Health Care

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April 2, 2014

1 Introduction

Few tribulations are worse than illness. The torment in our bodies and the turmoil in our souls darken even the most resilient characters. When the sick person is a relative or friend, our impotence in the face of his suffering can hurt as much as physical pain. That is why all religions praise the comfort of the sick as a work of mercy. And that is why medical doctors are, in every society, among the most esteemed professionals.[1] In movies, marrying the doctor is the perfect happy ending. I have yet to see a movie where the hero or heroine ends up marrying the economist.

The previous examples are manifestations of a more general principle: health care is a crucial piece in the tapestry of social conditions that allow us, either individually or as communities, to fulfill our goals in life and to attend to matters of ultimate concern. It is not by accident that John Finnis starts his celebrated enumeration of the basic forms of human good with life and the conditions for health.[2] It stands to reason that the common good requires the best health care possible given the state of medical knowledge and the practical reasonableness in the use of our material resources.

Note that I chose the words *health care*, not *health insurance*. The distinction between these two terms is the basis of a sound analysis of the topic. The goal is to deliver patient-centered,

[1] In the U.S., physicians were at the top of the list of occupational prestige scores in the 1989 General Social Survey.

[2] We can quote from John Finnis (1980), *Natural Law and Natural Rights*. Oxford: Oxford University Press, p. 86: "A first basic value, corresponding to the drive for self-preservation, is the value of life. The term 'life' here signifies every aspect of the vitality (*vita*, life) which puts a human being in good shape for self-determination. Hence, life here includes bodily (including cerebral) health, and freedom from the pain that betokens organic malfunctioning or injury. And the recognition, pursuit, and realization of this basic human purpose (or internally related group of purposes) are as various as the crafty struggle and prayer of someone fallen overboard seeking to stay afloat until the ship turns round; the teamwork of surgeons and the whole network of supporting staff, ancillary services, medical schools, etc." It is most interesting that Finnis explicitly mentions mental health, an area of growing concern in contemporary societies.

high-quality, and innovative health care for all. Health insurance is a means to achieve this goal. As I will argue below, an efficient and fair health system will consist of parts that involve health insurance (coverage against large, unforeseen events) and parts that do not (preventive and routine care).

The previous paragraphs are not redundant even if, in retrospect, they should be obvious. For it has been confusion about the ends of health care that have often led us astray. For example, sometimes costs containment seems to be an end in itself. Even worse, on occasion, positions that reflect personal values -perfectly respectable in a free society but not intuitively true to some of us- are presented as self-evident health care imperatives that government regulation should impose. When Aristotle stated that we deliberate not about ends but about means, he quickly added "For a doctor does not deliberate whether he shall heal."[3] Unfortunately, in the modern world, what Aristotle thought was beyond dispute is no longer a safe bet.

But let's abandon these foundational issues and dive into the matter at hand. There is much material to cover and space is limited.

2 Health Expenditures: High and Growing

If it seems that we talk more than ever about health care, that is because health expenditures are high and growing fast. Every year, the Organisation for Economic Co-operation and Development (OECD), a group of democratic market economies, compiles key indicators of health across its members, and when possible, for key emerging economies such as Russia and Brazil. In the 2013 release of these indicators, we learn that health expenditure per capita in OECD countries in 2011 (or nearest year) was $3322. From 2000 to 2011, the rate of growth on health expenditure per capita has been was 3.7 percent, that is, 44 percent accumulated in one decade.[4]

The figures for the U.S. are striking. The U.S. spent, in 2011, $8508 per capita on health (with a growth rate of 3 percent from 2000 to 2011). As a share of gross domestic product (GDP), health expenditure is 17.7 percent: more than one-sixth of all the goods and services produced in a year by the U.S. economy. Out of the $8508, the government spends $4066 (basically through Medicare and Medicaid) and families and firms spend $4442. The U.S. government spends more on health per capita than the governments of any other OECD country except Norway. In fact, the U.S. government spends more on health care than on Social Security or on national defense.

[3] Nicomachean Ethics, Book III.

[4] Three technical details. First, all the numbers are in what economists call purchasing power parity, that is, they already control for the fact that goods have different prices in different countries. Second, all changes in expenditure over time are in real terms, that is, after controlling for inflation. Third, unless otherwise noted, numbers include both public and private expenditure on health.

