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RETHINKING THE HEALTH CARE DELIVERY CRISIS: THE NEED FOR A THERAPEUTIC JURISPRUDENCE

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The intense debate over national health policy seems to reflect a new consensus about the need to overhaul our health care delivery system. As the nation moves toward health care reform, we must ensure that we create a system that is fair, that provides incentives both to reduce costs and encourage wellness, and that is sensitive to the delivery system's inevitable impact on patient health.

Health care costs are estimated at \$940 billion a year. These costs have escalated so dramatically—approximately ten percent a year—that even many in the middle class must go without adequate health care or obtain it only at great personal sacrifice. This is especially true for increasing numbers of people who cannot afford health insurance. One suggested solution is to require employers in businesses over a specified size to provide a certain level of health insurance for full-time employees. But the cost of insurance has risen so sharply that many employers will respond by hiring certain employees only on a part-time basis in order to avoid this requirement. The demand for a system of national health coverage has thus increased.

In designing a sensible system of national health insurance we need to avoid a repetition of the built-in inflationary pressures that followed the adoption of Medicaid and Medicare. Medicaid and Medicare eligibility encouraged many to increase their use of health care services, in part because they no longer needed to bear the costs (or full costs) of services. This increased demand, exceeding the supply of health care services, predictably produced price hikes. Other factors undoubtedly have contributed to the escalation of health care costs, including the tendency of some doctors to order unnecessary diagnostic tests, over-reliance on high technology, and the general unresponsiveness of medical costs to competitive pressures. But the increased demand produced by Medicaid and Medicare probably played a role. This is simple economics.

Freed of the disincentive of having to pay for, minimize, or avoid unnecessary services, many individuals overused health care, leading to problems of waste and inefficiency. For many customers, going to an "all-you-can-eat" restaurant where a fixed price buys an unlimited quantity of food seems to produce overeating. Similarly, a health care reimbursement scheme that reduces the disincentive to be parsimonious in the utilization of services will predictably produce inappropriate and inefficient use of resources. This is simple psychology.

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Moreover, when demand for services is unchecked by considerations of cost, their price remains unchecked by the pressures of competition. In a health care system in which someone else pays the bills—government or an insurance company—and in which providers can increase their profits by selling more, or more expensive, services, there is bound to be a constant escalation in services. Imagine if, in the all-you-can-eat restaurant, the restaurant gets paid by someone other than the customer based on the quantity of food consumed.

Similar problems have haunted health maintenance organizations (HMOs). HMOs are designed to encourage more preventative approaches by placing incentives on providers to keep consumers enrolled in their programs healthy in order to avoid the provision of more expensive treatment services. This is a good idea, placing the emphasis on wellness services, giving the provider an incentive to keep the patient healthy, and avoiding the incentive to provide unnecessary services in order to increase profits. However, these plans probably also have produced excess and inefficient service utilization by consumers, driving up costs to providers and discouraging many from offering services on an HMO basis. Providing valued services without any marginal cost to the consumer predictably will have the effect of reinforcing the *use* of such services, not necessarily their *appropriate use*.

A number of methods of cost containment have been discussed, including utilization review, upper limits on specified services, and price controls. In addition to these, we need to recapture, at least to some extent, the incentive for people to use health care services appropriately and efficiently. When people must pay for services out of their own pockets, they have a greater incentive to use only those services that they really need. Requiring people to pay out of their own pockets, however, is not truly possible for the increasing numbers in our society who lack pockets that are deep enough.

Instead of structuring national health insurance on a Medicaid-type reimbursement basis, we might develop an approach in which a specified level of health care dollars is guaranteed to any individual (or any individual within certain income categories). Any expenditures in excess of this amount would be subject to a co-insurance-type sharing in which the individual would pay a specified percentage of the extra costs, say twenty percent. To discourage consumers from spending the specified amount even if they do not need to do so, we might similarly allow them to receive a percentage of the unspent portion, for example, twenty percent or fifty percent. The proposal would not use a deductible amount, as some insurance schemes do, under which the individual must pay the first several hundred dollars before reimbursement could start. In the health care context, such a deductible may have the unintended effect of discouraging some people from obtaining important diagnostic and preventative services in order to avoid paying the deductible.

