

DEBATE

CONSUMER-DIRECTED HEALTH CARE

You won't hear many health experts claim that the American healthcare system is functioning perfectly in terms of core considerations such as cost, access, and quality. The question that arises with the advent of any new policy approach seeking to improve the system is obvious: Does the change represent a step forward or backward? Professors Kristin Madison, of Penn, and Peter Jacobson, of the University of Michigan, take up this question in regard to the latest innovation in health care policy—consumer-directed healthcare (CDHC).

Professor Madison argues that while CDHC is not a panacea, “[e]ven if its shortcomings prevent its full diffusion through the American health care system, CDHC will still . . . help[] to establish a foundation for future reforms in health care finance and delivery, [and] has the potential to improve the health care system in the long run.” Professor Jacobson’s response? “CDHC is a direct attack on the idea that health care differs from other market commodities because of its moral aspirations For those who believe that equity should be a fundamental attribute of health care delivery, CDHC represents a huge step backwards.” Nonetheless, Professor Madison is convinced that CDHC will be a lightning rod that stirs the American health care system out of its complacency and “forces us to confront the tradeoffs inherent in any health care system in a resource-constrained world.” Professor Jacobson is not content to wait and see how the American public reacts to CDHC: “If the policy focus is on CDHC, equity will be subordinated. If universal coverage dominates, CDHC proponents are probably right that cost and quality issues will be subordinate. For me, it’s an easy choice—helping those without insurance to have a minimal acceptable level of care.”

OPENING STATEMENT

*Is Consumer-Directed Health Care a Step Forward or a Step Backward for Health Care Policy?*Kristin Madison[†]

Consumer-directed health care (CDHC) has become a common topic of conversation among those interested in health care law and policy issues. Definitions of CDHC vary, but they share a common core: the notion of increasing consumers' control over their own health care. Consumer-directed care can be contrasted with care directed by physicians or others who deliver health care services, on the one hand, or employers and insurers who finance and manage payment for services, on the other. The term CDHC de-emphasizes the role these third parties play in the health care decision-making process, reinforcing instead the parallels between the purchase of health care and the purchase of everyday consumer goods and services. Consumers ordinarily exercise full decision-making power with respect to their purchases outside of the health care context and bear the full financial burden of their decisions; in a CDHC setting, enrollees ordinarily exercise some decision-making power over their care and bear at least some of the associated financial burden.

Practically speaking, CDHC is often implemented through a combination of a high-deductible health plan ("HDHP"), such as a plan under which an individual must pay for the first \$2,000 of care received, and a tax-favored, portable health savings account ("HSA"), in which individuals or their employers deposit funds that the individuals can direct toward purchasing medical care. According to the America's Health Insurance Plans Center for Policy and Research, by January 2007, enrollment in HDHP/HSA products exceeded 4.5 million individuals. While the HDHP/HSA combination is only one possible form of CDHC, it is the most widely recognized form.

CDHC's structural characteristics and rapid growth have prompted much discussion about its effects. One major advantage of CDHC (beyond the greater amount of choice it offers participants) is the likelihood that it will increase some patients' sensitivity to health care costs, decreasing demand for low-value services and possibly

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spurring greater levels of competition, which may in turn reduce health care expenditures. If quality joins cost as a criterion patients use in choosing health care providers and services, CDHC may lead to higher health care quality. In addition, by increasing the likelihood that individuals will bear some of the financial costs of treatment necessitated by unhealthy behaviors, CDHC may encourage healthier lifestyles. Drawbacks of CDHC include the high burden it imposes on those who lack the information, education, mental or physical ability, emotional capacity, or financial wherewithal necessary to make good choices about their care. Bad choices can produce both worse health outcomes and higher costs than would result under more conventional health plans. CDHC critics also highlight concerns about its effect on insurance pools: if HDHP/HSA plans attract healthy individuals looking for tax-favored savings vehicles, they may leave sicker enrollees in traditional plans, raising plan premiums and forcing the sickest to shoulder a higher proportion of their own costs.

