Macromedical Regulation

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The COVID-19 pandemic has dramatically shown that a localized disease can be transmitted to the broader population, nationally and worldwide. This Article analyzes how to design regulation to help control that transmission. To that end, we first observe that existing healthcare regulation focuses almost exclusively on regulating individual components of the medical and healthcare industry, while lacking a capacity to address how those components work together as a system—a system that pandemics can destabilize. Indeed, one factor that contributed to COVID-19’s spread was the inability of U.S. healthcare regulation to operate on a societal level, to protect certain components from the deficiencies of others. We contend that healthcare regulation must also include what we call “macromedical” regulation: regulation that focuses on protecting the stability of the healthcare sector as a system of interconnected parts. We find some useful analogies in the Dodd-Frank Act and other post-crisis financial regulation, particularly in macroprudential regulation designed to protect the financial system as a system.

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I. INTRODUCTION

The financial risk that emerged during the 2008 financial crisis was frequently analogized to a “contagion,” in which the instability of one financial institution led to instability in other institutions with which it had commercial ties. As the world recovered, scholars and policymakers recognized the need to construct a regulatory framework that accounts for systemic risk—by which we mean risk to a system, in that case to the financial system—and can respond to contagions that follow from financial shocks.

We currently write in what, hopefully, is the tail end of the COVID-19 pandemic, a global health shock in which the term “contagion” was a literal description, not a metaphor, of the spread of harm. COVID-19’s prevalence in


4 Although this Article refers throughout to pandemics, its analysis should apply equally, on a national level, to epidemics.
one geographic location influences its prevalence in nearby locations, and the inability to contain the virus’s original spread led to globally escalating illness. Just as we learned in 2008 that our financial system was ill-prepared for systemic financial risks, we are now learning that our health system—a term we use interchangeably with “healthcare” system—has been ill-prepared for the rush of COVID-related illnesses.

Many commentators have attributed the U.S. health system’s failures during the COVID-19 pandemic to its private control. Because most American hospitals operate independently either as for-profits or nonprofits and rely financially on providing care to insured patients, the critique goes, healthcare providers have constructed capacity that caters to the predictable, non-emergent needs of a stable patient population rather than to the long-term health of the population as a whole. When a healthcare crisis radically shifts demand for unpredicted medical services, U.S. providers find themselves unprepared to mitigate the ensuing pressing public health emergency, and their inability to provide much needed services jeopardizes the nation’s health. These critics argue that if the nation’s health system were funded by public dollars, healthcare providers presumably would be more socially oriented and more prepared to handle population-wide health needs.


6 Although this Article refers to healthcare, that term sometimes is spelled health care. This Article also interchangeably refers to healthcare regulation and health regulation and to the healthcare sector and the health sector.


10 We use the term “non-emergent” in the medical sense of care that is not required to avoid a serious and immediate medical crisis. Cf. 42 U.S.C. § 1395dd(e)(1) (defining “emergency medical condition” as a condition that, in the absence of immediate medical attention, could reasonably place the health of the woman or unborn child in serious jeopardy).

13 See, e.g., id.
However, America’s private healthcare institutions should be able to respond to public health crises just as America’s private banks—by which we refer to virtually all banks, other than the Federal Reserve Bank—can respond to financial crises.\textsuperscript{14} American banks can rise to the occasion in large part because they are now governed by a reformed regulatory framework that enables, and sometimes requires, them to cooperate and coordinate appropriate surge responses.\textsuperscript{15} A similar regulatory regime could redress the American hospitals’ glaring failures to mobilize against a common health disaster; a wholesale transition to nationalized healthcare is not required. In this Article, we argue that not only can we apply the lessons from 2008 to pandemics, but that the specific regulatory solutions developed in response to the financial crisis also offer targeted lessons on how to improve health sector regulation without sacrificing the benefits of private ownership and market competition.

The essence of our argument is that because many public health dangers impose systemic risk, the regulation of our health system must develop institutions and strategies that can anticipate and mobilize to contain that risk.\textsuperscript{16} To illustrate the needed reforms to current healthcare regulation, we make two arguments. First, we argue that although the current health sector is heavily regulated, the existing regulatory regime suffers from some of the same limitations that hindered financial regulation prior to the last financial crisis: it focuses almost exclusively on individual components of a system. In the case of financial regulation, the limited pre-crisis focus (in retrospect, referred to as “microprudential”) was on banks in their individual capacity.\textsuperscript{17} Post-crisis, the scope of financial regulation expanded to additionally focus on protecting the stability of the financial system as a system (this expanded focus is referred to as a “macroprudential” regulatory regime).\textsuperscript{18}

Second, we argue that the existing micro-focus of healthcare regulation on components of the medical and healthcare system likewise should include a macro-focus on protecting the stability of that system—a system that pandemics


\textsuperscript{17}Luca Enriques, Alessandro Romano & Thom Wetzer, Network-Sensitive Financial Regulation, 45 J. Corp. L. 351, 357 (2020).

\textsuperscript{18}Id. at 360.
can destabilize. To be sure, there already is significant investment in the control and containment of infectious disease, primarily through the Centers for Disease Control and Prevention (“CDC”), the National Institutes for Health, and assorted local public health departments.19 And policymakers, specifically the President and state governors, enjoy emergency powers to contain behavior that otherwise would cause infections to spread.20 But none of the primary actors in the national health system—hospitals, physicians, health insurers, or pharmaceutical and device manufacturers—is directly responsible for combating contagious disease, other than the individualized responsibility to care for the individuals who come through the doors to seek care.21 In short, these private actors are not organized to respond to a systemic threat to the healthcare sector even though, as the ultimate caretakers to those suffering from a contagious illness, they are perhaps the ones who would benefit most from an effective response. The severe shortcomings of our national efforts to prepare for known surges of demand from COVID-19 illnesses—let alone to contain COVID-19—reveal these structural gaps in national health policy.22 One might further observe that these same shortcomings were exposed when the nation failed to contain opioid-related deaths23 and other public health crises that were

19 But see generally Michael Lewis, The Premonition: A Pandemic Story (2021) (documenting the despairing incompetence and incapacity of the CDC and local public health departments, in large part driven by political incentives and funding limitations, to provide effective policy leadership in the face of a health crisis).


fueled by documented epidemiological (if not pathogenic) contagions. Equally important, we do not have any prospective regulatory frameworks in which we might harness these healthcare entities to act proactively to address the next pandemic.

Part II of this Article recounts the core lessons from the last financial crisis about developing a regulatory framework to address systemic risk. Although this recounting will be familiar to most financial scholars, this starting point illustrates—especially for health policy scholars—how a regulatory regime that governs private parties can account for collective dangers of contagion. Part III then shows that existing healthcare regulation, like much financial regulation prior to 2008, focuses almost exclusively on regulating individual components of the healthcare system while neglecting the interconnections and interdependencies among those components. It also shows that the healthcare system, and specifically the nation’s hospital system, is a “system” whose components are better understood as interlinking than as separate, and therefore should be directed to mitigate systemic risk. Part IV of the Article undertakes to design what we call “macromedical” regulation to regulate the healthcare system as a system that can systematically respond to spreading health crises. Among other things, macromedical regulation could prepare private healthcare providers for health shocks that require coordinated reallocations of resources and collective priorities.

We harbor no illusions that the financial sector achieved an optimal regulatory regime after the 2008 financial crisis, nor do we suggest that the health sector’s manifold problems will all be solved by implementing some of the financial sector’s lessons. We also do not presume that any smartly designed regulatory regime can overcome the incompetence of its leaders. We do believe, however, that the twenty-first century’s two most severe threats to the nation’s wellbeing have similar features, that lessons learned from one can apply to the other, and that the nation can and should garner the collective wisdom from having undergone these painful crises.

24 See Anne Case & Angus Deaton, Deaths of Despair and the Future of Capitalism 108 (2020) (“Across these countries suicide rates are correlated with deaths from alcohol, just as is true across the states of the US. . . . They are countries that are simply not delivering an acceptable life for a substantial fraction of their people. It is no exaggeration to compare the long-standing misery of these Eastern Europeans with the wave of despair that is driving suicides, alcohol, and drug abuse among less educated white Americans.”).

25 The original idea of macromedical regulation was conceived in Jackson & Schwarz, supra note 16, at 28.

26 See infra note 84 and accompanying text (discussing concerns about potential inadequacy of the post-financial-crisis regulatory regime).

27 Although we focus our analysis to the U.S. healthcare system and polity, its analysis generally should be applicable to any healthcare sector, whether subnational, national, or even global, with interlocking systemic features.
II. POST-2008 LESSONS: DEVELOPING A REGULATORY FRAMEWORK FOR SYSTEMIC RISK

Although a full narration of the events of 2008 is unnecessary, we begin with the general causes of and primary responses to the financial crisis. Because there is widespread agreement that the economic havoc was a product of a regulatory failure, learning lessons from that painful experience requires a retelling of its causes and the kinds of regulations that could have mitigated its harm. We show that pre-2008 financial regulation failed to address systemic risk, that regulatory design should anticipate and mitigate systemic risk, and that many policies enacted in response to the financial crisis offer models for how to contain systemic risk.

A. The Failure to Contain Systemic Financial Risk

The 2008 financial crisis is best remembered for the dramatic failures and, but for government bailouts, near-failures of major financial firms. Many also remember that financial crisis as having its roots in a series of poor financial investments in the nation’s housing market. However, the financial crisis was much more than a series of poor investment decisions by large companies. It instead is better conceptualized as a failure of regulators and industry players to account for the systemic risks that underlay much of the entire financial sector.

Bad investments were certainly at the genesis of the financial crisis. Investors and issuers of financial products miscalculated the capacity of individual borrowers (many of whom were victims to overzealous lenders and brokers) to make continued mortgage payments and the sustainability of the rise in housing prices. A general overestimate of the safety and lucrativeness of the mortgage market, in part encouraged by government assurances, led both to a surge in loans to finance and refinance home purchases as well as a dramatic increase in leverage of financial firms. Similar thinking underlay the default

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28 No less than former Fed Chair Ben Bernanke, who was at the regulatory helm when the financial crisis erupted, attributed primary blame to systemic regulatory failures, not to the imprudence of private financial actors. See Ben S. Bernanke, Chairman, Fed. Rsrv. Bd., Monetary Policy and the Housing Bubble, Address at the 2010 Annual Meeting of the American Economic Association (Jan. 3, 2010) (transcript available at https://www.federalreserve.gov/newsevents/speech/bernanke20100103a.htm [https://perma.cc/36KW-982M]) (“The crisis revealed not only weaknesses in regulators’ oversight of financial institutions, but also, more fundamentally, important gaps in the architecture of financial regulation around the world.”).


30 See id. (manuscript at 4).

31 Id.

32 Id.
models of credit-rating agencies and the pricing behavior of global markets, not just for the underlying mortgage loans but also for the mortgage-backed securities (MBS) into which these loans were packaged and the derivatives that guaranteed their value by reference to MBS pricing.

The instability of these unwise investments was revealed in 2007, when housing prices dropped precipitously and borrowers began defaulting on mortgage loans. As defaults mounted, several well-known subprime mortgage lenders filed for bankruptcy, financial institutions began selling or hedging against subprime mortgage assets, and rating agencies downgraded hundreds of MBS credit ratings. The downgrading impacted even the most highly rated MBS transactions, with some AAA-rated securities being downgraded to “junk” status.

