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Healthcare's Changing Landscape: How Big Healthcare Could Cost Lives in Rural America

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Healthcare’s Changing Landscape: How Big Healthcare Could Cost Lives in Rural America.

Nicholas J. Shabel

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I. Introduction

A plot of land to call your own, a small town where everybody knows everybody, and enough space in-between that you aren’t tripping over your neighbors are images conjured by such language as “Rural America” or “Small Community.” To many, living in rural America is the very picture of the American dream. In fact, some work their whole lives to achieve this ideal.

Unfortunately, this idyllic lifestyle is being threatened by some recent trends and as a result those living in rural regions may soon have to seriously consider whether they are healthy enough to live in a rural setting. As the healthcare market forces hospitals to consolidate to large population centers, it creates emergency care “deserts” in the areas between those centers. Accidents, such as car wrecks and hunting accidents become more dangerous in these “deserts.”

Moreover, living in these “deserts” may simply become too dangerous for the elderly and those who are already at risk for sudden acute illnesses, such as stroke and heart attack.

The hospital consolidation trend in our healthcare system has led to worse outcomes for patients in rural regions. Healthcare policymakers should take notice of this alarming trend and take action to ensure that the market in which these consolidated healthcare providers operate matches the externalities they create in rural communities.

This article will first set the stage by introducing the players in the national healthcare market, and describing how those market-forces may be changing and affecting healthcare in rural America. Then, we’ll see how the medical community relates distance to hospital and likelihood of a good or bad outcome. Next, we’ll take a close look at Chilton County, Alabama—a relatively new “emergency care desert” that is neither the first, nor likely the last such region. Finally, we’ll examine a few areas of law that may provide a “legal toolkit” that could help prevent this problem from spreading, or perhaps reverse the trend.

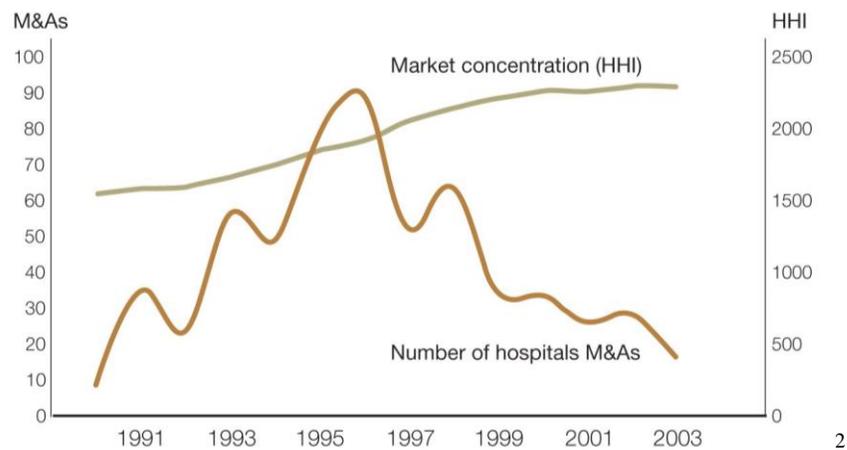
II. Hospitals are facing enormous market pressure to become part of increasingly larger healthcare corporations.

a. The Healthcare-Provider Corporation

The Healthcare-Provider Corporation does much what it says: it provides healthcare. This comes in the form of owning physical hospitals, employing doctors, and staying stocked with the technologies and supplies necessary to carry out that business. These healthcare-provider Corporations, like all corporations, have a tendency to take many forms; but they still have a few core things in common. In the case of healthcare provider corporations, and for the purposes of this article, they are identified by their function. That function is to deliver hospital care. Most

physical hospitals are corporations, or are part of a corporation that owns many hospitals. The corporate form allows these hospital groups to do a several useful things like lay claim to a larger chunk of market power, consolidate resources, and improve efficiency.

This consolidation of hospitals into larger corporations may be the result of increased cost pressure from insurers and the government (who bargain with healthcare providers to set prices), the new healthcare law, or the economic downturn in general. Although various rationales have been put forth to explain precisely why hospital consolidation exploded in the nineties and why it continues today (and there is some debate); the fact that it is happening is clear.¹ The chart below illustrates this principle:



Here you see total market concentration (shown as “HHI”—an index) compared to the number of mergers and acquisitions per year.³ Even though the total number of mergers is in decline, the concentration continues to rise. This rise in concentration, insomuch as it causes the closure of small hospitals and their emergency rooms, must be slowed or stopped regardless of

¹ William B. Vogt, Ph.D. and Robert Town, Ph.D., How Has Hospital Consolidation Affected the Price and Quality of Healthcare (Feb. 2006) available at <http://www.rwjf.org/en/research-publications/find-rwjf-research/2006/02/how-has-hospital-consolidation-affected-the-price-and-quality-of.html>.

² Id. Chart accompanying article. Original sourced as “American Hospital Association and authors’ calculations”; HHI is an acronym for Herfindahl Hirschman Index, an index of the market concentration for inpatient hospital services.

³ Id.

its cause. However, the various causes that have been advanced give insight into which regulatory and legal actions might be most efficacious in slowing the trend.

A key, and relatively obvious, reason for consolidation is that when these hospitals team up, they can consolidate resources (circle the wagons, so to speak) and they have more of everything. This means more CAT scan machines at local hospitals that couldn't afford them by themselves; more market power when the hospital bargains for prices with insurers; more doctors in one place⁴; "one stop shopping" for the patients and therefore more full beds at each hospital. All of this increases efficiency and profits at the hospital, which, at first blush, sounds like good news for everybody. But the motivations can, unfortunately, become complicated.

The corporate structure, or "the firm" as it is sometimes referred, in its highest level of abstraction is a model by which returns are increased when individuals work together. Everything else equal, competition between actors should regulate the market since each actor will make rational choices to their benefit given the information available—this is the Chicago school of economics, reduced.⁵ A machine is a common metaphor for the corporate structure. Corporations have a duty to make as much surplus as possible for the benefit of shareholders—almost universally in the form of stock dividends. The corporate machine takes raw materials and combines them together to make money as efficiently as possible.⁶ In many ways this is good! This reduces waste and drives the hospital's profits up. Unfortunately market failures like

⁴ There is some indication that doctors practicing alone are facing pressure to join hospitals in order to remain profitable. Shannon Pettypiece, Hospital Medicare Cash Lures Doctors as Costs Increase (Nov. 19, 2012), available at <http://www.bloomberg.com/news/2012-11-19/hospital-medicare-cash-lures-doctors-as-costs-increase.html>.

⁵ Thomas L. Greaney, Chicago's Procrustean Bed: Applying Antitrust Law in Health Care, 71 ANTITRUST L.J. 857, 870 (2004). It bears repeating that this is the Chicago school at the *highest* level of abstraction. The economic theories derived from the school are varied, in depth, and barely scratched here. There are many great articles on healthcare law debating the relative merits of Chicago school and other economic theories such as the one cited here, this isn't one of them. The purpose of this article is to indicate a specific and novel problem—consolidation and desertification—that continues to be overlooked, not argue economic theories.

