary extract is more valuable to the rich than to the poor family, because value is measured by willingness to pay; but the extract would confer greater happiness in the hands of the poor family than in the hands of the rich one.”⁴ It is far from clear that the equation of value with wealth instead of utility, however, captures anyone’s intuitive sense of the term. Posner himself is aware of the limitations of his argument, although he is unwilling to make any adjustments to deal with it.⁵

The health cases bring the tension between wealth and utility to the fore. The proper relationship between them and some ultimate criterion of value is, I think, as follows. As a matter of first principle, utility, not wealth,

is the better theoretical measure of what value is. But by the same token utility is difficult to isolate and measure. In most contexts the willingness to pay, or to work, is as good a proxy for utility as one is able to identify. By necessity, it becomes a rough-and-ready substitute for some ultimate concept of utility, which in general proves unworkable in practice. Notwithstanding the general tension between these two measures, voluntary contracts stand in a preferred place under both regimes. Where they take place we can be confident that each side has moved to a higher indifference curve (i.e., to a greater level of utility) than he held before; otherwise consent

We should be aware of the hidden perils associated with forced provision of medical care.

would not be forthcoming. By the same token, especially in dealings with strangers, it is difficult to see how private utility can advance while overall social wealth is reduced. In principle, people often enter into transactions that leave them both happier, on the one hand, and less wealthy on the other. That is the meaning of a consumption transaction. But for any given level of consumption, people will normally seek to spend as little wealth as possible. They purchase goods in the market because it is cheaper to buy and consume than to produce and consume. Since these contracts are positive sum transactions, they should in the aggregate raise wealth, not reduce it. Thus, the protagonists of wealth and utility both converge on the proposition that voluntary agreements should ordinarily be enforced unless there is some strong negative third party effect, as occurs with cartel and price-fixing arrangements. The defenders of voluntary markets, myself included, thus revel in the idea that one good idea—voluntary exchange—applied in countless transactions yields far better social results than the endless array of bad regulatory ideas that all too often move resources from higher to lower valued uses, creating private resistance and public disillusion along the way.

The differences between wealth and utility, however, surge to the fore in connection with those situations in which voluntary exchanges cannot take place. If wealth is the test of value, then the lives of the penniless are of no worth, so there is no concern with the transactions that fail to take place because of the inability to purchase. But if wealth is thought only to be a proxy for

utility, it then becomes far more plausible to say that wealth is a proxy worth using only where there is reason to believe that it provides us with some suitable approximation of the underlying good. However, that proxy is highly flawed in situations seen frequently in medical care cases, where need is great but wealth is absent. The difficulty for any theory that equates utility with value is that the gains in utility obtainable by one-sided transfers cannot be captured by a set of market exchanges that uniformly require both sides to benefit.

The following question then arises: where voluntary exchange presupposes a level of wealth that is not available on one side of the transaction, what should be done to make markets, or the social order more generally, responsive to the gap between need and wealth?

The modern response to this problem is one that calls for vast levels of government intervention. Such intervention requires hospitals and other health care providers to extend at their own expense medical services to persons who are in need but cannot pay. Recent COBRA legislation⁶ is representative of this modern view. It demands that hospitals admit and take care of women who are in active labor and people who are in a medical emergency until the medical condition is "stabilized" and alternative care can be provided. However, the COBRA statute contains no provision that provides any specific financial reimbursement for the hospitals on whom it imposes its duties. If some form of coverage, private or public, is available, then the hospital may claim it in the usual way. But if coverage is not available, then the hospital has to pay for the care out of its own resources, and in addition must bear the further cost of postponing elective care for paying patients in the process.

The absence of the carrot invites the heavy use of the stick. The obligations that are imposed by virtue of the COBRA statute are quite extensive, and the penalties that may be imposed for nonconformity with them can be quite steep. Not only are fines or malpractice actions routinely available, but it is also possible for the United States or the various states to impose heavy administrative and regulatory sanctions on hospitals. Sanctions can also include the termination and suspension from Medicare, whose fraction of the overall health care market is so large that no modern hospital can forgo participation in the program and remain financially viable. Yet the statute contains no discernible standards that link imposition of the sanctions to the severity of the offense.⁷ A form of administrative lawlessness is thus used to enforce the newly created access right, a right that is fully unfunded by the Congress that created it.