As investors lost confidence in the accuracy of credit ratings, not only for MBS but also for corporate debt securities, the capital markets that firms rely upon for continued funding started drying up. At the same time, counterparties began fearing for the solvency of major financial institutions, like Bear Stearns

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33 Cf. infra note 75 and accompanying context (discussing credit-rating agencies).
34 Cf. CORELOGIC, EVALUATING THE HOUSING MARKET SINCE THE GREAT RECESSION 4 (Feb. 2018) (finding that, prior to the last financial crisis, rating agency S&P modeled that housing prices could fall as much as twenty percent, whereas they actually fell around thirty-three percent).
38 See, e.g., Aparajita Saha-Bubna & Carrick Mollenkamp, CDO Ratings Are Whacked by Moody’s, WALL ST. J. (Oct. 27, 2007), https://www.wsj.com/articles/SB11934069826172889 (on file with the Ohio State Law Journal) (reporting on Moody’s downgrading of several MBS transactions from AAA to junk bonds). A “junk” rating is one that is below BBB-, which is less than so-called investment grade. U.S. FIN. CRISIS INQUIRY COMM’N, supra note 37, at 71.
and Lehman Brothers, that held substantial MBS portfolios. By early 2008, counterparties in short-term credit markets stopped doing business with Bear Stearns, deeming it too risky. Lacking liquidity, the firm collapsed and was purchased by JP Morgan, with federal government backing. Plagued by similar liquidity constraints, Lehman Brothers filed for bankruptcy in September 2008.

The Lehman bankruptcy panicked investors, halting trading even in the short-term commercial paper markets. Shortly after Lehman filed for bankruptcy, the federal government bailed out American International Group (AIG), the nation’s largest insurance company, to avoid its failure from endangering its counterparty financial institutions and to try to avoid further panic. AIG had sold billions of dollars of credit-default swap (CDS) protection, effectively insuring certain investors in MBS transactions against default; it was becoming unable, however, to post the increasing amounts of collateral contractually required to assure those investors that it could pay its CDS obligations. Notwithstanding AIG’s bailout, the illiquidity and uncertainty led to massive contagion effects. Commercial banks failed in significant numbers, with 25 banks failing in 2008, 140 failing in 2009, and 157 failing in 2010. The financial system collapsed, resulting in a worldwide recession.

The mechanisms of financial contagion are worth emphasizing. A panoply of financial products combined and interlinked mortgages and mortgage-related investments together. Although the intention was to diversify risk, a byproduct linked losses from some bad investments to broader instruments and thereby harmed broader markets. When investors realized the unreliability of MBS credit ratings and other sources of market information, they had little ability to distinguish poor investments from sound ones. This informational failure led to

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41 Cf. U.S. FIN. CRISIS INQUIRY COMM’N, supra note 37, at xix–xx (noting that by 2007, Bear Stearns, Lehman Brothers, Goldman Sachs, Merrill Lynch, and Morgan Stanley were borrowing significant amounts of money in overnight markets and were operating with leverage ratios as high as forty to one, such that a three percent devaluation in assets could cause the firm’s failure). Bear Stearns began to falter when two of its hedge funds holding significant MBS assets failed. Id. at 238–42.
42 See id. at 286–88.
43 See id. at 289–90.
44 See id. at 326, 338–39.
45 See Schwarcz, Understanding, supra note 40, at 552.
48 Id. at 959–61.
a general devaluation—what market watchers call a “lack of confidence”—of the broader debt market.

B. Reforming Financial Regulation to Overcome that Failure

The primary regulatory lessons of the financial crisis impressed the importance of anticipating and trying to address the dangers of systemic risk. These lessons spurred several relevant approaches to macroprudential regulation. Most of these approaches are entity-based, designed to protect against, or to mitigate the systemic impact of, the failure of systemically important financial institutions (“SIFIs”), but they also apply to systemic elements of the financial system.52

One category of financial regulation is devised to prevent the very onset of a financial crisis. These entity-based regulations are chiefly motivated by concern that SIFIs may engage in morally hazardous risk-taking because they deem themselves “too big to fail,” and thus they restrain the amount of risk SIFIs may assume.53 For example, capital-adequacy regulation protects SIFIs against unexpected losses54 by requiring them to hold minimum levels of equity so they cannot become excessively leveraged.55 Many SIFIs also are required to establish risk committees to help protect against failure.56 Entity-based regulation also includes liquidity requirements, which are designed to assure that SIFIs keep sufficient cash on hand to protect them against becoming unable to pay their debts when due.57 This helps to safeguard against the risk that maturity transformation—the funding of long-term investments through short-term borrowing—will cause SIFI defaults that trigger systemic shocks.58

Entity-based regulations have also been extended to what has been called “ring-fencing,” which refers to steps taken “to protect a firm from becoming subject to liabilities and other risks associated with bankruptcy; to help ensure that a firm is able to operate on a standalone basis even if its affiliated firms fail; to protect a firm from being taken advantage of by affiliated firms, thereby preserving the firm’s business and assets; and to limit a firm from engaging in risky activities.”59

53 Schwarcz, Systematic, supra note 39, at 5.
56 Schwarcz, Systematic, supra note 39, at 7.
57 Id.
58 Id.
A second form of regulation, which is also entity-based, is devised to ensure that SIFIs are sufficiently robust as to survive sudden market disruptions. If the first category of regulations focuses on preventing the onset of financial crises, this second category is designed to prevent the rapid spread of crisis. One significant example of this second category is stress tests. These examine a SIFI’s response to hypothetical “stressed” adverse financial conditions, such as high unemployment, stock-market crashes, liquidity shortages, and debt defaults. The Dodd-Frank Act mandates that SIFIs engage in periodic stress testing. This stress testing is now considered the “most powerful prudential tool . . . for safeguarding the resilience of the financial system.”

A third category of macroprudential financial regulation effectively focuses on correcting market failures that could trigger and transmit risk to the financial system. To minimize agency problems, for example, one relevant post-2008 approach focuses on aligning public and private interests when creating the types of transactions and products believed to be responsible for causing the

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60 Kress, McCoy & Schwarz, supra note 52, at 1472–80.

Finding [a new normal] is the task of hundreds of millions of individuals making decisions about production and consumption. The world’s major central banks are making this task all but impossible. . . . Clear price signals, for both goods and capital, are vital to making these judgments. Yet central banks’ correct instinct to smooth out a potential liquidity panic in March has morphed into ad hoc economic management. Consider the Federal Reserve’s willingness to buy so-called fallen-angel corporate debt—bonds that boasted an investment-grade credit rating before the pandemic but have declined to junk status now. The Fed has no idea how many of these companies will recover quickly—or at all—after the virus. . . . Doctors now believe that in many patients, coronavirus goads the body’s immune system into destructive overdrive. So too with monetary policy, the economy’s first immune response to a crisis. The comorbidity is a monetary system already prone to violent overreactions to negative stimuli. Voters are right to ask whether the economic fallout from Covid-19 is something the virus does to us or something we do to ourselves.

Id.
financial crisis. These transactions and products included certain securitization and derivative transactions and home-mortgage loans. Macroprudential regulation addressed securitization transactions by imposing risk-retention requirements to try to align incentives between originators of loans that are intended to be sold off in those transactions and the parties buying them. Macroprudential regulation addressed derivatives transactions by requiring most standardized derivative contracts to be cleared through central counterparties, which are well-capitalized entities that serve as “buyer to every seller and seller to every buyer.” They absorb counterparty risk and also help to net offsetting payment obligations among its members. Macroprudential regulation addressed home-mortgage loans not only by imposing risk-retention requirements to try to reduce moral hazard in the origination of mortgage loans but also by setting conditions to help ensure that mortgage-loan borrowers are able to repay their loans. Under one such ability-to-repay requirement, for example, mortgage lenders must make a “reasonable and good faith determination . . . that, at the time the loan is consummated, the consumer has a reasonable ability to repay the loan . . . .”

65 Schwarcz, Systematic, supra note 39, at 10.
66 See id. at 10–11.
69 Richard Heckinger, Derivatives Overview, in UNDERSTANDING DERIVATIVES: MARKETS AND INFRASTRUCTURE 1, 8 (2014).
70 See id. at 8.
71 See supra note 67 and accompanying text.
73 15 U.S.C. § 1639c. An additional form of entity-based regulation is resolution, which includes reorganizing the capital structure of, or else liquidating with minimal systemic impact, SIFIs that become financially troubled.” See Schwarcz, Systematic, supra note 39, at 9. The Dodd-Frank Act, for example, requires SIFIs to create “living wills” to facilitate their liquidation with minimal systemic risk, in the event of financial distress. Jessica Silver-Greenberg & Nelson D. Schwartz, ‘Living Wills’ for Too-Big-to-Fail Banks Are Released, N.Y. TIMES (July 3, 2012), https://www.nytimes.com/2012/07/04/business/living-wills-of-
Macroprudential financial regulation also focuses on correcting market failures that arise from information asymmetries. The organizations that assessed, and continue to assess, the quality of securities are referred to as credit-rating agencies, even though they are private for-profit companies. These organizations were criticized for contributing to the financial crisis by giving unduly high ratings to complex and highly leveraged MBS and subsequently downgrading those ratings, causing large market-value losses and a rapid drying up of liquidity. The Dodd-Frank Act authorized the Securities and Exchange Commission to supervise rating agencies’ internal record-keeping processes and to regulate their potential conflicts of interest.

Finally, macroprudential financial regulation relies heavily on emergency powers, invested in the Federal Reserve, to intervene directly at the source of contagion. The Fed’s emergency powers are authorized by section 13(3) of the Federal Reserve Act, which empowers the Fed to act as a lender of last resort to banks and other financial firms. The Federal Reserve Board has a variety of tools at its disposal to secure liquidity in times of financial stress, including aggressively purchasing financial assets, establishing secured lending facilities designed to support commercial paper and money market funds, and taking a host of other actions authorized for unusual and exigent circumstances under section 13(3).
The COVID pandemic provided a more current illustration of the Fed’s emergency powers. The Treasury Secretary and the Fed have worked closely in unison during the pandemic to extend emergency protections. These actions are reminiscent of actions taken over the course of the last financial crisis. “In some cases, the programs actually bear the same acronyms as those used in the last financial crisis, updated with new model numbers ([e.g.], TALF 2.0), and in certain cases, such as haircut requirements for TALF 2.0 collateral, the new term sheets track those used in the last financial crisis.” Moreover, “the CARES legislation includes a number of temporary reversals of Dodd-Frank Act limitations on uses of the Treasury Department’s Exchange Fund and the FDIC’s powers to increase bank guarantees.”

We do not claim that the post-2008 macroprudential financial regulation is perfect. Indeed, regulators and scholars worry that vulnerabilities still remain, and others have noted that many of the most egregious perpetrators of financial irresponsibility escaped the 2008 crisis without punishment or financial

80 LABONTE, supra note 79, at 9, 18. For some of these emergency protections, the Fed needs approval of the Secretary of the Treasury because Dodd-Frank Act section 1101 limited the Fed’s lending power under the guise of avoiding costly public bailouts and reducing moral hazard (the risk that banks will engage in risky conduct under the belief that the damage from their failure will be mitigated by the Fed’s safety net). See Schwarcz, Systematic, supra note 39, at 45.

81 For a helpful summary of these actions, see generally The Federal Reserve’s Actions to Address the Coronavirus Crisis, DAVIS POLK (May 22, 2020), https://www.davispolk.com/sites/default/files/the_federal_reserves_actions_address_coronavirus_crisis.pdf [https://perma.cc/RNK5-VH5K].

82 Jackson & Schwarcz, supra note 29 (manuscript at 11–12).

83 Id. at 12. For a helpful summary of the CARES Act provisions, see Congress Passes the CARES Act Fiscal Stimulus Package to Combat the Coronavirus Pandemic’s Economic Impact, DAVIS POLK (Mar. 27, 2020), https://www.davispolk.com/files/2020-03-26_senate_passes_cares_act_fiscal_stimulus_package.pdf [https://perma.cc/3VHA-A2D4]. It is possible that the Federal Reserve’s pandemic-related responses have overexposed it to credit risks. The Fed might be following the last playbook in which it arguably profited by its emergency actions. However, the uncertain duration and intensity of the current economic crisis make it possible that the models and assumptions used to justify the pandemic-related responses will prove inaccurate. Conceivably that might prompt some Fed critics to push for further restrictions on the Fed’s Section 13(3) powers. But cf. Kathryn Judge, Congress Should Endorse the Federal Reserve’s Extraordinary Measures, CLS BLUE SKY BLOG (Mar. 24, 2020), https://clsbluesky.law.columbia.edu/2020/03/24/congress-should-endorse-the-federal-reserves-extraordinary-measures/ [https://perma.cc/EW8Q-G9F6] (suggesting that Congress inoculate the Fed by endorsing the Fed’s use of its Section 13(3) powers in the current crisis).

reckoning. But the regulatory regime devised to preempt, mitigate, and respond to contagious financial panic that was assembled after 2008’s painful lessons has been credited with providing needed stability when financial markets falter. The taxonomy of macroprudential regulations can be grouped in the categories described above: entity-based regulation devised to avoid the origination of crises; regulation devised to preempt the spread of crises; regulation focusing on correcting market failures that could trigger and transmit risk to the financial system; and emergency powers that enable regulators to respond to crises.