⁶ See Milton Friedman, A Friedman Doctrine-The Social Responsibility of Business Is to Increase Its Profits, N.Y. TIMES, Sept. 13, 1970 (Magazine), at 32-33, 122-26.

“information asymmetries between patient and physician and the ‘nonmarketability of the bearing of suitable risks’ interfere with health care markets achieving optimal resource allocation.”⁷ Given the complexity of medical procedures, alternative treatments, and laws that protect personal health information and proprietary pharmaceuticals, it strains credulity to believe that patients or insurers have the information necessary to make the best decisions for their interest—and this is only one of several market failures that has been advanced.⁸ As a result, patients’, as well as insurers’ and sometimes doctors’ interests are only truly advanced when they are the same as the healthcare corporation. As just one example, many insurance lobby groups are quick to pick out that when hospital corporations gain market power from hospital consolidation, they have a tendency to use that power to get larger payouts from insurers, Medicare, and Medicaid.⁹

b. Insurance Companies

Insurance companies pay healthcare providers for the healthcare on behalf of patients who pay the insurers for their service—insurers are sometimes referred to simply as “payors.” Almost all of these companies are statewide to national coverers and quite large, but some specific factors of that relate to the hospital consolidation trend also cause insurance market failures insurers part of the same, poorly self-regulating market.

Insurance companies, should have a competitive interest to keep prices low for patients. This interest should pass up the chain to providers and force them to keep costs down, since rational

⁷ Thomas L. Greaney, Chicago's Procrustean Bed: Applying Antitrust Law in Health Care, 71 ANTITRUST L.J. 857, 862 (2004).

⁸ Id. at 864.

⁹ The obvious implication from the insurance lobby here is that they are effectively forced to charge those they insure more. Fact Check: Provider Consolidation Drives Up Prices, America's Health Insurance Plan Coverage (Feb. 17, 2012), [http:// www.ahipcoverage.com/2012/02/17/fact-check-provider-consolidation-drives-up-prices/](http://www.ahipcoverage.com/2012/02/17/fact-check-provider-consolidation-drives-up-prices/).

insurers should only buy competitively priced care. But costs rise anyway; instead of bargaining healthcare prices down, the “bargaining” takes the form of massive (over 50% in some cases) discounts for insurance companies.¹⁰ Equally inflated “charges” are listed by the healthcare corporation which are generally only paid by the uninsured, but increasingly are never actually paid by anyone.¹¹ Transparency and the simple inability of the uninsured to *ever* pay such prices are causing them to be near complete fiction.¹²

Any small insurer is likely to have trouble bargaining against a large healthcare corporation and any large insurer will likely not be able to afford not including the few hospitals that provide any one particular service. Moreover, if only one or two hospitals exist within travel distance from a remote area, any insurer who wishes to sell in that area virtually must include one as an issue of common sense. Some argue that there is functionally no bargaining happening at all.¹³ Instead of challenging the sellers of healthcare as they grow and consolidate, insurers are simply passing along the increased costs to the buyers (mostly employers) who are not organized in any substantial way and cannot bargain effectively against large insurance corporations.¹⁴

c. Medicare and Medicaid

Medicare and Medicaid together make up nearly half of national spending on medical care.¹⁵ This makes the government the largest price setter with the greatest bargaining power in the healthcare industry. However, even the biggest players in the healthcare game are subject to

¹⁰ Uwe E. Reinhardt, The Pricing of U.S. Hospital Services: Chaos Behind A Veil of Secrecy, 25(1) HEALTH AFFAIRS 57, 61 (2013).

¹¹ *Id.* at 61-62.

¹² *Id.*

¹³ Joseph White, Markets and Medical Care: The United States, 1993-2005, 85(3) THE MILBANK QUARTERLY 395, 424 (2007).

¹⁴ *Id.* at 424-425.

¹⁵ Reinhardt, 25(1) HEALTH AFFAIRS at 59-61.

some of the same basic forces as private insurers—namely that healthcare corporations set prices in a way that is so complicated that it is nearly impossible to assess the actual value of the services provided. Moreover, large governmental bureaucracies have a famous and legitimate problem moving from the complex scheme of today into some other, radical and more efficient scheme.¹⁶

d.Effect

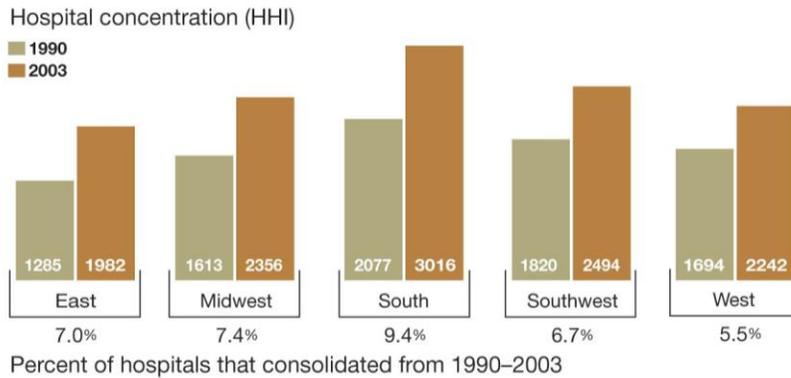
The effect of the insurers' (both private and public) attempts to raise prices, along with other factors, has been the growth of these healthcare corporations. Essentially, when faced with threats to their profitability, the corporations have grown. Challenges to this growth came mostly in the form of Anti-trust litigation and were mostly unsuccessful.¹⁷ This has created, as mentioned above, fewer but larger healthcare corporations. In no region has this change happened more dramatically than The South.¹⁸

¹⁶ See Id. at 68.

¹⁷ Viewed by the court under the Chicago school economic theory, the resistance to hospital corporation mergers has been weak and judgments have been overwhelmingly in favor of defendants. "The impact of Chicago School thinking has been, paradoxically, to *encourage* merger enforcement at a time when empirical economic analyses did not support application of the presumed positive relationship between market concentration and price to hospital markets." More recently, the Chicago School influence has been to *retard* enforcement by resisting unilateral effects analysis, which is best suited to the differentiated product markets that characterize hospital competition. More recently the courts have overlooked non-economic factors and were not "receptive to arguments that the performance of market participants does not conform to conventional microeconomic assumptions."

Thomas L. Greaney, Chicago's Procrustean Bed: Applying Antitrust Law in Health Care, 71 ANTITRUST L.J. 857, 911-915 (2004).

¹⁸ William B. Vogt, Ph.D. & Robert Town, Ph.D., How Has Hospital Consolidation Affected the Price and Quality of Healthcare (Feb. 2006) available at <http://www.rwjf.org/en/research-publications/find-rwjf-research/2006/02/how-has-hospital-consolidation-affected-the-price-and-quality-of.html>



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And these corporations have done the most natural thing for them to do: increase efficiency. One of the key ways that they’ve done this (and the focus of this article) is by closing smaller “unnecessary” hospitals throughout their systems.