CHOOSING THE MIX: EXCHANGE, COERCION, AND CHARITY

The central question of this paper is whether the modern transition from markets to coercion may be made as comfortably and smoothly as its supporters appear to believe, even if we accept the sharp disjunction between wealth and value in the context of health care. In the end, I think that the answer to this question is no, and that we should be aware of the hidden perils associated with forced provision of medical care. These perils may be as great, if not greater, than those generated by a system of medical care that operates without government coercion.

In order to understand the possible sources of difficulties, it is necessary to keep in mind two fundamental caveats: first, in any social setting the question is not whether any institutional arrangement is beset with imperfections. They all are, and the only question worth asking addresses the relative magnitude of the imperfections at hand. Second, the provisional definition of a market, as a set of voluntary exchanges that work to the joint benefit of the parties, is somewhat narrower than is appropriate for this context. Market exchanges and government coercion do not exhaust the universe of possibilities. The third possibility is the *charitable* provision of medical goods and services, which remains an important component of modern medical care that cannot be overlooked in examining the right of access to medical care.

Choosing the right rules of access to medical care is vexing; the proper inquiry is one that addresses the proper mix of exchange, regulation and charity. My own view is that the line between for-profit medical care and charitable medical care is forever blurry, and that there never will be a time when medical institutions will not subsidize needy patients. But the line between coercion and voluntarism raises very different issues. The case for governmental guarantees of an access right rests too much upon the vivid illustrations of desperately needed care that is supplied to people without means.⁸ Too little attention is paid to the long term and indirect institutional effects of these practices, which create as many long term difficulties for the provision of medical care as they eliminate. The situation here is a familiar one. The level of funds spent on health care, be it as a percentage of GNP or in actual dollars, is higher today than it has ever been before, and higher by far than it is in any other comparable country. The figure in the United States was around 12% of GNP in 1989, compared with 5% in 1960, and 8% in 1975; it is undoubtedly even higher today.⁹ Similarly, the United States spends a larger percentage of

its GNP on health care than does Canada, even though the Canadian system involves the universal provision of medical care without regard to ability to pay and funds its system with tax revenues.¹⁰ That system has serious defects of its own that cannot be ignored in any social reckoning.

Notwithstanding the enormous expansion in health expenditures in the United States, the gains in health fairly attributable to this expansion are hard to identify, whether in terms of the overall health of the population, or in terms of an increase in the expected life of our people. The degree of dissatisfaction with the American system is higher now than it has ever been. There are calls for reform that look north with envy, although the Canadian system has more difficulties than is perceived south of the border.¹¹ I wish I could believe that a system of government provided care could satisfy the demands for superior care at bargain prices. But I fear that this Canadian transplant would not do well on American soil even if (as there seems reason to doubt) it has done well in the place of its original birth. The existing structure of governmental and medical institutions will simply not permit the level of government domination of the health care industry that has been possible in Canada.

THE POSITIVE AND NORMATIVE SIDE OF MARKETS

To understand the difficulties with this absolute right to health care it is necessary to conceive of the theory of markets in two separate ways. First, there is the normative theory. This theory explains why markets will or will not achieve the optimal allocation of resources. In contrast, the positive theory asks a somewhat different question: how do people respond to the incentives they face in a particular setting, given their own individual self-interest? The normative argument in this context is designed to show that markets cannot work perfectly when great need is separated from the resources to satisfy it. Even though this argument has undeniable force, there is still the question of how health care markets will operate once the right to access at public expense is guaranteed. The imperfections must be taken into account.

The first problem that must be faced is how to ration health care if the inability to pay is regarded as an insufficient reason to deny people needed health care. With markets in place people are forced to make choices between the care they receive and the price they must pay. In some cases these choices are clearly unpleasant, but a system of markets is sufficiently powerful to facilitate long term health care arrangements that do not

require people to make uneasy market judgments on a case by case basis. For instance, they can pay some sort of a flat fee and then turn to administrative solutions within the firm to decide what care is given and how. That is the logic of the HMO and similar health plans. When this approach is taken, the incentive to ration resources is not eliminated, but is only transferred from patients to entrepreneurs. The right of access to medical care, however, does not place any discipline on the decision to demand health care. In principle, each person will seek health care until the net benefit of some additional unit is zero. In practice this extreme conclu-

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sion will be modified, as there are always some private costs to receiving health care even if it is freely provided: time is one element, and the possible risks of treatment are clearly another. But, for these purposes, we can ignore these additional constraints to see how a system would work if its ideal—all needed care at zero price—were achieved.

