Operationalizing Power in Health Law: The Hospital Abolition Hypothesis

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Abstract: This symposium Article describes how prison abolitionist arguments also support the hypothesis that a defining goal of health law should be the abolition of hospitals. Like prison abolitionism, the hospital abolition hypothesis can provide a constructive way to shift the focus of legal analysis from substantive dimensions (in health law — cost, quality, access, and equity) to the dimension of power.

> *"It happens that every man in a bank hates what the bank does, and yet the bank does it. The bank is something more than men, I tell you. It's the monster. Men made it, but they can't control it."*[1]

In recent years, criminal law scholarship has been jolted — some would say transformed — by the emergence into the mainstream of a long-percolating prison abolition movement.[2] To speak in broad brush strokes, the prison abolition movement holds that the defining purpose of criminal law should be the abolition of prisons.

Prison abolitionists support their bold argument with claims that as a substantive policy matter, incarceration is itself undesirable and inherently inequitable. But prison abolitionists also insist on a shift in focus from the dimension of substance to the dimension of power. They argue that as a political matter, meaningful criminal justice reform will be impossible so long as incarceration and its associated prison-industrial complex is on the scene, intervening in legislative and regulatory fights, and shaping the public's perspective, to promote incarceration.[3]

Heeding Charity Scott's encouragement of bold thinking and difficult conversations in health law — and inspired by the wonderful gathering in her honor at Georgia State University College of Law — this symposium Article suggests that health law might reinvent itself by taking a page out of criminal law's book. Specifically, I describe how prison abolitionist arguments also support the hypothesis that a defining goal of health law should be the abolition of hospitals. Like prison abolitionism, the hospital abolition hypothesis provides a way to shift focus from substantive dimen-

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sions (in health law — cost, quality, access, and equity) to the dimension of power.

Health law's fault is not in its stars but in itself, for health law makes health politics.[4] Health law politics is today largely a battle of titans among politically-empowered super-groups[5] including physicians, hospitals, insurers, and pharmaceutical manufacturers. The hospital abolition hypothesis is that to fix what is broken in health law, we should aim to take hospital power out of the picture, shifting hospitals' influence to other existing players or new, inherently salutary ones.[6]

The Article proceeds in five parts. Part I frames the inquiry, contrasting the importance of power in health law and the acknowledged, mutually co-constitutive interaction between health law and health politics, on the one hand, with the difficulty of operationalizing the power dimension in exploring nitty-gritty health law questions, on the other. Part II explains how prison abolitionism has gained traction in operationalizing power in criminal law by naming and targeting prisons as a central institution whose outsized power is inherently problematic. Part III notes how certain prison abolitionist premises and arguments apply as well to hospitals: Empowering the powerless is not alone enough, hospitalization is often a policy failure, hospitalization is inherently inequitable as a tool of public health, hospital power distorts medicine and public health more broadly, and it may be possible to reimagine hospital care without hospitals (as institutions if not also as facilities). Part IV concedes real counter arguments that make hospital abolition, even as a tentative hypothesis, more a project of shifting power than eliminating it. These include the point that hospital abolition differs from prison abolition in that health care is itself ordinarily not harmful to the patient and the troubling precedent of mental health deinstitutionalization. Part V notes how, even as a tentative hypothesis and despite its limitations, hospital abolition can usefully improve the analysis of nitty gritty health law questions such as the looming question of who should bear liability for medical AI failures.

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I. The Importance and Difficulty of Considering Power in Health Law

One of the great strengths of health law as a field is that it is so deeply embedded in the nitty-gritty of the way law actually plays out in practice. Thus, it makes sense that health law is largely structured around analyzing potential changes in law and policy on the core four substantive dimensions of access, cost, quality, and equity.[7]

A frustrating challenge of this nitty-gritty focus, however, is that what actually happens in health law often is driven by political factors that have little to do with what makes for good policy as a substantive matter. As a result, many great ideas for beneficial reforms go nowhere and many reforms are implemented that are in fact harmful.

There is a temptation to think of this often-determinative political dimension as somehow independent of law, an ultimate root cause beyond the ambit of health law scholarship. If so, the best we can do is devise or press incremental reforms that seem viable in the current political environment or work to stock the list of well-thought-out fundamental reforms so that, on that longed-for day when the political stars align and the "right people" get into office, they'll know what to do. This might well be true.

That said, the premise that health law and health politics are independent is, of course, incorrect as an empirical matter. A long line of scholars have pointed out that the politics of health law aren't just a matter of big, national, partisan presidential politics or random chance. Rather, the politics of health law are themselves in important ways constructed by health law — for better or worse. In other words, health politics has legal determinants. Indeed, if health law has a central text it may be Paul Starr's Pulitzer-prize winning account of how the medical profession secured power — both

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power over the laws that Congress enacts and independent power over what happens to patients — through the accretion of legal protections from licensure to reimbursement to accreditation, and beyond.[8] Consistent with that perspective, Erin Fuse Brown and Mark Hall tell a story of medical power's seizure by economic interests in the context of private equity.[9] Allison Hoffman carries Starr's story forward to explain how doctors have seen their power seized by other actors in the health care space (including hospitals).[10]