An “unnecessary” hospital from the prospective of a corporation is a simple concept. It’s one whose business can be more efficiently and profitably absorbed by another hospital in the system. In Alabama, and likely in similarly situated geographic regions, this means smaller population centers are losing their hospitals to larger population centers. In other words, those who live in and around small towns are having to drive to cities; and those who live in more distant outlying areas can no longer drive to those towns, but must now drive to quite distant cities. Bad news if you live in a small town. Very bad news if you live in the middle of nowhere.

One example of this alarming trend is the city of Clanton, Alabama. When Clanton lost its hospital, the Chilton Medical Center, in October of last year, the community was devastated.²⁰ Many in the community voiced concerns that this would cause a rise in mortality rate due to the distance to the nearest hospitals, which were each at least thirty minutes away from town in an

¹⁹ Id. Figure accompanying article. Original sourced as “American Hospital Association and authors’ calculations.”

²⁰ Emily Etheredge, *Leaders React to Hospital Closing*, CLANTON ADVERTISER, (Oct. 30, 2012), available at <http://www.clantonadvertiser.com/2012/10/30/leaders-react-to-hospital-closing/>.

ambulance.²¹ The hospital, which was owned and operated by a large healthcare-provider corporation, was reportedly unable to make payroll or unable to reach an agreement with the corporation that owned the building and was forced to shut its doors suddenly.²² This very geographic problem is specific to rural areas. In a densely populated urban area, corporations may grow and consolidate their physical premises within the population center without any significant change in the average trip time to the hospital; whereas in a more broad area, where the population is spread out, the removal of a hospital from one population center and consolidation to another has a vastly different effect.

While the Chilton Medical Center's closure made economic sense to its parent healthcare provider corporation, taking into account profits, stockholders, and market forces. It didn't make common sense to the people of Clanton, Alabama. These people took into account factors like, how long a person who is unable to breathe can survive, how many patients an ambulance can take to the hospital in a set time period, and the cost to the community of transporting emergency personnel to another county to be treated.²³ It would seem that the fastest possible access to critical care for the people who the corporation serves is not part of the corporate agenda, and not properly adjusted by the free market—at least in this case.

III. A Changed Landscape of Healthcare Resources, and a Change in Outcomes.

a. Outcomes Decrease as Distance to Hospital Increases.

The gut reaction when the only hospital in town closes is that it presents a health risk. Unsurprisingly, medical literature shows a correlation between distance between scene and

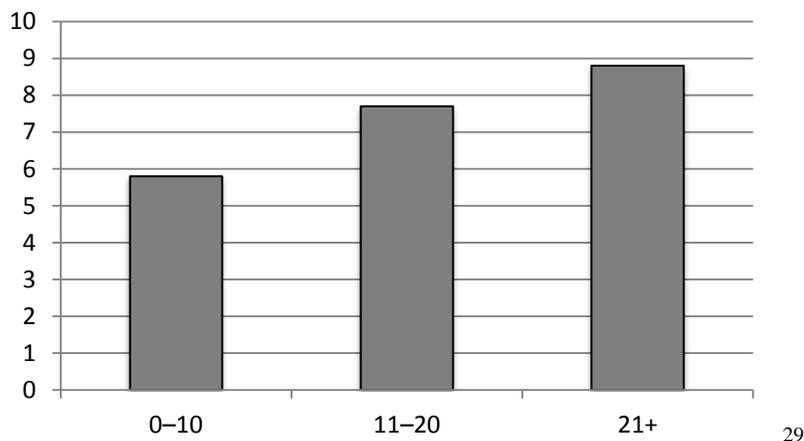
²¹ Id.

²² Id.

²³ Id.

mortality from life-threatening condition.^{24 25} In one study, straight-line distances were recorded for over 10,000 ambulance rides, and the study showed a correlation between mortality and straight-line distance to emergency care.²⁶ The study used straight-line distances rather than trip time to correct for discrepancies in times recorded and speed drivers chose to travel (which could be in part based upon their impression of the seriousness of the patient’s condition); they also took measures to adjust for illness severity and threshold for calling for help.²⁷ The study showed an increase in 10 kilometers of straight-line distance was associated with an over 1% increase in mortality among those with life threatening conditions.²⁸

Overall Mortality



²⁴ Jon Nichol, James West, Steve Goodacre, & Janette Turner, The Relationship Between Distance to Hospital and Patient Mortality in Emergencies: an Observational Study, 24(9) EMERG. MED. J. 665 (2007).

²⁵ While not very useful academically, propublica.org released an internet “News Game” based on distance to hospital and mortality that suggests, at a minimum, general acceptance of the concept and the Nichol/West/Goodacre/Turner data. Sisi Wei, Amanda Zamora & Al Shaw, HeartSaver: Experimenting with News Games to Tell a Story, (April 23, 2013) available at <http://www.propublica.org/nerds/item/heartsaver-an-experiment-in-using-news-games-to-tell-a-story>.

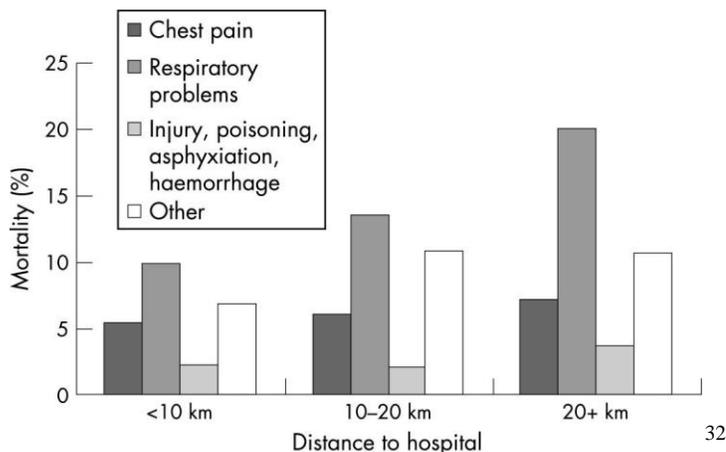
²⁶ Nichol, 24(9) EMERG. MED. J. 665.

²⁷ Id.

²⁸ Id.

²⁹ Id. Chart created from data figures in article.

The study broke the data down even more, noting that respiratory conditions were more susceptible, showing a sharper increase in mortality over distance (around 5% per ten kilometers), and that chest pain related conditions were slightly less than the 1% per ten kilometer mean.^{30 31}



The authors of the study concede that there may be an argument that higher volume emergency care facilities may offer better care in some capacities and for some conditions and that this, if true, may serve as an appropriate reason for closing local emergency care centers—although they do not have data to back up such a statement.³³ Some patients, however, (especially acute respiratory conditions) need emergency care that would be the same whether treated in an emergency room or by a specialist, such as hemorrhage or anaphylactic shock.³⁴

³⁰ Id.