Evidence of these effects is just beginning to emerge, and continued collection and evaluation of this evidence is essential to assessing CDHC's desirability. Perhaps the most important long-term implications of CDHC stem not from its direct effects, however, but instead from its indirect influences on health care finance and delivery. Even if its shortcomings prevent its full diffusion through the American health care system, CDHC will still constitute a step forward for health care policy in the United States. By helping to establish a foundation for future reforms in health care finance and delivery, it has the potential to improve the health care system in the long run.

CDHC's Long-Run Effects

CDHC's first potential long-run effect is to change the way that people think about health care and health care coverage. Once fully insured, individuals have reason to seek out any care they expect to benefit their health, regardless of the care's cost; insurance insulates them from the cost of care. By contrast, an HDHP enrollee may have to pay the full cost of his or her care. Besides providing incentives to consider whether care is necessary and to find low-cost sources of care, the payment obligation reminds enrollees that care is not free and in fact costs considerably more than the \$20 copayment or the 20% coinsurance rate that an enrollee in a more traditional plan might pay. Every time a patient dips into an HSA, the account balance drops, emphasizing the connection between the choices patients make and their financial consequences.

In the long run, these CDHC features may change people's attitudes. Mark Hall and Clark Havighurst have pointed to a number of possible changes: the need to set aside funds for purchasing services may undermine the entitlement mentality that many people have with respect to health care; patients' increased involvement in decision making sensitizes them to the tradeoffs inherent in medical care and may help them understand the need for limitations on insurance coverage; and the clearly differentiated roles for health plans, patients, and others under CDHC may increase recognition of the distinction between treatment decisions and decisions to finance care.

A second potential legacy of CDHC is the development of tools useful for addressing concerns about health care costs and quality. As CDHC critics point out, CDHC cannot realize many of its potential benefits if information about health care prices and quality is lacking. Without information about the care that they are considering, HDHP enrollees cannot make health care decisions that accurately reflect their underlying preferences, and competition based on price or quality is unlikely to develop.

While historically this information has indeed been lacking, the spread of HDHPs and HSAs has increased enrollee and employer demand for it. Insurers offering CDHC-oriented products have begun to fulfill this demand by disseminating physician-specific price and quality information. Moreover, in an effort to support consumer choice and expand value-driven health care, the U.S. Department of Health and Human Services has promoted greater transparency in prices and quality, and Medicare has begun to disclose some information about payments to physicians and others. Numerous states have joined the transparency campaign as well, requiring the disclosure of certain types of health care quality and cost- or price-related information. While declining costs of compiling information, increasing concern about quality deficiencies, and other factors have undoubtedly contributed to this recent disclosure trend, the desire to facilitate consumer involvement in health care decision making appears to be a major driving force behind it.

A third potential effect of CDHC's rise is further development of the legal framework within which CDHC functions. Peter Jacobson and Michael Tunick argue that in a CDHC setting, courts will be more likely to consider resource constraints in defining medical standards of care, which would reduce the likelihood of provider liability in cases where cost-conscious patients choose a course of care that injures them. Mark Hall suggests that courts' interpretations of the in-

insurance contract term “medical necessity” will change as CDHC growth prompts professional practice to become more cost-sensitive. E. Haavi Morreim notes that CDHC growth may increase litigation against health plans for providing poor-quality information about health care prices or treatment quality that leads to patient decisions with negative consequences. Regulations guiding information provision may also accompany CDHC’s spread.

Most obviously, these CDHC-associated developments matter for CDHC’s future success. If consumer attitudes fail to change, price and quality tools fail to mature, or the law fails to address CDHC-related issues, then CDHC may disappear as a result of consumer resistance and CDHC’s failure to realize hoped-for benefits. But these developments also matter because they will shape the next set of approaches we adopt to confront problems of health care cost, quality, and access—even if these approaches depart from the pure HDHP/HSA form of CDHC.