The answer is predictable. The care here still costs money, and it has to be provided out of general tax revenues. Those taxes are in turn imposed upon someone, where they create the usual distortions in other markets by imposing the kind of barriers to exchange that frustrate the efficiency of voluntary markets. The recent *New York Times* account dutifully notes, "Already the southbound Peace Bridge from Ontario to Buffalo is crowded with shoppers driving to avoid sales taxes totaling 15%, which have been driven up in part by health expenses."¹² Since the taxes are borne by the public at large, and the benefits are obtained by individuals, we can be confident there will be overconsumption of health care services. This conclusion remains even if it is assumed that wealth should be no obstacle to the receipt of health care, for if individuals received sufficient funds for health care, and were allowed to spend it on any good they chose, some of it, perhaps much of it, would not be spent on health care. Perhaps it would be spent on other goods that promise (in subjective terms) greater utility to their holder than medical care. Therefore, the effort to

have public funding of unlimited access trades in the problem of lack of access to the problem of lack of funding. It does not bring a stable equilibrium, either in markets or politics, to the provision of health care.

The Canadian system offers a useful illustration because it seeks to control funding through government budgets. However, in so doing, it creates a situation in which its expenditure figures are somewhat misleading; they only give a snapshot view of the system. First, patients in Canada who cannot gain immediate access to the system report considerable pain and discomfort because of delays in care provision.¹³ The pain, suffering, and loss of income are not registered in the Canadian calculus because they are not transfer payments, even if they are social costs. Their inclusion, however, would drive up the costs of its system, both in absolute terms and relative to the American system. In addition, the Canadian access rules have a perverse effect on patient behavior and treatment. If individuals were able to purchase care cheaply in a voluntary market, they would obtain medical care before a medical condition became serious, thereby avoiding major losses. But under the Canadian system, rationing forces the less serious cases to the back of the queue until they become more serious. Queues are a bad way to ration, whether we speak of gasoline or health care. Finally, the long term condition of the Canadian health care system has to be at risk, given the tendency to procure funding for current treatments, and not for long term capital expenses. Thus, eliminating a price system has some genuine effects. What are the possible substitutes?

FINDING SUBSTITUTES FOR PRICE

The obvious source of discipline within must be for some proxy that will substitute for the ability to pay certain medical services. It is possible to develop these proxies and to rigorously apply them, but the consequences will be unwelcome. It is costly to provide kidney dialysis machines, and therefore it is necessary to decide who will receive what care if these are not put out to bid. One possibility is to have special committees decide whose life is worth saving and whose life is not, but after a while the people who serve on these committees will learn that playing God in a world of imponderables is extremely difficult.¹⁴

So one shifts to some other system of allocation. Kidney dialysis could be allocated to all persons who are under a certain age on the theory that the longer the expected life and the better the expected health, the more likely kidney dialysis will do some good. Schemes of this sort are used in Great Britain and in Canada to

allocate kidneys in a more or less arbitrary fashion, and no one can claim that they invariably provide the treatment to the persons who can most benefit from it. More to the point, it seems clear that a system of this sort has no political future in this country. The widespread support for the Age Discrimination in Employment Act rests in part on the belief that it is arbitrary to rely on the "stereotypes" of age to determine who shall keep a job and who shall be fired.¹⁵ There is said to be a market failure in the common practice that tied job tenure to age. If age will not work in that market, then there is no reason to suppose it will work in the context of kidney dialysis or any other treatment.

Our political system stipulates that all recipients are of equal need regardless of anticipated benefits. The current rules in the United States make it clear that, in principle, all persons are eligible to receive treatment, and there would be a major political uproar if the dialysis that is now available was suddenly removed because of

People will consume too much of any good, even medical care, if others are burdened with its costs.

the adoption of a system of comprehensive access to medical services for all persons. This will not happen. The rough surrogates that are used to ration access in other socialized systems cannot be adopted in this country. If the services are rendered universal, there will be no way to exclude any part of the population from them on grounds of age or other formal characteristics. The problem of overconsumption of medical services is not easily overcome.

