

CAN HEALTH LAW BECOME A COHERENT FIELD OF LAW?

Einer R. Elhaug^{*}

I. TO BE A FIELD OR NOT TO BE A FIELD—HOW DO WE ANSWER THE QUESTION?

I want to concede at the outset that health law, today, is not yet a coherent field of law. It is, rather, a disjointed set of statutes and doctrines, designed mainly with nonmedical cases in mind, based on different principles and paradigms, which are applied to health care issues in a way that not only lacks coordination but results in each undermining the other. One could hardly contend otherwise, given that we are talking about a field in which three of the most momentous decisions were made largely by happenstance: (1) the linkage of insurance with employment, the unintended result of World War II wage and price controls that failed to include benefits like health insurance in the calculation of wages, coupled with a tax decision that treated health insurance benefits as deductible to the employer but untaxable to the employee;¹ (2) the widespread deregulation of health coverage provided by those employers large enough to self-insure, the result of a federal statute called ERISA that tried to provide national uniformity in the regulation of employee pensions and benefits by preempting state regulations that related to employee benefit plans other than laws regulating insurance;² and (3) the end of many features of professional self-

* Petrie Professor of Law, Faculty Director of the Petrie-Flom Center for Health Law Policy, Biotechnology and Bioethics, Harvard Law School. I am grateful for helpful comments from Gregg Bloche, Norman Daniels, Richard Epstein, Barbara Fain, Jenn Geetter, Lawrence Gostin, Mark Hall, Clark Havighurst, Stephen Latham, Kristin Madison, Anup Malani, Joe Newhouse, Barak Richman, Alan Stone, and the participants in the “Rethinking Health Law” Conference at Wake Forest University School of Law.

1. See Carolyn Juárez, *Liberty, Justice, and Insurance for All: Re-Imagining the Employment-Based Health Insurance System*, 37 U. MICH. J.L. REFORM 881, 885-86 (2004).

2. Employee Retirement Income Security Act (ERISA) of 1974, 29 U.S.C. § 1144 (2000). For a while, even employee health benefits that did not involve self-insurance were often held to enjoy preemption from state regulations of managed care, such as laws requiring insurers to cover all willing providers or

regulation, the result in large part of an antitrust decision motivated to end attorney price-fixing.³ None of these decisions reflected any systematic plan about how to fund health care or how to regulate the behavior of insurers and providers.

The problem is not just the haphazard nature of the relevant lawmaking. We have that in many areas of law; think of all the random statutory intrusions and case law detours in torts, civil procedure, and corporate law. The problem is deeper—the lack of any common intellectual framework for thinking about those laws. Thus, even when judges, regulators, and legislators try to make a thoughtful decision about laws affecting health care, they tend to think of it within the paradigm of some separate legal field without thinking through whether their decision will be undermined by doctrines in the other legal fields that also affect health care actors.

But this lack of present cohesion hardly determines the issue. Plenty of legal fields that now seem to be coherent and fundamental building blocks of legal thought used to be similarly disjointed. Consider contract law. It now seems relatively well organized around bargaining principles and their limits. But there was a time when it was just a hodgepodge of odd subjects understood to be separate legal fields: the law of sales, the law of negotiable instruments, the law of insurance, the law of suretyship, the law of shipping and maritime contracts, and so forth.⁴ Then people like Langdell, Holmes, and Williston recognized the common issues that ran across these then-disparate fields and reorganized them into one.⁵ (Some of these fields later drifted off again, like the law of negotiable instruments, but no one said the definition of a field is

mandating independent external review of denials of care on the grounds that those state laws did not regulate insurance activities. Although such preemption of state regulation of employee health insurance has been narrowed by recent Supreme Court cases (at least where the state law remedy does not exceed the ERISA remedy of payment for an improper denial of benefits), wholesale preemption remains the rule for self-insured employers even when they contract with health insurers to administer their plans. See Russell Korobkin, *The Battle over Self-Insured Health Plans, or "One Good Loophole Deserves Another,"* 5 YALE J. HEALTH POL'Y L. & ETHICS 89 (2005).

3. See Clark Havighurst, *American Health Care and the Law—We Need to Talk!*, HEALTH AFF., July/Aug. 2000, at 90-92 (describing effect of *Goldfarb v. Va. State Bar*, 421 U.S. 773 (1975)).

4. See GRANT GILMORE, *THE DEATH OF CONTRACT* (1974).

5. See C.C. LANGDELL, *A SELECTION OF CASES ON THE LAW OF CONTRACTS* vii (Legal Classics Library 1983) (1871) ("It seemed to me, therefore, to be possible to take such a branch of law as Contracts . . . and arrange all the cases which had contributed in any important degree to the growth, development, or establishment of any of its essential doctrines."); OLIVER WENDELL HOLMES, JR., *THE COMMON LAW* 247-88 (Dover Publications 1991) (1881) (providing "a short account" of the growth of contract law); SAMUEL WILLISTON, *A TREATISE ON THE LAW OF CONTRACTS* (1920) (summarizing the basic principles of contract law).

forever.) We thus should be careful not to leap from observations about the present-day disorganization of those various legal areas we currently group under the label of health law to the conclusion that we are dealing with a legal terrain incapable of being organized into a coherent legal field.

To say that a legal field can be organized is not, of course, to say that its underlying principles remain uncontested. The contours and principles of contract law remain controversial, as does its understanding of what the common issues and their limits are. Grant Gilmore declared the “Death of Contract” a few decades ago,⁶ and some people continue to think it should be folded into torts or amalgamated into something called “contorts.” Others think contracts should be expanded into areas that remain unruly exceptions to the grand movement from status to contract, like family law. Whatever one thinks about these points of view, the point here is that controversy about a field’s contours and principles does not prevent it from being a recognizable field of law. Nor does it prevent it from being a useful vehicle for organizing discussion and thinking about issues. Even less does a field require agreement about the best policy goals. Many people teach contracts coming from all sorts of disparate normative perspectives, and yet they share in common a vocabulary for thinking about contracts issues that helps them to better pinpoint just where their disagreements lie and to see its connections to other issues in the field we call contracts.

So I think it is also a mistake to conclude, as some seem to, that continuing controversy about the proper organizing principles and normative goals of health law indicates that it cannot become a legal field. But should it be one? Certainly, health law is important. The health care industry now consumes fifteen percent of gross domestic product (“GDP”),⁷ and, given its highly regulatory nature, probably consumes an even higher percentage of legal practice. Those of us who train lawyers for a living clearly need to teach them the law relevant to this industry. And regardless of whether health law is a field of law, it certainly seems to be a distinct field of practice, with lawyers who specialize in it and clients who seek their expertise.

But legal fields defined around a particular industry have a checkered history in American jurisprudence, outside perhaps of maritime law, which appears to be grandfathered by long-lasting history—or possibly protected by sheer obscurity—from the sort of angst that pervades those in other industry-specific fields. Unless

6. GILMORE, *supra* note 4, at i.

7. Robert Pear, *Health Spending Rises to 15% of Economy, a Record Level*, N.Y. TIMES, Jan. 9, 2004, at A16.

the various parts of health law hang together conceptually, one might sensibly conclude that what lawyers need to know is not health law, but the various conceptually coherent bodies of law that are all separately relevant to the health care industry. In short, health lawyers may need to understand not health law, but the laws of antitrust, tax, corporations, contracts, torts, ERISA, and insurance law in all their separate glory, as well as a few specialized subjects like Medicare, Medicaid, certificate of need regulation, and corporate practice of medicine law.

