The Health Justice Potential of Macromedical Regulation

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In their article Macromedical Regulation, Barak D. Richman and Steven L. Schwarcz draw from the macroprudential regulation following the 2008 financial crisis to offer recommendations for addressing systemic risk in health care. Although their focus is the efficient distribution of risk and the ability to respond to system-wide demand shocks and supply shortages, their proposal also has important implications for health justice. Macromedical regulation would not only improve the health care system’s ability to respond to widespread health crises, it could also help to increase health care access, improve outcomes, and decrease health disparities.

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I. INTRODUCTION

American health care is notoriously expensive, wasteful, ineffective, and fragmented. Not surprisingly then, this already broken system could not withstand the additional stresses of the COVID-19 pandemic. The novel coronavirus infected millions of Americans, leaving over 600,000 dead and thousands of others with debilitating long-haul symptoms. In their pathbreaking article, Macromedical Regulation, Barak D. Richman and Steven L. Schwarz argue that this breakdown occurred because law- and policy-makers failed to adequately account for systemic risk. While American health...
care is certainly not wanting for regulation, the authors propose that our current frameworks focus primarily on individual needs and services, while neglecting population health or the capabilities of the health care system as a whole.

Despite sounding in the register of efficient risk allocation and mitigation, their proposal could also have significant health justice effects. The potential for macromedical regulation to increase health care access, improve health outcomes, and address health disparities is the subject of this Response.

II. MACROMEDICAL REGULATION

The stresses of the COVID-19 pandemic demonstrated that individual medical institutions cannot deal with systemic shocks on their own. While some commentators assert that publicly funded health care is the answer, Richman and Schwarcz maintain that we do not need to abandon the private, for-profit system to have better disaster preparedness. Instead, they advocate for the system-wide regulation of private health care institutions to allow them to better respond to public health crises. Drawing from the macroprudential regulation that followed the 2008 financial crisis, Richman and Schwarcz offer “macromedical regulation” as a solution to better insulate American health care from health shocks, like the current infectious disease crisis. Their proposal includes four separate, albeit related, parts.

First, health care entities must bear at least some of the costs of responding to public health disasters. The bread and butter of our current health care system is non-emergent, highly reimbursed services. As a result, private health care institutions do not invest in creating a safety net to respond to large-scale public health emergencies. Requiring these entities to have skin in the game creates an incentive for them to prevent the spread of infectious disease, act proactively to mitigate the effects of public health disasters, and to create strategies to expand their capacity when emergencies occur.

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10 Richman & Schwarcz, supra note 8, at 764.

11 See id. at 743–44.

12 Id. at 729.

13 Id. at 730.

14 See id. at 729–30.

15 Id. at 763.

16 Richman & Schwarcz, supra note 8, at 765.

17 Id. at 763–64.

18 Id. at 764–65.

19 Id. at 765–66.
Second, hospitals should coordinate to respond to demand surges. This coordination would require health care institutions to quickly and accurately share information about both their capabilities and their constraints. Moreover, hospitals, like banks, should undergo stress tests to assess their ability to respond to a variety of health shocks to allow them to better mobilize their support networks in times of crisis.

Third, regulations could correct existing market failures to reduce negative externalities and address collective action problems. As noted, health care institutions have little motivation to prioritize population health. Private, for-profit hospitals put the interests of their shareholders first, sometimes even to the detriment of public welfare. Richman and Schwarz therefore suggest that regulators introduce a “public-health governance duty” to offset shareholder primacy and the current focus on profit maximization. Collective action problems may also impede an effective public health response. Not only can individuals fail to act in a way that serves the common good, nations may ignore the risks that their actions place on their sister countries. International law instruments, like treaties or cross-border conventions, could include a duty to disclose certain kinds of health risks and impose penalties for noncompliance.

And fourth, health authorities must have the necessary emergency powers to swiftly respond to public health crises and their accompanying demand surges. For example, federal agencies, such as the Centers for Disease Control and Prevention or the Centers for Medicare and Medicaid Services, could communicate with the public and provide recommendations. Additionally, the government could create an independent Medical Reserve Board (MRB). The MRB would engage in much-needed oversight by performing a number of different functions, such as anticipating health shocks, administering stress tests, managing information, coordinating response efforts, and responding to supply and other shortages.

Richman and Schwarz introduce their creative solutions as strategies for addressing systemic risk without renouncing the private ownership and market

20 Id. at 767–68.
21 Id.
22 Richman & Schwarz, supra note 8, at 768.
23 Id. at 769–70.
24 Id. at 770–71.
25 Id.
26 Id. at 772–74.
27 Id. at 773.
28 Richman & Schwarz, supra note 8, at 773.
29 Id. at 773–74.
30 Id. at 774–75.
31 Id.
32 Id. at 775.
33 Id.
competition that characterize our current health care system. Yet their suggestions also have important implications for health justice.

III. HEALTH INEQUALITY IN THE UNITED STATES

Sadly, the pandemic response in the United States has exacerbated many preexisting health disparities. By making the American health care system able to better respond to systemic risk, health shocks, and supply shortages, macromedical regulation will also address these disparities and improve health care quality and access, thereby moving us that much closer to just, equitable health care.