Scholars describe this co-constitutive relationship between health law and health politics in contexts well beyond the construction of medical power — in hospital finance, pharmaceutical regulation, and beyond. Thus, Jonathan Oberlander explains how "Medicare financing is the single most important pattern in program politics ... more than any other factor, [it has] driven the direction and timing of program reform."[11] Timothy Jost notes how "HHS and Congress 'are ... driven by special interest politics ... [b]oth Medicare payment formulas and coverage determinations often seem to be driven by political, rather than scientific or economic, considerations."[12] Liza Vertinsky explains how "pharmaceutical companies ... are in effect designing their own markets."[13] Clark. C. Havighurst and Barak D. Richman note that "industry and other interests ... manipulate people's thinking ... both as consumers and as voters."[14] David A. Hyman laments that "provider capture of state and federal legislators ... is the rule ..."[15] And Nick Bagley's "Bedside Bureaucrats" is, at its heart, a story about the power of the medical profession as the reason health reform hasn't worked, and a call to create countervailing, democratic power to check it.[16] Feminist and critical race theorists, too, have long centered questions of power, critiquing how these underlying determinants shape structural and substantive choices.[17]

In the same vein, Timothy Jost notes that President Franklin Roosevelt financed Social Security through a trust fund model not because it made fiscal sense but because he knew doing so would create a powerful political constituency to preserve the program.[18] In building one of the nation's most important social programs — which set the stage for the similar model employed by Medicare — Roosevelt was thinking in the power dimension.

Gabe Scheffler refers to the "dynamism" of health law[19]; a good term, we might also say health law's relationship to health politics is recursive, that health law and health politics are mutually constitutive, or, in economic terminology, that health politics is endogenous to health law (and vice versa).

Legal scholars seem to appreciate, too, that the way that health law constructs health politics is a problem, [20] part of the reason health law is tragically and inequitably "broken."[21] "Every system is perfectly designed to get the results it gets."[22] That means that if we don't like our health care system, we need to fix the underlying political dynamics constructed by health law. In evaluating health laws, we need to think about not just cost, quality, access, and equity, but also power. If we fail to do so, we are likely to make mistakes. We might endorse as "wise" (based on their immediate substantive impacts) reforms that are actually problematic (because of their long-term power impacts). And we might fail to identify reforms that could fix the politics of health care, and so enable meaningful structural and substantive health reforms to unlock (or "frack") the significant value trapped in our broken system.[23]

For example, certificate of need laws illustrate the shortcomings of analysis that fails to consider the power dimension. Concerned with cost growth associated with increasing hospital care, states implemented and the federal government encouraged laws limiting further development of health infrastructure absent approval by an "expert," politically-appointed board. These laws failed to consider the power dimension, however. Rather than curb hospital power and cost growth, the boards they created to make health care infrastructure decisions were themselves in many cases captured by existing, entrenched hospital interests.[24] Certificate of need laws thus paradoxically became a tool supportive of, rather than contrary to, hospital power, and ultimately fueled rather than curbed cost growth.[25]

Moreover, there is a serious argument that like health law's "fourth dimension" (equity),[26] health law scholars should be particularly focused on its fifth dimension (power) as compared to the traditional "iron triangle" dimensions of access, cost, and quality. Access, cost, and quality are important, but other disciplines that study health law and policy are well positioned to evaluate those. Health law scholars have a comparative advantage over other health policy experts when it comes to questions of equity and power, however, because of our distinctive institutional position. If a substantive or structural change would improve things from the perspective of the American Medical Association, we can count on the AMA or policy experts associated with the medical profession to bring that to light. Indeed, experts in other disciplines are better positioned than we law professors to do so. So too changes that would benefit hospitals, pharmaceutical manufacturers, and so on. If something would help

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the powers that be — the powers that be will make sure policymakers know about it.

As law professors, our comparative advantage lies not just in our specialized knowledge of law (a key allocator of power) but also in our aspirationally independent perspective. Law professors are unique in the health care ecosystem in that we focus on power as our bread and butter and in that our discipline is not centered on funding by soft money. We are generally empowered to study any questions we think important regardless whether wealthy donors, Congress, the NIH, or others think those questions are worth thinking about. We add the most value, then, by identifying and studying worthy questions that the powers-that-be ignore or discourage others from asking. This includes, of course, questions of equity, which is why it is so important for health law scholarship to trace otherwise-unnoticed impacts of health policies on marginalized (powerless) groups. But it also includes questions of power, especially when those questions challenge existing arrangements.

These are to me persuasive arguments that I should work to incorporate the power dimension in my own work, but there is a problem. It seems much easier to assess the impacts of health laws on cost, quality, access, and equity than it is to assess impacts on power. These dimensions are more readily quantified — at least today. This may be due simply to path dependence — to the fact that researchers in health law and other disciplines have spent so much time working to make them manageable — but it is also in part the nature of power. Power is notoriously slippery, and while one can define it in theory (as I do in the footnote[27]), measuring it in practice is hard. When one begins speaking the language of power — perhaps quoting Foucalt's critique of hospitals, or Ivan Illich's "Limits to Medicine"[28] — one begins to wonder what verifiable, operationalizable insights are possible. Power talk has a tendency to simultaneously explain much and prove little.

Understanding the interaction of law and power retrospectively through in-depth historical analysis like *The Social Transformation of American Medicine* is difficult enough.[29] Developing predictive insights about how a law might empower is another question entirely, and assessing whether the empowerment of one individual or another would ultimately be desirable is still another challenge. In short, whatever its importance, health law scholarship's failure to fully account for the power dimension may be due in part to the indeterminancy of power as compared to the more manageable (at least with present conceptual and methodological technology) dimensions of cost, quality, access, and equity.

