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THE FALSE PROMISE OF CONSUMER CHOICE*

DEBORAH STONE**

INTRODUCTION

Faced with mounting costs of health insurance for its employees, the state of Missouri hired a consultant from PriceWaterhouseCoopers to help it figure out what to do.¹ The consultant concluded that there were no answers to be found in other states, nor would it help to shop the state's business around to different insurance carriers.² Instead, the consultant suggested that Missouri offer "two plan choices" to its employees, in order to, as a *Wall Street Journal* reporter put it, "try to soften the rising cost for employees."³

One plan had low monthly premiums but high co-payments.⁴ The other had high monthly premiums but lower co-payments.⁵ The idea, of course, was that healthier employees would choose the plan with lower monthly premiums, and sicker employees would choose the one with the lower co-pays.⁶ Both plans, however, increased employee cost-sharing compared to the previous year's plan.⁷

The Missouri story encapsulates the thrust of American health policy over the last thirty years: substitute free markets, market competition, and consumer sovereignty for the system of professional authority, non-profit and voluntary agencies, and bureaucratic regulation that once governed the medical sector. In these times, the new buzzwords for market reform are "consumer choice," "consumer direction," "consumer empowerment," and "ownership."

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1. Barbara Martinez, *With Medical Costs Climbing, Workers Are Asked to Pay More*, WALL ST. J., June 16, 2003, at A1.

2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.*

6. Martinez, *supra* note 1.

7. *Id.*

In my view, the rhetorical emphasis on power and control for consumers disguises the real impact of market reforms, which is primarily to reduce the collective assistance and medical services that citizens receive. In this article, I cast a skeptical eye on consumer choice as a mechanism to enhance social welfare.

I. FROM THEORY TO POLICY

The theory of consumer choice says that given limited budgets, consumers think hard about their own needs and desires. They seek good information about alternative ways of meeting their needs and desires, and ultimately, they make careful trade-offs to arrive at good decisions. However, in health care, consumer behavior is distorted by health insurance.⁸ Because people with insurance do not pay the full cost of their medical care, they have few incentives to make careful decisions about consuming it.⁹ When their care is paid for by someone else (insurers), they do not see the price tag before they buy, and cost does not even enter into their thinking about whether to seek medical advice or what kinds of tests and treatments to undergo.¹⁰ “This has led to an absence of consumer vigilance,” explained Regina Herzlinger, one of the strongest advocates of consumer choice reforms.¹¹ Therefore, the theory goes, reducing insurance coverage and placing more financial responsibility on the users of services will make them better, more knowledgeable, and responsible consumers of health care.¹² “[B]y increasing deductibles and other payments, employees will think harder and become ‘more judicious buyers,’” wrote Milt Freudenheim in the *New York Times*, conveying the thoughts of the executive director of a business coalition.¹³ “Individuals empowered with health dollars will begin to act like consumers of health care,” explained a Manhattan Institute fellow in the *Wall Street Journal*.¹⁴

At the same time, economic theory holds, consumers’ careful choices will necessarily enhance their well-being. Choice increases consumer welfare primarily because every consumer knows better than anyone else what makes her happy. Each consumer can make better decisions than anyone else could

8. See generally Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 AM. ECON. REV. 531 (1968); Peter Zweifel & Willard G. Manning, *Moral Hazard and Consumer Incentives in Health Care*, in HANDBOOK OF HEALTH ECONOMICS: VOLUME 1A 409 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000).

9. See Pauly, *supra* note 8, at 531, 534–36; Zweifel & Manning, *supra* note 8, at 412–15.

10. See Pauly, *supra* note 8, at 531, 534–36; Zweifel & Manning, *supra* note 8, at 412–15.

11. Regina Herzlinger, *The Quiet Health Care Revolution*, 115 PUB. INT. 72, 89 (Spring 1994).

12. See Pauly, *supra* note 8; Zweifel & Manning, *supra* note 8.

13. Milt Freudenheim, *Employees Are Shouldering More of Health Care Tab*, N.Y. TIMES, Dec. 10, 2001, at C6.

14. David Gratzner, *HSA Man vs. Healthzilla*, WALL ST. J., Oct. 12, 2004, at A22.

make on her behalf. Choice also increases consumer welfare because the experience of freedom is part of the “utility” consumers derive from having choice in the first place.