CDHC’s Potential Role in Shaping Our Future Health Care System

CDHC may influence the future health care system by facilitating the development of other approaches to financing and delivering care. Hall and Havighurst point out, for example, that HSAs may lay the foundation for revitalizing managed care. The cause of managed care’s decline was multifactorial, but included the public’s and courts’ resistance to the constraints it imposed on access to care recommended by physicians. Hall and Havighurst argue, however, that HSAs will encourage the public and the legal system to recognize as legitimate the constraints established by well-run health plans. If HSAs change consumer attitudes so that consumers are more receptive to limitations on financing care, consumers may become more interested in managed care products that can assist them in making the necessary tradeoffs. If the legal system similarly supports such limitations, managed care will become more viable in the long run.

The trend toward quality disclosure may also increase consumer receptivity to managed care coverage limits. Consumers might be more likely to accept limited provider networks, for example, if they knew that the included providers were of high quality, or that excluded providers were excluded on the basis of low quality or low efficiency. If regulators and courts help to ensure that quality ratings are meaningful and accurate, consumers could use the ratings in selecting managed care plans, choosing providers, or deciding when to seek treatment outside of their plans.

CDHC could also lay the foundation for more dramatic changes, such as the adoption of a single-payer system. If HDHP/HSA enrollment expands to include many people who do not want the decision-making and financial responsibilities that these plans entail, a CDHC backlash rivaling the managed care backlash may ultimately develop. If the backlash does not lead to a more robust managed-care-based health care system, it may generate support for a single-payer system in which core coverage decisions are made by government organizations. If CDHC increases the public's recognition that medical care is costly and that tradeoffs are inevitable, for example, the public may become more interested in public financial support for core coverage and more willing to accept the benefit limits likely to be inherent in a single-payer system. CDHC's consumerist orientation may persist in the form of individuals' decisions to seek care outside of public programs.

Perhaps the most likely legacy of the rise of CDHC, however, is a pluralist approach to health care finance and delivery, accompanied by an increased focus on variations in costs and quality. Some people will take advantage of the flexibility that the HDHP/HSA combination offers, while others may turn to less intense forms of CDHC or more heavily managed insurance products. The choices made by individuals in CDHC plans will help us understand the sorts of tradeoffs individuals are willing to make, potentially helping not only to refine CDHC designs, but also to shape other kinds of insurance coverage. Building a framework for disseminating information about health care prices could help not only HDHP/HSA participants, but also the uninsured and anyone else financing their own care, particularly if CDHC promotes price competition. Developing and disseminating information about quality will facilitate decision making by CDHC participants, other privately insured individuals, the publicly insured, and the uninsured, as well as those putting together insurance networks; it can also assist providers seeking to improve their own quality. In short, even if CDHC fails to fully diffuse through the health care system, it is a step forward for health care policy in the long run.

REBUTTAL

Consumer-Directed Health Care (CDHC)—Not the Next Best Thing Since Sliced Bread (Or, Why Is This Fad Different from All Other Health Policy Fads?)

Peter D. Jacobson[†]

At the end of a recent presentation on how I expect the courts to rule in challenges to consumer-directed health care (CDHC) products, a member of the audience asked plaintively whether anyone here opposes CDHC. I responded that I had been invited to provide a legal analysis, but if I had been asked my opinion, I would have simply said, “I come not to praise CDHC but to bury it.”

After reading Professor Madison’s thoughtful arguments favoring the concept, I’m tempted to say that CDHC offers a potentially advantageous innovation to resolve the nation’s dysfunctional health system. But as one of Steve Martin’s *Saturday Night Live* characters would have said, “Nah!” Despite Professor Madison’s compelling arguments, CDHC will not be the panacea its proponents maintain and is likely to exacerbate the very problems vexing the health care system.

Professor Madison asks a sensible question: Is CDHC a step forward or a step backward? With some important caveats, she answers in the affirmative. To support her conclusion, Professor Madison makes two broad points. First, CDHC offers considerable advantages on its own terms. Second, even if it does not meet expectations, CDHC’s innovations will positively change how we think about health care reforms.