Judging by the literature, academic norms now require me to make the obligatory reference to Judge Easterbrook's famous disparaging quip comparing cyberlaw to the "Law of the Horse."⁸ But, I must confess, I have always found this analogy more clever than illuminating. Easterbrook was certainly right that the fact that lots of cases deal with horses does not mean that the law of the horse is a legal field; issues about contracts involving horses are better resolved by considering contract law, issues about torts involving horses by tort law, and so on. Grouping these cases together does not illuminate any common themes, and thinking about them without thinking about nonequine cases in areas like contracts and torts misses many commonalities and presents only a subset of the issues relevant to thinking about those issues. So surely Easterbrook is right that even a lawyer who plans to exclusively advise people in the horse trade is better off taking courses in contracts and torts and the like that put the horse cases in context, rather than taking a course in the law of the horse.

But this analogy has little purchase because the example is so tendentious. No one thinks the relations of persons to horses might somehow be thought distinctive from their relations to other animals and property in a way that arguably merited separate legal treatment from other relations and created commonalities in understanding different legal issues that bore on relations in the horse trade. The last I checked, horses do not minister to sick persons in ways that others do not, are not governed by separate standards of care and professionalism, do not provide services whose cost is widely insured in a way that produces distinctive problems of over-consumption, do not constitute staff that run large institutions in a uniquely decentralized fashion, are not thought to deserve special tax breaks and antitrust solicitude in their joint dealings, are not thought to implicate moral rights to access, and politicians do not deem it politically untenable to allow open tradeoffs between the costs of horses and their quality. The set of legal relations we

8. Frank H. Easterbrook, *Cyberspace and the Law of the Horse*, 1996 U. CHI. LEGAL F. 207, 207 (1996).

call health law, on the other hand, is distinctive in all these ways and more.

To me, this suggests an important element in many things we routinely consider legal fields: does the purported field address the legal treatment of a distinct set of relations? Sometimes what makes a set of relations distinct is something relatively episodic, such as whether an agreement exists between the parties (contracts) or whether one party physically injured the other (torts). But many bodies of law involve relations that are thought distinctive in other ways, often with the implication that these more episodic bases for relational law must, to some extent, give way. Consider family law, which addresses the legal framework of relations between family members. Here, the ordinary rules of contracts, torts, and property are often varied in ways that subordinate them to understandings of what best advances the interests of familial relations. And although one could try to separately address each of these areas, there does seem to be some value added by thinking through how common issues regarding the family affect each of the legal doctrines that bears on familial relations.

Health law seems like family law in that sense, for it also addresses a unique set of relations among persons involved in the treatment of health problems.⁹ To be sure, the relation between a physician and patient is not the same as one between husband and wife, but neither are they the same as other relations. Relations between physicians and patients are intimate in ways that surely differ from husbands and wives (we hope!) but also are unlike our relations with anyone else. Our relations with physicians and other health care providers are commercial in ways unlike our relations with loved ones (again we hope!) but are also less commercial than other relations because legal norms and systems of financing are designed to lessen financial influences on our decisions.

Moreover, there are other bodies of law defined around distinctive commercial relations. Consider property law. This is essentially the body of law that defines the legal treatment of our relations to others vis-à-vis rights to use or exclude others from the assets or rights we call property. One could think of property as a mish-mash of other legal fields rather than a proper legal field at all. For property law has a little bit of contracts (agreements about the transfer or use of property), a little bit of torts (actions for injury to our property or rights), a little bit of administrative law (systems of filing with registrars to bind or notify the public), a little bit of

9. See Mark A. Hall & Carl E. Schneider, *Where Is the "There" in Health Law?: Can It Become a Coherent Field?*, 14 HEALTH MATRIX 101, 103-04 (2004) (arguing that health law should be thought of as a law of relational webs).

constitutional law (takings), and, in many recent property courses, what we might think of as innovation law (the intellectual property subjects of patents, copyright, and the like). But again there seems great value in considering these issues as a unit because there are commonalities about our relations to others in how our property is treated that are worth thinking about together and that differ from how other types of relations are treated.

Health law could be thought to parallel property law in this sense. While property law governs the legal treatment of relations that affect our property, health law governs the legal treatment of relations that affect our health care. There seems no necessary reason why the relations that affect our property should necessarily be deemed more coherent and field-like than the relations that affect our health care.

To be sure, the relations that affect our health care are rather more complex, including not just old-fashioned relations between patients and physicians, but the relations of patients to hospitals, insurers, employers, and the government, as well as a complex web of relations between all those and physicians. But complexity hardly counsels against recognition of a legal field; if anything, it cuts the other way by suggesting a serious devotion of focused energy is necessary for professors and students to put their hands around the issue. Nor is there similar complexity without analogy in the realm of legal fields. Consider corporate law (or, more generally, business associations), which we might consider the law that governs relations among all the persons who have an interest in jointly owned property subject to the management of others.¹⁰ This involves a complex web of relations between shareholders, managers, directors, potential investors, and others that are nonetheless distinct enough from other relations and common enough in the issues they raise to merit treatment as a separate legal field. We might think of modern health law as being about a similarly complex web of relations that affect our health.

Of course, there is only so far one can go by analogy. Ultimately, the question of whether health law should be a field of law is not a conceptual question. It is a functional one that turns on the answer to a very practical question: do we gain insights from thinking as a group about the set of legal materials grouped under this rubric? We need not agree about precisely what those insights

10. Recent work in the theory of the corporate form and the theory of the firm stresses the way in which the firm holds and partitions property. See OLIVER HART, FIRMS, CONTRACTS, AND FINANCIAL STRUCTURE 29-72 (1995); Henry Hansmann & Reinier Kraakman, *The Essential Role of Organizational Law*, 110 YALE L.J. 387, 394-96 (2000).

are; indeed, we are unlikely to do so if we do not share common normative predispositions. It suffices that the juxtaposition of legal materials from these various areas does raise insights and issues that we might otherwise ignore and provide us with a common vocabulary for rationally discussing our varying resolutions.

II. THE FUNCTIONAL CASE FOR DEEMING HEALTH LAW A FIELD OF LAW

It seems to me that health law does meet the above functional test for what constitutes a field of law. Many different legal fields may, in some sense, apply to the health care industry but seem transformed in significant ways by the application. While understanding general rules of, say, tort, contracts, antitrust, and ERISA might be fine for a horse lawyer, it would actually be misleading to a health lawyer because each of those fields has specially tailored doctrines to deal with health care. For example, general tort law matters much less in health care than the special laws of medical malpractice, informed consent for medical treatments, and the particular forms of liability that sometimes exist for the work of medical subordinates. Contracts and antitrust law also seem to be applied quite differently to health care issues than they are normally, and the application of ERISA to health care issues hardly can be predicted neatly from the ERISA materials about pension plans and the like.¹¹ The distinctiveness of health care relations thus does seem to change the applicable law. Further, the nature of those changes reflects common issues about the nature of the underlying relations.