What other devices could be used to reach this goal? A second strategy that was adopted under the Canadian and the British systems is budgetary. The way to limit access to medical care is to limit the amount of money that is appropriated to that end, and then to require medical authorities to make their allocations between new hospitals, new equipment and general access. The budgets are kept low, but the queues are kept long and the quality of service is far below what most Americans regard as acceptable. I doubt very much that our system of guaranteed access could be accompanied by the same level of budgetary rigor. So once need determines the level of care, and budgets are then determined

to satisfy those needs, the problem of overconsumption is again not overcome. People will consume too much of any good, even medical care, if others are burdened with its costs. The descriptive and predictive power of economic theory remains even if wealth is not a suitable proxy for utility.

MORAL HAZARD: THE UNSPOKEN RISK

A second problem that must be addressed head-on is a familiar feature in the world of insurance. Moral hazard arises where there is risk that individuals are more likely to engage in dangerous activities with insurance than they would without. This problem exists in the health area (where indeed it was first isolated), for behind any promise of a right to access is a guarantee that operates like a promise of insurance embedded in some larger social arrangement.

Return for the moment to the COBRA statute that guarantees medical care where persons are in distress or in labor. The obvious rationale for that statute is that it requires treatment for persons who need it most. But, by the same token, it will increase the likelihood that persons will be in extremis. The question of whether one needs medical care is in part a function of accidental circumstances beyond anyone's control, and in part a function of care levels taken before illness occurs. If people know they will have to bear both the costs of precaution and the costs of extreme medical care, then they will seek to minimize the sum of both sorts of expenses, however imperfectly. If certain levels of care *ex ante* will reduce the risk of serious medical catastrophe, there will be a strong incentive to take that care. But once it is known that some other party will have to bear the costs of medical care in extremis, then the costs of getting into that condition is lowered, even if it still remains high. Therefore, there is a greater risk that early precautions will not be taken, thereby increasing the likelihood of a subsequent crisis.

Thus, if a woman knows that she *must* be admitted to a hospital when she is in active labor, she has less incentive to arrange for pre-natal care. There is then a greater chance that she will arrive with serious medical problems at a hospital, without medical records, and receive treatment which will be more expensive due to her serious condition. There are even instances of women unhappy in the final days of pregnancy taking cocaine to induce an early delivery. It is clear that not every woman will adopt behavior this radical, because COBRA is in place. Indeed, it is quite possible very few women would contemplate this strategy. But social questions must be analyzed with a view toward the

problem of large numbers, so that at the margin the set of incentives created by the legal system will in practice make a difference.

The situation is not that different from the position with the homeless.¹⁶ The greater the guarantees of shelter (or medical care) the more likely it is that these services will be used. One cannot act as though the question of distribution of care, given need, is the only question that has to be confronted to solve the right to access question. There is also the question of what is the frequency and severity of the underlying condition for which the remedy is provided. As a matter of first principle, we know that it is not constant.

The problems are still more complicated because there is a question of the distribution of the burden that follows from the adoption of the public choice to impose access duties upon hospitals. Under the current system the choice of *which* institution is left exclusively in the hands of the individual person entitled to exercise the

The problem here is not unique but crops up wherever mandatory benefits are imposed by laws that do not require the government to fund the social obligation that it imposes.

access right. There is nothing to prevent all people within the class from travelling to the single hospital that they regard as best able to meet their needs, and after COBRA, with its heavy sanctions, there is little that can be done to limit access on the other side. The net effect of this arrangement is that the regulated hospitals lose large control over their budgets: they have no direct control over which people they take in or over how many people they take in. At the University of Chicago Hospitals, for example, as many as 35% of the beds have been occupied by patients admitted through the emergency room, most of whom must be taken in and treated under COBRA, wholly without regard to any reimbursement, either public or private. A hospital that can operate in the black on its own budget could be pushed into financial difficulties if it is located in an area that exposes it to the risk of substantial forced utilization.