The OECD data also tell us that health expenditure is uniformly high among rich countries (with the U.S.' health expenditure being *very high*). This is despite the different ways in which health systems are organized: from a more market-oriented system in Switzerland (11.0 percent of GDP) to the single-payer system of Canada (11.2 percent of GDP) to the National Health System of the U.K. (9.4 percent of GDP). A similar statement holds for the growth in health expenditure. Thus, instead of focusing too much on the peculiarities of particular health systems, it is better to search first for common patterns.

Why do we spend so much on health care and why is expenditure growing so fast? Many economists emphasize four reasons:

1. Technological progress. As medical technology improves, we develop better treatments. However, these treatments are often increasingly expensive, as we run out of "obvious ideas."[5] Take coronary heart diseases, where death rates have fallen by more than two thirds over the last four decades. In the early 1970s, after a patient had a heart attack, hospitals could do little. Nowadays, hospitals offer an array of highly effective yet costly treatments to deal with heart attacks and pharmaceutical companies sell an impressive set of expensive drugs to prevent relapses.

2. Aging. Health expenditure is linked with age. Most 18-year-olds are healthy and except for checkups and perhaps glasses and the occasional aspirin, they do not spend much on health. Even the healthiest 90-year-olds require a fair amount of medical attention. Thanks to better medical knowledge, better behavior (mainly, less smoking), and higher income, life expectancy has increased dramatically. I could present dozens of statistics, but my favorite one come from Angus Deaton.[6] Only one out of 2500 girls born in 1910 in the U.S. celebrated her 100th birthday in 2010. It is a reasonable guess that one of each two girls born in the U.S. in 2010 to a white, middle-class family will celebrate her 100th birthday in 2110. Indeed, by 2050, 8 percent of the U.S. population will be 80 years or older.

3. Economic growth. As we become richer, we demand more health services. There are many goods of which, once we reach a certain level of income, we do not demand additional quantities. I drink the same amount of milk -and of the same quality- as when I was a poor graduate student. If my wage were to triple tomorrow, I would still consume exactly the same amount of milk as I do today. As our material needs (food, housing, transportation) are easier to meet thanks to economic growth, our demand for other goods (culture, amenities, health) increases. For example, health expenditures in South Korea have been growing a hard-to-believe 8.7 percent a year since 2000. As South Koreans have become well-off, they have started asking for more health care. Few things are more precious for a wealthy person than an extra year of life.

[5] Much of the gains in health in the first decades of the 20th century came from improvements in hygiene, vaccination, and drugs triggered by the discovery of the germ theory of disease. These advances, such as washing one's hands regularly, were surprisingly cheap.

[6] Angus Deaton (2012). *The Great Escape: Health, Wealth, and the Origins of Inequality*, Princeton: Princeton University Press.

4. Cost disease. There are many goods and services where technological improvements do not easily translate into higher productivity. If you want to have a 30-minute conversation with your doctor about treatment options, it takes the same 30 minutes that it took 50 years ago. However, as the general level of productivity in the economy increases, the opportunity cost of those 30 minutes or the doctor (and, hence, her wage in a competitive market) has grown as well.

While the first three causes (technological progress, aging, and economic growth) raise challenges for societies (how will we finance Medicare when an older, richer population demands the latest oncological treatment?), they are reasons to celebrate human ingenuity. For instance, according to Mark McClellan and Daniel Kessler, each dollar spent on cardiovascular care has brought four dollars in benefits.[7]

More problematic is the cost disease. However, there is no consensus about how important it is in practical terms: technologies, such as the Internet, allow for a better use of doctors' time, which can compensate for the negative consequences of activities, such as personal consultations, that are harder to mechanize. In fact, other service industries, such as restaurants and retail, have experienced large productivity improvements that seemed unlikely in the 1980s. Amitabh Chandra and Jonathan Skinner have argued that similar improvements in productivity are possible in the health sector.[8]

Interestingly, the growth in health expenditures in the U.S. has slowed down in the last few years (even after controlling for the effect of the financial crisis).[9] The consequences of such a slowdown, if maintained, are considerable. For example, the sustainability of the federal budget hinges on the growth rate of Medicare and Medicaid (in comparison, the expected growth in Social Security benefits as a percentage of GDP is rather small). The literature is still discussing the reasons for this slowdown and whether it will be permanent. While there are some reasons to be optimistic (such as the adoption of information technology across the medical sector), one must remain cautious. A similar slowdown in the second half of the 1990s turned out to be short-lived.