Indeed, the best evidence that health law *can* be a coherent field of law is that it used to be one. Prior to the changes of the 1970s and 1980s, every supposedly separate field of law was clearly transformed when it came into contact with the health care industry into a body of law that reflected a common relational theory that favored professional self-regulation. That model governed malpractice, with its professional standards of care that prohibited lower standards even if they might survive standard “BPL”

11. See M. Gregg Bloche, *The Invention of Health Law*, 91 CAL. L. REV. 247, 251 & n.9 (2003) (noting how courts have begun to interpret ERISA to limit cost-control methods by calling them health care provisions rather than plan administration); Einer Elhauge, *The Limited Regulatory Potential of Medical Technology Assessment*, 82 VA. L. REV. 1525, 1550-52 (1996) (noting how courts have molded ERISA to protect professionalism in various ways); William M. Sage, *Managed Care's Crime: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance*, 53 DUKE L.J. 597, 597-98 & n.3, 614-18 (2003) (noting how courts have cut back on ERISA preemption of state laws regulating exclusions of coverage or physicians).

negligence analysis. It governed contracts, with restrictions on contracts that tried to eliminate liability for offering less-than-standard professional care¹² and the frequent denial of ordinary expectation damages when physicians promised medical results.¹³ It governed insurance law, with coverage turning on medical necessity as determined by doctors. It governed antitrust, which de facto exempted medical self-regulation. And it governed hospital structure, which required control by medical staff.

All these elements were apparently not recognized and organized by the casebooks of the day, as Mark Hall shows in his interesting piece.¹⁴ But truly dominant ideas often go unstated because everyone just assumes them. Casebooks focus on interesting, difficult cases, and cases about these features were not then understood to raise any difficult questions because it was just assumed that self-regulation by medical professionals was the best method. Even economists thought so back then.¹⁵ What these earlier casebooks did cover largely involved medical inputs into legal decisions, like forensic evidence or testimony about the insanity of criminal defendants. That made sense back then because those were the more contested areas where medicine had to come to grips with the law. In contrast, for issues that back then were covered by professional self-regulation, there was no reason for medicine to grapple with the law in any day-to-day way; only those prone to scholarly reflection might ponder just why the law had conferred this self-regulatory power on professionals.

The dominance of professional self-regulation as the governing legal paradigm was then undermined by numerous legal changes. Those changes included greater variation in tort standards, greater willingness to allow modifications by contracting, greater antitrust intrusion, and increased willingness to allow or impose insurance methods that restricted or imposed cost pressures on physicians' decisions, such as pre-utilization review of expensive tests and procedures, requiring referrals to see specialists, capitated payments to physicians responsible for a covered patient group, and limiting coverage to providers that practiced the most efficient care.

And yet a market paradigm for making decisions never became dominant either. Instead, the professional paradigm continued to

12. See, e.g., *Tunkl v. Regents of the Univ. of Cal.*, 383 P.2d 441, 442, 447-49 (Cal. 1963); *Emory Univ. v. Porubianski*, 282 S.E.2d 903, 905 (Ga. 1981).

13. See, e.g., *Sullivan v. O'Connor*, 296 N.E.2d 183, 187-88 (Mass. 1973).

14. See Mark A. Hall, *The History and Future of Health Care Law: An Essentialist View*, 41 WAKE FOREST L. REV. 347 (2006).

15. See Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941, 949-51 (1963).

have a strong sway. Antitrust might impose competitive standards on the medical industry, but courts were reluctant to enforce them, sometimes deeming “procompetitive” various self-regulatory motives that would have been anticompetitive for any other industry¹⁶ and approving hospital mergers that led to concentrations and price increases that would have been banned in any other industry.¹⁷ Medicare, HMOs, and other insurers might have imposed payment systems or controls designed to limit excessively costly medical care, but remained subject to the limit that they could not really make rational cost-benefit tradeoffs because denying any care that was admittedly more beneficial than the alternatives would amount to denying medically necessary care and thus run afoul of insurance law, tort law, or various other laws that protected medical judgment from interference by nonmedical entities.¹⁸ Just to make sure, many states responded to the possibility that managed care might change the actual delivery of care by adopting statutes defining medically necessary care and requiring external review of whether insurers covered it, mandating access to specialists, and restricting financial incentives designed to induce physicians to curb costs.¹⁹

It is thus not surprising that the managed care revolution seems largely dead today. HMOs have lost market share and insurers have reduced reliance on managed care techniques like utilization review, policing referrals, capitated payments, and limiting physician networks.²⁰ Those methods proved to be too unpopular with insureds, and the reason is not hard to see: they interfered with choices without saving much money. Nor is it hard

16. See *Cal. Dental Ass'n v. Fed. Trade Comm'n*, 526 U.S. 756, 771 (1999); *Wilk v. Am. Med. Ass'n*, 719 F.2d 207, 221-22 (7th Cir. 1983).

17. See FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, *IMPROVING HEALTH CARE: A DOSE OF COMPETITION* ch. 4, at 32 (2004), available at <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf> (“[T]he most interesting result for antitrust policy is the finding that nonprofit hospital mergers lead to higher prices, not lower ones, and that the price increases resulting from a nonprofit merger are getting larger over time.” (quoting Emmet B. Keeler et al., *The Changing Effects of Competition on Non-Profit and For-Profit Hospital Pricing Behavior*, 18 J. HEALTH ECON. 69, 83 (1999))); Jennifer R. Connors, *A Critical Misdiagnosis: How Courts Underestimate the Anticompetitive Implications of Hospital Mergers*, 91 CAL. L. REV. 543, 549-50 (2003). For some examples of the government enforcement agencies' defeat in these cases, see *F.T.C. v Butterworth Health Corp.*, No. 96-2440, 1997 WL 420543, at *2 (6th Cir. July 8, 1997); *United States v. Long Island Jewish Med. Ctr.*, 983 F. Supp. 121, 149 (E.D.N.Y. 1997).

18. See *Rush Prudential HMO v. Moran*, 536 U.S. 355, 372-73 (2002); Elhaug, *supra* note 11, at 1549-63; Sage, *supra* note 11, at 597-98, 609-18, 640.

19. See Mark A. Hall, *The Death of Managed Care: A Regulatory Autopsy*, 30 J. HEALTH POL. POL'Y & L. 427, 428 (2005).

20. See *id.* at 426, 429-30.

to see why they didn't save much money: they cost money to operate and the law systematically refused to allow the sort of cost-benefit tradeoffs that might lead to serious offsetting monetary savings.²¹ Thus, although the initial adoption of managed care measures did manage to produce a short-term reduction in the rate of increase from 1993-97,²² it was entirely predictable that managed care would ultimately fail to restrain the forces pressuring for large cost increases, as indeed I did predict in 1996.²³

Accordingly, it is probably less accurate to say that the market approach was tried and failed than to say that it was never really tried at all, at least not in the full form it would have needed to accomplish its goals. Of course, whenever a prescription fails, one possible response is to double the dosage. Perhaps we should redouble our efforts to try a thorough-going market approach or at least see if it can succeed in limited areas or for limited sets of insureds.