The COVID-19 pandemic certainly highlighted the problem of health inequality in the United States. Yet disparities plagued our health care system well before the novel coronavirus. Health disparities are “[d]ifferences that exist among specific population groups . . . in the attainment of full health potential that can be measured by differences in incidence, prevalence, mortality, burden of disease, and other adverse health conditions.” Although most readily associated with inequalities across racial or ethnic groups, health disparities also impact LGBTQ+ people, people with disabilities, and both rural

34 Richman & Schwarcz, supra note 8, at 729–30.
36 Richman & Schwarcz, supra note 8, at 730.
37 See id. at 776.
38 Id. at 753.
and urban populations. As a whole, people of color in the United States are less likely to have health insurance coverage—which can impede health care access—and report having poorer relative health, as compared to white Americans. LGBTQ+ individuals also experience less access to health care, including preventive care and screenings, and greater rates of discrimination by health care professionals. People with disabilities report lower relative health and more difficulty accessing care than their able-bodied counterparts. Individuals who live in rural areas may lack access to health care providers, including basic care, and have higher rates of disease with worse health outcomes. Likewise, certain urban populations may have difficulty accessing needed health care and relatively poor health outcomes.

While these statistics provide examples of common health disparities in the United States, they are not comprehensive or mutually exclusive. People of color and people with disabilities also face discrimination in health care; LGBTQ+ individuals may have lower rates of relative health and poorer health

41 Id. at 11, 82, 84–85.
46 Alicea-Alvarez et al., supra note 39, at 733.
outcomes; and people in rural communities are less likely to be insured. It is not my goal to provide a thorough account of all the health disparities in the United States. I intend only to show that these inequalities are systemic issues that predate the current public health crisis.

To be sure, the COVID-19 pandemic did not create these disparities. However, it exacerbated them and with deadly consequences. People who are Black, Latinx, and Native American are more likely to be infected, hospitalized, and die from COVID-19 than whites. In a recent baccalaureate address, President Biden’s Chief Medical Advisor, Anthony Fauci, stated that these disparities revealed the “undeniable effects of racism” in the United States. Certain health conditions associated with adverse COVID-19 outcomes occur at higher rates in LGBTQ+ individuals, resulting in a disparate impact on those communities. People with disabilities have experienced both overt and implicit discrimination during the pandemic, especially with respect to the

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51 Id.


rationing of scarce health care resources.\textsuperscript{54} Individuals who live in rural communities seem more vulnerable to COVID-19.\textsuperscript{55} Yet many rural hospitals lack critical resources like ICU beds, ventilators, and EMS personnel, and people who live in rural communities must travel farther to obtain needed health care.\textsuperscript{56} On the other end of the spectrum, urban areas face their own set of challenges.\textsuperscript{57} Issues like poor air and water quality, a reliance on public transportation, and the absence of green or open spaces exacerbated the virus’ impact on some cities.\textsuperscript{58} Thus, COVID-19 has had a greater effect on several health disparities populations, many of whom already had difficulty obtaining just, equitable health care even before the pandemic.

\textbf{IV. MACROMEDICAL REGULATION AS A TOOL OF HEALTH JUSTICE}

American health care is both inefficient\textsuperscript{59} and discriminatory.\textsuperscript{60} Although presented as strategies to address systemic risk and insulate our health care system from shocks and supply shortages,\textsuperscript{61} the interventions outlined by Richman and Schwarcz will also promote health justice. Each of the four pillars of macromedical regulation described above also has the potential to improve health care access and quality in ways that could reduce health disparities that predate—and were exacerbated by—the pandemic.

First, the very business model that led to pandemic-era breakdown of the health care system is at the heart of many health disparities.\textsuperscript{62} Prioritizing profitable, highly reimbursed, often elective services over providing a health care safety net for individuals with ongoing health care needs shuts out many of the populations described above, leading to access issues.\textsuperscript{63} Patients without health insurance are simply not profitable.\textsuperscript{64} People of color, LGBTQ+

\begin{itemize}
\item[\textsuperscript{56}] CDC, supra note 50.
\item[\textsuperscript{58}] Id. at 4–10.
\item[\textsuperscript{59}] See supra Part II.
\item[\textsuperscript{60}] See supra Part III.
\item[\textsuperscript{61}] Richman & Schwarcz, supra note 8, at 732, 748.
\item[\textsuperscript{62}] See id. at 763–64.
\item[\textsuperscript{63}] Id.
\end{itemize}
individuals, people with disabilities, people in rural communities, and people in urban communities are all less likely to have health coverage.\(^65\) Thus, under the current system, hospitals often lack the financial incentives for serving these populations.\(^66\) Requiring health care institutions to bear the costs of public health crises will motivate them to invest in the health of the population as a whole, not just those whose health insurance can pay for the care.\(^67\) The result will hopefully be improved health care access and quality for many of the populations currently experiencing health disparities.