Indeed, the health sector has been more dramatically reconfigured according to market theory than any other sector of social policy. Starting in the 1970s, employer-based health insurance plans shifted from indemnity insurance (where a patient’s medical needs determined how much the insurer reimbursed) to pre-paid, capped-budget forms of insurance.¹⁵ Many plans placed annual and sometimes lifetime caps on specific benefits, such as mental health treatment or physical therapy, so that patients were required to ration their own treatments during the period of the cap.¹⁶ For people with disabilities, many programs have replaced the indemnity model of insurance with a cash-benefit model. Instead of providing all the services disabled people need, cash-benefit programs give them a fixed budget and let them choose how to spend it until the money runs out.¹⁷

Policymakers are thinking about similar approaches to restrain the burgeoning long-term care needs of the baby-boomer generation. Perhaps, as one prominent long-term care specialist suggests, we should rethink “whether public programs and private market efforts should offer a defined set of services (the indemnity approach) or provide a cash benefit (the disability approach) that allows the consumer to decide how to use available resources to meet his or her long-term care needs.”¹⁸ This is a fancy way of describing the shift from the current Medicare program to the individual health savings accounts that the Bush Administration promotes. From its inception, Medicare (and Medicaid) guaranteed its beneficiaries a defined set of services, based on their medical needs. The savings account approach would guarantee them a fixed sum of money from which they would pay for their care. If their care needs exceed their accounts, so be it.

In all of these ways, market reforms invite people to treat their health as a consumer good and to approach diagnostic, curative, preventive, and rehabilitative services as if they were part of the family market basket. Other reforms, such as the one in Missouri, address the consumption of health

15. See Jon R. Gabel et al., *Withring on the Vine: The Decline of Indemnity Health Insurance*, HEALTH AFF., Sept.-Oct. 2000, at 152 (describing the drop in indemnity health plans in job-based coverage).

16. See ALAN L. OTTEN, MILBANK MEMORIAL FUND, MENTAL HEALTH PARITY: WHAT CAN IT ACCOMPLISH IN A MARKET DOMINATED BY MANAGED CARE? (June 1998), available at <http://www.milbank.org/mrparity.html>; Patricia Anstett, *Cost of Rehab Can Put New Limits on Patients: Insurers Often Cap Coverage for the Latest Spinal Cord Injury Treatments*, DET. FREE PRESS, Jan. 22, 2007, at N1 (discussing lifetime limits on physical therapy coverage).

17. See Robyn I. Stone, *Providing Long-Term Care Benefits in Cash: Moving to a Disability Model*, HEALTH AFF., Nov.-Dec. 2001, at 96, 99–100.

18. *Id.* at 96.

insurance as opposed to health *care*. “Consumer-directed insurance” invites people to choose carefully among health insurance plans so that they might obtain the financial resources that best enable them to meet their future (as yet unknown) health care needs.

Market theory is so influential that public policy encourages health care *providers*, too, to behave like judicious consumers. If patients are supposed to monitor their consumption of insurance and medical care, providers are supposed to monitor their consumption of reimbursements (or revenues), allocating their fixed budgets to their highest-priority needs. Diagnosis related groups (DRGs), a system of fixed, per-diagnosis hospital reimbursement that replaced the old cost-plus method of paying hospitals, pushes hospitals to discharge patients who do not “pay their own way” in reimbursements. Following the transition to DRGs, prospective payment systems have been applied to nursing homes, home health care, and outpatient care, causing each type of provider to regard patients as “profit centers” or losses, not merely as humans in need of care.

II. COST-CONSCIOUS HEALTH CARE CONSUMPTION

To go back to the story at the beginning of this article, Audrey Simms is one of those Missouri state employees who was given a choice between two health insurance plans.¹⁹ Even though she has fairly high routine medical costs, she chose the low-monthly premium plan to save on her monthly bills.²⁰ She takes home about \$1,230 a month.²¹ Her daughter has sickle-cell anemia and gets hospitalized frequently, costing Ms. Simms a \$200 co-payment per admission.²² Living on \$1,230 a month, Ms. Simms really had no choice but to take the low monthly premium/high deductible plan, even though the other plan would have cost her less in the long run.²³ She simply did not have the cash flow to afford the higher premium plan.