The recent push for consumer-driven health care might be understood as precisely such an effort, trying to force consumers (rather than insurers or providers) to make the tough cost-benefit tradeoffs through high copayments and deductibles and limiting the covered services.²⁴ But such efforts can at best be marginal because any increase in copayments and deductibles or reduction in covered services necessarily decreases insurance protection that consumers find valuable. Such consumer-driven health care is thus largely limited to routine care rather than catastrophic care for the seriously ill. Perhaps it will decrease incentives to overconsume such routine care, though this effect may be offset by the tendency of Internet technology to reduce the time costs that used to be the only other significant bar to such overconsumption. But it will do nothing to reduce the incentives to overconsume care for the seriously ill that drive the lion's share of health care costs.²⁵ Moreover, unless coupled with subsidies to cover the out-of-pocket costs of patients (like tax credits to fund Health Savings Accounts), the effect will be to shift costs onto families who have chronically ill members who need to consume disproportionate amounts of routine care or of the special care excluded by coverage limits.²⁶ This will

21. See Elhauge, *supra* note 11, at 1546-64.

22. See K. Levit et al., *Health Spending in 1998: Signals of Change*, HEALTH AFF., Jan./Feb. at 124-32.

23. Elhauge, *supra* note 11, at 1526-27, 1534-36, 1546-66.

24. See James C. Robinson, *Reinvention of Health Insurance in the Consumer Era*, 291 JAMA 1880, 1881-83 (Apr. 21, 2004).

25. See *id.* at 1885.

26. See *id.* at 1885-86. If the government does give subsidies or tax credits that are adjusted for the health status of individuals, this will deviate from a pure market approach, and will predictably cause individuals to exaggerate

effectively lessen the insurance against any of us ending up being such a family, and thus create a ceiling on these efforts.

Although purely consumer-driven health care thus seems incapable of providing a complete legal framework for health care given market demand for insurance, one might imagine coupling such an effort with some revived efforts of insurers to offer managed care to force tradeoffs when consumers decide what insurance to buy and thus face the benefits and costs of expected care. But before we do so, we need to ask why the market approach was systematically thwarted by judges and lawmakers even during a conservative pro-market era in U.S. history. The answer seems to be that a decisive number of us share a fundamental moral discomfort with trading off health for money coupled with a strong desire for a medical sherpa to guide us through our health problems. Had health care been better understood as a legal field all along, this would have been more obvious as an unavoidable impediment to purely market approaches.

One possible response to this current situation is to return to the cozy paradigm of professional trust and self-regulation. This approach has its attractions. It is hard not to feel nostalgic for a simple world of doctors know best, especially when it may produce placebo effects that have important health benefits²⁷ and would restore a far more coherent paradigm than we now have for thinking about health care issues.

But the days are long gone when we can build a health law system on simple norms of professional trust and self-regulation. Those days are gone for many reasons. They are gone not because physicians and health care institutions turned out to be any worse than the rest of us, but because they turned out to be no better. Repeated studies have shown that they, like all of us, respond to financial incentives in the long run, or at least that those of them who do respond to financial incentives alter social norms or simply expand their operations at the expense of those who don't. They are gone because historical work showed that many rules of professional self-regulation were designed to further the financial interests of professionals.²⁸ They are gone because medical practices are often harmful and usually lack scientific proof of their effectiveness,²⁹ and

their poor health and providers to compete for patients by aiding them in such medical exaggeration.

27. See Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 479-80 (2003).

28. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982).

29. See Bloche, *supra* note 11, at 266-70; Elhauge, *supra* note 11, at 1542, 1592; Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1449,

the defense that medicine is an art rather than a science began to ring hollow as numerous studies showed that this artistic discretion was exercised in ways that resulted in systematic variations in the care given for the same ailments depending on the region³⁰ and race or ethnicity of the patient.³¹ They are gone because informed consent and other legal decisions have favored converting physicians from persons who made paternalistic decisions on behalf of patients into providers of informational input for patients to make their own decisions.³² They are gone because an explosion of medical information has made it more difficult for physicians to know everything about all their patients' ailments, while the widespread availability of medical information on the Internet increased each patient's knowledge about her particular ailment, so that the gap in knowledge (or at least perceived knowledge) decreased. They are gone because of the increasing usage of consumer-driven health plans with high deductibles and copayments designed to inform and incentivize consumers to make decisions.³³ They are gone because of the advent of constant drug commercials aimed at getting consumers to tell their physicians what they need. They are gone

1461 n.22 (1994); Sage, *supra* note 11, at 623.

30. See Elhauge, *supra* note 11, at 1543.

31. See, e.g., COMM. ON UNDERSTANDING AND ELIMINATING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE, BD. ON HEALTH SCIENCES POLICY, INST. OF MED., *UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE* 5 & app. B (Brian D. Smedley et al. eds., 2003); J. Z. Ayanian et al., *Racial Differences in the Use of Revascularization Procedures After Coronary Angiography*, 269 JAMA 2642 (1993); René Bowser, *Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities*, 7 MICH. J. RACE & L. 79, 83-91 (2001); J.J. Escarce et al., *Racial Differences in the Elderly's Use of Medical Procedures and Diagnostic Tests*, 83 AM. J. PUB. HEALTH 948 (1993); Mita K. Giacomini, *Gender and Ethnic Differences in Hospital-Based Procedure Utilization in California*, 156 ARCHIVES OF INTERNAL MED. 1217 (1996); Marian E. Gornick et al., *Effects of Race and Income on Mortality and Use of Services Among Medicare Beneficiaries*, 335 NEW ENG. J. MED. 791 (1996); Barbara A. Noah, *Racial Disparities in the Delivery of Health Care*, 35 SAN DIEGO L. REV. 135, 138-56 (1998); Eric D. Peterson et al., *Racial Variation in the Use of Coronary-Revascularization Procedures: Are the Differences Real? Do They Matter?*, 336 NEW ENG. J. MED. 480 (1997); Michael S. Shin, *Redressing Wounds: Finding a Legal Framework to Remedy Racial Disparities in Medical Care*, 90 CAL. L. REV. 2047, 2054-58 (2002); Mark B. Wenneker & Arnold M. Epstein, *Racial Inequalities in the Use of Procedures for Patients with Ischemic Heart Disease in Massachusetts*, 261 JAMA 253 (1989); Jeff Whittle et al., *Racial Differences in the Use of Invasive Cardiovascular Procedures in the Department of Veterans Affairs Medical System*, 329 NEW ENG. J. MED. 621 (1993).

32. Roger B. Dworkin, *Getting What We Should from Doctors: Rethinking Patient Autonomy and the Doctor-Patient Relationship*, 13 HEALTH MATRIX 235, 235-36 (2003).

33. See generally CONSUMER-DRIVEN HEALTH CARE (Regina E. Herzlinger ed., 2004).

because the best argument for emphasizing trust in caregivers was that it created a medically beneficial placebo effect, and that effect turns out to be empirically debatable,³⁴ with the linkage to trust in physicians even more questionable.³⁵ Most importantly, they are gone because the professional paradigm came to depend on a system based on insuring and providing any care a physician deemed medically beneficial regardless of cost, which necessarily fostered the creation of ever more expensive technologies to achieve ever more marginal gains.³⁶ This was never a tenable basis for organizing the system in the long run because the resulting cost increases would inevitably provoke reactions. Thus, from the beginning, the professional paradigm always carried with it the seeds of its own demise.