Part III next illustrates that, even though—as our current moment shows too painfully—the U.S. health sector is also vulnerable to contagion, healthcare regulation offers few powers to prevent or respond to contagion. This is in spite of the health sector being perhaps the most heavily regulated U.S. industry.

III. SHORTCOMINGS IN HEALTHCARE REGULATION: A FOCUS ON COMPONENTS RATHER THAN THE SYSTEM

The American health system has no lack of regulations or government presence. Even though the U.S. health system is often characterized as being distinctively market-oriented, i.e., that the public sector plays a less controlling role in the United States than in other nations, government fiscal and
regulatory involvement is pervasive throughout the provision and delivery of American healthcare. It is also worth noting that the United States spends nearly twenty percent of its economy on healthcare services, a vast amount compared both to what is spent on other industries and what other nations spend on their own healthcare, with much of its financing coming from public funding sources. If measured by public funding as a percent of the overall economy, the American health system is run by its government as much as many so-called “socialist” health systems.

Yet despite this outsized role of government, current U.S. healthcare regulation, much like financial regulation prior to 2008, reflects little attention to system-wide needs. Nearly all public governance focuses exclusively on regulating individual components of the healthcare system, neglecting the interconnections and interdependencies among those components that create the system. This means that while many rules and regulators are in place to ensure that hospitals can deliver quality care to the individual patient, there is little direction or support to ensure that the nation’s hospital system can care for its population.

This Part reviews the failures of the U.S. hospital system in the time of COVID. To be sure, the COVID pandemic has exposed failures at virtually every delivery point in the health system, from intensive care to primary care to part of the economy, a higher share of health-care funding has been provided by government.

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89 For all years from 2010 to 2018, U.S. healthcare expenditures accounted for between 16.1% and 16.8% of annual GDP, the highest percentage of any other OECD nation during the same years. Germany had the next highest healthcare expenditures as a percentage of GDP, spending 11.5% of GDP on healthcare in 2018. Of the other thirty-seven OECD nations, twenty-six spent less than 10% of GDP on healthcare expenditures in 2017. See Health Expenditure and Financing, ORG. FOR ECON. COOP. & DEV. (May 27, 2020), https://stats.oecd.org/Index.aspx?QueryId=107340 [https://perma.cc/7UEL-BCR6]. The U.S. budget represents 31% of GDP. Spending and GDP, DATA Lab, https://datalab.usaspending.gov/americas-finance-guide/spending/ [https://perma.cc/5PET-AZXX]. Of that budget, 19.2% is spent on national defense, 15.9% on Medicare, and 14.9% on social security including unemployment compensation, housing assistance, and federal employment retirement and disability. Spending Explorer: FY 2021, Q1, USASPENDING (Nov. 30, 2020), https://www.usaspending.gov/explorer/budget_function [https://perma.cc/39DX-VT2H].


public health initiatives. We focus, however, on the hospital system because it aptly illustrates the shortcoming of individualized regulation and the need to account for system-wide dynamics and also because it offers a fruitful analog to our banking system and thus a ripe opportunity to apply the lessons from post-2008 reforms.

A. A Systemic Failure to Meet Demand

For better or worse, the United States has a health system that primary responds to individual needs, not one that actively promotes a healthy population. Therefore, although the primary failure of U.S. healthcare policymakers has been to contain the spread of the COVID virus, the primary failure of the nation’s healthcare providers has been its inability to keep up with COVID-related demands.92 True to the adage that “an ounce of prevention equals a pound of cure,” most critics reserve their harshest criticism at public health officials who failed to implement containment strategies.93 Nonetheless, there has also been a very real failure by healthcare providers, most notably the nation’s hospital system, whose job it is to handle the needs of the sick, even if they are spared responsibility for preserving the healthy.

The purpose of this discussion is not to recount the many failures, some of which devastating in impact,94 in the nation’s COVID response. It also is not to

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demean individual healthcare providers, many of whom were no less than heroic during the pandemic and have had to endure enormous physical and emotional strain.⁹⁵ Instead, it is to illustrate how the lack of communication and coordination of healthcare providers, as a sector, prevented some effective responses.

By all accounts, our national healthcare system was woefully unprepared for the surge of COVID patients. Many hospitals in hotspot areas were unable to provide an adequate supply of hospital beds.⁹⁶ These hospital bed shortages took place even as the United States spends far more on health care relative to its GDP than other OECD nations (seventeen percent of GDP for the United States versus about ten percent for the OECD average).⁹⁷ But the additional spending has not meant more hospital beds. The United States has no more beds per capita than the United Kingdom and Canada, about 2.8 hospital beds per 1,000 population and far fewer than Germany.⁹⁸

Perhaps more troubling, even when those hospitals were filled to capacity, they suffered severe revenue losses.⁹⁹ Hospitals during the pandemic have lost

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billions of dollars, and their employees lost hundreds of thousands of jobs. Why have hospital revenues gone down while illnesses went up? “In no well-working market should demand exceed supply while revenue falls.”

The grave dysfunctions exposed by the COVID-19 pandemic are best characterized as a systemic failure to meet a surge in demand. Most industries have mechanisms to address supply shortages: sellers of gasoline can obtain emergency supplies in assorted downstream exchanges; banks lend cash to each other to maintain systemic liquidity; demand surges for professional services are met by firms with temporary or mobile workers. But hospitals failed to divert COVID patients in need of intensive care to facilities that had remaining capacity, or even to establish productive communication to help overwhelmed facilities.

The poor coordination of regional hospital systems provides an unfortunate comedy of errors. Perhaps the central cause is that inter-hospital transfers are misaligned with hospital administrators’ incentives to generate revenues. Public hospitals, though overwhelmed, were reluctant to send away patients to whom revenue is attached, and private hospitals were unwilling to receive patients without private health insurance. Bureaucracy, turf battles, and communication failures also hampered transfers to overflow hospitals such as the Billie Jean King field hospital in New York City, which only served 79 patients in total. For example, Billie Jean King’s ambulances were not allowed to pick up transfers because hospitals had exclusive contracts with ambulance companies.

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101 Herzlinger & Richman, supra note 98.
103 Herzlinger & Richman, supra note 98.
104 See id.
106 See Gold & Evans, supra note 96.
107 Id.
109 Id.
Another explanation is the lack of an interoperable and modernized health information systems, which could enable coordination. In this sense, the hospital sector’s failure to respond as a robust system, including to redistribute medical resources to address varying demands among different hospitals, reflects poor sharing of data, such as I.C.U. bed counts and available supplies of protective personal equipment (PPE). Further, the fragmented health information system hindered case reporting and contact tracing, which are crucial to controlling the contagion. Public health departments have experienced difficulties compiling COVID testing data due to the lack of a uniform and modernized data standard.

Hospital beds were not the only scarce resource that was overwhelmed by demand shocks. Multiple parts of the country suffered from shortages in

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respiratory ventilators, testing capacity, adequately protected healthcare workers, medical personnel to administer vaccines, telemedicine for patients, and other materials needed to combat COVID spread. Moreover, the impact was unevenly distributed. The impact of these supply shortages was especially painful to small practitioners and nursing homes with fewer resources. FEMA tried to meet some emergency needs, yet


120 Shawn Radcliffe, Why We May Run into PPE Shortages Again, HEALTHLINE (July 16, 2020), https://www.healthline.com/health-news/why-we-may-run-into-ppe-shortages-again [https://perma.cc/6NML-D5HV].
its intervention was at times confusing\textsuperscript{121} and inadequate.\textsuperscript{122} Widespread shortages illustrated the severity of the health sector’s fragmentation.\textsuperscript{123}

Supply shortages cannot be an accepted feature of the nation’s hospital sector. In markets with elastic demand, supply shortages are self-corrected by price increases.\textsuperscript{124} In the market for intensive care, however, unmet demand leads to unnecessary deaths,\textsuperscript{125} overworked and strained healthcare providers,\textsuperscript{126} and in the case of a pandemic, avoidable transmissions.\textsuperscript{127} Accordingly, the nation’s hospitals cannot be viewed simply as a collection of independent competitors but instead must be regarded as a system that needs certain collaborations to maintain stability. Independent banks recognize the collective need to avoid individual bank failures and have established mechanisms to avoid supply shortages. The COVID-19 pandemic suggests that hospitals need to adopt similar mechanisms to secure system-wide vitality.\textsuperscript{128}


\textsuperscript{123} On the need for elastic supply chains, and their absence in many healthcare markets, see CIVICA, https://civicarx.org/ [https://perma.cc/8Q9R-69C3], and Herzlinger & Richman, supra note 98.

\textsuperscript{124} Adam Hayes, Elasticity, INVESTOPEDIA, https://www.investopedia.com/terms/e/elasticity.asp [https://perma.cc/T3B5-4MNA].


\textsuperscript{127} Jacobs, supra note 125; Linderman & Mendoza, supra note 125.

\textsuperscript{128} Interestingly, it seems that there were some occasions in which organized policies led to a reduction in the supply of hospital beds. For example, the Commission on Health Care Facilities in the twenty-first century (also known as “Berger Commission”) initiated a hospital closure plan to lower unnecessary healthcare expenditures of New York State. See COMM’N ON HEALTH CARE FACILITIES IN THE 21ST CENTURY, A PLAN TO STABILIZE AND STRENGTHEN NEW YORK’S HEALTH CARE SYSTEM 6 (Dec. 2006), https://nyhealthcarecommission.health.ny.gov/docs/final/commissionfinalreport.pdf [https://perma.cc/BQT2-5DPS] (identifying the excess capacity of hospitals as “a fundamental driver of the
B. An Individualized Health System

It has been said that the U.S. health system is like everything else: you get what you pay for.\textsuperscript{129} Despite spending more on healthcare, by any measure, than any other nation on earth, the U.S. health sector failed to meet the challenge of the COVID pandemic in large part because of how it spends that money. The problem can be put succinctly: the United States pays for individual services, not system-wide capabilities.

The United States spent a total of $3.6 trillion on health expenditures in 2018, amounting to an average of $11,172 per person.\textsuperscript{130} Private health insurers paid for $1.2 trillion of healthcare costs, representing thirty-four percent of national healthcare spending.\textsuperscript{131} Private out-of-pocket spending covered an additional ten percent of healthcare costs.\textsuperscript{132} Most of the remaining health spending came from government healthcare programs, including Medicare, Medicaid, the Children’s Health Insurance Program, and the Department of Veteran’s Affairs, which accounted for a collective forty-one percent of total source funding.\textsuperscript{133} Third-party payers and other programs, including Workers’ Compensation, covered around eight percent of healthcare spending.\textsuperscript{134}

\textsuperscript{129} See David Hyman, \textit{Health Care Fragmentation: We Get What We Pay For 2} (Univ. of Ill. L. & Econ. Rsch. Paper, Paper No. LE09-012, 2009).


\textsuperscript{131} Id. at 12.

\textsuperscript{132} Id. at 9 (showing that private out-of-pocket spending for healthcare was $375.6 billion in 2018, as compared to $3.6 trillion total health expenditures in that same year).