Like Ms. Simms, when people live at the margin, they are apt to choose the option with lowest short-term costs over the one with the lowest long-term or total costs. People living at the margin—and that margin may be well up into the middle class when families face chronic disease, disability, job loss, income decline, and all the other factors that make for economic squeeze—are simply not able to behave like the rational economic actors of consumer choice theory. They cannot afford to take the long-term view. They are forced to be “penny wise and pound foolish.”

19. Martinez, *supra* note 1.

20. *Id.*

21. *Id.*

22. *Id.*

23. *Id.*

It is bad enough that many consumers can not afford to behave rationally in an economic sense. Under constrained budgets, consumers are unable to behave rationally in a clinical sense either. Ms. Simms is supposed to take several drugs for chronic conditions, but with the high co-payment plan, she faces a squeeze every time she has to decide whether to fill a prescription. “Audrey Simms can’t afford to get all three of her prescriptions filled each month. So she alternates, sometimes skipping her thyroid medication, at other times forgoing her acid-reflux pills or her hormone treatment.”²⁴

When health care consumers are given the “freedom” to allocate limited care dollars, they are pushed to choose on the basis of cost, not medical criteria. Co-payments and other up-front costs are intended to make people economically conscious, and indeed, they do push economic criteria to the forefront of consumer consciousness, displacing medical criteria.

What does it really mean to become a cost-conscious consumer of health care? To understand how cost-conscious consumers use health care, we have only to look at people who lack health insurance. As consumer choice advocates never tire of saying, nobody is more cost-conscious than someone who has to pay their full medical care bills by themselves. And what we know from voluminous studies of the uninsured is that people without health insurance are not—*cannot be*—wise consumers.

When people are uninsured, they postpone or avoid doctor visits, do not fill prescriptions, and fail to seek or continue prescribed follow-up care.²⁵ Under tight budget constraints, they choose between filling this prescription or that prescription, between taking the prescribed doses or skipping doses, between getting themselves treated and getting another family member treated, or between having their chest pains checked out or not. They often delay seeking professional advice, and even when they do seek advice, they often go without appropriate care.

“Like many elderly people on fixed incomes,” the *Wall Street Journal* wrote about a New York City woman who has no health insurance, “Ms. Kaur often tries to stretch her prescriptions—and her budget—by skipping doses [of her glaucoma medication] for days and weeks at a time. Sometimes she stops taking a medication if she doesn’t feel it’s working well. Sometimes she ignores a doctor’s advice because she can’t afford the prescriptions.”²⁶ Ms. Kaur is blind in one eye from her glaucoma, and is at high risk of developing glaucoma and losing sight in the other eye.²⁷ One ophthalmologist who has

24. Martinez, *supra* note 1.

25. COMM. ON CONSEQUENCES OF UNINSURANCE, INSTIT. OF MEDICINE, CARE WITHOUT COVERAGE: TOO LITTLE, TOO LATE 28 (2002).

26. Lucette Lagnado, *Uninsured and Ill: A Woman is Forced to Ration Her Care*, WALL ST. J., Nov. 12, 2002, at A1.

27. *Id.*

seen her says she needs to be monitored closely, but her pattern of seeking care is “erratic.”²⁸ She owes hundreds of dollars to the clinics she has visited over the years.²⁹ “Ms. Kaur has become a virtual fugitive from health care—or at least from hospitals and clinics to which she owes money,” the *Wall Street Journal* explains.³⁰

People without health insurance do not get immunizations, cancer screening tests, dental hygiene, and other preventive services nearly as often as people who do have insurance. They receive much less care for chronic conditions. They are unable to take (because they cannot afford) prescription drugs regularly, or to undergo monitoring and follow-up care. Uninsured people with hypertension, for example, are less likely to have their blood pressure monitored and to begin or stay on drug therapy. Uninsured people with diabetes are less likely to have their blood glucose monitored and controlled. As a consequence, the uninsured are more likely to suffer more severe consequences of their illness and injuries; they are more likely to die from them. Women with breast cancer, for example, have a 30% to 50% higher risk of dying from it if they are uninsured than if they are insured.³¹