³¹ The mortality rate data for chest pain related illness were likely corrupted by the availability and public awareness of “AEDs” or Automated External Defibrillators. These can reduce mortality significantly where applied correctly. Each minute without defibrillation where needed is associated with a 7-10% rise in mortality. These devices can be applied before the emergency personnel arrive by bystanders or by the emergency personnel themselves. While such a patient is still in desperate need of emergency care and is still affected by the mortality-distance dynamic, the variability in scenarios and additional variables (whether or not there were bystanders, time until ambulance arrived at scene) makes such patients less useful for our purposes. See Implementing an AED Program, AM. HEART ASS’N. (2012) available at http://www.heart.org/idc/groups/heart-public/@wcm/@ecc/documents/downloadable/ucm_438703.pdf.

³² Nichol, 24(9) EMERG. MED. J. 665. Figure accompanying article.

³³ Id.

³⁴ Id.

Although the study is observational, similar statistics in other studies have confirmed that there is a strong correlation between time or distance to hospital and mortality in respiratory cases.^{35 36} Other sources suggests that the economy of scale not only fails to improve quality of care in emergency rooms, but that it is merely economically beneficial to the hospital and fails to improve quality at all.³⁷

b. When a Market Change Doesn't Match a Healthcare Reality, Patients are the Ones Who Take the Blow

Patients are pretty bad at being consumers.³⁸ Which is bad news since the ideal market upon which Chicago school antitrust analysis depends assumes patients are making informed choices as consumers.³⁹ A few key issues that make sick patients especially bad consumers. First, being a good consumer means making informed decisions and the sick tend to be weak, irrational, cloudy headed deciders who don't understand the product and are forced to rely entirely on the doctor (or salesman, to stick to the form).⁴⁰ Second, the pricing system is so very convoluted that it is sometimes actually impossible to know the cost of the service until weeks after it has been

³⁵ Jones A.P., Bentham G, Horwell C. Health Service Accessibility and Deaths from Asthma, 28(1) INT. J. EPIDEMIOLOGY. 101 (Feb. 1999).

³⁶ Jones A.P., Bentham G, Health Service Accessibility and Deaths from Asthma in 401 Local Authority Districts in England and Wales, 52(3) THORAX 218 (March 1997).

³⁷ William B. Vogt, Ph.D. and Robert Town, Ph.D., How Has Hospital Consolidation Affected the Price and Quality of Healthcare (Feb. 2006) available at <http://www.rwjf.org/en/research-publications/find-rwjf-research/2006/02/how-has-hospital-consolidation-affected-the-price-and-quality-of.html>

³⁸ Thomas L. Greaney, Chicago's Procrustean Bed: Applying Antitrust Law in Health Care, 71 ANTITRUST L.J. 857, 864 (2004). It's not that people are willfully bad consumers, or that they're negligent, it's that there is an information disparity that is virtually insurmountable between patients and doctors, between patients and insurers, and between patients and healthcare corporations.

³⁹ Id.

⁴⁰ Mark A. Hall & Carl E. Schneider, Patients as Consumers: Courts, Contracts, and the New Medical Marketplace, 106 MICH. L. REV. 643 (2008).

rendered.⁴¹ The final, and most important issue for our purposes is that patients in need of critical care don't have the right to choose at all.

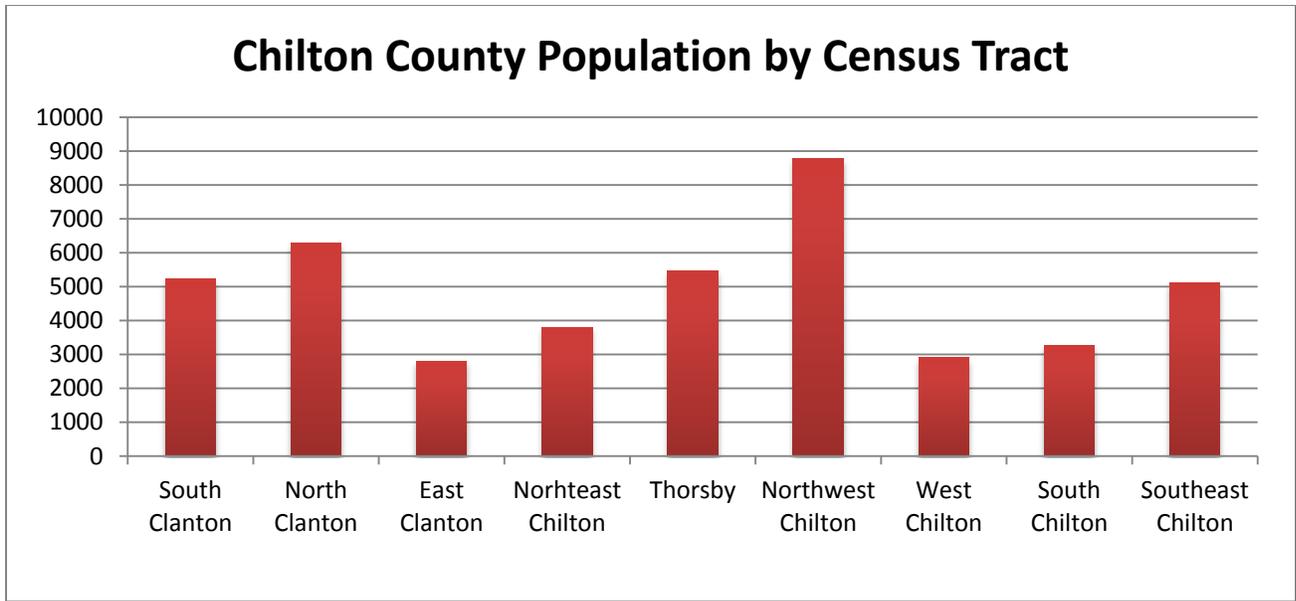
A critical-care patient may have the right to choose their insurance and they may have the right to choose specialists within their plan, but they simply cannot create a "market force" on the healthcare corporation that will make them maintain nearby emergent care. The issue is "walking rights" or the right to not give business. If McDonalds is far away, you don't drive through and McDonalds has to change to get your business; if Whole Foods doesn't build a store in town, you buy non-organic; if there is no emergency room in town, you have a very long ambulance ride. You have a long ambulance ride because your other option is dying. This is not a situation in which the free market adjusts, it is a situation that requires government intervention and regulation.

c. Case Study: Chilton County

When the Chilton Medical Center in Clanton closed, the average travel distance to emergency room and critical care service jumped. Patients then had to travel to other counties for these services. By using Census data, we can look at exactly how much this distance increased, who was most affected, and then we can think about how this change might affect outcomes.

Chilton County is divided into nine "census tracts." Each tract has a population between two and nine thousand. The population of the county isn't evenly divided and each tract has a unique shape and size.

⁴¹ The metaphor used it that it's like expecting someone to be a good consumer in a clothing store by making them fill their cart while blindfolded. Uwe E. Reinhardt, The Pricing of U.S. Hospital Services: Chaos Behind A Veil of Secrecy, 25(1) HEALTH AFFAIRS 57, (2013).