\textsuperscript{133} CTRS. FOR MEDICARE & MEDICAID SERVS., NATIONAL HEALTH EXPENDITURES ACCOUNTS: METHODOLOGY PAPER, 2019 3 (2019), https://www.cms.gov/files/document/definitions-sources-and-methods.pdf [hereinafter CMS REPORT] (“The two largest government health care programs, Medicare and Medicaid, purchased $1.4 trillion in health care in 2019, accounting for 37 percent of total health care spending. Finally, the Children’s Health Insurance Program (CHIP), the Department of Defense (DOD), and the Department of Veterans Affairs (VA) accounted for a combined 4 percent.”).

\textsuperscript{134} Id. at 3–4. The remaining seven percent of spending is by federal, state, and local governments on research, infrastructure, equipment, and public health. See id. at 4 (listing expenditures on public health and other investments).
It is important to parse what those enormous funds actually purchase. The majority of national healthcare spending goes to individualized treatment of patients: hospital stays, physician and clinical services, and prescription drugs. A significant portion of this individualized treatment is federally funded. Altogether, the federal government spends more than twenty-six percent of its annual budget on healthcare programs. Medicare alone covers twenty-five percent of all spending on hospital care, twenty-three percent of spending on physician services, and thirty percent of spending on prescription drug sales.

On a relative basis, however, very little money is devoted to public health activities. Of the $3.6 trillion of U.S. health expenditures in 2018, less than 2.5% went towards public health. The federal government spends only $13 billion to fund public health activities annually, much of which is allocated to the CDC to be used for immunization programs, infectious disease control, and

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135 Hartman et al., supra note 130, at 15 (finding that hospital care, physician and clinical services, and retail prescription drug spending represented thirty-three percent, twenty percent, and nine percent, respectively, of total healthcare spending).
136 Id. at 11.
137 See Juliette Cubanski, Tricia Neuman & Meredith Freed, The Facts on Medicare Spending and Financing, KAISER FAM. FOUND. (Aug. 20, 2019), https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/ (showing that Medicare represents fifteen percent of the federal budget while Medicaid, ACA, and CHIP represent a combined eleven percent of the federal budget); see also Nunn, Parsons & Shambaugh, supra note 87, at 1 (calculating that the healthcare sector “accounts for 24 percent of government spending”).
138 See Cubanski, Neuman & Freed, supra note 137 (“Medicare plays a major role in the health care system, accounting for 20 percent of total national health spending in 2017, 30 percent of spending on retail sales of prescription drugs, 25 percent of spending on hospital care, and 23 percent of spending on physician services.”).
139 See TR. FOR AM.’S HEALTH, THE IMPACT OF CHRONIC UNDERFUNDING ON AMERICA’S PUBLIC HEALTH SYSTEM 3 (Apr. 2019) [hereinafter IMPACT OF CHRONIC UNDERFUNDING] (noting the chronic underfunding of public health initiatives); see also David Himmelstein & Steffie Woolhandler, Public Health’s Falling Share of U.S. Health Spending, 106 AM. J. PUB. HEALTH 56, 56 (2016) (“Despite widespread rhetorical endorsement of prevention, public health programs have received less attention and far less funding than personal medical services.”).
140 See supra note 130 and accompanying text.
141 See IMPACT OF CHRONIC UNDERFUNDING, supra note 139, at 3 (“In 2017, public health represented just 2.5 percent—$274 per person—of all health spending in the country.”); see also CMS REPORT, supra note 133, at 4 (showing 2019 expenditures on public health activities as $97 billion).
other programs.142 The vast majority of public health funding, collectively around $84 billion annually, comes from state and local governments.143

The individual, rather than systemic, emphasis is also reflected in how the United States regulates the health sector. The health sector is among the most thoroughly regulated in the United States, with a panoply of federal and state laws designed, ostensibly, to protect the public.144 Critically, these laws generally focus on the delivery of healthcare to individual patients, not on the general health of populations. At least to that extent, health law and regulation can be broadly characterized as micro-level regulation, focused on protecting individuals and not populations.

Among the most critical health sector regulations are those charged with protecting the quality of healthcare services. But rather than focusing on population metrics or population health, these regulations almost exclusively aim to benefit individual patients and to monitor individual procedures. The underpinning of healthcare quality assurance lies in state licensure regimes that regulate entry into the medical profession and monitor the healthcare services provided both by licensees145 and by healthcare facilities.146 Similarly, private organizations monitor the quality of care through the accreditation of facilities, board certification of physicians, and intra-institutional staff privilege credentialing.147 Finally, the torts of medical malpractice and negligence disincentivize physicians from providing substandard care.148 All of these quality assurance mechanisms hold professionals and facilities responsible for the medical care they provide to individual patients. An injured party can bring a tort suit, for example, or a medical error might trigger disciplinary sanctions by a professional board.

Public initiatives to improve population health also operate on an individual level. Medicare and Medicaid provide health insurance redeemable by

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142 See CMS REPORT, supra note 133, at 4 (listing federal expenditures on public health); IMPACT OF CHRONIC UNDERFUNDING, supra note 139, at 4 (finding that the CDC’s 2018 budget was $8.229 billion).

143 See CMS REPORT, supra note 133, at 4 (listing state and local expenditures on public health). Not all federal spending is spent on individuals. One exception (which might prove the rule, given its relative insignificance) is the Public Health Service Act (PHSA), which authorizes funding to states for disease prevention and control activities, as well as direct service programs for medically underserved areas and populations. See Eleanor D. Kinney, Accessing Hospitals and Health Professionals, in THE OXFORD HANDBOOK OF U.S. HEALTH LAW 119, 136 (I. Glenn Cohen, Allison K. Hoffman & William M. Sage eds., 2017).

144 See, e.g., Field, supra note 88, at 607.


146 Id. at 48–49.


individuals for specific medical services.\textsuperscript{149} Even these insurance programs are structured to pay healthcare providers for individual services,\textsuperscript{150} in a much-maligned fee-for-service system.\textsuperscript{151} In addition, the Emergency Medical Treatment and Labor Act (EMTALA)\textsuperscript{152} and nondiscrimination regulations\textsuperscript{153} ensure the access—or prohibit the discriminatory denial—of individual patients to specific medical services.\textsuperscript{154}

\textsuperscript{149} See Mark A. Hall & David Orentlicher, Health Care Law and Ethics in a Nutshe\textsuperscript{l}l 9 (4th ed. 2020) ("Traditionally, health insurance has been structured on a piecework basis known as ‘fee-for-service,’ whereby doctors, hospitals and other providers are paid a separate amount for each discrete item of service."). Health insurance programs pay little for public health, with the exception of vaccinations. See, e.g., Medicaid & CHIP Payment & Access Comm’n, MacStats: Medicaid and CHIP Data Book 50 (Dec. 2019) (showing that Medicaid spent $4,389 million on the Vaccines for Children program in 2018).

\textsuperscript{150} Some Medicaid programs have started to cover services deemed to be part of the “social determinants of health,” such as transportation and housing. See, e.g., Samantha Artiga & Elizabeth Hinton, Kaiser Fam. Found., Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity 5 (May 2018), https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social determinants-in-promoting-health-and-health-equity [https://perma.cc/42UY-PWLT] ("For example, Colorado and Oregon are implementing Medicaid payment and delivery models that provide care through regional entities that focus on integration of physical, behavioral, and social services as well as community engagement and collaboration."); cf. Barak D. Richman, Behavioral Economics and Health Policy: Understanding Medicaid’s Failure, 90 Cornell L. Rev. 705, 710 (2005) (attributing Medicaid’s failure to mitigate health disparities to policymakers’ narrow focus on healthcare services and poor understanding of behavioral factors’ influence on health outcomes).


\textsuperscript{152} See Furrow, Greaney, Johnson, Jost & Schwartz, supra note 145, at 280–81 (providing that EMTALA mandates a medical screening test and stabilizing treatment to any individual who visits an emergency department and observing that the EMTALA enforcement process is driven by complaints from individuals).

\textsuperscript{153} See id. at 293–95 (discussing major nondiscrimination statutes, such as Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act, which enable individuals to sue healthcare facilities for instances of discrimination); see also Ruqaijah Yearby, Breaking the Cycle of “Unequal Treatment” with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias, 44 Conn. L. Rev. 1281, 1315 (2012) ("The [ACA] focuses mainly on individual solutions, which, unfortunately, will never fully eradicate racial disparities because there are systemic problems with the U.S. health care system beyond access to insurance that must be fixed.").

\textsuperscript{154} See Furrow, Greaney, Johnson, Jost & Schwartz, supra note 145, at 279.
However, none of these regulatory or financing mechanisms focuses on whether the health system, as a totality, is meeting the population’s health needs, and none holds healthcare providers accountable for the population’s health (this is painfully apparent now, amidst a pandemic in which the health and economic costs of COVID exacerbate long-present health disparities and population inequalities). The presumption behind this policy strategy is that financing care for individuals and assuring the quality of individual services is sufficient to enable supply to adequately meet demand. The year 2020 has revealed the strategy’s failure and has illustrated the need for systemic regulation to complement the oversight of individual components.

C. Prior Ad Hoc Pandemic Responses

To the degree that U.S. regulators have responded at all to prior threats of epidemics, they have acted in ad hoc manners that have produced few sustainable lessons to apply to subsequent contagions. The United States has responded to a number of pandemic and epidemic threats over the past two decades, and these exceptions—instances in which government policy aims to mobilize sector-wide systemic responses to healthcare needs—prove the rule. Prior ad hoc responses are revealing both in how unusual they were, i.e., they represented unique departures from standing policy, and in how policymakers did little to convert the individual responses into institutionalized lessons.\textsuperscript{155}

In late 2002, a novel coronavirus known as Severe Acute Respiratory Syndrome (SARS) emerged in China and, by January 2003, began spreading across the globe.\textsuperscript{156} SARS ultimately infected an estimated 8,096 people across twenty-nine countries, with a fatality rate of almost ten percent.\textsuperscript{157} The CDC led the U.S. national response, involving more than 800 CDC employees in global


\textsuperscript{157} Summary of Probable SARS Cases with Onset of Illness from 1 November 2002 to 31 July 2003, WORLD HEALTH ORG. (July 24, 2015), https://www.who.int/csr/sars/country/table2004_04_21/en/ [https://perma.cc/H23L-AANL]. The bulk of SARS cases were concentrated in China, Hong Kong, Taiwan, Singapore, and Canada. \textit{Id}. 
efforts to control the virus’s spread. The CDC’s response, undertaken in partnership with the WHO, likely prevented significant outbreaks in the United States, which experienced no fatalities and relatively few documented cases.

Still, the virus highlighted shortcomings in the CDC’s capacity to respond to infectious disease, especially its shortage of skilled personnel. After the SARS threat diminished, the CDC took steps to expand its capacity to respond to pandemic-scale outbreaks by developing a scalable system for integrating its newly built Emergency Operations Center with traditional public health responses.

The H1N1 influenza pandemic in 2009 and the Middle East Respiratory Syndrome (MERS) outbreak in 2012 also provided opportunities for the United States to develop its infectious disease response capabilities. H1N1, an influenza A virus, appeared in Mexico in 2009 and quickly spread to the United States and Canada. The virus reached pandemic status later that year, leading to an estimated 284,400 deaths worldwide in its first year in circulation.

Several measures adopted in the aftermath of SARS were put to the test during the H1N1 and MERS responses, including new international health regulations establishing protocols for coordination among countries.

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158 See Learning from SARS, supra note 156, at 13. A team of eighty-four CDC employees were sent to eleven SARS-infected countries to assist on the ground. Id. at 52. The remainder were divided into domestic teams focused on a number of issues including “clinical care and infection control, epidemiology of the outbreak, diagnostics and laboratory studies, quarantine issues, information management, occupational health issues (including staff from the National Institute for Occupational Safety and Health), communications, environmental issues, and community outreach programs focused on the challenges of providing accurate information to special groups such as immigants and the Asian community.” Id. at 51.