To overcome this methodological challenge, more work is needed to think about *how* the power dimension can be workably operationalized in the normative analysis of health laws. This might be done through legal theory (like feminist legal theory[30]), critical perspectives (like law and political economy[31]), and inter-disciplinary work (like looking to public choice and political sociology[32]). It might also take the form of comparative work, exploring how other fields have operationalized the power dimension. The remainder of this Article suggests that analogizing health law to criminal law offers a promising way to operationalize power in health law.

II. The Prison Abolition Movement

Criminal law has long faced an analogous challenge — a recognition that criminal law has constructed a criminal law politics that is broken, on the one hand, and that crafting changes in criminal law to fix criminal law politics is very difficult, on the other. In recent years, many scholars in the field have found it possible to overcome this challenge through an institutional approach. Rather than assessing the power implications of each law anew, criminal law scholars have identified a particular empowered institution — the prison-industrial complex — as a root problem in criminal law politics. This has facilitated the incorporation of questions of power into criminal law through the controversial "prison abolitionist" perspective (or "ethic"[33]), which holds that a defining goal (perhaps the defining goal) of criminal law should be the abolition of prisons (and with them, carceral power).

Abolitionists evaluate substantive policies based not only on their immediate impact but on their dynamic interaction with the power arrangements that determine which substantive policies get enacted and which don't. Like feminism, abolitionism is an approach that is less focused on one substantive outcome as the "correct one," and more focused on developing the broader social and political conditions necessary for justice.[34] A proposal to make incarceration or prisons incrementally better will quickly be met at a contemporary criminal law conference with questions whether the reform would merely "legitimize" or even "strengthen" the prison-industrial complex and so prove counterproductive in the end.[35]

Prison abolitionist arguments might helpfully be separated into "hard" and "soft" versions. Hard abolitionists would oppose (or at least, decline to advocate for) criminal law reforms that expand the influence or resources of the prison industrial complex, *even if they*

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might help present-day prisoners. [36] They might even oppose reforms like evidence-based approaches to law enforcement or incarceration on the ground that doing so "reifies" the larger incarceration project.[37]

On the other hand, soft abolitionists would not necessarily oppose such mixed-impact reforms, but they would actively search for ways to reduce the power of the prison-industrial complex and, where substantive implications are themselves indeterminate or mixed, they would argue that when in doubt policies that disempower prisons should be preferred.[38] Notably, even in its soft form scholars have found prison abolition's institutional focus — its identification of an empowered institution whose influence is itself problematic — to make workable otherwise-indeterminate questions about the interaction of law and power.

III. The Hospital Abolition Hypothesis

1. Empowering the Powerless Requires Disempowering the Powerful

Scholars thinking about power in health law have largely sought to achieve balance by empowering the powerless. For example, Silver and Hyman propose empowering patients economically as consumers.[39] Too, "health justice" sets as the north star of health reform a "communitarian approach" that "emphasi[zes] [] collective problems and collective problem-solving[] to ensur[e] the essential conditions for human well-being, including redistribution of social and economic goods and recognition of all people as equal participants in social and political life."[40] Building on this health justice framework, a "civil rights of health" further focuses on "the health effects of subordination" and the creation of "new legal tools for challenging subordination" to "ultimately reduce or eliminate unjust health disparities."[41] This approach sees racism and subordination as the "root cause" of health disparities, among other problems in our health care non-system.[42]

These are all worthwhile efforts, and I hope to build on them. The success of the prison abolition movement suggests, however, that it would be helpful not only to focus on empowering the powerless but on naming and disempowering the powerful. Criminal law has long emphasized the importance of empowering otherwise-powerless interests, problematizing felony disenfranchisement and calling for community-engaged budgeting.[43] But central to the prison abolition movement has been the insight that power is zero sum. This is undoubtedly true of political power — if one person or group's ability to influence legislation, regulation, or litigation increases, than another's necessarily decreases. It is also largely true of other forms of power — multiple actors cannot control the same information, or shape individuals' values in contradictory ways.[44] For efforts to increase the power of currently-marginalized interests and groups to be successful, someone must be disempowered.

In the view of prison abolitionists, then, the fundamental power problem is not that incarcerated persons or communities impacted by incarceration are too weak (though they get there). In the view of prison abolitionists, the fundamental problem is that carceral institutions are too strong — and that they use their influence to entrench incarceration as criminal law's dominant response to crime. As Stahly-Butts and Akbar put it, "[t]he criminal legal system is central to the political economy of the United States, a tool of stratification by race, gender, and class within our unequal society."[45]

In thinking about power in health law, we might also think not only about giving otherwise-excluded groups a seat at the table, but about the powerful groups who always have a seat (and often host the conference). Jamila Michener calls on us to do just that in a recent issue of this journal, emphasizing that the struggle for health justice requires not just "building power" but "breaking power."[46] But Michener recognizes that the "amorphous" nature of power has left mechanisms and methods for breaking power "difficult to identify" and "less well investigated,"[47] focusing in her own contribution on minimizing profit, administrative regulation, and institutional negotiation. The question posed by the prison abolition comparison is whether we might gain still more traction by naming one of the core powerful groups that dominate health care policymaking — such as physicians, insurers, pharmaceutical companies, and hospitals (including hospital systems). Are any of these super-groups usefully understood as health law's antagonist?