But the professional paradigm is not quite dead yet, as the various legal roadblocks to its elimination attest. The result today is, unfortunately, an incoherent mish-mash of approaches. Various bodies of law impose cost pressures on participants in the health care industry, but other laws punish those participants for responding to those pressures by making any openly rational cost-benefit tradeoffs. So, predictably, they instead cut costs in ways that are more difficult to notice even though they are not the least cost-effective care, or they focus efforts on trying to select healthy patients and insureds rather than make rational cost-benefit tradeoffs.³⁷ The law gives substantial deference to professionals on the grounds that they self-regulate, yet exposes them to the risk of antitrust liability if they do so. So we defer to a method of regulation we have largely paralyzed. We rely on competition among insurers, the main value of which is to encourage innovation

34. See generally Asbjørn Hróbjartsson & Peter C. Gøtzsche, *Is the Placebo Powerless?: An Analysis of Clinical Trials Comparing Placebo with No Treatment*, 344 NEW ENG. J. MED. 1594 (2001). For an excellent review of the literature on both sides and explanation of why it is inconclusive, see Anup Malani, *Testing for Placebo Effects Using Data from Blinded: Clinical Trials* (U. Va. John M. Olin Program in L. & Econ. Working Paper Series, Working Paper No. 17, 2005), available at <http://law.bepress.com/cgi/viewcontent.cgi?article=1036&context=uvalwps>.

35. Professor Malani proposes his own test for measuring the placebo effect that uses blinded clinical trials and does find significant, indeed remarkable, placebo effects for ulcer medication and cholesterol-lowering statins. See Malani, *supra* note 34, at 17. But it is hard to attribute this sort of placebo effect to patient trust that physicians are doing the right thing (as opposed to the Hawthorne effect from being studied) when, by definition, the patients in such a blind study get treatment from persons who explain that it is random whether the patient gets beneficial medication or not.

36. See Elhauge, *supra* note 11, at 1525-26, 1544-46.

37. *Id.* at 1567-70.

in insurance design, yet the law generally prevents insurers from competing by varying insurance terms.³⁸ Antitrust and other laws seek to impose competitive markets that are designed to expand the role of efficient suppliers and eliminate inefficient providers. But, in many states, the law restricts the ability of a successful hospital to expand with certificate of need regulations that bar the purchase of new capital equipment if less successful hospitals don't attract enough business to fully use their capital. And, when competition actually results in the bankruptcy of an inefficient hospital, our political process frequently treats that as an unacceptable result and provides subsidies to avoid that result. The law in many ways tries to encourage managed care by insurers³⁹ but imposes restrictions like the corporate practice of medicine doctrine when they actually try to manage care.⁴⁰ The law also increasingly imposes liability on HMOs and hospitals to encourage them to control quality yet restricts their ability to do so not only with the corporate practice of medicine doctrine, but also with accreditation standards that require staff control and with laws that make it hard for them to select the physicians they want by giving excluded ones litigable rights to hospital staff privileges or insurance payments. And the list of contradictory doctrines goes on and on.

The result is that, right now, our health care system can only be described as horribly mismanaged. To be sure, it daily performs many miracles and is full of impressive, dedicated workers. But judged as an overall system, the U.S. system remains more expensive than any other nation's, with costs continuing to rise annually at a rate that will eventually prove unsustainable, yet with surprisingly poor overall results, widespread consumer dissatisfaction, and haphazardly inequitable access. Although it produces aggregate benefits that exceed its costs, it also produces large amounts of marginally beneficial health care that is extravagantly expensive to some, while denying significantly beneficial and relatively low-cost health care to others. This mismanagement cannot be laid at the feet of health care executives, who are doing the best for their institutions given the incentives our system imposes on them. Nor can it be blamed on health care professionals, who daily work their hardest and yet have their efforts constantly misdirected. The mismanagement has to be laid at the feet of the law that systematically structures the incentives

38. See Havighurst, *supra* note 3, at 96-97.

39. Elhauge, *supra* note 11, at 1547-67; Robert F. Rich & Christopher T. Erb, *The Two Faces of Managed Care Regulation & Policymaking*, 16 STAN. L. & POL'Y REV. 233, 243-44 (2005).

40. Elhauge, *supra* note 11, at 1560.

and powers of those who work within our health care system. And no small part of that blame has to be fixed on the legal academy that has so far failed to persuasively think through such systematic issues.

But, to me, this does not show that health law cannot be a legal field. It shows, rather, the importance of treating it as a legal field. For all the legal mismanagement results because different legal areas and doctrines are based on different underlying paradigms and applied in ways that undermine each other. It is, thus, highly beneficial to analyze these laws *as a group* to see what their overall effect is on actors in health care. Putting these doctrines in juxtaposition to each other can only increase our ability to see their interactive effects.

III. COMPARATIVE PARADIGM ANALYSIS AS A METHODOLOGICAL FRAMEWORK

So on what organizing principles would I base a coherent theory of health law? The traditional health law casebook or course divides the field into the issues of quality, cost, access, and autonomy. But each of these issues relate to each other and any sound social policy requires tradeoffs between them. Discussing them separately fails to advance analysis. To the contrary, such separate discussion is a recipe for entrenching the current problem that myopic focus on any of them tends to undermine sound resolution of the others.

It has always seemed to me that wisdom in this area must instead focus on how the law can best frame decision-making processes. It should start by recognizing that each of the possible decision-making paradigms has flaws and limitations. But then the next step should be fashioning laws in a way that limits the scope of each paradigm to where it works best and prevents them from interfering with the other paradigms where they work best.⁴¹ This comparative paradigm methodology holds the most promise for helping us systemically think through health law issues in a coherent and common way that can make for a legal field.

Of course, everyone will have different views about how best to limit and coordinate the various decision-making paradigms. I have my own views about those issues. Yet for present purposes what matters is not so much the conclusions one would draw from using such a comparative paradigm methodology, but, rather, that this would provide some common methodology for discussing and disputing health law issues. That would suffice to create a legal field, for no field of law enjoys consensus, which is only natural since

41. See Elhauge, *supra* note 29, at 1452, 1541-44.

every legal field addresses contestable social problems. A common methodology and vocabulary for framing and discussing issues is what is needed.

One might object that this sort of comparative paradigm analysis may be useful but is not unique to health law because it is relevant in any area of law.⁴² But while this may be true for the basic struggle in most areas of law between the market and political paradigms, it seems clear to me that the hold professionalism and moral rights have in health care is unlike what exists in any other industry or body of law. This creates a distinctive set of relational norms that makes health law unlike other areas and requires an understanding of the interaction among those paradigms that is not relevant in other legal areas.

In any event, as with assessing any claim, one has to ask: what are the alternatives? Here, the main alternative appears to be to leave such issues to some ill-defined “tension” through which we will cycle or muddle through in perpetuity.⁴³ But that has always struck me more like giving up and throwing up one’s hands than a real solution. Indeed, it is precisely the maintenance of this continuing tension that has created the mismanaged state of current health law. What we have today are not tragic choices, but tragic failures to make choices that would lead to a more rational system under any metric one cares to posit.