159 Id. at 51 (“Despite several introductions of the virus from returning infected travelers, the United States was spared from the worst of SARS, given that there was no significant secondary spread, no large hospital-based outbreaks as seen in several countries, and no fatalities.”).

160 Id. at 55.

161 Stephen S. Papagiotas, Mark Frank, Sherrie Bruce & Joseph M. Posid, From SARS to 2009 H1N1 Influenza: The Evolution of a Public Health Incident Management System at CDC, 127 PUB. HEALTH REPS. 267, 268 (2012).

162 See Holly Ann Williams et al., CDC’s Early Response to a Novel Viral Disease, Middle East Respiratory Syndrome Coronavirus (MERS-CoV), September 2012–May 2014, 130 PUB. HEALTH REPS. 307, 308 (2015) (examining the lessons the CDC learned in responding to MERS and H1N1 viruses).


165 See Fineberg, supra note 164, at 1336–37.
CDC, internal reorganizations during and after H1N1 prioritized scientific expertise within the agency and provided for stronger response oversight. MERS, a coronavirus, emerged in Saudi Arabia in 2012 and had caused an estimated 450 infections by May 2014, when the first, and only, two cases were identified in the United States. The CDC initiated its MERS response long before that time, with a focus on maintaining records of confirmed cases, conducting research on biological samples, building testing capacity, and implementing border health measures. Other preparedness measures taken by the CDC included training 50,000 federal employees to identify and manage cases at borders, developing contact tracing protocols, training healthcare providers, and preparing communications around travel.

These measures laid important groundwork for the CDC’s response to the subsequent Ebola outbreak in 2014–2015 in West Africa. Early support by the CDC and USAID was ad hoc and uncoordinated because those agencies assumed that the WHO was capable of directing responses. As the outbreak spread and the WHO’s inadequacies became apparent, the U.S. President directed the National Security Council (NSC) to integrate federal agencies’ response efforts. Domestically, the CDC implemented infection-control measures similar to those taken in response to MERS. Despite those measures, the Texas Health Presbyterian Hospital, which received the first incoming Ebola case, mishandled the patient and exposed two nurses to the virus. To prevent further contagion, the President appointed Ron Klain as the Ebola “czar” to head the White House Ebola Task Force.

166 See Papagiotas, Frank, Bruce & Posid, supra note 161, at 271.
167 See Williams et al., supra note 162, at 309.
168 Id. at 310–11.
169 Id. at 315–16.
170 Id. at 316.
172 Id. at 12.
174 Scott L. Greer & Phillip M. Singer, The United States Confronts Ebola: Suasion, Executive Action, and Fragmentation, 12 HEALTH ECON., POL’Y & L. 81, 88 (2017). Some scholars found the Texas Health Presbyterian Hospital’s misstep unsurprising due to the advisory nature of CDC guidelines and fragmentation of the healthcare system. See id. (“None of this should really have been surprising in a fragmented system where CDC is largely advisory, public health authorities have little legal authority or capacity to direct patients around the health care system, health systems are both diverse and often left to themselves, and ex post regulation via lawsuits is common.”).
175 Kirchhoff Memorandum, supra note 171, at 25. President Biden recently appointed Klain as his White House Chief of Staff. Alexandra Jaffe, Biden Chooses Longtime Adviser
centralized the decisionmaking process and worked closely with government agencies to coordinate response measures. Although only four Ebola cases occurred in the United States, the task force’s effectiveness cannot be fully measured because the virus’s low contagiousness (being spread only through blood or other bodily fluids) and high (and rapid) mortality rate may have self-limited its spread. 

The COVID-19 (the SARS-CoV-2 coronavirus) presented greater challenges to the American emergency management system because, although less fatal, it was much more contagious than Ebola. Soon after the first domestic COVID case was confirmed, the White House established its Coronavirus Task Force to coordinate the response. The task force started holding daily briefings and directed FEMA to allocate PPE supplies and expand testing capabilities. The task force was properly criticized, however, for inconsistent leadership and for sidelining the CDC and wasting its disease-containment expertise and experience. At least some of the task force’s


Kirchhoff Memorandum, supra note 171, at 26. While some senior officials recognized the task force’s crucial coordinating role in the crisis, others contended that agencies should have integrated themselves. Id.


Id.


Oliver Milman, Where Is the CDC? How Trump Sidelined the Public Health Agency in a Pandemic, GUARDIAN (May 14, 2020), https://www.theguardian.com/world/2020/may/14/where-is-the-cdc-trump-covid-19-pandemic [https://perma.cc/L258-PULS]; see Jason Dearen & Mike Stobbe, Trump Administration Buries Detailed CDC Advice on Reopening, ASSOCIATED PRESS (May 7, 2020), https://apnews.com/7a00d5ba3249e573d2ead4bd323a4d4 (on file with the Ohio State Law Journal) (reporting that the Trump administration shelved the CDC’s guideline to local authorities on when and how to reopen public places and noting that “the CDC has not had a regular, pandemic-related news briefing in nearly two months”).
responsibilities were later transferred to FEMA, but a comprehensive and adequate response never materialized.

These prior experiences offer some useful lessons. A White House task force can be effective by coordinating a national response among federal agencies (such as the CDC), as well as between those agencies and state governments. That coordination may require strong and centralized leadership, such as that provided by Ronald Klain for the Ebola task force. By contrast, the Coronavirus Task Force’s twelve-member model is reported to have engendered a pass-the-buck mentality that hampered communication. Intergovernmental coordination also may require expert guidance; the Ebola task force, for example, convened knowledgeable lawyers to clarify useful jurisdictional lines between federal and state authorities. Additionally, the effectiveness of a White House task force may depend on recognizing and utilizing existing governmental capabilities. The Coronavirus Task Force has been criticized for interfering with the capabilities of federal agencies, including frustrating plans designed by FEMA experts and directing inexperienced volunteers to procure PPE supplies.


186 Nicholas, supra note 185.

187 Kirchhoff Memorandum, supra note 171, at 27.

188 At least one scholar argues that White House task forces are generally inefficient at responding to public health emergencies and interfere with the work of qualified professionals at CDC, FEMA, etc. See Elaine Kamarck, Get Rid of the White House Coronavirus Task Force Before It Kills Again, BROOKINGS (May 7, 2020), https://www.brookings.edu/blog/fixgov/2020/05/07/get-rid-of-the-white-house-coronavirus-task-force-before-it-kills-again/ [https://perma.cc/GK6U-4X5F] (arguing that White House task forces are unnecessary, and often ineffective, in leading crisis responses and may dangerously interfere with the work of qualified professionals).

But the greatest takeaway from these experiences is that there was so little taken away. White House task forces were disassembled and then reassembled as needed. FEMA was never given a standing role in preparing for future pandemics. And there was little question that any meaningful federal response to the COVID-19 outbreak would have to be constructed anew. The past history is revealing in what it lacks: no institutional continuity, no accumulated regulatory expertise, no formalized learning or competencies, and no preparations for the next pandemic.

D. Regulating the Healthcare System as a System

A key feature of the regulatory failure exposed by the COVID pandemic has been health policy’s incapacity to address systemic challenges. This reflects a growing consensus among healthcare policy experts that, in spite of how healthcare is regulated, national health sectors are better understood as systems, with interlinking parts, rather than as a group of separate components. Several commentators have used the occasion of the COVID-19 crisis, and the associated regulatory failures, to emphasize the systemic and interconnected features of healthcare delivery and have encouraged a reorientation of policy accordingly.190 This is not a new idea. The World Health Organization (WHO), for example, describes the health sector as “a set of inter-connected parts that must function together to be effective” and notes that “[c]hanges in one area have repercussions elsewhere” and that “[i]mprovements in one area cannot be achieved without contributions from the others.”191

In the midst of a pandemic, it has never been clearer that the health of one population—and the performance of one wing of healthcare delivery—has a direct impact on neighboring populations. But other features of the U.S. health system, even those unrelated to the epidemiological spread of disease, illustrate the need to treat the health sector as a system and to deemphasize the individualized paradigm that dictates so much of the governing regulatory regime.

Existing regulation of the health workforce focuses on the skills and performance of individual professionals but not on their geographic or clinical-

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190 Cf. Siddhartha Mukherjee, What the Coronavirus Crisis Reveals About American Medicine, NEW YORKER (Apr. 27, 2020), https://www.newyorker.com/magazine/2020/05/04/what-the-coronavirus-crisis-reveals-about-american-medicine [https://perma.cc/ED6Z-C77X] (arguing that “[m]edicine is a system for delivering care and support . . . [and] also a system of information, quality control, and lab science”).

191 WORLD HEALTH ORG., EVERYBODY’S BUSINESS: STRENGTHENING HEALTH SYSTEMS TO IMPROVE HEALTH OUTCOMES 3 (2007) (identifying the six building blocks of the health system as service delivery, health workforce, health information systems, medical products and technologies, financing, and leadership/governance); see also RAYMOND L. GOLSTEEN, KAREN GOLSTEEN & BENJAMIN GOLSTEEN, JONAS’ INTRODUCTION TO THE U.S. HEALTH CARE SYSTEM 11 (8th ed. 2017) (identifying the five major components of the U.S. healthcare system as facilities, workforce, suppliers of medical products, educational and research organizations, and financing mechanisms).
practice-area distributions. Absent regulations that redress unbalanced
distribution, health professionals tend to concentrate in metropolitan areas and specialty care. In 2020, around sixty-eight percent of “Health Professional Shortages Areas” are rural or half-rural. Moreover, the fraction of medical graduates who opt for primary care is constantly shrinking, which exacerbates the perennial shortage of primary care providers. Consequently, we have “an overbuilt, high-priced, wasteful, and frankly confiscatory system of hospitals and specialty care” with too much specialization in some areas and inadequate healthcare access in others. A better system would not just focus on the quality of individual providers but also their distribution across the population.

Regulation of health information systems has also focused largely on individual vendors and providers. This narrow focus ignores such critical

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193 See JAMES A. JOHNSON, CARLEEN STOSKOPF & LEIYU SHI, COMPARATIVE HEALTH SYSTEMS: A GLOBAL PERSPECTIVE 85 (2d ed. 2018) (finding that a specialty-oriented medical education and disparities in income motivate the majority of medical students in the United States to choose specialty training).

194 HEALTH RES. & SERVS. ADMIN., SECOND QUARTER OF FISCAL YEAR 2020 DESIGNATED HPSA QUARTERLY SUMMARY 3 (Mar. 2020); see also Stephen M. Pettersson, Robert L. Phillips, Jr., Andrew W. Bazemore & Gerald T. Koinis, Unequal Distribution of the U.S. Primary Care Workforce, AM. ACAD. Fam. Physicians (June 1, 2013), https://www.aafp.org/afp/2013/0601/od1.html [https://perma.cc/4M6W-PPJT] (“There are about 80 primary care physicians per 100,000 people in the United States; however, the average is 68 per 100,000 in rural areas and 84 per 100,000 in urban areas.”).

195 Andy Lazris, Alan Roth & Shannon Brownlee, No More Lip Service; It’s Time We Fixed Primary Care (Part One), HEALTH AFFS. (Nov. 20, 2018), https://www.healthaffairs.org/doi/10.1377/hblog20181115.750150/full/ [https://perma.cc/5SSW-MEC5] (showing that the number of young clinicians entering primary care fields has dropped to 20% and that only about 35% of all clinicians in the United States provide primary care services, contrasted by 70% in other developed countries).

196 Donald M. Berwick, The Moral Determinants of Health, 324 JAMA 225, 225 (2020); cf. Barak D. Richman, Kushal T. Kadakia & Shivani A. Shah, The Shadows of Life: Medicaid’s Failure of Health Care’s Moral Test, 28 ANNALS HEALTH L. & LIFE SCIS. 163, 182 (2019) (“[A]n insufficient provider network not only fosters illness and creates a pent-up need for health services, but also rewrites how people interact with the health care system. Specifically, an insufficient provider network causes individuals to seek out more accessible, and often more expensive, forms of care, which, in turn, increases health care costs.”).

