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REVIEW ARTICLE

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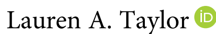
Review of Dranove and Burns, 2021. *Big Med: Megaproviders and the High Cost of Health Care in America*

Lauren A. Taylor 

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David Dranove and Lawton Burn's new collaboration *Big Med: Megaproviders and the High Cost of Health Care in America* provides readers with a comprehensive tutorial on consolidation in United States healthcare markets over the past 40 years. Although the book is most explicitly aimed at those who look around and wonder how we arrived at a healthcare landscape dominated by giants, anyone with a serious interest in the prices of U.S. healthcare will want to have this rigorous and timely treatment on their bookshelf.

Dranove, an economist, and Burns, a sociologist, met at the University of Chicago in the early 1980s, but this is their first jointly authored endeavor. Among the authors' many successes with *Big Med* is how they managed to blend their voices, and perspectives, so that it reads as a coherent whole rather than a relay race of chapters. The authors are senior enough in their respective fields to say what they mean without defensive qualifiers. The result is clear prose on a complex set of topics.

The book is structured to take up a handful of questions. Several of the early chapters allow the authors to respond to: How did we get to the current, very consolidated healthcare provider landscape? One of their key insights is that it was no accident. In the 1990s, healthcare providers were intentional about wanting to become part of successively larger organizations. They pursued scale under the premise that doing so would reduce costs of delivering care and benefit patients. Twenty years later, another round of integration (also known as *consolidation*) was spurred on by government policies in 2010's Affordable Care Act.

Within this section of *Big Med*, the authors help readers to appreciate how healthcare provider and insurer behavior were often predicated on *fears* of what the other side was about to undertake. For instance, Dranove and Burns note that it was "fear among providers that managed care was coming that drove [provider] consolidation." In a later chapter titled "Countervailing Power," the authors again highlight the game theoretic nature of provider–insurer relations by showing that both providers and insurers have made the case in court that they should be permitted to grow in order to provide a check on the already-too-powerful other side. The story of healthcare providers and insurer consolidation is such a seesaw of historical events, the reader is grateful for Dranove and Burns' narration of

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who moved when and why. Simply observing the historical record on one's own would deliver nowhere near the value.

Several of the *Big Med's* middle chapters take up the question: Why have the purported benefits of integration failed to manifest? Here, the authors help readers see what lies beneath the veneer of many integrated healthcare organizations—often little more than hospitals, physician practices, and outpatient surgery centers clumsily appended to one another. The real work of integrating organizational structures, to say nothing of cultures or workflows, has rarely been accomplished. Without it, the cost savings on which the integration was premised is often unrealized. Even where a megaprovider is realizing cost savings, neither they nor quality improvement is regularly delivered to patients. Dranove and Burns write, "The problem is that no one seems to know what alignment is, no one can show that integration fosters alignment and no one can show that alignment leads to better quality or lower costs."

Given megaproviders' failure to deliver value, the authors subsequently confront the question: Why have not policymakers halted the continued march toward consolidation? Chapters 4 and 7 are especially focused on anti-trust regulations and landmark anti-trust cases, emphasizing the importance of the definition of a "market" in barring mergers and the slipperiness of healthcare market boundaries. These chapters may offer more than the casual reader cares to spend time on but will make for great primers in graduate coursework on health policy and industrial organization.

The end of the book tries to anticipate ways out of the current consolidated landscape, though the authors are hardly rosy about the future. Chapter 9 entertains the notion that a Clay Christensen-style "disruptive innovation" is coming for the healthcare industry, though Dranove and Burns clearly believe that features of U.S. healthcare markets make true disruption unlikely. The final two chapters stake out recommendations for competition policy (Dranove's sweet spot) and management policy (Burns' sweet spot) in turn.

Competition as a Means and an End

In a handful of places, Dranove and Burns skirt the opportunity to weigh in on single-payer "Medicare for All" debates and reaffirm their commitments to markets generally. With both authors hailing from the University of Chicago, this should be of little surprise, but given how gloomy their outlook is about the future of healthcare markets, it does leave the readers to scratch their heads a bit. What is it about their analysis that sustains their confidence in competition as a means of creating social value? It is not exactly clear.

Many people maintain ideological commitments to markets in contrast to centrally planned economies. Libertarians are often the most vocal constituency in this respect but plenty of more moderate, pro-market thinkers refer back to Adam Smith's invisible hand metaphor and Friedrich Hayek's view that no social planner could ever have access to the information relayed by markets. Pro-marketeers often position themselves as proponents of competition *instead of* cooperation as a way of producing social value. (Arguments against price gouging laws bring these commitments out most starkly.) What pro-marketeers can overlook is that market competition is a particular kind of cooperation rather than a contrast to it. Joseph Heath's *Morality, Competition, and the Firm* is particularly instructive on this point, suggesting that societies establish markets to order cooperative relations between buyers and sellers. Markets are, in this sense, artificially adversarial in order to pursue collaborative ends (e.g., efficient distribution of goods). Of course, this strategy comes with drawbacks, many of which we feel acutely when allocating healthcare goods that many believe should be considered human (or at least political) rights. "What is necessarily absent in such markets," according to Alasdair MacIntyre, "is any justice of desert."