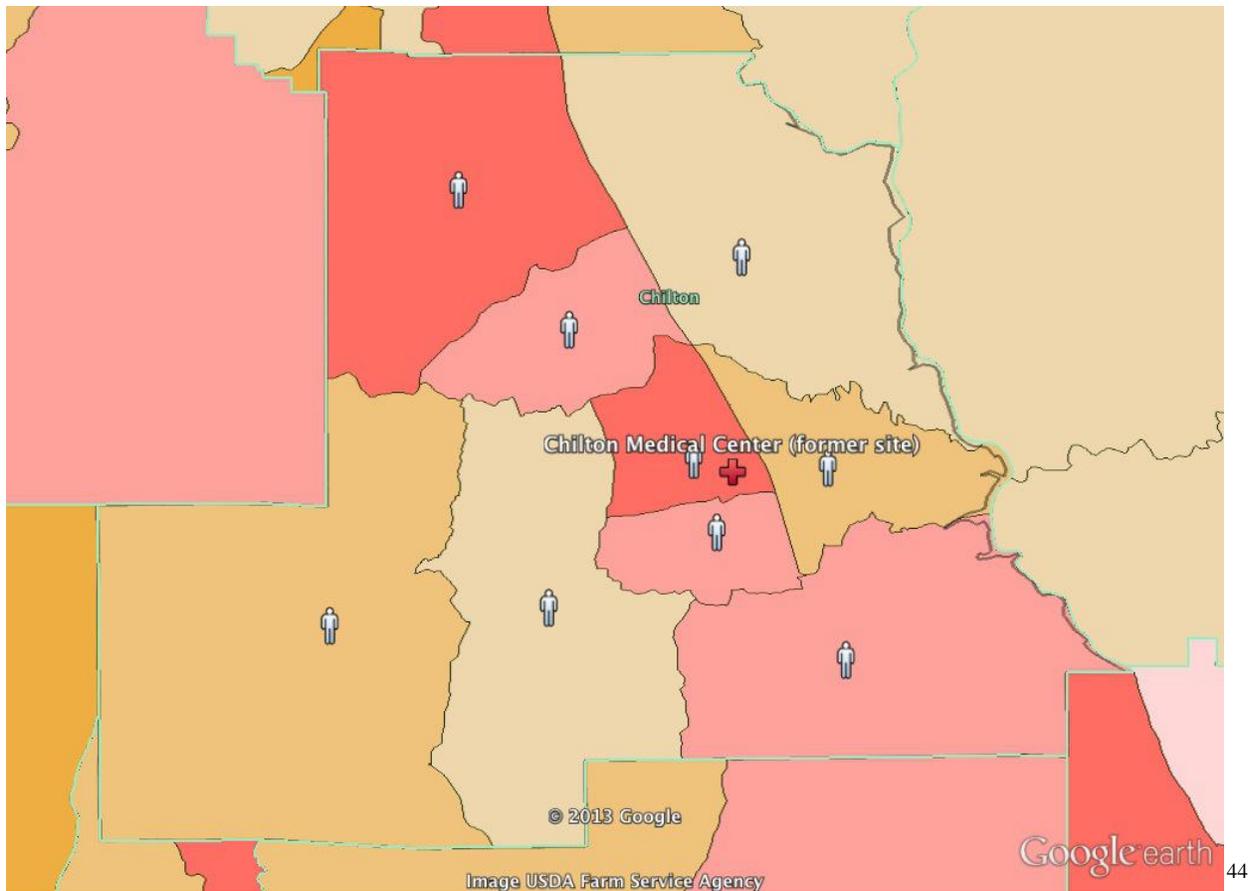


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In addition to population, another bit of data about these tracts is useful to our purpose: population centers. This data tells us where the “average person” in each tract lives and gives us a point to measure the average distance between an “average person” in that tract and the nearest hospital. When we layer these two pieces of data together on a map, several things are apparent: first, a few of the population centers are much closer to CMC than they are to any point outside the county; second, while the population centers are slightly off geographic center within the tracts, their central tendency suggests that the populations are evenly dispersed and the population center is a fair estimate of average distance.

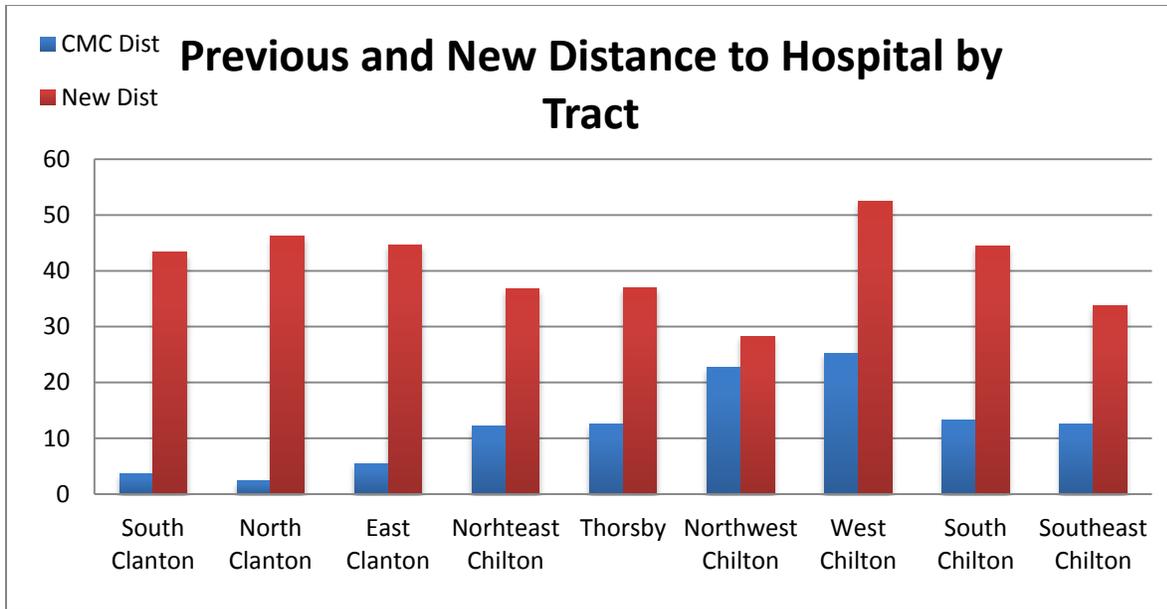
⁴² Chilton County Quick Facts, U.S. CENSUS BUREAU, available at <http://quickfacts.census.gov/qfd/states/01/01021.html> (last visited March 1, 2013). Raw data source.

⁴³ Demographic Profile - Alabama, U.S. CENSUS BUREAU, available at http://www2.census.gov/census_2010/03-Demographic_Profile/Alabama/ (last visited March 1, 2013). Raw Data Source.