2. Hospitalization is a Policy Failure

Prison abolitionists begin by focusing on the powerful institution in criminal law that itself exists to serve a function — incarceration — that is ultimately undesirable as a substantive matter (whether or not arguably warranted in individual cases). Incarceration is harmful to those who experience it and costly to the state.[48] Moreover, incarceration may (or may not) prevent the recurrence of crime but it cannot undo crimes already committed. And critically, as a means of addressing crime incarceration is inherently biased, disparately impacting Black people and other marginalized groups because of its own biases and because of the way it bakes in existing societal disparities in wealth and access to cultural capital.[49] Because they exist to serve an ultimately undesirable function, prisons have

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an inherent incentive to put their power toward counter-productive ends as a matter of self-preservation.

Thus, prison abolitionists argue, while we might differ about how to proceed incrementally toward a world without prisons, can we all not agree that such a world should be our ultimate goal?[50] This is an important move in bringing a power perspective into a substantive field that does not necessarily care about balancing power for its own sake. While constitutional law or public law scholars might aspire for political equality or oppose domination in the abstract (for best *processes*), scholars in a substantive field like criminal law or health law are primarily concerned with just *outcomes*.

From a substantive perspective, it would be unwise to seek to disempower a dominant institution simply because it is dominant if that institution uses its dominance to entrench substantively-desirable policies. If, for example, the AMA's outsized political power entrenches quality health care against populist threats, that might be a good thing.[51] Indeed, I have written elsewhere that the political dominance of the AMA in particular and of physicians in general may be defensible as a second-best substitute to a constitutional right to quality health care.[52] The same could be said for PhRMA's political influence — perhaps it might be defended on the whole as entrenching support for investment in innovation — whatever the downsides, public choice arguments, at least, could be mustered to support such a counter-majoritarian fixture in the "constitution beyond the constitution."[53] If so, then it would be a mistake to aspire to counteract PhRMA's power in all cases (even if we might want to modulate how it uses its power).

Prison abolitionism overcomes this challenge by targeting an institution that is itself devoted to a policy failure, and so incentivized to use its influence to pursue ends that are substantively undesirable. There is more work to do to fully survey health law's superpowers (including physicians, pharmaceutical manufacturers, insurers, and hospitals), but hospitals are a plausible target for such an approach. Hospitalization is, in a sense, itself a policy failure. Sickness and medical care are inevitable, unavoidable features of the human condition,[54] but hospitalization is often avoidable. Today, even judged within current institutional dynamics, a significant percentage (estimates range from a plurality to a significant majority) of emergency room visits are believed to be unnecessary — a byproduct of inadequate primary care and inadequate mental health care. Moreover, as discussed further below, even seemingly essential hospital functions might be reimagined within other physical contexts (and, indeed, already are being forcibly reimagined in rural hospital shortage areas), and hospital facilities can exist without powerful hospital institutions.

3. Hospitalization is Inherently Inequitable

Relatedly, as a tool of promoting public health hospitalization is inherently inequitable, just like incarceration is inherently inequitable as a means of addressing crime. Today, everyone benefits equally from the eradication of smallpox — one of prevention's great successes.[55] Neither wealth, race, class, or any other factor determines a person's likelihood of experiencing health harms due to smallpox. Eradication can thus be an equitable public health tool. The same cannot be said of hospitalization, and it seems doubtful that it ever could.

So long as inequity persists in other basic societal institutions, access to care in hospitals and the quality of that care will be distributed inequitably. No reform — not single payer, not expanded antidiscrimination laws, not universal basic income, not the abolition of wealth inequality or even capitalism — will create a world in which underlying societal disparities (in resources, relationships, education, cultural capital, etc.) will not determine both access to hospital care and the quality of such care. Such inequality may come from greater ability to pay; from differential access to care work or job supports to accommodate time away due to hospitalization; from familial, social, or reputational access to providers; from political influence; or from other sources.

There is a level on which this point is more trite than controversial. Of course, we all understand that an ounce of prevention is better than a pound of cure. But from that perspective, hospital abolition is *already* the defining goal of health law, and health care focused frameworks like the "iron triangle" and "triple aim," which seek to improve health care rather than make it unnecessary, are mere incremental stand-ins on the path toward that end.

If so — if hospital abolition is already the goal of health law — the abolitionist position would nudge that unattainable though abolition might seem in the short term, centering our thinking around the goal of a world without hospitals rather than (or in addition to) other proxy endpoints (like "universal coverage") will permit us to imagine paths we might otherwise miss toward that end — paths that lie outside the existing health care infrastructure.