With one very strong exception, my answer is negative—CDHC is decidedly a step in the wrong direction. Before addressing my exception to that answer, let me raise two other questions. First, why is CDHC different from any other health policy fad? Answer—it’s not. And second, is CDHC likely to achieve the spectacular advances its proponents predict? Answer—not very likely. At this point, any advantages must be presumed—there is no empirical evidence supporting CDHC’s benefits. Nonetheless, I agree that the failure of CDHC will compel new thinking about health care reforms, but with a somewhat different prospect than Professor Madison’s.

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The core policy question regarding CDHC remains what it has been in all post-World War II health policy debates. In a country that values individualism and markets and largely distrusts government, what is the proper balance between governmental intervention and reliance on markets to provide health care? Is health care different from other market goods and services? Do we care?

CDHC: Advantages and Deficiencies

Advantages. The core components of CDHC are high-deductible health plans (HDHPs), usually paired with tax-favored health savings accounts (HSAs). Whatever the exact combination chosen, the essential feature is to shift the risk away from the employer or health insurer to the individual patient. Essentially, CDHC is the latest variation on a theme of a market-oriented health care system. Shifting the risk of health care choices to patients has the potential to fundamentally transform health care into a market commodity and to change the nature of what differentiates health care from other goods and services.

Professor Madison very capably outlines the case for CDHC. Its proponents argue, more on faith than on empirical evidence, that a market-driven system will result in lower costs and increased quality of care. In turn, this will lead to lower numbers of uninsured patients. In contrast to the health care delivery models that preceded CDHC, first fee-for-service and then managed care, patients will take increasing responsibility for what treatment to seek and how much treatment to receive. Whether CDHC will benefit or harm individual enrollees is an empirical question that has not yet been answered.

Deficiencies. Without dwelling on CDHC's limitations, it is worth mentioning that at a time when many observers argue that the system should emphasize prevention, CDHC is likely to encourage patient underinvestment in prevention. Equally important, far more than in either the fee-for-service or managed care eras, CDHC is premised on patients' ability to obtain adequate information. The information asymmetries that have constrained the shift to a market-based health care system in the past are magnified in CDHC.

For CDHC to achieve its anticipated objectives, providing patients with adequate cost and quality information is essential. If patients are expected to make choices about the value of various treatment options relative to costs, including choosing high-quality providers and facilities, the burden rests with institutions providing and controlling

the flow of data to demonstrate transparency—showing that the information is complete, accurate, and up-to-date. As many observers including industry insiders have noted, proponents vastly underestimate the challenges of providing information in a form that the average patient can absorb. At this point, the promise of transparency exceeds its reality.

On these issues, Professor Madison and I seem to have some agreement. Where I disagree is her characterization of CDHC's potential legacy. Many of the innovations she describes, such as transparency on price and quality data, predate CDHC and are needed improvements regardless of how the system is organized and financed.

Health Care as a Commodity

But CDHC's potential deficiencies are secondary to my opposition. What proponents see as CDHC's primary attribute, transforming health care into just another market commodity, is what concerns me most. Bringing market discipline to health care delivery is fine. Yet there is a big difference between introducing value into the system and shifting altogether to a market commodity. Even accepting that some of the proponents' claims are likely to be valid, it is important to recognize and weigh what will be lost in the transition, particularly the attendant distributional consequences.

Dan Brock and Norman Daniels, in *Ethical Foundations of the Clinton Administration's Proposed Health Care System*, 271 J. AM. MED. ASS'N 1189 (1994), have argued that health care is of fundamental moral importance in protecting the opportunity to pursue life goals, reducing pain and suffering, and preventing premature loss of life. Brock and Daniels further argue that health care is a fundamental good. As such, moral ideals of justice, equality, and community require that the health care system be universal, comprehensive, and equitable in sharing its benefits and costs.