Such preventative services, designed to keep people healthy and avoid more expensive treatment, should be encouraged rather than discouraged. The system should be structured so as to remove impediments to preventative approaches, some of which (for example, immunizations and nutritional counseling) could be available at reduced costs in order to encourage their utilization. In addition, services classified as preventative could be exempted from "co-insurance" or cost-sharing, or could be made the subject of cost-sharing at a reduced rate to the consumer. In these ways the health care

system can be reconceptualized as a wellness system rather than merely as one designed to respond to and treat illness. By encouraging wellness services and providing the individual with a cash incentive to stay healthy, the system would be employing a form of "wagering" or behavioral contracting with individuals to look after their own health.²

To further encourage proper utilization of services, the cost of obtaining a second opinion prior to certain types of surgery or other expensive or hazardous interventions could be exempted from co-insurance or otherwise subsidized. Getting a second opinion would allow patients to avoid unnecessary services, and may produce added confidence in the need for appropriate services, a feeling that may in itself increase their therapeutic value.

The specified annual amount of health care payment guaranteed each individual could be set legislatively, or through use of a flexible administrative process that each year could establish the amount in light of changing circumstances, much the way the New York City Rent Stabilization Board each year specifies permissible limits for increased rent for apartment lease renewals. Such an annual adjustment would also function as a mechanism of health care cost containment, limiting the inflationary spirals that we have had in recent years. The specified annual amount could either be identical for all individuals, or vary with income level in accordance with a principle similar to the one used in the progressive income tax. Above certain income levels, perhaps determined as a matter of adjusted gross income for federal income tax purposes, an individual's or family's health benefits might decrease and be eliminated altogether when income exceeds higher levels.

There are several categories of patients for which the limits on reimbursement and the incentive scheme suggested here could not work or would work imperfectly. Those born with certain conditions, such as Down's syndrome or cerebral palsy, will require more medical care at considerably higher expense, and hence should not be subject to the same reimbursement limits applicable to most people. Similarly, those experiencing catastrophic illnesses or accidents—cancer, AIDS, or an auto accident leaving them paralyzed, for example—cannot control their health needs and will require additional help as a matter of equity. Moreover, veterans who have suffered service-related disabilities, for which under our long-standing tradition they receive free care from Veteran's Administration facilities, have a legitimate entitlement claim to the continuation of such care that should not be disturbed by the restructuring of our health care system applicable to people generally. The elderly similarly should be given special consideration. Advancing age itself produces increased health needs. At least those whose income has fallen below certain limits as a result of retirement or partial retirement should be eligible for a higher degree of eligibility for reimbursement. In addition, some adjustments in eligibility may need to be made for the poor, or at least for those

²See Bruce J. Winick, *Harnessing the Power of the Bet: Wagering with the Government as a Mechanism for Social and Individual Change*, 45 U. MIAMI L. REV. 737 (1991).

eligible for welfare, who cannot be expected to share in the costs of their medical care.

Caring for the health needs of those with congenital abnormalities or other severe disabilities, those suffering catastrophic illnesses or injuries, veterans who have become injured in the defense of their country, and the poor and the elderly will be expensive. But an emerging social consensus regards the provision of basic health care for those in our community who cannot afford it for themselves to be a matter of equity. For others, however, a system employing reimbursement limits, cost-sharing, and incentives toward wellness and appropriate and efficient service utilization seems appropriate.

Paying for the high cost of a new national health care delivery system will require creative approaches. The proposal that a portion of the amounts needed should be raised through a special tax on tobacco and alcohol is a good one. Use of these substances undeniably causes serious health risks and necessitates costly treatment services. Taxing their sale in a way that discourages their use can be defended as a public health measure in addition to providing a source of revenue for paying for the health needs of all. Similarly, a special tax can be considered for certain "junk foods"—those with little nutritional value that pose risks to health. These should not be considered "sin taxes," as some have termed them, but rather as methods of discouraging unhealthy practices and requiring those who persist in being unwise to internalize the costs of their bad habits.