4. Hospital Power Corrupts Medicine

Prison abolition is not merely a conceptual point about how criminal law scholars should frame the end goal of their work, however. It is primarily an effort

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to center and operationalize power by giving power-informed analysis a target. Prison abolitionists are not shy. Rather than offer a conciliatory approach to thinking about power in criminal law that seeks power arrangements that are "fair" or "just," that "tend toward crime prevention rather than incarceration," or that "empower the weak" (like incarcerated persons), prison abolitionists name and target what they see as the antagonist. They call for abolition based on the view that any reform that relies on or strengthens the prison-industrial complex (on the power dimension) is likely, in the end, to do more harm than good (whatever its benefits on substantive dimensions).[56]

The same could be said of hospital power; that because of their institutional focus on addressing severe illness, hospitals are a political force entrenching rescue-focused responses to public health problems as opposed to proactive, prevention-focused reforms. Other super-powerful institutions in health law — doctors, pharmaceutical companies, and insurers — do not necessarily depend on severe illness for their status and wealth. Primary care doctors — who represent a (shrinking) plurality of the profession — are primarily in the business of preventing severe illness. Pharmaceutical companies certainly profit off of hospitalization, but they profit off of prevention as well and could see plenty of opportunities for profit in a world without hospitals. Insurers process health care claims without regard to their nature or setting.

Unlike health law's other politically dominant groups, hospitals by definition[57] depend largely on severe illness for their position — for their economic strength, for their epistemic strength, for their strength over the health care workforce, and for their associated political strength. Hospitals have an inherent conflict of interest when it comes to any reform that would actually prevent severe illness and, along with it, a perverse incentive to distort health care policymaking toward greater reliance on hospitalization as a public health tool — despite its flaws.

To be clear, I am not talking about the goals of individual actors within hospitals. I volunteer for a hospital charity and have immediate family members who work for hospitals. Every hospital employee I have ever met was a devoted, hard-working person committed to improving patients' lives and health care; many had sacrificed a great deal to pursue that end and had, in fact, improved many lives a great deal. I am speaking of the power of hospitals as institutions in our health care system, not about people who work in hospitals. The hospital abolition hypothesis holds that such people would be empowered to do even more impactful work in a world without hospitals as we understand them today.

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Because the core work of hospitals as institutions is treating serious illness — and hospitalization is their core source of revenue — hospital institutions have a perverse incentive to favor policy reforms that direct a greater share of the nation's health expenditures toward severe illness and hospitalization (by increasing reimbursement), and disfavor (or even advocate against) reforms that would direct a greater share of the nation's health expenditures toward prevention. This perverse incentive has in important and observable ways influenced hospitals' collective political behavior and, so, policy outcomes in the U.S. health care system. Professor Oberlander, among others, has documented ways that the hospital lobby pushes successfully for increased hospital reimbursement

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in Congress and in courts.[58] Jessica Mantel has also described hospitals' role in driving health care costs.[59]

Hospitals' political influence might not be problematic if public health (including health care) spending were zero sum, but that is often not the case. Congressional "paygo" rules and persistent fiscal concerns mean that hospital cost growth often brings cuts in other health care and public health programs.[60]

The persistence in the American south of certificate of need laws are a well-studied example of how hospitals use their political influence to preserve and expand their role in the health care system, as the expense of other treatment modalities.[61] Indeed, at this writing, the American Hospital Association is lobbying actively, vigorously, and so far effectively against "site neutral payment" recommended by the independent Medicare Payment Advisory Commission that would merely see Medicare pay the same for a service whether it is provided inside or outside a hospital — currently, payment rates reward hospital-based treatment at the expense of community-based treatment.[62] Others have described the perverse policy impact of hospitals on the nursing workforce, the health care staffing workforce, and access to health care in rural settings.[63]

In addition to lamenting the direct impacts of incarceration and incarceration institutions on political outcomes, abolitionists point out the way that prisons, by their conflicted existence, corrupt other players in criminal law — lawyers, academics, social programs, and the like — so that these other institutions contribute to rather than work to dismantle incarceration's central place in criminal law.[64] The same might be said of hospitals. There is a serious argument that hospitals' mediating position within other major health care relationships — between doctors and patients, between doctors and insurers, and between insurers and patients — prevents doctors and insurers from playing salutary roles they might otherwise play, from taking responsibility for patients' financial distress to unlocking the power of markets in health care.

Consider two examples of the way hospital power may distort other institutions. First, hospital power over billing, staffing, and care management arguably prevents medical ethics from checking health care abuses; hospitals may be holding the medical profession back from living up to its ideals by giving it a convenient institutional scapegoat. As an essential, justifying constraint on the power wielded by physicians, members of the medical profession take an oath to use their power to serve patients. As Charity Scott observed, this means that "doctors [] owe an obligation to promote their patients' best interests and welfare"[65] that can be extended beyond the clinical setting. But as Jessica Mantel points out, "physicians may be subconsciously biased toward making clinical decisions consistent with their personal self-interest, as shaped by hospital policies."[66]

Moreover, by off-loading many non-clinical responsibilities to hospitals — billing, electronic health records, treatment of staff, overall care management, patient intake, etc. — the medical profession is able to launder its professional and ethical obligations. Hospitals' mediating role allows physicians to dodge serious claims that they are ethically bound to bill humanely — to prevent the "financial toxicity" that comes from arbitrary or outrageous billing practices.[67] But by shifting the responsibility for billing from themselves (and their ethical obligation to serve patients) to hospital administrators and staff (whose ethical obligations to patients are checked by fiduciary obligations to the hospital as an institution), doctors can have their cake and eat it too. As Zack Buck describes, the institution can sue doctors' patients for them or send outrageous bills,[68] or it can dump patients,[69] overwork nurses,[70] exploit staff,[71] and press profitable-but-questionably-necessary services,[72] while disempowered doctors ostensibly keep their hands clean.