Thus, CDHC implicates the larger philosophical question that needs to be addressed regarding societal values. CDHC is a direct attack on the idea that health care differs from other market commodities because of its moral aspirations, including a special concern for an equitable health care delivery system. For those who believe that equity should be a fundamental attribute of health care delivery, CDHC represents a huge step backwards. By its very nature, a CDHC-based system will be less concerned about equity and will most likely exacerbate existing disparities in access to health care and clinical outcomes.

This is not to suggest that health care must be egalitarian—providing everyone with access to the same level of care based solely on medical need. Nonetheless, health care is a public good that should not be wholly subjected to the caprices of the market. Indeed, much of the current policy debate is sadly reminiscent of the objections to enacting Medicare and Medicaid in the 1960s. For all of those programs' deficiencies, would the elderly and low-income people covered be better served had they not been enacted? The market failed the Medicare and Medicaid populations before and there's no reason to believe that the results will be different this time around.

To be sure, market competition is generally good at reducing costs and improving quality. To that extent, the ongoing changes in health care that Professor Madison discusses are positive developments and should be encouraged. Where market competition is unlikely to help is in providing access to health care for uninsured and underinsured populations. At best, CDHC can only address discrete aspects of what ails health care delivery.

For those who believe that excessive costs and poor quality are the most glaring health care failures, CDHC could be a viable option. But the argument that reducing costs will lead to increased access lacks any plausibility. I can't think of any area of social policy where the market losers have been aided by even the most well-functioning markets absent governmental intervention.

Now we get to the exception that I mentioned at the beginning regarding my opposition to CDHC. Professor Madison observes that a backlash to CDHC, similar to the managed care backlash, could lead to public support for a single-payer system. A serious backlash to CDHC may be the best way to achieve some form of universal health care, which I favor. As a result, part of me wants to adopt CDHC because doing so will simply hasten the enactment of some form of universal health care or single-payer system. After the experiment with CDHC fails, as it inevitably will, the only reasonable alternative will lie with greater governmental involvement. Once the market solution is exposed, there will be no more excuses and no justification for further delaying universal health care. To that extent, CDHC may be the necessary precursor to a more equitable health care delivery system.

As a practical matter, I doubt that the public is ready for the inevitable analogies to used car salesmen. *Caveat emptor*, a reality of a functioning market, does not strike me as a very effective marketing campaign for health systems. In fact, the slow acceptance of CDHC

among employers and employees alike suggests the limits to a purely market-based approach.

Health Policy Fads

Health care is a field driven by fads. Repeatedly, health policy proves the wisdom of H. L. Mencken's famous aphorism that "there is always a well-known solution to every human problem—neat, plausible, and wrong." If there's a field of domestic policy that is more subject to the fad-of-the-month than health care, it eludes me. CDHC is the current fad of the day. Before the current fascination with CDHCs as the panacea for the health care mess, we heard the same claims for the following magic potions:

- Managed competition
- Managed care
- Health insurance purchasing cooperatives
- Business health purchasing coalitions
- Medical liability reform
- State health reforms

In its time, each of these policy innovations was heralded as the solution to the cost, quality, and access concerns facing the health care non-system. Needless to say, each one of these failed miserably as the solution. Despite this woeful litany of failures, CDHC proponents still maintain that this innovation will be different. It reminds me of the old adage that second marriages represent the triumph of hope over experience. For what other than unbridled faith in markets can explain proponents' irrational exuberance favoring CDHC?

Or, to put it differently, why is this fad different from all other health policy fads? Much like the previous fads, CDHC will be exposed as flawed and then another fad will emerge, unless the public demands the inevitable universal health care coverage. Until then, not only is CDHC the wrong approach to solving the problems at the core of our broken health care non-system, but its widespread adoption will actually exacerbate existing inequities.

CLOSING ARGUMENT

Kristin Madison

In taking the position that CDHC is a step in the wrong direction, Professor Jacobson argues that CDHC will lead to underinvestment in preventive services, that innovations in the dissemination of price and quality data predate CDHC, that CDHC undermines the equity that should be a fundamental attribute of health care delivery, and that CDHC is just another in a string of flawed health policy fads and is “the wrong approach to solving the problems at the core of our broken health care non-system.”