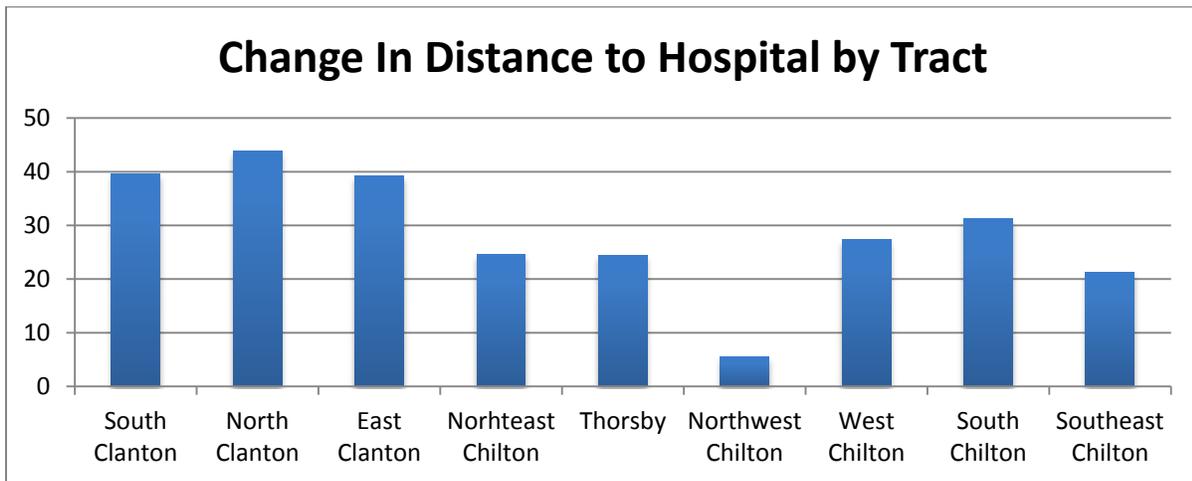
Actually measuring the distance between the population centers and the two hospitals allows us to quantify the data. To reach the nearest hospital, each of the northern tracts would travel to Shelby Baptist Medical Center in Alabaster, Alabama and the southern tracts would travel to Prattville Baptist Hospital in Prattville, Alabama. Measuring, we find that new travel distances range from 28 to 52 kilometers and an average of about 40 kilometers. Compare that to the previous range of 2.4 to 25 kilometers and an average of approximately 12 kilometers.

⁴⁴This map was created on Google Earth for Mac. It layers data from a free census tract map available through the program (Earth Gallery Feature; search: Census Tracts; Map entitled “2010 Census – Total Populations Map”) and uses data from these sources: American Factfinder, U.S. CENSUS BUREAU, available at <http://factfinder2.census.gov>; Demographic Profile - Alabama, U.S. CENSUS BUREAU, http://www2.census.gov/census_2010/03-Demographic_Profile/Alabama/ (last visited March 1, 2013).



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This data can be used to determine the change in distance, which, is related to mortality—as noted above. While each of the individual distances increased, some increased very significantly.



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When these numbers are averaged (weighted by population) you find an average increase in distance of 26.5 kilometers countywide. These figures are unpleasant at first glance, but become

⁴⁵ This chart was created using data from Google Earth for Mac. It layers data from a free census tract map available through the program (Earth Gallery Feature; search: Census Tracts; Map entitled “2010 Census – Total Populations Map”) and uses data from these sources: [American Factfinder](http://factfinder2.census.gov), U.S. CENSUS BUREAU, available at <http://factfinder2.census.gov>; [Demographic Profile - Alabama](http://www2.census.gov/census_2010/03-Demographic_Profile/Alabama/), U.S. CENSUS BUREAU, http://www2.census.gov/census_2010/03-Demographic_Profile/Alabama/ (last visited March 1, 2013).

⁴⁶ This chart is derived from the data on the previous chart. See sources [Id.](#)

ghastly when compared with the results of the above-mentioned study. An average increase in mortality among the critically ill of nearly 3% could be expected county wide with some areas as much as a 4.5% increase.⁴⁷ Specific illness groups such as “respiratory problems” and “Injury, poisoning, asphyxiation, and hemorrhaging” should see total mortality rates in excess of 20% across the entire county—the distances faced by Chilton County residents are all within the highest distance group studied.⁴⁸

These percentages are likely conservative given the lower general health in Alabama, most notably obesity, and the known health hazards that come with it.⁴⁹

IV. Making the Market Match the Externalities

Policy makers and stakeholders must take any action available to mitigate the negative effects these healthcare corporations are having by changing the market in such a way as to encourage more, smaller, and more local hospitals. The remainder of the article will discuss methods to remedy these negative externalities. These “tools” could be used independently or in concert and represent a model—not only for Chilton County, but other similarly situated regions across the country.

a. Certificates of Need

Alabama, like many other states, has a Certificate of Need (“CON”) program.⁵⁰ CON programs first became widespread following the federal “Health Planning Resources

⁴⁷ Jon Nichol, James West, Steve Goodacre, & Janette Turner, The Relationship Between Distance to Hospital and Patient Mortality in Emergencies: an Observational Study, 24(9) EMERG. MED. J. 665 (2007).

⁴⁸ Id.

⁴⁹ S.D.H. Malnick & H. Knobler, *The Medical Complications of Obesity*, 99 Q. J. MED. 565 (2006).

⁵⁰ Certificate of Need: State Health Laws and Programs, NAT’L CONF. OF STATE LEGISLATURES, <http://www.ncsl.org/issues-research/health/con-certificate-of-need-state-laws.aspx> (last visited April 2, 2013).

Development Act” (“HPRDA”) of 1974.⁵¹ The idea behind the legislation, and the state mechanisms created under it, was that the government could reduce healthcare price inflation by taking measures to ensure that an area’s hospitals only had as many beds and equipment as met that area’s actual need—if the duplication of service is lower, the logic goes, efficiency is higher and price is reduced.⁵² One core problem, which manifests in many ways, is that these savings in hospital efficiency are rarely passed along to healthcare consumers. Another core problem, and the real concern of this article, is that mere efficiency and reduction in duplicity can lead to bad outcomes for healthcare consumers when they are not coupled with factors like access.

The federal law that mandated and funded these CON programs was eventually repealed in 1987⁵³ and, as a result, state law has become less uniform as far as these programs are concerned. Nevertheless, a majority of states still have regulations in place to regulate the healthcare industry in this way. The courts should interpret these laws in such a way as to ensure that the efficiency at the core of this body of regulations and law is not only financial efficiency, but also efficiency of outcomes and access.

The “mechanism” or regulatory scheme that Alabama developed under HPRDA outlines a system of review under which healthcare entities may or may not expand. Entities wishing to undertake capital programs, large technology equipment acquisitions, and other expansions are either approved or denied upon the decision of the State Health Planning and Development Agency (“SHPDA”).⁵⁴ The decision is based on administrative regulations and the State Health Plan (“SHP”), a “comprehensive plan prepared, reviewed, and periodically revised by the

⁵¹ Id.