In the short run, it looks as though there is only a transfer of wealth to those who need it from those who do

not, but the indirect effects make the overall analysis far more complicated. The budget controls exercised by COBRA reduce the expenditures available for other programs, and may compromise the ability of the hospital to engage in planning for long term improvements. In the long run, closing down or reorganization is always a possibility for hard-pressed institutions, and short of that a curtailment of other beneficial health programs. It is just impossible to say what the magnitude of these effects are, but they cannot be inconsiderable, given the size of the subsidy that is conferred under the Act. It is unwise to ignore them.

MANDATED BENEFITS

This situation could be substantially altered if the financial obligation associated with the duty of access were transferred from the host institution to the general health care system, where it could be funded by general revenue taxes, where the risks of overconsumption are reduced but not eliminated. The problem here is not unique to the provision of welfare benefits, but crops up wherever mandatory benefits are imposed by laws that do not require the government to fund the social obligation that it imposes.¹⁷ It can happen with rent control statutes that require landlords to rent out units at below market prices; or with statutes that require employers to issue insurance (as with AIDS patients) at a fraction of market prices, at least if they wish to issue insurance at all; or with statutes that require landowners to admit disabled persons by altering the condition of their facilities at their own expense.

There is a unifying theme. In each case the choice of off-budget financing is not simply a question of redistribution of the burdens and benefits of society. It also has an intimate effect on the quantity of goods and services that are supplied as well. Where the state mandates that the care be given, but insists that a designated group of private parties pay for it, the state will opt for more rather than less extensive duties. The mandated benefit is another form of externality (we receive, you pay) which results, if not in excessive consumption, then in consumption above and beyond what would otherwise be demanded if the state picked up the tab, say by reimbursing the hospital for the cost of care (not easy to determine in a world of high fixed costs and lots of joint ones) in each hospital. There is in short a public choice dimension to the provision of health care, just as there is with any other service. The risk of government failures offsets the dangers of market failures.

With the financial constraint comes the modest urge to economize, to try to route the care of the needy to

hospitals that are low cost providers of the service. With the financial constraint comes the modest incentive to limit access, or even to collect some reimbursement from the parties who have received the direct benefit of the services in question. Indeed it is precisely the unwillingness to face the budget questions directly that lead modern American legislatures at all levels to specialize in mandates instead of direct payments. Yet once the same idea is tried more than once, there is no way to instill any sense of fiscal responsibility. The indirect harms are difficult to measure, and the inability of private institutions to work well under regulation is then treated as a further justification for imposing yet other restrictions and regulations of hospitals and others. With the politics of access rights there is no way to determine when a policy has succeeded or failed. There is only a strong incentive to demand that more be done.

CONTROLLING THE COST SIDE

The argument thus far has shown that there is no easy way to overcome the obvious problem that pervades medical care: there is no easy way to guarantee service to those who need it but cannot pay for it. The usual responses are to mandate the benefit, and then to ignore all the indirect financial consequences that flow from this policy choice. The alternative way to look at the problem is to ask, what if anything can be done to lower the cost of access so that medical care becomes more affordable in an ordinary market? The point of dealing with the cost side is simple enough: whatever the imperfections of a market in health care, more care will be purchased if that care can be provided at a lower unit cost. How then might those costs be reduced?

For convenience, it is instructive to isolate two different sets of costs that should be taken into account. First, there are the costs that are directly and uniquely associated with the provision of medical care. Thus, at one level it might be possible to increase access to medical care by relaxing the licensing limitations on physicians, or by allowing various kinds of group practice. In addition, it might be possible to deregulate the care that must be provided under employee benefit plans. Once employers are told that *if* they choose to provide any medical care, they must provide a long list of benefits, it may well be that they will choose to provide no one any benefits at all. The plan itself if chosen without regulation could have promised net benefits of \$X per employee. The regulation imposes a set of restrictions that costs \$Z more than the benefits that they provide. Employers and employees are better off with no plan, and \$0 gain, than with an enhanced plan and a loss equal to \$Z-

\$X. The repeated references to the decline in the percentage of employees covered by employee benefit plans may be attributable to just this problem of insisting that all medical plans cover expensive specialties, psychiatric care, dental care or whatever.