As it turns out, Professor Jacobson and I agree on a lot of things.

We agree that CDHC raises concerns about preventive services, that information dissemination is an important policy issue even outside of the CDHC context, and that CDHC could undermine equity. We even agree that CDHC is a flawed health policy initiative that cannot itself solve the problems of our health care non-system.

And yet we still disagree about the answer to the question at the core of our debate: Is CDHC a step forward? Despite Professor Jacobson’s insightful arguments, I still think it is.

Why the difference in conclusions, despite our areas of agreement? One explanation is that I believe that CDHC’s flaws need not be fatal. For example, while it is true that CDHC can encourage patient underinvestment in prevention—enrollees may choose not to seek cost-effective preventive care, either because they cannot afford it or because they do not understand the health consequences of their decisions—some CDHC-oriented plans try to address this problem by offering first-dollar coverage of the costs of certain types of care. Furthermore, while it is true that providing the information critical to the effective functioning of CDHC is a challenge, we have made considerable progress in this area in just the past few years.

Another, more significant contributor to our divergent conclusions is our differing views of the implications of CDHC’s potential status as a health policy fad. Like Professor Jacobson, I doubt that the HDHP/HSA in its current form will ever become the predominant approach to financing health care. The burdens it imposes on enrollees are just too big for it to be accepted by the population as a whole. But even if it does fade into the background, replaced by another policy fad, it can have a lasting legacy. Managed care may have “failed

miserably” “as the solution to the cost, quality, and access concerns faced by the health care non-system,” but it did advance the development of cost containment techniques (such as utilization review) still in use for some health care services today. It also made clear enrollees’ preferences for a broader choice of providers, preferences that the CDHC approach was in part developed to accommodate.

Like managed care, CDHC could have lasting effects, even if it is eventually displaced by another fad. As I argued in my opening statement, CDHC may benefit policy in the long run by changing attitudes, helping to develop legal tools, and promoting the development and dissemination of health care price and quality information. With respect to this last benefit, I agree with Professor Jacobson that the initial creation and publication of quality measures predated the rise of CDHC. However, CDHC analysts and advocates recognize that if it or indeed any market-based approach is to take full advantage of the benefits that markets can offer, information problems must be addressed. Their voices have joined those who support information dissemination as a mechanism for improving quality, in an effort to advance the development of techniques for assessing and reporting quality. As Professor Jacobson recognizes, price and quality transparency are beneficial features of a health care system, regardless of the form that the system ultimately takes. In short, even if it is a fad, CDHC could constitute a step forward.

Perhaps the most important explanation for our disagreement, however, is our differing views of the role that equity concerns should play in determining whether CDHC constitutes a step forward. Professor Jacobson is concerned that CDHC will “transform[] health care into just another market commodity,” a transformation inconsistent with “moral ideals of justice, equality, and community” that would undermine equity and worsen health disparities. This is a valid concern, but I do not think that it means that CDHC is a step backward. Somewhat sideways, perhaps, but not backward.

CDHC will not do much to improve equity. If it reduces health care costs by discouraging unnecessary care, then it could increase access by lowering financial barriers to purchasing insurance. But by placing financial and decision-making responsibilities on individual enrollees, CDHC is likely to increase the health care access and outcome disparities associated with enrollees’ differing abilities to handle these responsibilities. Innovations that assist enrollees in meeting these responsibilities, such as alterations in CDHC design or the provision of decision support tools, may reduce disparities, but are unlikely to eliminate them.

But inequities in health care are not the problem that CDHC is designed to address. Instead, CDHC advocates hope that it will harness the power of markets to efficiently deliver care that reflects enrollees' preferences. As Professor Jacobson suggests, market competition can achieve some goals but is unlikely to increase health care access. To improve equity, CDHC should be layered on top of other kinds of policy approaches designed to promote access: public subsidies for the purchase of private insurance, for example, or expanded public insurance programs.