In this section, I have argued that health care is expensive and likely to get more so over time. Our next task is to ask how we can provide it to all in a way that is both efficient and fair.

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[7] Mark McClellan and Daniel Kessler (2002). *Technological Change in Health Care: A Global Analysis of Heart Attack,* Ann Arbor: University of Michigan Press.

[8] Amitabh Chandra and Jonathan Skinner (2012). "Technology Growth and Expenditure Growth in Health Care." *Journal of Economic Literature* 50(3): 645-80.

[9] Amitabh Chandra, Jonathan Holmes, and Jonathan Skinner (2013). "Is This Time Different? The Slowdown in Healthcare Spending." *NBER Working Paper No. 19700.*

3 The Market in Health Services

Every morning, I can drive to Le Petit Mitron, a patisserie close to where I live, outside Philadelphia. For a few dollars, I can buy some of the shop's outstanding baguettes. Patrick, the owner of the shop, is a small business owner. The market provides him with incentives to ensure that his customers have a reliable supply of high-quality bread. Yes, there are health regulations and, yes, the price of the ingredients that go into the baguettes are distorted by agricultural subsidies. But, by and large, the government plays a minor role in guaranteeing that I can have my morning toast. Indeed, most people would find odd the idea of a public bread system. Similarly, most voters would respond with outrage to the idea of being forced into buying a bread-insurance plan.

The reason is simple: many markets work well. There is bread in the bakeries, there are cars at the car dealer, and there are books at bookstores because the price system provides economic agents with incentives to ensure these results. Of course, markets are never perfect outside economics textbooks. More often than not, we face inefficiencies such as limited competition or externalities. The intelligent case for markets has never been that they are flawless, a proposition so obviously untrue that it is not even worth discussing.[10] The case for markets is that they *usually* work *better* than *feasible* alternatives.

Note that I italicized three words, *usually*, *better*, and *feasible*. The word *usually* tells us that, sometimes, markets fail. A market for national defense is unlikely to work because it is impossible for a private air force to defend my house but not that of my neighbor, who refuses to buy the service. The word *better* reminds us that, even when markets do not work well, the alternatives may be worse. Flying with a private airline is a ticket to an unpleasant experience. But those of us who have flown in government-run airlines understand that service can be considerably worse. The final word, *feasible*, emphasizes that one should not judge market behavior against an idealized public service staffed by angels. Alternatives to market systems are run by humans, with their greatness and their shortcomings, and, in particular, without the incentives provided by the profit motive.

Do markets for health work like the market for bread or like the market for national defense? There is no widespread consensus among economists. While few economists would deny that the market for bread works well and even fewer would claim that a market for national defense would work satisfactorily, there is less agreement about the market for health care.

Why this divergence of opinion? The answer comes from a seminal article by Kenneth Arrow, who pointed out that markets for health care suffer from a few peculiarities.[11] Here, I will highlight four of them.

[10] Many enemies of the market system in academia and the media love to draw caricatures of economists so in love with markets that they cannot see their flaws. These caricatures may make for amusing fiction, but they are a rather mediocre sociological observation of my profession.

[11] Kenneth J. Arrow (1963). "Uncertainty and the Welfare Economics of Medical Care." *American Economic Review* 53(5): 941-73.

First, the demand for health care is irregular and unpredictable. I never know when I will be diagnosed with cancer. The costs associated with these unforeseeable contingencies may run into the millions of dollars. Except for the very rich, a health care system exclusively based on one's wealth implies too much risk-bearing. We need a mechanism for sharing these risks. Some of us will never have major health care costs and will die peacefully in our sleep; others will be less fortunate and will use millions of dollars of care. But it is difficult to tell today who will be in each group in 40 years.

Unfortunately, insurance markets are plagued by what economists call *moral hazard* and *adverse selection*. *Moral hazard* means that I change my behavior when I know I am covered by insurance. I once went without health insurance for a week. During that week, I was *really* careful going down the stairs in my apartment building. Now that I am covered, I pay less attention. Moral hazard does not require that everyone start misbehaving (I do not jump down the stairs!), only that some people will be a bit less careful. *Adverse selection* means that I will only enroll in insurance when, in my assessment, the probable benefits I will get out of it are higher than the costs. Many young people enroll in the cheapest, low-services insurance plan they can find. Later, as they age or they marry, they switch their insurance to a more expensive, high-services plan. While this behavior is rational at an individual level, it presents problems for a society. The high-services plans only pool bad risks, raising their costs and hence their prices. A higher price will induce even more people not to take up good insurance, making the pool of risks worse and worse. In fact, you can even have a complete breakdown of the insurance market.