What about people who do have health insurance? Do they behave any differently when their plans require them to bear more of the costs of care and thus behave more cost-consciously? A RAND study of 90,000 people with chronic diseases such as diabetes and hypertension found that doubling co-payments for prescription drugs results in a 10% to 12% decrease in use of drugs for those conditions.³² Other studies have found similar inverse relationships between cost-sharing and use of essential drugs.³³ One Nebraska man, to “prepare” for the likelihood that his Medicaid benefits would be cut, began taking less of his diabetes medicine and “stockpiling” pills for later.³⁴

There is indeed price elasticity in health care consumption, just as economic theory predicts. But elasticity in medical consumption decisions is a good thing only if there is a corresponding “clinical elasticity” in health status when patients consume their medical care as if it were a discretionary good. If a person with high blood pressure takes his hypertension medicine only 90% of the time, does he receive 90% of the protection against stroke? Or—more likely—does his risk of stroke rise dramatically because of his erratic blood pressure control? Ms. Kaur, the uninsured woman with glaucoma who was the subject of *Wall Street Journal* story on the uninsured, once “stretched her

28. *Id.*

29. *Id.*

30. *Id.*

31. COMM. ON CONSEQUENCES OF UNINSURANCE, *supra* note 25.

32. *See* Martinez, *supra* note 1.

33. *Id.*

34. Sarah Lueck, *Facing A Crunch, States Drop Thousands From Medicaid Roles*, WALL ST. J., June 26, 2003, at A1.

cache of prescriptions out for more than a year by using them only when her eye felt its worst.”³⁵ She told the reporter that she thought to herself, “‘Why am I wasting the money’ on doctor visits?”³⁶

Consumer-driven medical care decisions would seem to undermine the basic tenets of preventive medicine: regular check-ups, monitoring, and compliance with prescribed therapies. Medical care decision-making by the uninsured and the underinsured is the clinical equivalent of “penny wise and pound foolish.” Market reforms that offer people more choice over how they spend less money will generate “penny wise, pound foolish” medical care.

Cost-conscious health care decisions are often terrible clinical decisions because they substitute relatively uninformed lay decision-makers for highly-trained expert decision-makers. In tight straits, with not enough money to pay for all needed medical care, consumers ration their own care. They engage in *self-prescribing*, deciding which prescriptions to fill, and how much medicine to take. They engage in *self-referral*, deciding when and whether to seek medical help largely on the basis of cost instead of on the basis of medical need or their own concerns about their symptoms. They engage in *self-triaging* instead of letting professionally trained personnel make these judgments. This is perhaps the worst feature of the consumer choice approach: it substitutes lay judgment for professional judgment. It undermines the professionalism and expertise that is supposed to be at the heart of modern medicine. It undermines the evidence-based decision-making that we otherwise try so hard to promote in the health care system.

III. INFORMATION IS NOT A SUBSTITUTE FOR MONEY AND SERVICES

The theory of consumer choice says that if people have enough information and the right kinds of information, they can make the best decisions that will yield the greatest individual and collective welfare. Better information and better ways of distributing information are the answers to all the problems with consumer sovereignty. But this part of the theory is as flawed as the rest.

One major arena for consumer choice is health insurance. In theory, if consumers choose among different insurance plans by finding the plan best suited to their medical needs, health care expenditures will be spent in the most efficient way possible for society as a whole. Under consumer choice reforms, people are exhorted to make wise health insurance purchasing decisions. In an article tellingly titled, “Your Health Plan’s New Math,” the *Wall Street Journal* advises, “Whether a plan is a good buy or a bad one will depend, in part, on your health care needs.”³⁷ Exactly, and therein lies a problem.

35. Lagnado, *supra* note 26.

36. *Id.*

37. Ruth Simon, *Your Health Plan’s New Math*, WALL ST. J., Oct. 15, 2003, at D1.

When choosing among health insurance plans, consumers need to take into account their current health status, how it is likely to change, what illnesses and injuries they are likely to get, what care and drugs they are likely to need, and what drugs and new treatments are likely to become available. If they are choosing insurance for family members, they have to assess all these factors for other people as well.³⁸ Yet, people cannot know most of these things. Few of us are very well informed about specific diseases and their treatment until we get sick with one of them. And to the extent future health care needs are unknowable, choosing health insurance plans wisely requires unknowable information.