People can take oaths, institutions can't. In a world without hospitals, the medical profession could not so easily avoid responsibility for the abuses of the health care system, and doctors' professional and ethical responsibilities would have a better chance of pushing them to use their power to check those abuses. Hospital abolition might thus make possible the "ethical reengagement by physicians and other health professionals" that William Sage sees as "essential to renegotiating the interplay of professional self-regulation, market processes, and the state, and therefor in defining a productive path forward."[73]

Similarly, the presence of hospitals impedes the ability of insurers to act as a check on medical pricing, and so of patients "as consumers" to contribute to rational hospital pricing.[74] The increasingly-severe concentration associated with the hospital form as the gateway to health care has meant that "health insurers are unable to effectively hold down costs."[75] The problem is so bad that some advocate allowing insurers to merge to market power to serve as a "check" on concentrated hospital systems, though others doubt the viability of this "two wrongs make a right" path.[76] Antitrust scholars like Zephyr Teachout attack the problem from a different direction — one that might be called hospital abolitionist — if the problem is concentrated hospital power, the solution is to "break 'em up."[77]

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5. Could We Re-Imagine Care without Hospitals?
Of course, hospitals serve some functions that are seemingly unavoidable, even desirable, in any health care system—they are often sites of cancer care, neo-natal care and delivery, cardiac care, emergency trauma care, emergency mental health care, and so on. It is not plausible to think of a world without a need for these sorts of acute medical care. Moreover, unlike incarceration, health care is ordinarily itself beneficial to the people who receive it. Don't those facts make hospital abolition implausible, and the comparison between prison abolition and hospital abolition a strained one?

Certainly the question of prison abolition is different from the question of hospital abolition, and while drawing lessons from the comparison we should not overstate it. But here, too, prison abolitionist arguments are illuminating. Prison abolitionists respond to analogous arguments (that there will always be a need to incapacitate the "dangerous few" to benefit those they might harm) by pushing for imagination.[78] Could not functions of the carceral system that we see as unavoidable, they ask, be re-conceptualized and relocated to other institutions — institutions without a conflict of interest born of the fact that they exist primarily to address a policy failure, and are empowered by that failure? Or, at least, should we not focus elsewhere in contemplating reform, not allowing our thinking to be centered around and bound by a policy failure even if we believe it inevitable?

Thus, some prison abolitionists argue they seek "[n]ot so much the abolition of prisons but the abolition of a society that could have prisons."[79] "[I]f it's difficult to imagine what such a world might look like, that's precisely the point."[80]

We might ask similar questions — and challenge ourselves to similar reimagining — when confronted with the reality of functions we think of as essential hospital functions. For example: If neo-natal care and delivery were located in childcare-centered institutions — institutions that existed to support care of infants generally, not just at birth— then the money that goes into labor and delivery would empower institutions committed to healthier child rearing. If care for serious children's health harms were located in schools, then the money that goes into caring for childhood cancers and broken arms would empower institutions with broader, less-conflicted interests. If cardiac care were housed in elder-care community centers; if cancer care were housed in institutions committed to population health; if emergency mental health services were housed in community health clinics or safe injection facilities; etc. I'm not saying any of these are the right ways to conceptualize public health and health care in the United States, but to emphasize that the way we do so is in some sense up to us, and that conceptualizing all these activities as "hospital" activities is a choice. Indeed, as hospitals close or shutter essential services (like labor and delivery) in rural areas across the country, communities are already being forced to imagine and effectuate alternatives to hospitalization.[81]

Moreover, it is readily possible to imagine a world featuring multi-bed, acute-care *facilities* that are not controlled by, and do not enrich or empower, hospital *institutions*. Indeed, in earlier eras "hospitals" were controlled by providers in furtherance of their and thier patiens' interests. Focused on the power dimension, hospital abolition would seek a return to such a world through reinvigorated medical staff control and corporate practice constraints.

To return to the theme: The way we construct the health care system shapes the politics of the health care system. Fragmenting[82] the experience of care based on the line between prevention and illness, moderate illness and severity — and creating a superpowerful institution that exists to address severe illness without creating super-powerful institutions that exist to further prevention — has perverse political consequences. Fragmenting health care and public health in different ways would have different consequences — and could clear the path to meaningful health reform.

IV. Lessons from Deinstitutionalization

There are of course counter-arguments. For present purposes of drawing lessons health law might learn from the prison abolitionist approach to operationalizing power, I focus on counter-arguments developed in the prison abolition literature. Rachel Barkow, in a skeptical take on prison abolitionism, points to mental health care deinstitutionalization as a cautionary tale through which criminal law might learn from health law. In the 1960s and 1970s, a deinstitutionalization movement was driven by the goal of "empty[ing] large state mental asylums"[83] and shifting investment to "community care."[84]

The deinstitutionalization movement succeeded in reducing mental health hospital populations by 80%, or 440,000 people.[85] But it failed to secure adequate community services, so "patients were discharged from state hospitals" without "adequate support services, such as housing and jobs."[86] Cuts in social services exacerbated the problem, leaving many people suffering mental illness with no treatment and often no housing whatsoever. Deinstitutionalization is thus

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understood to have been a "stunning public policy failure."[87]

Barkow notes in this story important challenges for prison abolitionism. For one, deconstructing the power of an existing institution is one thing, but constructing something better in its place is quite another. Would funding cut from prisons be invested in social services or go away altogether?[88] Would deinstitutionalization entail shifting harms from visible actors to invisible ones, especially unpaid family and loved ones forced to do their best to address a care work gap left by the removal of formal services?[89]

Barkow's cautions apply with full force to the hospital abolition hypothesis. As a substantive matter, eliminating hospital services without providing alternatives would undermine access to care and the quality of care. Moreover, as a political matter, taking hospital power out of the health care system entirely might mean not *better* societal investment in public health, but *less* societal investment in health care. An entrenched lobby pushing for investment in rescue-oriented care may not be as desirable as an entrenched lobby pushing for investment in proactive, preventive public health interventions — but it's better than nothing.