⁵² Id.

⁵³ Id.

⁵⁴ See generally Brookwood Health Services, Inc. v. Baptist Health Services, Inc., 936 So.2d 529, (Al. Ct. Civ. App. 2005).

Statewide Health Coordinating Council and SHPDA, and approved by the Governor.”⁵⁵

Healthcare Entities submit an application to SHPDA at which point a Certificate of Need Review Board (“CONRB”) is created. The CONRB hears evidence and submits an opinion. The applicant may then request a “fair hearing” appeal from an administrative law judge. That decision then becomes the SHPDA’s final decision.⁵⁶ That decision is then appealable to the Court of Civil Appeals.⁵⁷

The relevant statutes and regulations in Alabama outline a variety of qualifications and findings that must be made by a Certificate of Need Review Board (“CONRB”) and illustrate, somewhat clearly, an intent that the CONRB look at the entirety of the situation surrounding a hospital which has an interest in expanding.⁵⁸ The CONRB is statutorily mandated to make five specific findings before a CON may issue.⁵⁹ If the CONRB is “unable to make *any* of the five findings required by § 22-21-266, then a CON ‘cannot be issued.’”⁶⁰ Only two of the required findings are particularly on point: whether there are alternative, less costly, or more effective methods of providing the service”; and whether there is “substantially unmet public requirement for the proposed service” including “evidence of locational appropriateness...such as transportation accessibility.”⁶¹

⁵⁵ Id.; Alacare Home Health Services, Inc. v. Alabama State Health Planning And Development Agency, 27 So.3d 1267, 1270 (Al. Ct. Civ. App. 2009) citing to § 22-21-260(13) Ala.Code 1975; Rule 410-2-1-.02, Ala. Admin. Code.

⁵⁶ Section 22-21-275(14), Ala.Code 1975.

⁵⁷ Alacare Home Health Services, Inc. v. Alabama State Health Planning And Development Agency, 27 So.3d 1267, 1270 (Al. Ct. Civ. App. 2009).

⁵⁸ Section 22-21-264, Ala.Code 1975.

⁵⁹ Id.

⁶⁰ The Alabama Court of Civil Appeals, quoting an earlier case by that same court. The statute being referenced is Section 22-21-266, Ala.Code 1975. Alacare Home Health Services, Inc. v. Alabama State Health Planning & Dev. Agency, 27 So. 3d 1267 (Ala. Civ. App. 2009).

⁶¹ Section 22-21-264(3)-(4), Ala.Code 1975.

The Alabama Court of Civil Appeals has held that “less costly, more efficient or more appropriate alternatives” may mean that the best alternative is the more efficient use of already existing hospital resources. In Humana Med. Corp. v. State Health Planning & Dev. Agency, 460 So. 2d 1295, 1296 (Ala. Civ. App. 1984), a hospital corporation was seeking a CON for “transfer of thirty-one hospital beds from two other hospitals in the same health service area to [the corporation] was denied by SHPDA.” The health service area in question was currently operating with excess beds to the tune of 160 additional beds.⁶² The hospital bed occupancy rate in the service area was less than 80%.⁶³ Given those factors the Fair Hearing Officer found that “there was a lack of community need for the proposed application, based upon evidence of the utilization of existing hospital beds in [the health service area].”⁶⁴ The Court upheld this decision finding that it was not “arbitrary and capricious” and that “[a]pparently, better utilization of the existing hospital beds in Huntsville and Madison County would foster cost containment.”⁶⁵

This use of the law is not precisely on point with the situation in Chilton County, but it lends serious support drawing from its marked similarities. First, the Chilton County closure, and similar closures, could perhaps be prevented if a careful foresight and market analysis had been utilized at the CON hearings for expansions and bed transfers to the nearby Shelby and Prattville Medical Centers. Of course, the ultimate problem here is that market foresight is extraordinarily difficult to attain. Second, in cases where the hospital’s business is being transferred to other entities in the same system and the facility is being “sold for spare parts,” so to speak, the CON

⁶² Humana Med. Corp. v. State Health Planning & Dev. Agency, 460 So. 2d 1295, 1297 (Ala. Civ. App. 1984).

⁶³ Id.

⁶⁴ Id.

⁶⁵ Id.

hearing for the transfer could stand as a gateway to prevent the closure of critically needed facilities.⁶⁶

The regulations give additional clarity to these requirements that tend to support not just a legislative intent, but also an administrative intent to ensure that situations like the one in Chilton County do not occur. Regarding the requirement of access to the service, the Administrative Code indicates that CONRB should ensure that “the medically underserved will receive equal access to care” and consider the “means by which a person will have access to the proposed services.”⁶⁷ The section which interprets the “availability of alternatives” language from the statute states that “less costly alternatives must be judged against the need for greater accessibility, and the impact on the total health care system”⁶⁸ Finally, but no less importantly, the state health plan itself states expressly that “[p]olicy makers must realize that rural facilities have fewer health care and political resources than do their urban counterparts and that rural hospitals may be one patient away from closing.”⁶⁹

The SHPDA and CONRB should interpret the Code of Alabama and the Alabama Administrative Code in such a way that it prevents urban hospitals and hospital corporations from growing and choking out small rural centers. One alternative to denying growth to such a corporation is to compel it to open one or more Freestanding Emergency Departments

⁶⁶ While the Chilton County case study does not match the hypothetical here created, a fact similar instance can be pulled from the headlines. In Long Island, New York, a coalition of doctors, nurses, and concerned citizens have banded together and got a restraining order to prevent the closure of a financially troubled, but vital healthcare facility. If CON laws are available and properly implemented, then the hospital closure has a clear legal remedy. *see* Denis Hamill, Hamill: Decision not to close Long Island College Hospital a victory of Brooklyn, N.Y. Daily News (April 29, 2013) <http://www.nydailynews.com/new-york/brooklyn/hamill-decision-shut-hospital-victory-article-1.1330658>.

⁶⁷ Ala. Admin. Code r. 410-1-6-.07.

⁶⁸ Ala. Admin. Code r. 410-1-6-.04.

⁶⁹ Ala. Admin. Code r. 410-2-2-.04.

(“FEDs”)⁷⁰ in rural communities. Unlike urgent care centers, FEDs are prepared accept ambulances, take critical patients (such as burn victims and critical respiratory illnesses), and treat them or stabilize them for transportation to an inpatient facility.⁷¹ While these facilities are normally advanced as a solution to crowding at urban medical center emergency rooms⁷², they can be utilized as a win-win for rural areas as well. Alabama’s CONRB has already embraced the concept of FEDs in urban areas to reduce not only crowding in urban emergency rooms, but, vitally, as a way to reduce transport time to critical care for those Alabamians living on the far end of Alabama State Highway 280 (commonly recognized as the most traffic congested thoroughfare in the state) under the apparent conclusion that they are too far away from emergent care.⁷³ The same logic leads suggests that CONRB would make a favorable decision for the residents of Chilton County as they are, in almost all instances, further from care. If the CONRB made establishment of a FED or the maintenance of an emergency department of a hospital that was otherwise being closed a condition of granting the CON to expand or transfer beds, both the corporate and public interests would be served.