Next there is the issue of medical malpractice liability, where the present law makes it quite clear that individuals cannot contract out of the present negligence system in exchange for a lower price for the services rendered.¹⁸ There are many reported instances where health clinics specializing in care for the poor cannot remain in business, or cannot expand their services because they cannot meet the malpractice bill that the state insists it pay.¹⁹ The evidence points to the way in which professional malpractice liability has led to a decrease in services available to the poor. There is yet another situation where malpractice law imposes a budget allocation on patient and provider that neither would choose voluntarily. The standard response from providers of health care to the poor is a larger subsidy for the malpractice costs.²⁰ It is not to move to a regime of contract. The right response—to be dogmatic—is for public agencies and their clients to be able to hire physicians who limit their liability to their patients by contract. The greater gains from wider access more than offset any losses from a marginally increased level of physician negligence.

The problem of cost is not restricted to direct medical expenditures. Many of the inputs that are needed to provide medical care come from labor markets or real estate markets that are subject to their own forms of regulation: minimum wage laws, unionization, unemployment insurance, social security laws, workers' compensation benefits. One might believe that it is a crime to offer a job that promises only a cash wage. These additional costs drive up the costs of medical care. Yet I find it almost incomprehensible to see what social policy is advanced by giving protection to labor monopolies in the provision of essential services. Real estate and zoning restriction can drive up the cost of setting up a medical clinic substantially, and yet these costs too are often treated as beyond the scope of serious discussion on any issue of medical care. Yet this simple proposition remains: where the costs are driven up, the access to care is reduced. Medical administrators are loathe to take up the cudgels to battle reform in areas that are dominated by other institutions. But the difficulties that we have with medical costs are often attributable to choices that are made in other arenas.

FOUR SOBER SUGGESTIONS

So what then should be done? I have several cautious suggestions.

First, one should cease to speak of this incredible morass of regulation and subsidy of medical care as though it were a market. It is no more a market than the systems of state provided care that are found in Canada and Europe, and may be as misguided as are those programs. It is a tough empirical call that I am not prepared to make.

Second, do not act as though the argument that all persons are entitled to adequate medical care regardless of their ability to pay is a self-evident trump that displaces all other considerations. To the extent that scarcity issues are ruled out of bounds at the ground floor, questions of access are sure to be answered incorrectly. The argument that access must be provided as of right in order

The difficulties that we have with medical costs are often attributable to choices that are made in other arenas.

to overcome the undeniable problems of poor people in need is a vital consideration, but it is not a trump. It surely explains the rise of voluntary charitable care, and may well justify some public provision of care funded by tax revenues. But so long as resources are consumed that might have been devoted to alternative uses, medical planners and legal analysts cannot act as though the rectification of one error does not give rise to any alternative dislocations that may be of equal or greater magnitude.

Third, do not seek to justify the claims for direct access rights by treating the current failures as though they were market failures. Our markets are shot through with regulation that is both unique to the medical area and extensive in other markets, such as labor and real estate. It is too much to ask hospitals and other health care providers to restructure the broader rules of the game under which goods and services are allocated in a complex economy. But it is equally misguided to act as though internal reforms of the health care system will restore order if imperfections elsewhere in the system are left unchanged.

Fourth, do not be optimistic, or try to make others so. It is clear that costs of health care have gone up and

will continue to rise. It is also clear that there will be constant struggles between government and health care providers to provide subsidies for health care on the one hand and to subject it to external regulation on the other. "The Lord giveth, the Lord taketh away," goes a famous passage from Job. He might have been thinking of the provision of health care. But when givings and takings are combined as they are in the current health system, then everyone emerges the poorer. ♣

NOTES

¹On the critical role of transactions costs, see Ronald Coase, "The Problem of Social Cost," *Journal of Law and Economics* 3(1) (1960), a deservedly obligatory citation.

²The point is not universal. In employment markets, workers are normally not constrained by any financial limitation, since they sell labor and receive cash. Arguments about the inequality of bargaining power therefore must assume a different form from the issue at stake here. It is that workers are worse off with their contracts than without, wholly apart from duress, fraud or mistake.