Making good choices among prescription drug discount plans is equally difficult. Different plans cover different drugs; different drugstores honor different cards. Consumers can shop on the basis of what drugs they are currently taking, but if their needs change, the benefits or savings they derive from their card will change, too.³⁹ When the new Medicare benefit plan was rolled out in May 2004, most consumers were baffled. One woman studied her options and found she faced “73 competing drug discount cards, each providing different savings on different medications and all subject to change.”⁴⁰ “Even the person who came to explain it to us didn’t understand it,” said a woman who had attended an education session at a senior center.⁴¹ A *U.S. News & World Report* article concluded that a person would need multiple cards to increase the odds that their drugs were covered and that the advertised features of cards are so disparate that “comparison shopping is all but impossible.”⁴²

Good consumers are supposed to take into account their own “tastes and preferences”—how they feel about their medical status, how much their symptoms bother them, how much they care about their health relative to other things they value, and how much they can tolerate risk. These feelings are also uncertain. People do not know very well how they are going to feel about discomfort, pain, and disability until they experience them, or how frightened they will be about a risk until they confront it.

Whether the choices are clinical or financial, health care choices are inherently complex and unwieldy. Even if people could have all the answers to the relevant questions about their health care choices, sometimes “enough” information makes choices too complex, overwhelming, and even paralyzing. Social psychologists find that most people experience “information overload.”

38. *Id.*

39. See U.S. GEN. ACCT. OFF., *PRESCRIPTION DRUG DISCOUNT CARDS: SAVINGS DEPEND ON PHARMACY AND TYPE OF CARD USED* 17 (Sept. 2003).

40. John Leland, *73 Options for Medicare Plan Fuel Chaos, Not Prescriptions*, N.Y. TIMES, May 12, 2004, at A1.

41. *Id.*

42. Avery Comarow, *Plastic Price Cuts?*, U.S. NEWS & WORLD REP., Apr. 15, 2002, at 74.

Even when people are offered a very limited range of alternatives, as is often the case with health insurance plans, if each option has several important features that must be compared, the decision becomes overwhelming. People are likely to oversimplify and ignore some factors.⁴³ For example, in simple consumer choices among chocolates or jams, items much less emotion-laden than health care, people faced with more than about six options find the experience of choosing unsatisfying and are more likely to decide not to buy anything rather than choose among the options.⁴⁴

What about choosing medical treatments once a person is already ill? A huge infrastructure of “informed consent” is supposed to ensure that patients have the proper information before they make choices, especially choices about invasive diagnostic tests, surgery, and highly risky treatments and procedures. Armed with good information, each patient can in theory take responsibility for the quality of his or her care. But informed consent is often a *pro forma* ritual that discourages patients from asking too many questions and thinking hard about their choices.⁴⁵ Patients are apt to have long legalistic forms thrust at them and are told to sign. The forms are typically administered by non-medical, clerical staff who do not understand the first thing about the medical issues confronting the patient.

A few years ago, I went into a hospital for a breast biopsy. (It was benign.) The admitting clerk handed me a consent form, saying, “This just allows us to bill your insurance company.” I read it over. Billing my insurer was only one of about six or seven things for which the form asked my permission. Most notable to me was authorization for the hospital and its physicians to do anything to me they deemed necessary while I was in their custody. Given that I was going in for a breast biopsy and given the history of breast cancer treatment—namely radical mastectomies performed at the surgeon’s discretion without consultation with the woman—I found this consent form horrifying, no matter that I had discussed this very issue with my surgeon and that she had assured me she never did surgical treatment or even lymph node dissections at the same time as the initial biopsy.

I pointed out to the admitting clerk that the form was about more than permission to bill my insurer. “Oh really?” She professed surprise. Only faith in my doctor, not the law, gave me any sense that I had some control over the medical “choice” I was making. Moreover, facing the possibility of breast

43. See Russell Korobkin, *The Efficiency of Managed Care “Patient Protection” Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 51–54 (1999).

44. BARRY SCHWARTZ, *THE PARADOX OF CHOICE: WHY MORE IS LESS* 19–20 (2004) (citing Shanto Iyengar & M. Lepper, *When Choice is Demotivating: Can One Desire Too Much of a Good Thing*, 79 J. PERSONALITY & SOC. PSYCHOL. 995 (2000)).