Professor Jacobson advocates adopting some form of universal health care, which I agree would do much more to reduce inequities than CDHC. But just as CDHC is a flawed policy innovation that cannot itself be "the solution to . . . cost, quality, and access concerns," so too is universal health care. If we more heavily subsidize private insurance or adopt a single-payer health care system that covers everyone, we can improve equity. However, because inequities and disparities arise from a variety of factors, not just financial barriers to insurance, they will not disappear. Furthermore, there is little reason to believe that a universal health care system would stem increases in health care costs, improve health care quality, or be well-tailored to meet the needs of those it serves. Simultaneous achievement of cost, quality, and equity goals will depend both on the features of the particular reforms adopted and on the implementation of complementary policies designed to achieve these goals.

In short, I doubt that any single reform will ever be able to achieve health care cost, quality, and access goals simultaneously. In my view, then, any innovation that increases the likelihood of achieving at least some of them, either in the short term or in the long term, constitutes a step forward. For this reason, I believe that CDHC constitutes a step forward despite its flaws.

There is one other equity-related argument, however, that remains to be addressed. My opening statement argues that one potential benefit of CDHC would be to transform attitudes about health care. CDHC would increase the transparency of the link between health care choices and their financial consequences. Because it emphasizes the consumer role in health care decision making, it encourages consumers to think more systematically about which aspects of care they value and how much they value them, just as they do for other goods and services they purchase in the marketplace.

This transformation is important because it forces us to confront the tradeoffs inherent in any health care system in a resource-

constrained world. But the CDHC feature with the potential to produce this transformation, the link between an individual's decisions and the consequences for the individual, could distract enrollees' attention from the issue that most concerns Professor Jacobson: equity across the population as a whole. In other words, CDHC-related attitude shifts could start to chip away at individuals' beliefs that health care is different from other goods and services in the marketplace, as well as their willingness to support health care policies that reflect such beliefs. If people start to see health care as just another commodity, then existing support for public financing of health care, including through universal health care systems, may erode.

I do not believe that this will happen. Just as people purchase food in the marketplace while also supporting government financial assistance in ensuring adequate access to food, people purchasing health care in the marketplace will support continued government financing of care. Individuals who have adopted more market-oriented views may accept more variation in access to care, just as individuals accept variations in access to food, a prospect disturbing to those who believe that everyone is entitled to exactly the same health care or exactly the same health care choices. Ultimately, however, I believe that regardless of whether CDHC flourishes or falters, public concern about equity will persist, as will policies designed to improve it.

CLOSING ARGUMENT

Peter D. Jacobson

On one level, I completely agree with Professor Madison that our different conclusions regarding the desirability of CDHC seem odd given our agreement on many of the issues. With some nuance, I even agree with how she characterizes the sources of our disagreement. For instance, I certainly agree that universal health care would not eliminate all disparities or inequities. There is no magic solution that will simultaneously redress all of the health system's problems. To some extent, the policy choice is one of emphasis.

Yet on another level, these small differences mask more profound disagreements and explain why we reach such divergent conclusions. Take, for example, Professor Madison's assertion that CDHC's flaws need not be fatal. From a design perspective, I certainly agree. The greater problem, though, is conceptual and everything else in our exchanges follows from this difference.

CDHC's proponents maintain that the health system's flaws emerged because health care is not a market good. Even assuming that a CDHC-based system will achieve efficiency goals more effectively than a government-based system (an unproven assumption given differential administrative costs), I think the likely gains are wishful thinking. For reasons I'll get to in a moment, consumer sovereignty is neither desirable nor achievable.

CDHC as a Distraction

In theory, there is certainly no incompatibility between the market-driven CDHC components and a governmentally expanded system for uninsured populations. Indeed, one might argue that the two should be conjoined in a type of grand bargain across ideological perspectives. For example, I could see an expansion of CDHC through changes in federal tax policy combined with some type of health stamps (similar to food stamps) that uninsured patients can redeem for a minimally acceptable level of health care benefits. As Haavi Morreim has long argued, the real issue is defining the set of minimally accepted health care benefits that should be made available to all citizens.