³But see Richard A. Posner, *Economic Analysis of Law*, 3rd ed. (Boston, MA: Little Brown & Co. 1986), 11-12, defending in a health context, the conception of value tied to wealth over one tied to utility. For a more extended statement of his views, see Richard A. Posner, "Utilitarianism, Economics and Legal Theory," *Journal of Legal Studies* 8: 103 (1979).

⁴Posner, *Economic Analysis of Law*, 12.

⁵Id., 12-13.

⁶Consolidated Omnibus Budget Reconciliation Act, Pub. L. No. 99-272, § 1921, 100 Stat. 82 164-67 (1985) (codified as amended at 42 U.S.C. § 1395dd (1986) (hereafter COBRA—an acronym which had to be chosen by design). For strong and one-sided defenses of the COBRA statute, see Andrew J. McClurg, "Your Money or Your Life: Interpreting The Federal Act Against Patient Dumping," *Wake Forest Law Review* 24: 173 (1989) (hereafter, McClurg, "Patient Dumping"); Karen Rothenberg, "Who Cares? The Evolution of the Legal Duty to Provide Emergency Care," *Houston Law Review* 26: 21 (1989) (hereafter, *Who Cares?*).

⁷COBRA, § 1395dd (d) (1). The statute also calls for civil monetary penalties, § 1395dd (d) (2); and civil enforcement through private damage action, § 1395dd (d) (3).

⁸Both McClurg, "Patient Dumping," 174-76, and Rothenberg, *Who Cares?*, 21-22, begin with just these harrowing examples.

⁹See Elizabeth Rosenthal, "Canada's National Health Plan Gives Care to All, With Limits," *New York Times*, 30 April 1991, A1.

¹⁰Id.

¹¹Id.

¹²Id., A8.

¹³Id., A8.

¹⁴See David Sanders and Jesse Dukeminier, "Medical Advance and Legal Lag: Hemodialysis and Kidney Transplantation," *UCLA Law Review* 15: 357 (1968), 381, recounting the difficulties of the "God Committee" in Seattle, which had to decide which individuals were deserving of receiving a limited supply of kidneys and which were not. The enterprise was abandoned in part because making comparisons of human utility is a lot harder in concrete cases than one often supposes.

¹⁵See Age Discrimination in Employment Act of 1967, 29 U.S.C. § 621 et seq. § 2.

¹⁶Robert C. Ellickson, "The Homelessness Muddle," *The Public Interest*, 99 (Spring 1990), 45.

¹⁷For an account of the economic problems that these benefits raise, see especially Simon Rottenberg, "Unintended Consequences, The Probable Effects of Mandated Medical Insurance," *Regulation* 13(2): 21 (Summer 1990), which details the anticipated, if unwelcome effect on labor and health markets, of mandating comprehensive medical benefits for all workers who work more than 17.5 hours per week, as has been proposed under Senator Edward Kennedy and Representative Henry Waxman's Basic Health Benefits for All Americans Act. For example, the sharp discontinuity in employer obligations at 17.5 hours per week will induce employers to either hire workers for fewer hours, to avoid the burden, or for far longer hours, in order to limit the size of the employee base over which the benefits are payable. Similarly, the new subsidy would place a further upward pressure on the price of health services, which will increase the costs for existing providers under current plans.

¹⁸I urged the adoption of a contract system for limiting medical malpractice liability in the 1970s. See Richard A. Epstein, "Medical Malpractice: The Case for Contract," *American Bar Foundation Research Journal* (1976), 87. This approach has been taken up by others, see, e.g., Patricia M. Danzon, *Medical Malpractice: Theory, Evidence and Public Policy* (Cambridge, MA: Harvard University Press, 1985), 209-213; Glen Robinson, "Rethinking the Allocation of Medical Malpractice Risks between Patients and Providers," *Law and Contemporary Problems* 49: 173 (1986); and considered seriously even by its critics, see, e.g., Paul Weiler, *Medical Malpractice on Trial*, (Cambridge, MA: Harvard University Press, 1991), 93-113. But there is no common law or legislative motion in this direction and the allocative errors induced by a faulty set of common law rules on damages and liability remain uncorrected and uncorrectable.

¹⁹See, e.g., Committee to Study Medical Professional Liability and the Delivery of Obstetrical Care, *Medical Professional Liability and the Delivery of Obstetrical Care* 1: (1989), 54-73.

²⁰Id., 13.