Another approach that Mark Hall has recently proposed is to focus on the essential features that make medicine distinctive, which he defines as the vulnerability of patients, the professionalism of caregivers, the trust relation between patient and caregiver, the high stakes of medicine, and the uncertain complex nature of medical science.⁴⁴ But the fact that an industry may have distinctive essential features hardly suffices to make the law regarding it a legal field. Art is distinctive, as are entertainment and sports, but it remains quite controversial whether art, entertainment, and sports law are really legal fields. Being a professor or columnist or spiritual medium are also distinctive occupations, but I don’t see fields of law being built around them. Ultimately, the question is whether the features that differ raise distinctive legal issues that are best analyzed as a group focused on that industry rather than in a more general way that cuts across industries.

Moreover, to make choices about which features are “essential”

42. See Hall, *supra* note 14, at 357.

43. See, e.g., GUIDO CALABRESI & PHILIP BOBBITT, TRAGIC CHOICES (1978); Bloche, *supra* note 11, at 256.

44. See Hall, *supra* note 14, at 357-62.

is to simply assert conclusions about what health care ought to be without going through the argument to establish why this is so. Consider the features identified as “essential” by Mark Hall. They are all certainly important and distinctive in health care. Indeed, they are many of the features that I would say here make a comparative paradigm approach distinctive and uniquely situated to deal with problems of health law. But if these features were really *all* that mattered, then one would think that it would have long been obvious to everyone that we should return wholesale to the professional paradigm. Why haven’t we?

The answer, in part, is that there are other essential features of the health care system that cut the other way, like the need to finance health care costs through insurance and the incentives this creates to spend excessively on health care. The answer, in other part, is that many features that aren’t distinctive about health care are nonetheless important because they limit these “essential” features. This includes the fact that these professionals nonetheless operate in a commercial industry and respond to financial incentives, that trust is limited by increasing distrust and questioning, that consumers want freedom of choice, and that, in the end, we must somehow pay for the health care we receive and trade off health benefits against other things that make for a good life. These other essential features, costs, and tradeoffs raised by health care also explain why we cannot define health law simply around various measures of health benefits like health promotion, rescue, and relieving patient suffering.⁴⁵

What we need is less an assertion about what the essential features of health care “are” than a methodology for analyzing and arguing about what the best decision-making process would be for any particular sort of issue that does not presuppose the answer. But is it possible to employ a comparative paradigm methodology to reach any logical concrete conclusions? My answer is yes. Indeed, even if we ask the question at the highest level of legal abstraction—what generally should be the systematic legal framework for health care—this methodology directly leads me, as I show next, to some surprising specific policy outcomes given a relatively small number of empirical and normative presuppositions. This ability to generate rather specific conclusions strikes me as a benefit of this approach compared to other approaches that can only weakly suggest the relevant tensions. But my goal here is less to persuade you that I am right on the various conclusions I offer than to illustrate what such a methodological approach might look like and to provide a concrete framework for analyzing where we might disagree. Those

45. *See id.* (discussing several such claims).

who find themselves disagreeing with one presupposition or another should readily be able to apply the same methodology to create their own ideal health law regime.

As I see it, the market paradigm has the following obvious strengths. If consumers are knowledgeable, have similar resources, and have incentives to trade off the benefits and costs of each product, then market competition promotes productive efficiency, accommodates varying consumer preferences, and achieves allocative efficiency. Of course, equal wealth is unlikely to ever be present in any market economy that preserves incentives to produce. But the problem of unequal wealth is largely external to the market paradigm and potentially remediable through some form of health care vouchers, so it is not the major problem that explains the inability of the market paradigm to dominate health law.

The more fundamental problem with applying a pure market paradigm to health care flows from the inherent division between the knowledge and incentives to make appropriate decisions. Unlike in other markets, there is no decision maker who has both the knowledge and the incentives to decide when the costs of supplying a particular good or service exceed its social value.

Patients lack the knowledge or expertise to evaluate it and, given the fact that others (such as insurers or employers) cover much of the social costs, also generally lack the necessary incentives. Moreover, people who become ill generally do not want to make health care decisions—even if they are physicians who supposedly have the necessary expertise—and sickness often disables the capacity to make such decisions.⁴⁶

Physicians and other health care providers are knowledgeable about medicine but not about social benefits and costs. Moreover, under market systems, they either have incentives to provide too much care (if paid on a fee-for-service basis) or incentives to provide too little (if paid on a capitation basis). Insurance plans generally lack the information to make case-by-case cost-benefit decisions and have incentives to provide too little care or to select for low-risk enrollees unlikely to need much care, because the insurers pay the costs of health care but do not enjoy its benefits.

The professional paradigm, which allocates resources using medical criteria rather than market signals, has its own strengths. It offers a scientific basis for assessing what care is beneficial to the patient's health and what care is harmful. Further, it offers a professional commitment to provide patients with only the former. The main weakness of the professional paradigm is that it provides

46. See Carl Schneider, *After Autonomy*, 41 WAKE FOREST L. REV. 411, 411-44 (2006).

no means for trading off the benefits of care against its costs.⁴⁷ This paradigm offers net advantages in a world, which arguably existed a few decades ago, when the benefits of whatever care was beneficial were clear and large in magnitude compared to its costs, and the amount of harmful and unnecessary care eliminated through professional self-discipline was high.⁴⁸ However, such a world no longer exists because new technology has spawned much care that offers only marginal benefits at much larger costs. And, for reasons noted above, it was probably inevitable that the professional paradigm would spawn the innovation of technology with such low marginal benefits and, thus, trigger its own demise.

But the market and professional paradigms are not the only ones that influence health law. The moral and political paradigms for making health care decisions also play a strong role. We thus need to understand them as well to fully make sense of modern health law.

The moral paradigm denies that the question of what resources should be devoted to and within health care is a matter that should be resolved by either market forces or professional judgment. Instead, decisions about the provision of health care should require respecting the moral autonomy of individuals because they affect profound matters of life, death, and health. Unfortunately, the moral paradigm provides little help in making tradeoffs between health care benefits and costs. When weighed against “mere” costs, it always seems immoral to deny beneficial health care to a patient who wants it. Yet, if we provided all the health care that had some positive health benefit, we could easily spend one hundred percent of our GDP on health care. At some point, a tradeoff with the other things we value besides health care is necessary, particularly when one realizes that dollars spent on education and housing have a greater impact on health than dollars spent on health care.⁴⁹ But even when moral theory recognizes the inevitability of such tradeoffs, it provides little aid in deciding precisely how to make them.

However, the moral paradigm does offer four important lessons for designing a sound health care system. First, it highlights that decision makers will have grave moral difficulties denying health care to identifiable individuals based on mere monetary costs. Second, it suggests that no health care system is likely to achieve public moral acceptance unless it provides health care without

47. See Elhauge, *supra* note 11, at 1529, 1533-34, 1537-38, 1594-95.

48. *Id.* at 1545.