These concerns, standing alone, may well be enough to reject a "hard" version of hospital abolition that sees shrinking hospitals or reducing their power as desirable in any case, regardless of substantive implications, that is, regardless of implications for cost, quality, access, or equity. Relatedly, they are a reason to seek not so much to reduce hospital power standing alone, but rather to seek to reallocate hospital power toward other actors committed to promoting public health (through health care or other means). As Sage and Laurin note in emphasizing the similarities and interaction between medicalization and criminalization of poverty, the political influence of hospitals can be both salutary from a health ecosystem perspective (fighting "anti-redistributive" tendencies) and perverse (shifting health spending toward less-effective, less-equitable purposes).[90]

"Prison abolitionists frequently define their work as consisting of two simultaneous activities, one destructive and the other creative."[91] This is an essential imperative for the hospital abolition hypothesis. Public health should seek to abolish hospitals not by leaving health care needs unmet or reducing the resources the nation invests in health, but by shifting responsibility for meeting health care needs (and the resources necessary to address those needs) away from hospitals and toward other actors in the broader public health ecosystem like providers, public health authorities, and patients. The goal should be abolishing hospitals, not abolishing health promoting interventions.

V. Cost, Quality, Access, Equity, and Power

More work would be required to fully elaborate, establish, or disprove the hospital abolition hypothesis. This has been a one-sided analysis focused on exploring lessons health law might draw from criminal law in thinking about how to operationalize power.

I have not attempted here to address all the arguments for or against, or even to fully articulate the idea. That said, while tentative, I plan to consider the hospital hypothesis in two ways in future work.

First, hospital abolition can be relevant in analyzing particular health law and policy questions. In addition to analyzing particular health reforms on the dimensions of cost, quality, access, and equity, it is clear to me that I should also consider power — and that I could usefully focus on hospital power when doing so. In cases where substantive dimensions are indeterminate or cross-cutting, power might offer a helpful tie-breaker. In others, the power implications of a reform may be so clear as to overcome (or dictate) implications for cost, quality, access, and equity.

Moreover, in thinking about power in health law, the hospital abolition hypothesis can at least be a useful heuristic (though I don't mean to foreclose the possibility it could be more). Like using "insurance coverage" as a proxy for access, hospital abolition could be a desirable focal point in assessing the power implications of a reform. This would entail skepticism of laws or reforms — like reimbursement rules discriminating in favor of hospitals, or proposals to address shortfalls in the Medicare Part A trust fund by making cuts to Medicaid or increasing seniors' premiums — that aren't obviously substantively desirable (or undesirable) but do obviously enhance hospital power relative to other health care players.

To illustrate how hospital abolition might change nitty gritty analysis of incremental health law questions, consider questions about liability for AI harms in health care. New technologies pose a difficult balance of innovation and risk that makes for difficult — even indeterminate — substantive analyses of the "right" policy.[92] But history indicates that new technologies are also a key means of dislodging the entrenched power of a super-group; the power of railroads and telephone companies was not so much confronted as it was circumvented through technological innovation.[93]

Thus, where scholars find the substantive questions posed by emerging technologies difficult or indeterminate, as they have (to an extent) for artificial

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intelligence[94] and telehealth,[95] they could see hospital abolitionism as a tiebreaker, favoring approaches to regulating new technologies that would permit threats to hospitals' power and position to develop, and disfavoring approaches that would entrench and empower hospitals. In short, hard questions about the regulation of emerging medical technologies should be resolved in favor of what Schumpeter might have called creative hospital destruction.[96]

For example, Price and Cohen offer a careful analysis of the substantive question of who should be responsible for harms caused by medical AI.[97] They ultimately identify two potentially viable substantive alternatives: targeting hospitals with enterprise liability while also giving hospitals rights to information needed for adaptation and monitoring, on the one hand, or targeting health AI developers, on the other. Considering the question from the power dimension could shift this conclusion somewhat, or at least point to additional questions to ask.

From a power perspective it may be preferable for medical AI to develop in directions that dislodge hospitals from medicine's center of gravity while empowering others in the broader public health ecosystem. This means that if targeting hospitals for liability and giving hospitals exclusive information about AI systems could permit AI development to further entrench hospitals (an open question but the one to ask), then it might be preferable to target health AI developers rather than hospitals. But, recalling the lessons of deinstitutionalization, that question might well depend on whether the liability regime (or broader political economy of medical AI) can be constructed in a way that empowers patients or institutions with a vested interest in protecting public health.