197 See Miriam Reisman, EHRs: The Challenge of Making Electronic Data Usable and Interoperable, 42 PHARMACY & THERAPEUTICS 572, 572 (2017) (observing that the Health Information Technology for Economic and Clinical Health (HITECH) Act has largely focused on the adoption of certified EHRs by individual health sectors and not interoperability).
systemic implications as interoperability, which is the ability to enable different healthcare information systems to “access, exchange, integrate and cooperatively use data in a coordinated manner” in a way that can “optimize the health of individuals and populations globally.” Interoperable electronic health record (EHR) systems, for example, would enable doctors to access medical data of their patients regardless of where the patients had previously been treated, thereby improving diagnostic efficiency and enhancing treatments. Broader data sharing across EHR systems could facilitate useful health analytics, which could have vastly improved the response to COVID-19.

Although in 2020 the U.S. Department of Health and Human Services (HHS) finalized two rules aiming to promote health information exchange, more collaborative efforts from healthcare stakeholders are needed to overcome the technical and cultural barriers to interoperability. Indeed, the need for systemic approaches extends far beyond addressing the systemic failure to a pandemic. All healthcare, either good or bad, is highly interconnected. Poor prevention by some could easily frustrate others’ preventive efforts in stopping the spread of a contagious disease. But good prevention could reduce treatment

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203 See Reisman, supra note 197, at 575.
Recognizing the value of prevention, the Affordable Care Act expanded access to preventive care by requiring private insurance plans to cover such services. Still, however, only a small fraction of American adults receive proper preventive care, suggesting the need for more preventive-care investment.

On a conceptual level, these observations lend themselves to broader lessons on regulatory policy. Simply regulating the components of a system is insufficient for at least two reasons: first, that micro-focused regulation may fail to regulate all such components; second, even if it does, that micro-focused regulation may inadequately regulate how those components interact as a system.

The idea that protecting all of a system’s components may inadequately protect the system might appear counter-intuitive. Regulators struggled with this after the last financial crisis; they had believed that protecting all systemically important financial firms individually would be sufficient because, if no such firm fails, no such failure would trigger a systemic collapse. That belief extrapolates the logic of the distributive law of mathematics, that “the result of first adding several numbers and then multiplying the sum by some number is the same as first multiplying each separately by the number and then adding the products.”

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208 Cf. Rizwaan Jameel Mokal, Liquidity, Systemic Risk, and the Bankruptcy Treatment of Financial Contracts, 10 BROOK. J. CORP. FIN. & COM. L. 15, 21 (2015) (criticizing the widely held view “that ‘the whole financial system is sound if . . . each institution is sound’” (quoting Claudio Borio, Rediscovering the Macroeconomic Roots of Financial Stability Policy: Jo...88 (2011))).

209 Distributive Law, BRITANNICA (June 5, 2019), https://www.britannica.com/topic/distributive-law [https://perma.cc/3SJN-SQDY]. The distributive law is stated symbolically as: a x (b + c) = a x b + a x c. Id.
However, the distributive-law analogy between mathematics and systemic risk is dubious. As already demonstrated, that analogy does not take into account how a system’s components interact as a system.\(^{210}\) Protecting individual components of a system can sometimes even aggravate systemic instability. In a financial context, for example, regulators had a “simplistic view that systemic risk is pro tanto reduced to the same extent as the reduction in risk to each individual financial institution in the system.”\(^{211}\) That view is not only wrong but, in at least one context, seriously misleading:

[Reducing risk to individual financial institutions through] netting encourages greater leverage and inter-party concentrations, weakens lending standards by exacerbating financial agency and adverse selection costs, redistributes counterparty risk rather than reducing it, exacerbates market volatility in times of stress, and thus creates an additional channel for risk transmission, propagating the effects of shock through the financial system.\(^{212}\)

The distributive-law analogy also fails because weak components of a system, such as financially troubled hospitals or firms, are not always resolved in a way that reduces systemic risk.\(^{213}\) For example, corporate reorganization law, which applies to resolving both troubled hospitals and troubled firms, normally looks to the parties in interest to reach a consensual debt restructuring plan.\(^{214}\) The parties in interest are limited primarily, however, to that entity, its creditors, and its shareholders.\(^{215}\) For similar reasons, providing healthcare services to protect individuals within a population does not necessarily protect the healthcare of the population.

Finally, the distributive-law analogy does not address correlated triggers that cause the concurrent failure of multiple components. Regulation intended to protect individual components may then be overwhelmed—such as a

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\(^{210}\) See supra notes 188–189 and accompanying text.

\(^{211}\) Mokal, supra note 208, at 19.

\(^{212}\) Id.


\(^{214}\) See 11 U.S.C. § 1109(b) (listing the parties in interest). Absent a consensual plan, the entity being resolved could attempt to cram down a plan over those parties’ objections; failing that, it could be liquidated. Compare 11 U.S.C. § 1129(b)(1) (discussing the cram-down requirements that a plan be fair and equitable and not discriminate unfairly), with 11 U.S.C. § 1112 (discussing the ability of bankruptcy courts to convert a reorganization case to a liquidation for cause, including inability to confirm a plan of reorganization).

\(^{215}\) See 11 U.S.C. § 1109(b).
pandemic disease spike that overwhelms the ability of individual hospitals to provide sufficient ventilators.\textsuperscript{216}

For these reasons, the healthcare system also needs to be regulated as a system. We next examine how to accomplish that.

IV. DESIGNING MACROMEDICAL REGULATION

In this Part, we articulate a macromedical approach to regulating the healthcare system. It draws heavily from macroprudential regulation that addresses systemic risk in the financial sector and conceives of analogous strategies for a systemic approach to the health sector.

We follow the lessons from financial regulation because they offer the most sophisticated and developed precedents for systemic regulation and because the COVID-19 pandemic offers an analogous contagion that the global financial system experienced during the 2008 financial crisis. Part II of this Article grouped the macroprudential regulatory strategies into four categories: entity-based regulation devised to avoid the origination of crises; regulation devised to preempt the spread of crises; regulation focusing on correcting market failures that could trigger and transmit risk to the financial system; and emergency powers that enable regulators to respond to crises. This Part considers how these same categories could be used to help protect the healthcare system.

A. Regulating Healthcare Entities to Avoid the Origination of Crises

Though it might be counterintuitive, there are close parallels between how banks triggered the 2008 financial meltdown and how hospitals trigger the spread of contagious pandemics. The central commonality is that hospitals, like banks, pursue profit motives with a particular business model, and the implementation of this profit-maximizing strategy imposes costs on the rest of the U.S. health sector and, especially, the U.S. population. For banks that deem themselves too big to fail, the profit-maximizing strategy appeared to be exacerbated by morally hazardous risk-taking.\textsuperscript{217} For hospitals, the profit-maximizing strategy reflects a governance model that largely ignores public welfare.

\textsuperscript{216}See \textit{supra} notes 99–108 and accompanying text on supply shortages. In some contexts, regulation designed to protect individual components of a system can even create correlated triggers. For example, regulators generally require insurance companies to divest corporate bonds that are downgraded below an investment-grade rating in order to protect individual insurers against a loss in the value of assets available to pay claims. See Daniel Schwarcz & Steven L. Schwarcz, \textit{Regulating Systemic Risk in Insurance}, 81 U. Chi. L. Rev. 1569, 1596, 1602 (2014). That requirement, however, has the potential to correlate an industry-wide dumping of bonds that lose that rating, in turn causing a systemically risky bond-market collapse. \textit{Id.} at 1602–03.

\textsuperscript{217}See \textit{supra} note 53 and accompanying text.
The heart of the American hospital business model is the provision of lucrative, highly predictable, and usually non-emergent services, such as joint replacements, cardiac procedures, and chemotherapies. Accordingly, hospitals do not supply a safety net for patients in need of long-term intensive care, and for this reason they were ill prepared to provide a safety net to COVID patients. To the contrary, because hospitals in 2020 had to treat COVID patients and postpone their staple of elective, non-emergent, and lucrative procedures, hospitals exhibited the unusual paradox of being filled with patients but losing money.

Devotion to lucrative procedures is not a quirk in our national health system; it is what drives our system. Hospitals are not paid to provide safety net care, and consequently they make few investments to offer a safety net. In normal times, health dollars do little more than feed this ravenous hospital model instead of building robust health initiatives, including for infectious diseases, that can keep people out of the hospital. We have long known that we underinvest in population health, and the recent pandemic illustrates that we also underinvest in systems that can triage patients and manage population illnesses.

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218 Herzlinger & Richman, supra note 98; see also Kliff, supra note 8 (highlighting that hospitals needed to rethink their business model because lucrative surgeries are being cancelled during the pandemic); Laurie McGinley, Patients Are Still Delaying Essential Care Out of Fear of Coronavirus, WASH. POST (July 13, 2020), https://washingtonpostproxy.lib.duke.edu/health/wooring-patients-back-is-tricky-business-as-coronavirus-spikes-in-many-states/2020/07/13/b86d676e-bbb1-11ea-8c18d784c6_story.html [https://perma.cc/2QFJ-RGTY] (finding cancer, cardiac, orthopedic surgeries critical to hospital revenue).


220 See Kliff, supra note 8 (noting Mayo Clinic lost millions of dollars a day as elective surgeries were cancelled due to COVID concerns).


222 See id. (noting business models reliant on charging for services are undermined by value-based reimbursement by insurance companies, especially if the insurance company decides the service is inefficient or unnecessary).

223 See Sarah Levy, Preparing for the Next Wave with AI-Driven Triage and Diagnostics, FORBES (June 29, 2020), https://www.forbes.com/sites/forbestechcouncil/2020/06/29/preparing-for-the-next-wave-with-ai-driven-triage-and-diagnostics/?sh=7c5fe6830699 [https://perma.cc/TGD3-Y9N8] (noting forty-eight hour delays in COVID reporting and coordination issues need to be resolved to implement an AI system for triage); see also Bean, supra note 110 (attributing overcrowding in NY hospital to failures to establish an information sharing system for ICU bed capacity).
In this sense, it might be said that the hospital business model imposes externalities on the rest of the population. Hospitals do not provide the care the population needs, and the shortcomings are most evident in a pandemic. The failure to invest in preparing for public health crisis is a reflection of shortsighted thinking and can be likened to the excessively risky bank dealings that reflected a moral hazard.

A second parallel, which is more obvious though less important, is the capacity of hospitals to be the source of infection spread. Hospitals are centers in which patients with contagious diseases gather and thus offer opportunities for contagion. In fact, hospital-borne infections are a common cause of death in the United States, and until relatively recently, American hospitals were often reimbursed for treating patients for the avoidable hospital-acquired infections. Hospitals, payers, and government regulators have pursued significant measures to reduce hospital-born infections—and many have earned deserved credit for meaningful progress—but the problem itself is another form of an externality that hospitals impose on the rest of the health system and the population.

Health policy experts have long appreciated these externalities imposed by the hospital business model and the shortcomings of hospital care. Most demand reforming Medicare and other payment systems, so hospitals and other healthcare providers are reimbursed based on the value they generate—i.e. the aggregate healthy improvements in populations—but both theory and practice are far from inducing hospitals to change business practices. Certainly, a systemic approach to national healthcare policy would demand widespread payment reform, with dramatic changes to how hospital care is paid for. But following the lessons from financial regulations, health policymakers might also require hospitals to assume financial responsibility for the costs of pandemics and thus financially induce them to prepare for population crises. If hospitals were to assume the financial burdens of population health, including those borne from contagious infections, they might make meaningful efforts to prevent infectious spread (generated both inside and outside their walls), take

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227 Richman, Kadakia & Shah, supra note 196, at 182–83 (finding “an insufficient provider network . . . fosters illness and creates a pent-up need for health services”).
preemptive measures to reduce the infection rates in their communities, and hone the ability to swiftly increase capacity when emergencies arise.228

Some more modest adjustments are possible as well, particularly those that enable hospitals to provide additional capacity with greater flexibility. One recent innovation in hospital care has been the growth of “hospital at home” care, in which providers offer inpatient care, including intensive care traditionally offered at ICUs, at a patient’s home.229 Though it is currently unknown whether in-home intensive care will meaningfully replace care provided at hospitals, in-home options certainly can and should be available to meet a sudden surge in demand, even—perhaps especially—for contagious illnesses. An even more rudimentary adjustment is to encourage, or require, hospitals to prepare for supply shortages. Because hospitals are not financially exposed to the cost of many inputs (the prices of drugs, devices, and personnel are paid separately by payers), they have invested little in preparing for shortages, even when such shortages are accompanied by hikes in prices.230 In response to some drug shortages, a consortium of hospitals created Civica Rx, which will provide supply reserves for hospitals.231 Hospitals historically have not been forced or incentivized for rudimentary advanced planning of this kind.232 Perhaps payment and regulatory rules should both allow and require these kinds of adjustments.