I raise this only to remind myself and perhaps other readers that market competition in healthcare need not be retained for its own sake. We should be willing to retain competition only if we think it is our best available shot at achieving desired cooperative outcomes. While I suspect that neither Dranove nor Burns believes competition to be an end in itself, *Big Med* left me wishing they had addressed a

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fundamental question: At what point, if ever, do we simply accept that market competition in healthcare has failed?

Their analysis left this reader feeling like we had landed in a bit of a between-two-stools scenario. With some exceptions like the Veteran's Administration, American society has chosen to forego a centrally planned healthcare delivery system that could guarantee access to care as a political right on account of the administrative bureaucracies it would entail. Instead, we have elected for a market-based approach and have been willing to stomach unequal access to care in return for supposed efficiencies. But as Dranove and Burns make clear, now we face a scenario in which many markets have failed to remain competitive, so we have achieved neither the idealized efficiency and patient choice that a pure market would deliver nor the equal access that a centrally planned approach promises. The current market-driven provider landscape is dotted with provider organizations that are so large that they have become the very bureaucratic monstrosities that the market approach abhors. The enormous marketing budgets that providers continue to spend to capture more customers is another example of inefficiency in our current system. Clearly, we are a long way from the efficiency frontier.

While ethical analysis is not *Big Med's* focus, the book provides a robust empirical basis for ethical considerations. There is ample room for the ethically inclined to pick up the baton from where Dranove and Burns leave off. What follows are two of my own suggestions for directions in which to run.

A Place for Ethical Analysis

Dranove and Burns' managerial recommendations more or less concede that megaproviders may be here to stay and ask how we can make them produce more value. Their policy recommendations suggest that we need to change the rules of the game, such as the way markets are defined by the Department of Justice and the Federal Trade Commission (Chapter 10). What is odd about Dranove and Burns' emphasis on regulation here is that their own analysis very effectively demonstrates the ways in which regulators have been captured by healthcare providers (and insurers). In Chapter 1, they write:

> When firms are threatened, either by competition or by regulation, there are two very different strategies for survival. The first is to create more value for consumers: find a way to become more efficient improve the product, or both. The second is to use whatever power they have to subvert the competition and capture the regulators. Faced with competitive and regulatory threats in the mid twentieth century, hospitals chose the latter strategy, with considerable success.

Subsequent chapters make clear that this strategy did not die in the mid-twentieth century but rather took new forms. While the authors do make occasional reference to ways that the capture can be limited (e.g., nationalizing Certification of Need [CON] processes rather than relying on local elected officials), there is little in the book that inspires confidence that the regulatory capture will relent.

I would like to propose that ethicists could effectively augment the scholarly discussion and also improve the functioning of healthcare markets by enunciating a set of moral responsibilities that would constrain healthcare organizations' competitive action. I propose this because internalizing constraints on organizational tactics seems essential. Though refining market regulations is always a worthy endeavor, perfect regulations do not exist. Even if regulators were not captured by healthcare organizations, they would not have the resources to intervene in all instances of unfair competition. *Big Med* is, in one sense, a several-hundred-page meditation on how very smart people have, for a long time, tried to set the rules of the healthcare market and misfired, often with harmful effects on the public.

So it is here that I would suggest departing from Dranove and Burns to try to chart a path for further ethical consideration. While they essentially concede that organizations will continue to pursue their own self-interest unchecked and thus rely on laws to constrain organizational behavior, I am interested in conceding that law is a blunt instrument with which to try and constrain organizational behavior and we should therefore try to institute some moral "rules of the road" that would function as internalized constraints. Economist Kenneth Arrow, who substantiated the "invisible hand theorem," was similarly

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interested. Arrow emphasized that when the Pareto conditions are violated, “the classical efficiency arguments for profit maximization do not apply and it is wrong to obfuscate the issue by invoking them.”[1] As a result, he suggested the need for “ethical codes” to constrain the conduct of business.

Ethicists who take on the task of delineating permissible and impermissible forms of competition will quickly realize that standard healthcare strategy textbooks often encourage behavior that undermines free and fair competition. Take the work of Harvard Business School’s Michael Porter, for instance. His brand of strategy became widespread in healthcare after the publication of *Redefining Health Care* (with Elizabeth Olmsted Teisberg), but his most famous contribution to the strategy literature is his “5 Forces” framework, which provides managers with a way of thinking about their organization’s strategic positioning.[2] When the framework is taught to MBA students, they are encouraged to minimize two of the forces: “Threat of Substitutes” and “Threat of New Entrants.” Assuming that these MBAs eventually lead healthcare organizations, is it any surprise that healthcare organizations routinely engage in competitive tactics that we think violate the spirit of fair competition? The creation of new standards for what constitutes *inappropriate* competitive behavior will have to wrestle with what Business School strategy departments consider *vigorous* competitive behavior.