Second, hospital abolition can be useful in crafting a reform agenda and developing new ideas for reform. In a health policy environment dominated by powerful interests, it seems that the only reforms with any chance of success are those that either garner the support of all health care's super-groups (and it is the rare change to the status quo that does that while also improving public health) or that split the super-groups. Surprise billing reform split insurers and hospitals; Medicare Advantage reform splits providers and insurers; and so on. Given that hospitals are the one super-group whose power comes from health policy failure, it may make sense even for reformers who are skeptical of the abolition hypothesis nonetheless to prioritize, as a second-best matter, reforms that "divide and conquer" at the expense of hospital power rather than reforms that do so at the expense of other supergroups. For example, the hospital abolition hypothesis provides a default answer when reform entails a zero sum choice between disempowering providers or hospitals.

Conclusion

"For every complex problem there is an answer that is clear, simple, and wrong."[98] From managed care to consumerism to ACOs, health law is no stranger to the Mencken trap. It could be that hospital abolition is another "clear, simple, and wrong" answer to the problems that beset health law and policy in the United States. And yet ...

In "On War," Prussian General Carl von Clausewitz famously explained that "[t]o achieve victory we must mass our forces at the hub of all power and movement. The enemy's 'Center of Gravity.'" Clausewitz' "center of gravity" theory is a foundation of military strategy; as the United States Department of Defense defines it, the center of gravity is "the source of power that provides moral or physical strength, freedom of action, or will to act" to an opponent. Military conflict is certainly a complex problem, but the idea that to overcome an opposing force it is necessary to identify and focus resources at their center of gravity is clear, simple, and, apparently, correct.

Clausewitz' theory makes me think of the first health law article I remember reading, Bill Sage's "Managed Care's Crimea." Drawing a military analogy himself, Sage begins by noting that "[a]n oddity of the Crimean War was that nobody much cared about capturing the Crimean Peninsula ... [i]t was mainly a convenient place for the armies to fight."[99] Sage suggested the controversy surrounding medical necessity determinations could be understood in this light, as reflecting not only their importance but, more fundamentally, a place for power struggles to take place between physicians, on the one hand, and insurers and corporate interests, on the other. "Health policy debates over medical necessity are sometimes about [] benefits ... but they are just as often about ideology or political advantage."[100]

The question then becomes — if we want the outcome to be health justice, where should we focus future health law battles? Whether prison abolition is ultimately right or wrong, the movement has given criminal law a way to focus on power and given momentum to scholars and advocates developing and implementing reforms. As a defining agenda for many in the field, focusing on dislodging criminal law's center of gravity — incarceration — has helped criminal law scholarship and reform move from a time of stagnation to a time of energy and movement. Perhaps health law scholars hoping for a path out of our own

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field's stagnation — to creative destruction addressing health disparities and unlocking investment in prevention and public health—would be wise to take a page out of the prison abolitionists' (and the military strategists') book. Perhaps we should concentrate our efforts on dislodging the center of gravity (the "locus," as Zack Buck puts it[101]) of our contemporary health care non-system. That is, perhaps we should focus on hospital abolition.

Note
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82. Ani B. Satz, "Overcoming. Fragmentation in Disability and HealthLaw," *Emory Law Journal* 60, no. 2 (2010): 277–319.
83. See Barkow, *supra* note 2 at 55.
84. *Id.*
85. R. Weisberg, "Restorative Justice and the Danger of 'Community,'" *Utah Law Review* 23, no. 2 (2003): 335–366, at 343.
86. U.S. Senate Committee on Appropriations, Departments of Labor and Health, Education, and Welfare and Related Agencies Appropriations for Fiscal Year 1974, 93rd Cong., 1st Sess. 5221 (1973).
87. D. Mechanic and D. A. Rochefort, "Deinstitutionalization: An Appraisal of Reform," *Annual Review of Sociology* 16 (1990): 301–327, at 302.
88. See Barkow, *supra* note 2, at 57.
89. *Id.*
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91. D. E. Roberts, "Foreword: Abolition Constitutionalism," *Harvard Law Review* 133, no. 1 (2019): 1–122, at 45.
92. Cf. M. Wansley, "Regulation of Emerging Risks," *Vanderbilt Law Review* 69, no. 2 (2016): 401–478.
93. See R. White, *The Republic for Which It Stands; Sitaraman et al., The Law of Platforms and Utilities* (Oxford University Press, 2022): at 2–3, *available at* <https://api.pageplace.de/preview/DT0400.9780190619060_A35477263/preview-9780190619060_A35477263.pdf> (last accessed May 22, 2024).
94. E.g. W. N. Price II and I. G. Cohen, "Locating Liability for Medical AI," *DePaul Law Review* 73, no. 2 (2024): 339–368.
95. B. Barsky, "Telehealth and CSA Prescribing," (forthcoming, Washington Law Review).
96. Cf. J. Schumpeter, "Capitalism, Socialism, and Democracy," (1942) (discussing "creative destruction").
97. Price & Cohen, *supra* note 94.
98. See M. A. Hall and J. D. Columbo, "The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption," *Washington Law Review* 66, no. 76 (1993): 307–330 (quoting H.L. Mencken).
99. W. M. Sage, "Managed Care's Crimea: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance," *Duke Law Journal* 53 (2003): 597–651, at 600.
100. *Id.*
101. See Buck, *supra* note 68 at 191 ("hospitals have naturally become the locus of the worst of the collision between consumerism and universality, between cost and access — a gloomy setting for citizens who simply cannot afford the health care they need to flourish, or to survive.").

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