45. See RUTH FADEN & THOMAS A. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* 91–100 (1986).

cancer and having already considered three different surgeons, I did not feel I had any choice about whether to have a biopsy or whether to have it at this hospital rather than another. The hospital's informed consent procedures did not add anything to the information I had already gathered, nor did they make me feel any more "free" in my decision to undergo the procedure.

The inadequacy (if not sham) of informed consent is a topic unto itself, but one new development in patient information has probably done more than anything else to decrease the effectiveness of informed consent procedures. Ever since the implementation of the Health Insurance Portability and Accountability Act privacy regulations in 2003,⁴⁶ every medical encounter now begins with patients being handed a privacy notice and told they must sign it. What they are actually asked to sign is an acknowledgment that they have received a copy of the provider's privacy policies with respect to medical information, but few patients understand that distinction. The privacy notices are typically two to four pages long, written in bureaucratese. One notice I received (from Concord Imaging Center in Concord, New Hampshire) was four pages, single spaced—just to have to an ultrasound examination. I would not have had time to "read it carefully," as the instructions in bold capital letters at the top of the first page urged me to do, even had I wanted to. Most patients believe they must sign the privacy practices form in order to receive treatment, and few bother to read these notices. Thus, a law meant to enhance patient rights probably has the perverse effect of inuring medical consumers to printed information.

At Concord Imaging Center, there is a large wooden wastebasket just inside the door to the waiting area. A sign taped to the side of the basket says, "Please Discard Unwanted Privacy Notices Here." On a recent day at about 5 p.m., the basket was two-thirds full of white and yellow sheets. The white sheets were the four-page description of the Center's privacy policies. The yellow sheets were the patients' copies of the form they had signed acknowledging they had received the white sheets. The wastebasket, it seems to me, is pretty good measure of how much consumers value the information they receive.

46. In 2002, the Department of Health and Human Services (HHS) promulgated regulations governing the use of personal medical information by health care providers and insurers. 45 C.F.R. §§ 164.500–164.534 (2003). These regulations were mandated by the Health Insurance Portability and Accountability Act of 1996 and went into effect on April 14, 2001, though health care entities did not have to comply with rule until April 14, 2003. U.S. Dep't of Health & Hum. Servs. Off. for Civ. Rts., General Overview of Standards for Privacy of Individually Identifiable Health Information (Apr. 2003), available at <http://www.hhs.gov/ocr/hipaa/guidelines/overview.pdf>.

IV. CONSUMER CHOICE AS PUBLIC PHILOSOPHY

Even at the very core and essence of medical care—clinical decision-making—the ideology of consumerism has made its mark. Before the rise of market thinking in health policy, American culture located medicine firmly in the domain of science. Physicians and medical researchers, as Paul Starr noted in his history of American medicine, exercised an almost unquestioned cultural authority.⁴⁷ Whatever doctors prescribed or recommended, insurers and patients tried to obtain. Third party insurers saw their role as helping patients afford whatever doctors recommended.

Over the second half of the twentieth century, the sheer technical capacity of medical personnel to perform helpful diagnostic, therapeutic, and rehabilitative procedures fuelled an explosion of health care costs. Economic theory, though, blames most of the cost growth on distorted consumer incentives. Insurance, or third party payment, the theory goes, removes budget constraints from patients and allows them to think of medical care as free. Without economic constraints, patients are wont to accept medical advice uncritically and run up the medical tab with abandon. (Remember Herzlinger decrying the lack of “consumer vigilance.”)⁴⁸ Based on this economic theory, the gist of most health insurance reforms since the 1970s was to “restore” proper economic incentives to patients—in other words, to get people to think of health care as the consumption of material goods rather than as the receipt of professional advice and help.

This shift in cultural thinking about the nature of medical care began with a simple idea: cost is one dimension of medical care, not the only dimension, but a dimension that ought to be considered when people make decisions about their care. Professional judgment would still be the most important aspect of clinical decision-making. Almost inevitably, however, once the door was opened for lay people to participate in clinical decision-making as consumers, lay judgment gained a kind of authority and weight almost equal to professional judgment. Worse, the rhetoric of consumer empowerment disguises the real social trade-offs behind the consumer choice movement. Under the twin banner of “consumer freedom” and “citizen power,” consumer choice reforms such as Missouri’s new health insurance plan actually take away resources and options. The bottom line: citizens like Ms. Simms get less medical care and probably suffer poorer health.