49. See Bloche, *supra* note 11, at 284-85; Elhauge, *supra* note 29, at 1459-61.

regard to individual ability to pay. Third, the moral paradigm can greatly aid medical professionals in deciding how to trade off certain health benefits to one person against different health benefits to others. Fourth, the moral importance of respecting individual autonomy, and the indeterminacy of moral philosophy on many points of interest, counsel for designing a health care system capable of accommodating a diversity of moral choices.

The political paradigm instead relies on a collective decision-making process for governing our health care decisions. The weakness of this approach is that the political process cannot be expected to make effective operational decisions about what health care is received by particular individuals; it lacks the information and speed to make such individualized decisions.⁵⁰ Further, it evidences a systemic bias for the interests of identifiable individuals, such as persons who need organ transplants, over non-identifiable persons, such as those who would benefit from prenatal care.⁵¹ Finally, the political process is likely to make a hash out of complex regulatory issues because citizens face high information costs in understanding such issues, meaning that interest groups will have a relative advantage over ordinary citizens.⁵²

What the political process *can* do well (or at least better than the alternatives) is make global decisions on highly salient, simple-to-communicate issues. The mass of voters cannot be aroused on the intricacies of banking regulation, but nothing mobilizes them like the issue of how high their taxes should be. It thus makes sense to have the political process determine one crucial global issue: how high should the government set the health care budget and associated tax?

In setting the national (or state) health care budget and associated tax, the political process would implicitly be making the basic cost-benefit tradeoff that must somehow be made. The voters will not approve a one hundred percent tax on themselves. Polls reveal people are willing to spend huge amounts on health care in the abstract, but that their willingness sharply plummets if the spending proposal is coupled with a tax to pay for it.⁵³ There will thus be some limit to the budget, and the health care benefits that can be provided with that budget will be all we can receive. Other, more marginal health benefits will be denied and will, thus,

50. See Elhauge, *supra* note 11, at 1604-07.

51. *Id.* at 1601-05.

52. See Elhauge, *Does Interest Group Theory Justify More Intrusive Judicial Review?*, 101 YALE L.J. 31, 35-44 (1991); Elhauge, *supra* note 11, at 1600-01.

53. See DANIEL CALLAHAN, *WHAT KIND OF LIFE* 84-85 (1990).

implicitly be deemed not worth the cost of providing them. It must be admitted that there would be no particular science or logic to this tradeoff. It would require a rough, basic value judgment. But those are precisely the open-ended judgments the political process is best suited to provide. And political decision makers will at least have some incentives to weigh benefits against costs because both are experienced by the polity.

Of course, having limited the political process in this manner, we would need some system for distributing the total health care resources among the various health care needs in a desirable manner. It seems to me the best method is to divide the national (or state) budget among plans based on the number of individuals enrolled by each plan, with adjustments to account for the different health risks (and thus costs) posed by different individuals. Each plan would bear the responsibility of allocating its budget of health care resources among those enrolled in the plan. To be consistent with our views regarding the value of professionalism, each plan must have personnel who are medical professionals. To be consistent with our moral beliefs, all individuals would have access to free care from one of the plans.

Would any role be left for the market? Absolutely. For if we have learned anything from this century, it is that public monopolies, like private monopolies, can grow lazy and indifferent to the needs of their customers. Consumer choice and supplier competition are vital components to a well-functioning health care system.

Consumers may not be able to judge what sort of health care they should receive, but they can plausibly judge whether they prefer their plan to other nearby alternatives. Thus, consumers should be able, once a year, to switch between different plans. Because each plan's budget would depend on how many persons elect that plan (with adjustments for the different health risks they pose given their age, sex, and condition), this inter-plan competition would encourage plans to improve not only service quality, but also rationing decisions. A plan may find itself without very many enrollees if it decides to expend—as our nation does—sixty percent of its hospital resources on patients in the last few months of life but little on prenatal care. By the same token, individuals can put their money—or rather their share of the national budget—where their mouth is if for moral or other reasons they approve of our current national choice to expend sixty percent of hospital resources on patients in their last months of life. Competitive rationing thus not only confronts us with the costs of our moral choices, but also accommodates diversity in moral beliefs.

Allowing a diversity of moral choice is important because there

is no neutral or scientific method of measuring what maximizes the health of a group. Instead, supposedly neutral methods of measuring health benefits like quality-adjusted life years all raise morally problematic issues, and the choice between them and other measures requires moral, not medical, judgment.⁵⁴ A single uniform method of allocating health care resources to advance some collective health goal thus cannot be imposed wholesale on the population without denying the individual autonomy to make other reasonable choices on a profoundly moral matter. This does not mean we should dispense with attempting any rational method of allocating resources to maximize aggregate health goals. It means, rather, that we should allow individuals to express their diversity of moral views by giving them a choice among plans, each of which offers its own method of allocating scarce resources to produce health benefits.⁵⁵

A role must also be left open for supplier competition. For a system of competitive rationing to function properly, the rationing plans must be in charge of ordering all health services for their covered population. But that does not mean that the plans must deliver the care themselves. Rather, the delivery of health care services should remain largely with private providers who compete to sell to the plans. Indeed, a major virtue of a system of plans is that it effectively restructures the market to create purchasers (the plans) who have a far better combination of knowledge and incentives to make the necessary tradeoffs. A process of open market competition to service such plan-purchasers is the process best calculated to result in cost-reducing innovation and improvements in productive efficiency, thus lowering the cost of providing any given health service.

The plans themselves should be relatively lightly staffed and small since they need only the range of expertise to order services, not to provide them. Indeed, they should be as small as consistent with any economies of scale in order to maximize competition between plans.⁵⁶ Moreover, although the plans must have a public duty to utilize their budget for their members, they need not be

54. See Bloche, *supra* note 11, at 274-77; Elhauge, *supra* note 29, at 1455, 1493-1524; Elhauge, *supra* note 11, at 1585-88, 1603-04.

55. See Elhauge, *supra* note 29, at 1456, 1524-41.

56. We may well find the economies of scale far smaller for such plans than for current insurers or HMOs because under this scheme these plans need not bear financial risk nor provide nondiagnostic care, and should have to do far less monitoring and paperwork since they are simply making purchase decisions rather than reviewing the purchase decisions of others. Indeed, economies of scale may be low for insurers even under the current system. See Robinson, *supra* note 24, at 1884.

governmental. They can be private nonprofit entities, or even for-profit entities receiving a separate bonus payment per subscriber, as long as the number of subscribers fixes the budget that can and must be spent on patients.⁵⁷ Their sole incentive should thus be to do a good enough job rationing to keep and attract enrollees. Because the payments they get are risk-adjusted, they would not have incentives to engage in adverse selection against unhealthy enrollees.⁵⁸

For such a scheme to work, we will need to reconceive professionalism, or at least the professionalism of those involved in the plans. Rather than seeing their goal as maximizing the health of each individual patient without regard to cost, these professionals will have to see their goal as using their expertise to derive the maximum health benefit for the enrolled *group* out of a limited set of resources. Unfortunately, maximizing the health of a group is not solely a scientific issue amenable to objective technical resolution.⁵⁹ Deeply moral considerations are relevant. But if each plan's chosen maximization measure can be legitimated by individuals' consensual choices to enroll in that plan, then medical expertise can provide an objective method of determining what allocation of resources best fulfills the measure adopted by the plan in question.