If the new health care system works as intended, it may help to pay for itself through increased productivity. Preventative approaches will lessen employee absenteeism and lengthen the productive lives of workers. Although the added tax revenues thus produced may be difficult to estimate, they could go a long way toward paying for the added cost of ensuring universal health coverage.

The reimbursement scheme could be structured to use a "voucher" system in order to harness the psychological power of choice. Individuals like to make decisions for themselves. Indeed, allowing an individual to choose his or her own health provider or type of service would produce not only greater patient satisfaction, but predictably also would increase the efficacy of treatment.³ Expectancy theory and other principles of social and cognitive psychology support the prediction that people will respond better in a variety of therapeutic situations, with a higher degree of compliance with treatment recommendations, when they have a measure of choice in regard to both the treatment itself and the selection of the provider of services. For these reasons, the restructured health care system should reject the approaches of some health insurance schemes and managed care proposals that restrict patients to a list of providers or that assign them to particular providers. These approaches ignore the psychological power of choice and may actually reduce the effective

³See Bruce J. Winick, *Competency to Consent to Treatment: The Distinction between Assent and Objection*, 28 HOUS. L. REV. 15 (1991); Bruce J. Winick, *On Autonomy: Legal and Psychological Perspectives*, 37 VILL. L. REV. (forthcoming, 1993).

provision of services as well as patient satisfaction, compliance, and positive response.

The private market would presumably adjust for varying demands for different kinds of providers and services by providing a wide array of such services that consumers could purchase with their "vouchers." In economic terms, the market would respond to consumer demand by providing differing services to meet different individual demands, and competition for health vouchers would keep prices down and produce an efficient and rational allocation of resources.

There are problems, however, with "voucher" systems. Food stamps are illustrative. A secondary market is often created in the vouchers, which may defeat the purpose of the program. For example, in some cities there exists a black market for food stamps in which some individuals barter their stamps for money or other commodities (including illicit drugs or alcohol). In order to avoid such a secondary market, and the high administrative costs of having a bureaucracy involved in the issuance and redemption of vouchers, the program could use some credit card-type arrangement in which individuals would be issued a credit card with which to charge their health services, or perhaps those with existing credit cards could use them. This would decrease the potential for fraud, and because the "voucher" would not be negotiable bearer paper, would make it difficult for the development of a secondary market in vouchers. The use of already existing credit cards, or the provision of incentives for credit card companies to develop and administer the use of a card for this purpose, could minimize the potential bureaucratic inefficiencies of having government itself play the major operational role.

Employers should be encouraged to provide a variety of health insurance and health care packages for their employees which employees can elect as alternatives to the credit card voucher system guaranteeing the specified limits of services described above. Perhaps tax credits could be used to provide an incentive for employers, the way tax incentives have been used to encourage the construction of low-income housing. Providing incentives to employers to participate in solving the health care delivery problem may be preferable to requiring them to do so in ways that might produce unanticipated negative effects, such as reduction of full-time positions.

In redesigning the health care delivery system, we need to be sensitive to the inevitable impact of the system we develop on patient health.⁴ We should therefore build in appropriate incentives for the proper utilization of preventative approaches, for patients to assume responsibility for their own health, and for efficient and effective use of services generally. We also need to

⁴See DAVID B. WEXLER & BRUCE J. WINICK, *ESSAYS IN THERAPEUTIC JURISPRUDENCE* (1991); David B. Wexler & Bruce J. Winick, *The Potential of Therapeutic Jurisprudence: A New Approach to Law and Psychology*, in *LAW AND PSYCHOLOGY: THE BROADENING OF THE DISCIPLINE* 211 (James R. P. Ogloff ed., 1992); David B. Wexler & Bruce J. Winick, *Therapeutic Jurisprudence as a New Approach to Mental Health Law Policy Analysis and Research*, 45 U. MIAMI L. REV. 979 (1991).

maximize the opportunities for patient choice and control in matters of health care in order to realize the psychological benefits this can produce, increasing the efficacy of treatment, patients' sense of self-efficacy, and consumer satisfaction. The legal and regulatory structures we adopt can produce positive or negative consequences for individual and public health. In addition to considerations of equity and economy, we should take these therapeutic implications into account in redesigning our health care delivery system.