The story of Missouri’s health insurance reform for state employees reflects the general trend in American social policy: give people less help, but more choice. Give them meager allotments, but wax eloquent about how they are getting “options” and “autonomy” and “freedom of choice.” It is a trend toward replacing substance with process, toward replacing actual social aid

47. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 4–5 (1982).

48. See Herzlinger, *supra* note 11, at 89.

with mechanisms of consumer choice, and toward replacing a commitment to meeting individuals' needs with a commitment to meeting collective budgets.

Contemporary American social thought is enamored of the consumer choice idea. No matter what the problem—education, housing, retirement income, or health care—consumer choice promises to contain costs and enhance quality by empowering citizens. By giving people “ownership” of the resources to meet their needs, as George W. Bush called his bids for privatization of Medicare and Social Security during the 2004 campaign, government can harness consumers' savvy and energy to make health care or any social service more efficient and effective. We see the same trend in the shift from defined-benefit to defined-contribution pension plans, in the push to replace Social Security and Medicare with private savings accounts and individual investments, in the move toward individually-spendable vouchers to replace public schools and public housing, and in replacement of a welfare entitlement with a limited lifetime budget of social assistance.

The consumer choice approach to social policy represents a cynical turn in American public philosophy. It is cynical to think that people will feel better about deprivation or bad outcomes as long as they believe they have had a hand in choosing their fate. Instead of giving people greater access and higher-quality care, as the theory holds, consumer choice offers citizens procedural comfort but less substantive help. More often than not, “consumer choice” and “consumer direction” are glittery wrappings in which employers, insurers, and politicians package benefit reductions, program contractions, and budget cuts.

Giving people a budget that is too small for their needs does not give them the experience of freedom. Instead, they experience every decision not as a free choice but as a terrible trade-off. Ms. Simms told the *Wall Street Journal* that her drugs now cost her as much as \$40 each in co-payments. “So I decide between . . . medicine and . . . food. . . . And I have a 12-year old daughter to feed.”⁴⁹ I doubt Ms. Simms feels liberated by having made her choice or that her welfare has been improved by having had a choice to make. She could not have afforded the other high monthly premium plan either, so it seems unlikely that having a choice “softened the blow” when Missouri cut her benefits.

Giving people freedom to make their own clinical choices is not likely to improve access and quality of care so long as they have to make decisions in the context of very strained financial resources. So long as they must factor finances into their every medical care consumption decision, they are apt to choose on the basis of costs, not medical criteria. They will ration their own care, decide for themselves when to seek professional advice, which drugs to take, and which tests and treatments to undergo. Consumer choice elevates lay decision-making over professional and expert decision-making. By most definitions of quality, health care suffers.

49. Martinez, *supra* note 1.

Health and medical care are rife with uncertainty. Health financing and medical care choices are gambles. Whether the gambler wins or loses depends not so much on the wisdom of the choice but on the luck of the draw. The imagery of better information and informed decision-making shifts moral responsibility onto individuals. Through the theory of consumer choice, citizens are taught to believe that if they lose the great health sweepstakes, if they need more care than they can afford or than society is willing to provide them, or if their diagnostic and therapeutic decisions do not pan out as they hoped, it is their own fault. They could have made better choices.

Consumer choice theory is thus an ideology. It is a way of seeing the world, and particularly, a way of interpreting social justice. It is a philosophy that minimizes communal obligations to citizens, maximizes individual responsibility for one's own well-being, and tolerates great inequalities in well-being as morally acceptable. It replaces a social commitment to meeting needs with commitment to meeting budgets. It uses the rhetoric of "freedom" and "autonomy" to justify the abdication of social responsibility and the failure to provide appropriate and compassionate care.

There is an alternative vision. Instead of individuals being responsible for their own health and well-being, communities are responsible for the well-being of their members. Yes, individuals bear responsibility to act wisely, with foresight, restraint, and creativity, but they do not and cannot control all that happens to them, most especially not in the realm of health. That is why we live in communities. We hope to help the people we love and we hope that other people will care about us and help us when we are in need.