Second, health care is a market where information is highly asymmetric between the seller (the hospital or the doctor) and the buyer. In addition, the buyer often cannot test or value the product. In nearly all markets the seller of a good knows more than the buyer. Patrick, the owner of Le Petit Mitron, knows better than I do the ingredients he uses for bread. But I can easily taste the bread and assess its quality, perhaps not perfectly, but to a fair degree. Also, I know that I prefer an almond croissant to a regular croissant. In comparison, it is much harder for me to asseses the quality of an oncological treatment or to decide which of the different treatments I "prefer." When the difference in information between seller and buyer is small, markets work better than when the difference is large. As other examples, think of the problems of taking your car to the mechanic or hiring a contractor at your house: do you really need that new transmission fluid or that new roof insulation? Few people rank dealing with car mechanics or with contractors as thrilling experiences.

Often, these problems are solved through reputation, either through repeated interaction with the seller or through "social knowledge" such as online reviews. However that leads us to the third peculiarity of the market: purchases of health services are often urgent and non-repeated. If my car breaks down tomorrow morning, I can always rent a car for a couple of days and search for a good mechanic. On the other hand, if I suffer a heart attack, I need immediate attention and I cannot carefully consider the merits of different hospitals. Also, I will not have repeated heart attacks so that I can compare several hospitals.

Finally, many improvements in medical technologies are derived from research that has little immediate "market value." Without research in fundamental mathematics, your cell phone would not work. However, phone companies would have never financed mathematicians in the 1960s who were developing those algorithms because nobody knew at the time that their discoveries would be crucial for a product that had not been invented yet. Without public subsidies for research, technological innovation is bound to slow to a crawl.

Of course, many of these arguments lie in a "gray area." Yes, there are asymmetries of information, but the Internet has lessened them. Yes, the need for many health services is unexpected, but many other services, such as checkups or maintenance treatments, are routine. Yes, we need subsidies for research, but the products that come from it also need to get to consumers. It is a matter of degree and we lack a perfect index to assess whether we are closer to the situation in which *markets work well* or the situation *markets do not work*.

My assessment of the theoretical arguments and my reading of the empirical evidence is that when all considerations have been weighed, a carefully designed market for health care that includes vouchers for basic insurance (taking into account the needs of lower-income families and the chronically ill) plus public subsidies for research and development in basic medical sciences is the best way to organize our health system.

But, before I can outline how such a market would work, I need to discuss how health care is, right now, not working well in the U.S. Those failures, however, cannot fully be blamed on the market system: distortions and regulations are so pervasive in the system that it is hard to call it market-based.

4 Health Care in the U.S.: Problems

I have already pointed out that the U.S. spends considerably more on health care than any other country. That fact, by itself, is neither positive nor negative. The problem comes when we realize that we do not get a good return on our investment.

First, in terms of outcomes. In 2011, the life expectancy at birth in the U.S. was 78.7 years, lower than the average of the OECD (80.1 years) and more than fours years below the leader (Switzerland, 82.8 years). A child born in Slovenia, Portugal, or Greece will live longer, on average, than a child born in the U.S. Part of the difference comes from a high homicide rate, a high traffic accident rate, a high suicide rate, and rampant obesity (all areas where the U.S. does poorly, particularly in the area of overweight, where the U.S. defeats all competitors by several pant sizes). While all of those statistics are deplorable, they are largely beyond the scope of the health care system. However, part of the difference comes from a health care system that falls short for many.

This can be seen, for example, in the case-fatality in adults age 45 and over within 30 days after admission for ischemic stroke, in the rate of surgical complications, in the life expectancy

of cancer patients, or in vaccination rates. While, in most cases, the U.S. does better than the average OECD country along those dimensions, it never reaches the tops of the table and, often, it is outclassed by countries that spend much less on health care.