But in practice, it is difficult for policymakers to focus on more than one idea at a time. Here, ideological zealotry or purity is likely to get in the way. As we know from the political science literature, policy windows of opportunity are fleeting. Because conservatives are so committed to free market solutions and liberals find reliance on the market anathema, it will take extraordinary leadership to forge a coalition. Does anyone see that type of political leadership? I don't. Despite the plethora of political rhetoric on reforming the health care system, I predict continued political stalemate.

In the end, my differences with Professor Madison are both practical and conceptual. As to the practical, patients are not equivalent to physicians. What underlies CDHC is the notion that patients are equipped to make health care decisions as though they were purchasing an automobile. The pendulum of informed consent has swung so far as to minimize the importance of specialized knowledge. To be sure, patient involvement in one's clinical treatment is essential, especially where questions of value underlie treatment choices, such as with treatments for prostate cancer where outcomes data are indeterminate. But CDHC carries patient responsibility and expectations far beyond value choices into areas where even the most informed patients are likely to be overwhelmed.

Conceptually, CDHC is a huge distraction from the health care system's core problems. Because no one disagrees that reducing costs and improving quality should be pursued regardless of what the system's dominant organizing principle is, it seems to me that, at best, CDHC accelerates desirable initiatives already underway. Hence, my focus is on rectifying the lack of health care access millions of Americans face. If the policy emphasis is on CDHC, it seems inevitable that the problems facing uninsured populations will be further marginalized and ignored. In this sense, a CDHC orientation will crowd out policy initiatives designed to mitigate the access problems.

Why It Matters

As Larry Gostin and I argue in *LAW AND THE HEALTH SYSTEM* (Foundation Press, 2005), four conceptual paradigms can be applied both to transform and to understand the health care system: economic (the standard competitive model); professional (professional self-regulatory norms); rights-based (social justice); and institutional (comparative institutional analysis). As distinct organizing principles, these analytical frameworks compete for dominance in shaping how the health care enterprise is organized, financed, and delivered. Each

approach will emphasize different sets of norms and ideals, alternative policy goals, diverse organizational structures to achieve those goals, and divergent legal rules and levels of regulatory oversight.

We further argued that no one model is inherently superior to another, and no one paradigm operates to the exclusion of the others. For the most part, various aspects of each paradigm will be incorporated into public policy and legal analyses. This much I think is consistent with Professor Madison's arguments. Yet at any given point in time, my view is that one model is likely to dominate the policy sphere. Which one of the competing paradigms prevails is a deliberate policy choice, with important patient care implications. The policy choice is a function of many factors, including the political zeitgeist, the feasibility of the chosen alternatives, and determinations of which problems seem to be the most pressing and which populations are most affected by the changes. Since the policy responses follow from the dominant paradigm, a CDHC-based system will treat access disparities very differently than a system based on universal coverage. That's why the policy frame matters so much.

In practice, we see aspects of each paradigm at work in the current health care system. Although it would be misleading to suggest that the policy apparatus ignores any of the four elements, history suggests that a dominant frame will emerge. If the policy focus is on CDHC, equity will be subordinated. If universal coverage dominates, CDHC proponents are probably right that cost and quality issues will be subordinate. For me, it's an easy choice—helping those without insurance to have a minimal acceptable level of care. As suggested earlier, the cost and quality concerns are now so embedded that no organizing principle will ignore them.

Conclusion

Professor Madison has written an impressive rejoinder to my arguments. In truth, there is much we agree on, and much to be gained from greater market competition in health care. But there is also something to be lost in the process. And I think that's why we reach such divergent conclusions despite relatively narrow differences. We are so close, and yet so far apart. Even in a society organized and driven by markets and individual responsibility, it is morally unacceptable to tolerate the levels of people lacking basic health insurance in the United States.

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