Second, better coordination and communication between institutions could also improve pre-pandemic health inequalities. Recall that geography plays a significant role in American health disparities.\(^68\) Rural hospitals lack many essential resources, even outside the context of public health disasters.\(^69\) And urban hospitals that serve the inner-city poor continue to close, leaving those populations with even less access.\(^70\) A greater network of support between hospitals could address supply and staff shortages even in non-pandemic times, allowing these critical and overburdened institutions to better serve their communities.\(^71\) Again, the result would hopefully be better health care access and improved health outcomes for those populations. Thus, a systemic, regional approach to health care could help to erode geographic health disparities.

Third, addressing market failures may serve health justice, in the United States and beyond. Richman and Schwarcz’s duty of public health governance would require health care institutions to think beyond their bottom lines.\(^72\) Public health is population health. The proposed duty would provide yet another motivation to address the health disparities that currently lead to poorer relative


\(^{66}\) E.g., Richman & Schwarcz, supra note 8, at 745.

\(^{67}\) Id. at 763–65.

\(^{68}\) See Warshaw, supra note 45.

\(^{69}\) Id.


\(^{71}\) Richman & Schwarcz, supra note 8, at 767–68.

\(^{72}\) See id. at 772.
health, decreased access, and worse health outcomes. The authors explain that collective action problems plague not only individuals but nations. Globally, requiring disclosure could then improve international health disparities. COVID-19 hit many poorer countries harder. Reliable communication between nations would also generate better information and create incentives to limit spread, and it could also allow more vulnerable countries to prepare.

Fourth, better agency oversight, insulated from political influence, could ensure a nondiscriminatory, inclusive disaster response and could better deal with potential shortages, both of which would further health justice. As the pandemic begins to wane, health disparities persist, now with respect to vaccinations. Unfortunately, certain populations may experience vaccine hesitancy due to negative experiences with the health care system. A trustworthy health authority providing reliable, evidence-based

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73 See supra Part III.
74 Richman & Schwarzc, supra note 8, at 773.
75 See id. at 773–74.
77 See Nambi Ndugga, Latoya Hill, Samantha Artiga & Noah Parker, Latest Data on COVID-19 Vaccination by Race/Ethnicity, KAISER FAM. FOUND. (July 21, 2021), https://www.kff.org/coronavirus-covid-19/issue-brief/latest-data-on-covid-19-vaccinations-race-ethnicity/ [https://perma.cc/69GX-YSJT] (noting that as of July 19, 2021, the CDC reported that race/ethnicity was known for 58% of the people who received at least one dose of the vaccine, out of which nearly 60% were White, 9% were Black, 16% were Hispanic, 6% were Asian, 1% were American Indian or Alaska Native, less than 1% were Native Hawaiian or Other Pacific Islander, and 8% reported multiple or other race); see also Gianna Mellillo, Disparities in COVID-19 Vaccine Rates Tarnish Swift US Rollout, AM. J. MANAGED CARE (Apr. 1, 2021), https://www.ajmc.com/view/disparities-in-covid-19-vaccine-rates-tarnish-swift-us-rollout [https://perma.cc/APP5A-KZXC]; Bhavini Patel Murthy et al., Disparities in COVID-19 Vaccination Coverage Between Urban and Rural Counties – United States, December 14, 2020–April 10, 2021, 70 MORBIDITY & MORTALITY WKLY. REP. 759, 759 (2021), https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7020e3-H.pdf [https://perma.cc/SZYY-54NG] (noting that COVID-19 vaccination coverage was lower in rural countries, which had a 38.9% reported vaccination rate, than in urban counties, which had a 45.7% reported vaccination rate); Jillian Kramer, In Covid Vaccine Data, L.G.B.T.Q. People Fear Invisibility, N.Y. TIMES (May 10, 2021), https://www.nytimes.com/2021/05/07/health/coronavirus-lgbtq.html [https://perma.cc/A4U9-NCT3]; MaryBeth Musumeci & Priya Chidambaram, COVID-19 Vaccine Access for People with Disabilities, KAISER FAM. FOUND. (Mar. 1, 2021), https://www.kff.org/medicaid/issue-brief/covid-19-vaccine-access-for-people-with-disabilities/ [https://perma.cc/2RBH-4Q2J].
recommendations might counteract some of these negative effects. Finally, the proposed MRB would not just improve the liquidity of supplies to health care providers in times of crisis. It could also ensure that all hospitals—even those serving health disparities populations—have access to needed medical supplies in regular times. Having adequate supplies of necessary resources will allow those institutions to provide better health services to more patients, thereby increasing access and improving quality.

V. CONCLUSION

In their article, *Macromedical Regulation*, Richman and Schwarcz offer novel solutions for addressing health shocks and mitigating systemic risk during public health disasters. But in addition to accomplishing these important goals, macromedical regulation could also further health justice. The individualized, profit-driven approach that the authors identify as responsible for the breakdown of the American health care system during the pandemic has also generated serious health disparities.\(^7^9\) Regulating health care as a system recognizes our inherent interconnectedness and the need to ensure that all Americans have access to just, reliable, and effective medical services.

\(^{79}\) Richman & Schwarcz, *supra* note 8, at 753.