The transition from loyalty to individual patients to loyalty to a group of enrollees will not be easy. But it is surely more plausible than current efforts to persuade physicians to somehow "take costs into account" under the current system. Much as we may exhort them to, medical professionals cannot be expected to weigh the monetary costs of care against the health benefits. Such tradeoffs lack any scientific basis. And they run counter to medical education, professional ethos, and physician market incentives. Moreover, my analysis minimizes the deviation from professionalism because the bulk of physicians would not be part of such plans, but, rather, would remain in the supplier market. There they would be free to press with undivided loyalty for maximizing the health benefit for each individual patient. But when they do so they would be confronted with a purchaser knowledgeable enough to determine when those services come at too great a cost to the health of others.

Finally, individuals should also be free to buy medical care

57. Being a nonprofit would not suffice because nonprofits can retain profits as long as they do not distribute them to investors.

58. Although any system of risk-categorization is inevitably imprecise, this will be true both for plans and the national system. Thus, the national system should be able to largely eliminate adverse selection by adopting any risk-adjustments that plans (or today's insurers) might feel tempted to adopt.

59. See Bloche, *supra* note 11, at 274-76; Elhauge, *supra* note 29, at 1455, 1493-1524; Elhauge, *supra* note 11, at 1585-88, 1603-04.

additional to the minimum provided by the state. After all, it is hard to see the moral imperative to prevent persons from choosing to spend more than the national average on health care, especially when the alternative to them doing so may just be to spend it on fancy cars and vacations. The countervailing concern is that allowing the purchase of additional care might undermine the willingness of the rich to vote for a sufficient health care budget. But it is unlikely that the freedom to buy additional care would significantly discourage voting for a generous state-funded system for at least three reasons. First, buying individual insurance policies for unpooled risks is extremely expensive compared to the cost of pooled risk coverage through the state-funded system. Second, the state-funded system will enjoy the efficiency advantages noted above in providing plans with the expertise and ability to make efficient cost-benefit tradeoffs, thus making individual purchases a comparatively less efficient way to buy medical care. Third, the current level of spending will be a natural baseline that risk-averse voters are predictably unlikely to cut (if their views about Medicare are any indication), and are already, if anything, likely to be excessively generous (especially if spent more efficiently) compared to the tradeoff most of us would make between medical care and other goods in life. In any event, prohibiting individuals from buying beneficial medical care with their own money might well be unconstitutional and in any event unenforceable in a globalized world where people can travel to other nations for care if need be.

This, then, is the outline of the legal framework I believe a coherent health care system should have:

- (1) The political process should largely be limited to one crucial task, setting an annual health care budget, funded by an associated tax that is not linked to employment. A politically appointed agency, whose members are insulated from removal, must also be created to perform two tasks: setting risk adjustments and licensing plans by verifying their diagnostic expertise and fiscal soundness. Such a government agency should not dictate a uniform schedule of covered services because there is too much reasonable diversity in moral choice on that issue; rather, the schedule should be up to each plan.
- (2) All individuals should have free access to a plan and be free to choose among plans once a year. These plans would each receive a share of the government budget based on the number of individuals they enroll, adjusted for each person's health risk, and would not be able to retain profits from their budget

(other than a possible bonus linked to total number of enrollees) but would, instead, be required to spend it on those enrollees.⁶⁰ Individuals would also be free to purchase additional care outside these plans.

- (3) These plans should have personnel with the range of diagnostic expertise necessary to evaluate the health care needs of their enrollees, who have salaries unaffected by spending decisions (other than a possible bonus per enrollee), and who have a duty to decide how to allocate each plan's budget to purchase those health services that maximize health benefits for the plan's enrollees.
- (4) The vast majority of health care providers should be private suppliers of procedures, tests, and technologies that compete with each other to sell to the plans. This should create incentives for cost-effective innovation, because suppliers will now face purchasers who have both the knowledge and incentives to trade off the costs and benefits of care.

Indeed, it may be precisely toward such a system that the national health care systems of the world are (from different directions) slowly converging. The United States is doing so by making the government more and more responsible for health care in a market structure that maintains consumer choice and professional discretion. And various abortive health care reforms, such as the Clinton Health Plan⁶¹ and the Gingrich Medicare Reform,⁶² would have moved us closer to such a scheme through a mix of global budgets and competition among insurance plans. Indeed, it is striking how similar the health plans of those two bitter political adversaries were, with the main difference being that Clinton aimed to move the more market-oriented part of our system toward such a solution, whereas Gingrich aimed to move the more governmental part of our system toward a similar solution.⁶³ We see something of the same convergence internationally. Countries that have national health care systems, like Britain and Sweden, or national health insurance, like Germany and Canada, are coupling

60. As with Federal Employees Health Benefits Program, plans should have an obligation to keep a "contingency reserve" of three percent of annual contributions which can be used in limited conditions. 5 U.S.C. § 8909(b)(2) (2000); 5 C.F.R. § 890.503(c)(2) (2006).

61. Health Security Act, H.R. 3600, 103d Cong. (1993).

62. Medicare Preservation Act, H.R. 2425, 104th Cong. (1995).

63. See Elhauge, *supra* note 11, at 1565-66.

their tradition of budgetary limits with the introduction of increasing market pressures.⁶⁴ Because these systems begin from a baseline of much more governmental control, they appear to be moving in the opposite direction as the United States, but toward what looks like a common destination. This trend will, I predict, continue because the various reform proposals and national health care systems now in place suffer from decision-making flaws that make each of them unlikely to provide a desirable and stable long-term solution to the health care problem.

However, the point here is not the particular plan but the methodology. The plan I indicate above is quite specific. People are bound to disagree on those specifics, and, no doubt, some will disagree about most or all of them. But if we can focus the disagreement on the issue of why they think another decision-making paradigm is best for resolving the issue in question, then we can more precisely frame the analysis. And if the argument that another paradigm is better suited to decide a particular sort of issue carries the day, then we can determine how best to systematically restructure *all* the laws relevant to health care in order to put that issue in the hands of that paradigm without being undermined by others. For part of the problem today is that a decision to, say, favor the professional paradigm over the market paradigm in hospital admissions decisions (or vice versa) cannot be made in a doctrinal context that allows that decision to affect all the legal doctrines that bear on whether such decisions are left to professionals or the market. Contrast, say, a decision to make contracts binding without consideration if there is reliance, which could suffice to change the relevant decision-making process necessary to reach a binding contract in a cohesive way. We would need to restructure health law doctrine around the relevant decisions being made in health care to allow a similar synchronicity of doctrine.

What we can't continue to do, unless we are policy masochists, is to haphazardly leap from one paradigm to another, based not on the sort of decision in question but on the area of law that bears on the decision, so that each paradigm undermines the other. Indeed, that leads to even worse outcomes than would a procrustean decision to impose one single paradigm—market, professional, political, or moral—to govern all decisions. But, although any such imperialistic approach would be preferable to what we have now, it seems to me that history demonstrates it is also doomed to failure because it just won't be accepted. In any event, we can aspire to do better by using a combination of each of these paradigms that limits each to the sort of decisions it governs best.

64. *Id.* at 1548.