Again, philosopher Joseph Heath’s work points to a promising way forward. What has become known as his “market failures approach” to business ethics suggests that firms should engage in competition only insofar as it furthers the end that market competition has been accepted to achieve—efficient outcomes. He writes,

> The central ideal of an adversarial ethic for business should be the preservation of healthy competition, even when the law fails to offer sufficient guarantees.[3]

Where ostensibly competitive practices undermine the market’s efficiency rather than enhance it, Heath deems them impermissible. A profitable line of future scholarship could aim to apply Heath’s principles to healthcare markets. Dranove and Burns describe exclusive contracting, where an integrated provider network refuses to contract with rival providers in the same market, as common practice. Is this the exploitation of a market failure that should be avoided or standard competitive behavior that should be preserved?

The Question of Charitable Nonprofits

Thus far, I have followed Dranove and Burns’ lead in making no distinction between for-profit healthcare organizations and nonprofit ones. In fact, the authors take a rather dim view of nonprofits, as indicated by sentences like “The [real] threat to competition would come from local nonprofits” and “When it comes to exploiting monopoly power, nonprofits do behave like for-profits in disguise.”

And yet, I cannot resist at least raising the question of whether nonprofit healthcare organizations, which are designated as charitable entities by the Internal Revenue Services and generally pay no municipal property nor state and federal income tax, should face particular obligations to compete in ways that accord with the public interest.

It is tempting to answer affirmatively and root the additional obligations in their tax-exempt status. I found a weak precedent for this line of thinking in a 2001 report by the Massachusetts Attorney General’s Office titled “Report on the Legislature on the Springfield Health Care Market” (The Report).[4] The Report was the Attorney General’s response to the Massachusetts legislature, which had asked for a review of the relationships between healthcare players in Springfield, with a particular eye toward whether access to care was being hampered by competitive tactics.

The core of the Legislature’s concern was the relationship between two nonprofit health systems. The first was the large and reasonably wealthy Baystate Health System (BHS), which included a hospital, ancillary healthcare providers, and Health New England, one of the region’s largest insurance plans. The second was the small and financially vulnerable Sisters of Providence Health System (SPHS). The two systems’ primary hospitals offered many of the same services but Sisters of Providence also offered a

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number of services that were known to be low or negative margin, including adolescent psychiatry and certain skilled nursing facilities. The Report described concerns that "certain practices by the dominant provider…threaten the viability of health services offered by SPHS and may limit access to affordable care in the future." Most at issue were Health New England's refusal to contract with SPHS, which the report suggested caused anticompetitive harm. The authors of The Report confronted but did not strongly answer the question of whether BHS's behavior toward their competitor Sisters of Providence violated charities law. The Report concluded as follows:

> The relationships between health care charities impact not only the success of the individual hospital or health plan but also the health care delivery system generally and the communities these charities serve. It is important to recognize that actions or policies by a hospital or insurer that may further its own competitive position, may at the same time have a substantial adverse impact on other charities serving the community, to the detriment of the community as a whole.
>
> Those institutions—like BHS—organized as public charities, and their boards of directors, should take into account the impact of their business decisions on the important providers of health care services in the area and the impact on the community if those other providers should be substantially weakened or fail. The appropriate role of and responsibility of public charities in the delivery of health care is an issue that should be considered, bearing in mind the need to preserve competition in the marketplace (see note 4).

The Report concluded that there was significant potential for anticompetitive behavior but that access to care remained adequate at the time of the report's drafting. The Attorney General (AG) declined to take action beyond urging the board of BHS to behave. That Report was filed on Sept 12, 2001, and appears to have rarely been accessed or cited since. Still, the question at the heart of the AG's inquiry remains highly relevant 20 years later.

Let me return briefly to the question of whether it would be prudent to assert special obligations for nonprofit players in the healthcare market. Tempting as it may be to do so, the following problem quickly rears its head: what to do about for-profits competing in the same market with nonprofits? It may be unreasonable to expect nonprofits to survive long-term if they are saddled with constraints that their competitors do not face. Clearly, there is a great deal to consider with regards to this question of nonprofit and charitable status, even beyond the general issue of whether we can and should assert moral responsibilities to constrain the behavior of competing firms. Dranove and Burns have provided readers with an incredibly sturdy foundation from which to launch these inquiries and for that, we owe them a great deal.

Notes

1. Heath J. An adversarial ethic for business: Or when Sun-Tzu met the stakeholder. *Journal of Business Ethics* 2007;**72**(4):359–74.
2. Porter M, Teisberg EO. *Redefining Health Care: Creating Value-Based Competition on Results.* Boston, MA: Harvard Business School Press; 2006.
3. See note 1, Heath 2007.
4. The Commonwealth of Massachusetts Office of the Attorney General. *Report to the Legislature on the Springfield Health Care Market*; 2001 Sept 12.

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