Less a novel interpretation of the law, the use of the CON in this way is imperative to the spirit of this line of legislation. If SHPDA continues to fail to properly interpret the states CON law, the core intent of providing healthcare to the underserved will fail—and the dim future of rural healthcare that is already spelled out in the administrative code will continue to become a the reality for rural Alabamians.

⁷⁰ Colin Luke, Free Standing Emergency Rooms: When Do They Make Sense? (2008), <http://www.birminghammedicalnews.com/news.php?viewStory=1292>

⁷¹ Id.

⁷² Id.

⁷³ Brookwood Granted CON to Build Freestanding Emergency Room, BROOKWOOD MEDICAL CENTER (July 21, 2010) <http://www.bwmc.com/en-us/aboutus/hospitalnews/pressreleases/pages/brookwoodgrantedcontobuildfreestandingemergencyroom.aspx>

b. Federal Anti-Trust Law

A subset of these cases can be brought as Federal Anti-Trust claims. The basic elements of a Sherman Anti-Trust claim are: (1) a contract or conspiracy that (2) unreasonably restricts trade (3) in interstate commerce.⁷⁴ Generally, anti-competitive *behavior* must be between business entities (in other words, it must bring together market force); although there are some exceptions in the case of interests external to the interest of the business.⁷⁵ The anti-competitiveness of said behavior must be shown to be in both a product market and a geographic market, as a threshold matter.⁷⁶ In other words, a Sherman case exists where more than one entity (or one entity acting anti-competitively) reduces competition in one product and geographic market. For our purposes that product would be the critical-care and stabilization discussed above and the market would be some region reasonably small enough that mortality rates are not substantially affected—about a twenty-kilometer radius.

Unfortunately, this does not apply well to the situation in Chilton County because although a large hospital corporation owned CMC, that corporation did not own either of the hospitals to which CMC's patient load would logically divert—they simply lost the business. Moreover, the hospitals were not in the twenty-kilometer zone; the closure essentially destroyed the last reasonable option (the entire market) in the area.

The strongest anti-trust cases would exist in situations where the smaller hospital is purchased by the system of a nearby hospital (within the same twenty-kilometer zone) and then

⁷⁴ 15 U.S.C. § 1.

⁷⁵ *see generally* Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752 (1984) for the concept that activity within a business generally doesn't stifle competition; and Nurse Midwifer Associates v. Hibbett, 918 F.2d 605 (6th Cir. 1990) for an example of the exception.

⁷⁶ Federal Trade Commission v. Tenet Health Care Corp., 186 F.3d 1045 (8th Cir. 1999) referencing 57 Fed. Reg. 41552.

closed by that system. Here the buying of the hospital or hospitals and assimilating them into the larger system could be making the system anti-competitive even before the larger system began closing the smaller hospitals—especially if they are merging services. In *Tenant Health Care*, the 8th Circuit found that the consolidation of two hospitals within the town of Poplar Bluff, Missouri was not anti-competitive because the same or better primary and secondary care could be found a nearby city.⁷⁷ The Court also found problems with the lower court’s under-consideration of non-price and other competitive factors.⁷⁸

The situation is entirely different in a case where time-sensitive critical-care is completely evacuated from a region by consolidation. In an emergency care situation, it is difficult to imagine that any court would interpret *Tenant Health Care* as analogous and controlling. Non-economic factors advanced by the Eighth Circuit, such as patient choice and quality of care, are much less persuasive when the patient is unconscious and outcome is tied to the time factor.⁷⁹ Moreover, economies of scale (another factor the Circuit Court considered) are called into question as a quality improver in emergency rooms.⁸⁰ In the future, courts should look to the same totality of non-price related factors such as quality, efficiency, and access when determining whether the behavior underlying the creation of healthcare deserts increases competition or is actually anti-competitive.

One factor that may damage anti-trust cases is the state action doctrine. The state action doctrine protects the state from being subject to anti-trust law and applies to private entities when they are acting within a “clearly articulated and affirmatively expressed” state grant to suppress

⁷⁷ Id.

⁷⁸ Id.

⁷⁹ Jon Nichol, James West, Steve Goodacre, & Janette Turner, The Relationship Between Distance to Hospital and Patient Mortality in Emergencies: an Observational Study, 24(9) EMERG. MED. J. 665 (2007).

⁸⁰ Lisa Scott, Will We Like Tomorrow’s Giants?, 26(32) MODERN HEALTHCARE, 79 (Aug. 5, 1996).

competition.⁸¹ The question turns on, essentially, legislative intent. If anticompetitive activity or result was the “foreseeable result” of the grant, then the immunity attaches.⁸²

In *Phoebe Putney*, the Supreme Court found the “clear-articulation test” did not immunize Georgia’s public hospital corporations when they behaved anti-competitively because anticompetitive acquisitions were not a foreseeable result of the Georgia legislation.⁸³ This broad ruling opens the door for anti-trust liability for Georgia’s public hospital corporations when they acquire hospitals anti-competitively. Alabama’s private hospital corporations, following the Supreme Courts logic, would be even less likely than Georgia’s public corporations to have state immunity based on the CON approval process, which merely ratifies capital projects and does not affect acquisitions.

V. Conclusion

Rural communities are one of the backbones of our American culture. Alabama, and similarly situated states should take proactive steps to prevent the “emergency care deserts” that are forming in these already underserved rural communities. Without state intervention, the market pressures and internal corporate pressures to increase efficiency and profit are too great and lead to the closure of these vital resources. “The essential issue remains, however, that without some emergency strategies and relief, the only alternative for the state's rural hospitals may be closure.”⁸⁴ In areas like Chilton County, the data shows that these critical care voids are likely to increase mortality—perhaps substantially.

⁸¹ Community Communications Co. v. Boulder, 455 U.S. 40, 52 (1982).

⁸² FTC v. Phoebe Putney Health System, Inc., 568 U.S. ___, 8 (2013).

⁸³ Id.

⁸⁴ Ala. Admin. Code r. 410-2-2-.04.

The best tool available to combat this trend is the Certificate of Need review process. If states interpret the laws they already have appropriately (and in the spirit of the original federal legislation) they can manipulate the market to prevent the growth of hospitals that are too big for the region they serve while encouraging the maintenance of local hospitals and freestanding emergency departments. The critical care and stabilization these entities can provide will improve the public health.

Anti-trust law may be an avenue that helps reduce the hospital consolidation problem overall, but it is a far less precise instrument for specific problem of ensuring access and the best possible outcomes for the critically injured. In fact, anti-trust might be best considered as a first line of defense; preventing certain unhealthy corporate structures that lead to the hospital deserts of concern.

When the interests of healthcare corporations produce externalities that harm patients, it is incumbent upon the states to act.