Other players responsible for financing healthcare might also assume responsibility for ensuring that hospitals plan for and provide emergency services. Insurers certainly would serve their subscribers by ensuring that the hospitals in their networks have the capacity to meet the needs during a demand surge, and insurance regulators ought to see that they do by requiring that “contingency plans” are included in the essential health benefits that insurers must cover.233 Like all medical care, planning for contingencies should start when we purchase our insurance coverage, not when we need medical treatment.

228 See Brent C. James & Gregory P. Poulsen, The Case for Capitation, HARV. BUS. REV., July–Aug. 2016, at 103, 106–07 (“Recognizing that volume-based payments fuel expenditures, increase waste, and potentially worsen quality, government officials are moving toward ‘pay for value’ systems, which give providers financial incentives to hold costs down by improving clinical outcomes and patient satisfaction.”).


231 CIVICA, supra note 123.

232 See Shah & Kocher, supra note 230.

233 Herzlinger & Richman, supra note 98.
B. Regulation Enabling Healthcare Entities to Preempt the Spread of Crises

The COVID crisis exhibited disastrous coordination within the hospital system. As Part III illustrates, the nation’s hospitals failed to respond not just to COVID surges in their localities but also to offer relief to overwhelmed areas. What was desperately needed was a page from the banking sector: when individual banks meet a surge in demand, whether from borrowers or withdrawals, they engage fruitfully with other banks to engineer reciprocal financing or short-term loans. In this way, the nation’s banks act as a system in which individual components reinforce and support each other.

The COVID pandemic illustrated the need for hospitals to do the same, and it requires little imagination on what systemic macromedical solutions might be. First, hospitals need to share information accurately and swiftly. At the outset of the pandemic, hospitals had no reliable mechanism in which they could determine the available capacity and constraints of nearby hospitals. Counties and states did not share ICU and ED statistics, and there were even fewer mechanisms to learn of shortages of specific components, such as ventilators or PPE. Perhaps policymakers realized the costs of failing to disseminate this kind of information. In December 2020, HHS started publishing facility-level

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235 The provision of central bank liquidity to prevent default—a regulatory approach used to mitigate interconnectedness by reducing tight coupling, see infra notes 242–242 and accompanying text, would apply more appropriately in the healthcare context to lack of substitutability as a transmission mechanism. The goal would be to keep hospitals and other essential healthcare providers operating by extending credit and protecting them from default. Cf. Steven L. Schwarz, The Case for a Market Liquidity Provider of Last Resort, 5 N.Y.U. J.L. & Bus. 346, 350 (2009) (explaining why such a market liquidity provider is needed to stabilize panicked financial markets). To the extent this approach is considered, we are not necessarily suggesting that the government should provide such liquidity. Any such liquidity provider could be privatized—such as being collectively self-funded by the healthcare providers that could benefit from that liquidity. Cf. Iman Anabtawi & Steven L. Schwarz, Regulating Ex Post: How Law Can Address the Inevitability of Financial Failure, 92 Tex. L. Rev. 75, 122–28 (2013) (arguing that the costs of providing liquidity to systemically important financial firms and markets could be at least partly privatized by assessing healthy systemically important firms, and comparing that to other government-mandated privatized self-insurance programs).

data for hospital utilization on a weekly basis. An accompanying data sharing initiative tracked the number of ventilators, masks, eyewear, and respirators on the facility level. Having lacked this information for most of the pandemic, however, many hospitals in 2020 encountered enormous difficulty anticipating their needs, in large part because they had no historical or regional data. As a result, “many hospitals . . . over-estimated surges and thus hoarded supplies, while many under-estimated and were frantically providing intensive care in hallways and other ill-suited locations.”

Second, hospitals should undergo “stress tests,” much as banks do, to determine their capacity to handle population health crises. Such stress tests would simulate not just the consequences of pandemics but also earthquakes, nuclear attacks, severe weather, and other sudden disruptions that would lead to surges in needed hospital care. Hospitals that cannot exhibit the capacity for effective responses should either be fined or lose Medicare funding. The ability to respond to crises is not just desirable for a hospital’s patients; it is also necessary to slow the spread of a crisis. A hospital’s capacity to alert neighboring providers that it has available capacity for more patients can alleviate emergent conditions nearby and reduce the spread of a health hazard.

Stress tests should also assess a hospital’s ability to procure necessary inputs to provide critical services. Currently, for example, “health-care providers rely extensively on supply chains for just-in-time delivery of medicines, keeping

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237 These data are derived from reports with facility-level granularity across HHS TeleTracking and reports provided directly by state and territorial health departments on behalf of their healthcare facilities. COVID-19 Reported Patient Impact and Hospital Capacity by Facility, HEALTHDATA.GOV, https://healthdata.gov/Hospital/COVID-19-Reported-Patient-Impact-and-Hospital-Capacity-by-Facility [https://perma.cc/J9LC-V8M9].


limited supplies on hand to prevent wasted value on stock shelves.”

Although these types of just-in-time-delivery supply chains are “highly efficient” in normal times, they epitomize a tightly coupled system—one that is so highly interdependent that a disturbance to one part of the system can spread almost instantaneously to other parts of the system. Healthcare organizations themselves have recognized this risk. To reduce this tight coupling, public health regulators should consider mandating reasonable stockpiling, at least for the most critical supplies.

The limited precedent for the government itself engaging in this type of stockpiling is not encouraging. Although the HHS has tried to maintain a stockpile of essential medical equipment, it has been unable to supply sufficient personal protective equipment to respond to the COVID-19 pandemic. Furthermore, efforts to solve the stockpiling problem by government action alone, without involving the private healthcare sector, could encourage moral hazard. Private healthcare providers are unlikely to pay the costs of stockpiling essential inventory if they believe that the government is already stockpiling to solve supply-chain discontinuities.

It is bewildering that hospitals rely so heavily on centralized funding—from Medicare, large insurers, and other sources of aid—but so severely lack other coordinating capabilities to function as a robust system in times of national need. Enabling hospitals to cooperate and forcing them to prepare for regional crises requires little cost and effort, and it takes little effort to imagine a future disaster in which hospitals, without reform, will again serve the nation poorly.

C. Regulation Correcting Market Failures That Could Trigger and Transmit Risk to the Healthcare System

Market failures could trigger unexpected exogenous shocks that destabilize a system. For the financial system, these market failures included agency

242 Id.
244 See, e.g., HCA HEALTHCARE, INC., 2019 ANNUAL REPORT TO SHAREHOLDERS 44 (2020) (observing that “a pandemic, epidemic or outbreak might adversely affect our operations by . . . disrupting or delaying production and delivery of materials and products in the supply chain”).
246 See generally Steven L. Schwarcz, Conclusion: Closing Perspectives on Regulating Systemic Risk, in SYSTEMIC RISK IN THE FINANCIAL SECTOR: TEN YEARS AFTER THE GREAT
problems and misinformation.\(^{247}\) For the healthcare system, the most relevant market failures stem from the hospital business model, which prioritizes lucrative individual services over expenditures that prioritize population health,\(^{248}\) and from collective action problems.

The hospital business model—which mirrors the profit-maximizing strategy resulting from a governance model that can ignore public welfare\(^{249}\)—can create negative externalities, requiring a systemic solution. Though economists often consider regulatory interventions or Pigouvian taxes to mitigate negative externalities,\(^{250}\) another solution might involve reforms to the shareholder-primacy model of corporate governance. For-profit corporate entities generally, including not only financial institutions but also for-profit hospitals and other healthcare providers,\(^{251}\) are managed for the primary benefit of their shareholders.\(^{252}\) This shareholder-primacy governance means that these entities

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\(^{247}\) See supra notes 64–77 and accompanying text. More generally these market failures could be described as involving complexity (including resulting information asymmetry), conflicts (agency problems), behavioral limitations, moral hazards, change that renders regulation obsolete or inefficient, and a type of tragedy of the commons. See Schwarcz, Perspectives, supra note 246, at 269; cf. supra text accompanying note 58 (observing that maturity transformation also can leave financial firms and markets vulnerable to unexpected systemic shocks).

\(^{248}\) Herzlinger & Richman, supra note 98.

\(^{249}\) See supra text accompanying note 217. This market failure also represents the type of tragedy of the commons referenced. Schwarcz, Systematic, supra note 39, at 33.

\(^{250}\) See INT’L MONETARY FUND, TAX POLICY HANDBOOK 105 (Parthasarathi Shome ed., 1995) (explicating that Pigouvian taxes force the taxpayer to internalize the cost of negative externalities by charging a fee reflecting the externality costs).


\(^{252}\) See, e.g., Dodge v. Ford Motor Co., 170 N.W. 668, 684 (Mich. 1919) (shareholder-primacy’s classical articulation); see also Christopher Cheney, Top 5 Differences Between NFPS and For-Profit Hospitals, HEALTH LEADERS (June 20, 2017), https://www.healthleadersmedia.com/finance/top-5-differences-between-nfps-and-profit-hospitals (on file with the Ohio State Law Journal) ("Although nonprofit and for-profit hospitals are fundamentally similar, there are significant cultural and operational differences. ... All hospitals serve patients, employ physicians and nurses, and operate in tightly regulated frameworks for clinical services. For-profit hospitals add a unique element to the mix: generating return for investors."); Nick Price, For-Profit Healthcare Organizations vs. Not-for-Profit Healthcare Organizations, BOARD EFFECT (May 16, 2018), https://www.boardeffect.com/blog/for-profit-vs-not-for-profit-healthcare/ [https://perma.cc/5B3L-ZPD3] (“It’s true that for-profit hospital boards maintain a business-driven culture. They have to because they’re accountable to their shareholders. ... Shareholders don’t always have the same interests or level of compassion as community members.”); John F. Horts & Daniel M. Mulholland Ill, Legal Differences Between Investor-Owned and Nonprofit Health Care Institutions, in THE NEW
engage in activities that sometimes have positive expected value to their investors but negative expected value to the public. If the entity is a systemically important financial institution whose failure can significantly harm the economy, that governance can create a critical misalignment between private and public interests. Tort law and regulation normally readjust this misalignment by limiting externalities, but they are not effective to limit indirect systemic economic harm.

Similarly, if the entity is a critically important for-profit hospital or other healthcare provider, tort law and regulation cannot effectively readjust the misalignment between private and public interests. As a result of shareholder-primacy governance, the healthcare provider may well focus its business on income-producing inpatient services, rather than on maintaining a population’s health or being prepared to care for an unexpected flood of patients resulting from an incipient pandemic. In the context of macroprudential regulation, the misalignment calls into question whether managers of systemically important financial institutions should have some type of a public governance duty.

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253 See Steven L. Schwarcz, Misalignment: Corporate Risk-Taking and Public Duty, 92 NOTRE DAME L. REV. 1, 2 (2016) [hereinafter Schwarcz, Misalignment] (observing that because much of the harm from a systemically important firm’s failure would be externalized onto the public, such a firm can engage in risk-taking ventures with positive expected value to its investors but negative expected value to the public—creating a critical misalignment between private and public interests); see also Regina E. Herzlinger & William S. Krasker, Who Profits from Nonprofits?, HARV. BUS. REV., Jan.–Feb. 1987, at 93, 93–94.


255 Schwarcz, Misalignment, supra note 253, at 2–5, 18–21.

256 See generally Joseph Zeballos-Roig, supra note 8 (linking limited hospital bed capacity and shortages of critical equipment such as masks and ventilators to the for-profit healthcare model). But see FREDRIC BLAVIN & DIANE ARNOS, HOSPITAL READINESS FOR COVID-19: ANALYSIS OF BED CAPACITY AND HOW IT VARIES ACROSS THE COUNTRY (2020), https://www.urban.org/sites/default/files/publication/101864/hospital-readiness-for-covid-19_2.pdf [https://perma.cc/PPP4-2AH7] (finding higher hospital bed capacity for COVID-19 patients, by percentage of total beds, at for-profit hospitals as compared to nonprofit hospitals and nonfederal government hospitals).

257 See Schwarcz, Misalignment, supra note 253, at 21–31 (arguing for a SIFI public governance duty and explaining why it could be feasibly implemented). A kind of non-profit legal form—the mutual organization—is common in the field of finance, and has been
Healthcare regulators should ask this same policy question: Should governments legislate some type of public-health governance duty requiring critical healthcare providers to give greater attention to maintaining public health, including preparing for rare but consequential events like a pandemic? A similar question arises even for not-for-profit hospitals, which are ostensibly managed “based on the organization’s mission and bylaws” but, according to abundant empirical research, act almost indistinguishably from for-profits. Should governments require the bylaws of critical not-for-profit healthcare providers to include such a public-health governance duty? Requiring changes to the corporate governance of important hospital systems and “health SIFIs” would be significant and would not come without costs, but the question warrants further consideration precisely because of the importance of harmonizing hospital policies with the public interest.

We wish to emphasize that the public-health governance duty would be consistent with our claim that America’s private healthcare institutions should be able to respond to public health crises without being publicly owned or funded by public dollars. The governance duty would focus on modifying shareholder primacy to limit the right to externalize harm onto the public, not on ownership or funding. Limiting the right to externalize harm is what regulation and tort law are all about. In a healthcare context, though, ordinary regulation and tort law are insufficient to control externalities, requiring supplementary regulation in the form of a public-health governance duty.

The other relevant market failure stems from collective action problems. A collective action problem results when all members of a group would benefit from cooperation but one or more members of that group fails to cooperate understood as a structure that tends to mitigate risk-taking, as compared to the more familiar shareholder-owned corporation. See Michael S. Barr, Howell E. Jackson & Margaret E. Tahyar, Financial Regulation: Law and Policy 354 (2d ed. 2018) (discussing the role of mutual form in insurance regulation). When the world’s major stock exchanges all converted from the mutual form into stock corporations a few decades ago, there was widespread recognition that the new entities needed to be subject to enhanced and reformed public supervision. See Stavros Gadinis & Howell E. Jackson, Markets as Regulators: A Survey, 80 S. Cal. L. Rev. 1239, 1244 (2007).

Cf. Schwarcz, Misalignment, supra note 253, at 28–44 (explaining how a SIFI public governance duty could be feasibly implemented). For more detailed discussions of how managers could perform such a public governance duty, see id. at 30–31, and Schwarcz, Systematic, supra note 39, at 40–41.

Price, supra note 252.


Cf. Schwarcz, Misalignment, supra note 253, at 32–37.

See supra text accompanying notes 14–19.

Schwarcz, Misalignment, supra note 253, at 17–18, 20.

See supra notes 249–255 and accompanying text.

In a separate context, one of us explains in detail how a public governance duty could be feasibly designed and implemented to reduce externalities without weakening corporate wealth-producing capacity. Schwarcz, Misalignment, supra note 253, at 28–44.
because of a conflicting interest. Collective action problems that increase the transmission of infections can arise not only among interconnected people but also among interconnected nations. This type of problem occurred, for example, at the beginning of the coronavirus infection in Wuhan, China. Chinese government authorities devalued and dismissed healthcare workers’ reports about a new SARS-like virus, and even reprimanded some workers who posted information about the virus on the internet. Some argue that “if Chinese authorities had acted three weeks earlier than they did, the number of coronavirus cases could have been reduced by 95% and its geographic spread limited.”

That type of collective action problem among nations is not necessarily individually irrational. No nation would want to be identified as the source of a new infection. Sometimes, too, that identification would be misleading. The so-called “Spanish” flu of 1918, for example, did not originate in Spain. It originated elsewhere but was not widely recognized until the Spanish newspapers reported it (because Spain was neutral in World War I, its newspapers were not censored).

Public health regulators should seek to address this collective action problem among nations. As soon as a novel infection with the potential to be transmitted into a pandemic is recognized, it should be publicly disclosed to the world’s public health community in order to reduce that transmission. National regulation requiring that disclosure would not solve the collective action problem because performance of that duty might be compromised—as happened in China. To address (or, at least, attempt to mitigate) this collective action problem, governments should consider entering into a cross-border convention or treaty that imposes a collective disclosure duty with penalties for


268 See, e.g., id.

269 Id.


271 Id.
breach. Existing international law only requires disclosure to the WHO.\(^{272}\) There is no penalty, though, for failure to disclose,\(^{273}\) which might partly explain why China delayed notifying the WHO\(^{274}\) and, after finally being notified, the WHO itself was not fully responsive.\(^{275}\)

**D. Emergency Powers Enabling Regulators to Respond to Crises**

The financial regulatory precedents show that emergency powers that enable regulators to respond to crises could be used to protect the healthcare system. Statutory authority and institutional independence were critical to the Fed’s swift and effective response during the last financial crisis, allowing it to undertake a variety of innovative, sometimes even controversial, measures to stabilize the financial system.\(^{276}\) The Fed’s independence, for example, substantially insulated its economic experts’ decisionmaking process from political pressures.\(^{277}\) Members of its Board of Governors enjoy long-term appointment and “for cause” job security.\(^{278}\) Budgetary autonomy also enables the Fed to rapidly implement lending decisions.\(^{279}\)

The same types of authority could empower a healthcare emergency responder, perhaps the CDC or CMS, to organize more proactive and effective

\(^{272}\) Article 6 of the International Health Regulations requires each government to “notify WHO . . . within 24 hours of assessment of public health information, of all events which may constitute a public health emergency of international concern within its territory.” WORLD HEALTH ORG., INTERNATIONAL HEALTH REGULATIONS 12 (3d ed. 2005), https://apps.who.int/iris/bitstream/handle/10665/246107/9789241580496-eng.pdf?sequence=1 [https://perma.cc/XD68-YVDD]. The goal of these Regulations is “to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks . . . .” Id. at 1.

\(^{273}\) See supra notes 268–269 and accompanying text (discussing China’s delay in responding to the novel coronavirus).


\(^{275}\) See supra notes 78–79 and accompanying text. One feature that enables the Federal Reserve to identify and respond to financial crises is the ability to recognize the creation of one. See Judge, supra note 83; Mehra, supra note 79, at 227.

\(^{276}\) See Judge, supra note 83; Mehra, supra note 79, at 227.


\(^{278}\) See id. at 273.
responses to pandemics.\textsuperscript{280} Shielded from political influence, the CDC could better facilitate science-based public communication and issue stronger and more consistent recommendations on protective measures.\textsuperscript{281} One also could envision giving such power to a “permanent” White House task force working with the CDC, though such a task force could be subject to changing presidential administrations and thus not be truly permanent or politically independent. It also would have to be wary of political considerations that easily and frequently disrupt pandemic responses; when political factors have influenced past CDC policymaking, the Agency has not fared well.\textsuperscript{282}

It might also be worth developing an institution that, like the Fed, can directly address problems in demand surges. A Medical Reserve Board (“MRB”), fashioned similarly to the Federal Reserve Board as an independent regulator, can anticipate demand shocks and coordinate responses to health crises. In addition to managing information systems and implementing stress tests, described in Part IV, the MRB could also respond to supply chain delays and shortages of critical inputs, such as vaccines, PPE, drugs, and other medical supplies that suffer from shortages. Though managing this liquidity is more challenging than managing the money supply—the Fed can print money, whereas MRB cannot print PPE—the MRB’s job would be to ensure the ready availability of critical supplies to healthcare providers, just as the Fed ensures a stable supply of liquid money.

\textbf{V. CONCLUSIONS}

The COVID pandemic exposed many shortcomings in the U.S. health sector, a sector that already consumes one out of every six dollars in the economy and yet performs unfavorably compared to systems in other OECD nations.\textsuperscript{283} But many of these shortcomings—and in particular, the problems in meeting demand surges—can be readily addressed by learning from regulatory solutions from the financial sector.

Our hypothesis can be stated very simply: Both financial crises and healthcare crises involve contagions that individual institutions cannot address on their own. The stability of our banking system relies on ensuring that individual banks exhibit minimal resiliency, that banks offer support to each


\textsuperscript{281} See id.

\textsuperscript{282} See \textit{LEWIS}, supra note 19, at 285–89.

\textsuperscript{283} See supra notes 89–90 and accompanying text.
other collectively as a system, and that federal regulators offer centralized support. The same approach would enormously benefit the nation’s hospitals. Because regulation cannot completely prevent systemic shocks from being triggered in a complex system, such as the healthcare system, ex ante preventative regulation should be supplemented by ex post mitigative regulation, devised to break the transmission of inevitable shocks and limit their impact. Accordingly, we recommend a macromedical approach to regulating the hospital sector, so that individual hospitals are better prepared to handle demand surges, hospitals can coordinate with and reinforce each other as a sector, and regulators offer instrumental and regulatory leadership to mitigate surges from the next crisis. The nation suffered immensely in both 2008 and during the 2020–2021 pandemic, and it is incumbent upon policymakers to ensure that similar suffering is not repeated in the next crisis. Financial services reforms incorporated many corrective actions to prevent another 2008 financial meltdown, and policymakers must act similarly to avoid another pandemic year.

We are cognizant that we do not write on a blank slate, and that this Article follows a rich history of policies designed to regulate the supply of medical care in the United States. We are also cognizant that most of those policies are widely considered to be failures. The Hill-Burton Act, for example, stimulated the construction of many hospitals, but it has been blamed for inducing overspending and constructing an unsustainably expensive healthcare infrastructure. Certificate-of-need laws, designed in part to stem the overkill of Hill-Burton, were intended to reduce the construction of unnecessary healthcare facilities, but those laws have been blamed for creating costly monopoly power by incumbents and stymieing innovations in healthcare delivery. Moreover, when policymakers respond to lessons learned from a recent crisis to stop the next one, they institute responses that are much better at

284 Cf. Lynn M. LoPucki, The Systems Approach to Law, 82 Cornell L. Rev. 479, 481 (1997) (applying “systems analysis,” a methodology developed in the fields of engineering, business information systems, and computer programming to manage complexity, to law by “identifying systems, discovering their goals or attributing goals to them, mapping their subsystems and the functions each performs, determining their internal structures, depicting them with attention paid to efficiency of presentation, and searching for internal inconsistencies”).


286 See Schwarcz, Systematic, supra note 39, at 44, 49.


avoiding an identical crisis than they are responding to the actual risks of the future. We therefore must proceed with a healthy dose of modesty, recognizing both the limitations and errors of past policies to moderate our provision of healthcare services and the general shortcomings of predicting future crises accurately. The history of American healthcare policy offers many humbling moments.

Nonetheless, we should persist in learning and applying the lessons of recent history. To be sure, the nation has other health crises in its future. Policymakers cannot prevent the emergence of novel viruses, natural disasters, or other events that threaten the health of millions, but they can take preventive measures to better prepare our hospital system. The first critical step is recognizing that healthcare is a system, and thus susceptible to systemic risk. Controlling that risk requires us to learn from systemic regulation that has been applied successfully to other systems.