Second, in terms of fairness. In 2009, 26.2 percent of the poorest Americans visited their dentist, while 56.9 percent of the richest ones did. In France, 63.9 percent of the poorest French visited their dentist in the same period and 82.3 of the richest ones did. The U.S. ranked second in a sample of 16 OECD countries with the greatest inequality in access to dental care (after Canada, although Canada has a much higher level of overall access). Poor Americans go less to the dentist than in any of the other countries in the sample.

Obviously, not everything is bleak: some of the leading hospitals in the world are in the U.S. and U.S. universities, clinics, and firms are world-leaders in medical innovation. When potentates around the world fall ill, they quickly forget their virulent anti-americanism and find their way to the Mayo Clinic. Every year, when the Nobel prizes in medicine and physiology are announced, U.S.-based researchers get a disproportionate share of them.[12]

Where do the problems come from? Why is the U.S. not getting a good return for its money? Because a number of misguided policies undercut cost-control, competition, and efficiency. Let's enumerate some of them.

4.1 The tax deductibility of employer-paid health insurance

In 1942, in an effort to curb war-related inflation, Congress authorized and directed the President to impose widespread price and wage controls. Firms, suffering from shortages of labor and searching to lure employees, started to offer health insurance as an alternative to the temporarily unavailable wage increases. The Internal Revenue Service sanctioned the practice when, one year later, it determined that some forms of employer-based health insurance would be tax free. In 1954, a new Internal Revenue Code solidified and extended the ruling.[13]

This tax deductibility generates important distortions:

1. It changes the relative prices of goods and services. Once you add up my federal, state, and local income tax, my marginal income tax rate is close to 50 percent: all the goods I pay for with pre-tax money are effectively half as cheap as the goods I pay

[12] There is a subtle point here. Canada can afford to squeeze drug companies and obtain better prices from them because Canadians understand that, by doing so, they change little the incentives of those companies to innovate at the world level. If the U.S. were going to do the same, the incentives *would* change and innovation would slow down. There is a compelling case that Europe and Canada enjoy a cheaper health care system because they free ride (or at least they do not contribute their fare share) on U.S. medical innovation. It also shows that those who propose that we copy the Canadian system may not be fully aware of what economists call the general equilibrium effects of policy reform.

[13] Melissa A. Thomasson (2003). "The Importance of Group Coverage: How Tax Policy Shaped U.S. Health Insurance." *American Economic Review* 93(4): 1373-84. There is also a deductibility of out-of-pocket health expenditures, but only for large expenses (currently, 10 percent of adjusted gross income).

for after-tax.[14] Thus, I bias my consumption toward pre-tax goods even when it is not socially efficient to do so. This is why economists are suspicious of tax deductions (for health, education, or pretty much any other good).

2. It induces individuals to purchase low-deductible, low-copay insurance instead of more efficient high-deductible, high-copay plans (a similar problem occurs with Medicare's low-deductible limits). Since the marginal decision about whether to use health care is not determined by price, patients demand extra services, such as redundant tests or luxurious hospital amenities.

3. It triggers the inclusion in health insurance of goods and services that do not have an insurance component. A large share of health insurance premia are, right now, pre-paid health care plans. Imagine that my health insurance could include toothpaste (after all, it is related to dental health). Since health insurance payments are pre-tax, I would rather add toothpaste to it. Given that the insurance company would need to spend some administrative effort in handling the reimbursement of toothpaste, resources are wasted. At the same time, if my insurance pays for the toothpaste, I would be less careful about its use. The health insurance company will respond by setting-up standards for the use of toothpaste (three tubes a year per person!). Before I realize it, I will be spending hours on the phone fighting with a representative of the company about my latest toothpaste reimbursement.

Also, the tax deductibility of employer-paid health insurance means that most employees would not get their health insurance through the individual market but through their employee. This choice has several important drawbacks:

1. It reduces the options of individuals. Most employees are offered only a small set of health insurance options, and they cannot search for those insurance plans that are more convenient for them.

2. It limits labor mobility and entrepreneurship. Workers are "locked" into jobs that are not a good fit for them, but that offer good health benefits. Individuals are reluctant to create their own small businesses because they would lose their health insurance.

3. Finally, it increases the risk associated with unemployment: not only does the worker lose her job, but she also loses her insurance.

4.2 Prices are negotiated by third parties

Since most health care is paid through third parties (insurance companies, Medicare, etc.), the prices of medical services (and the reimbursement formulas) reflect negotiation tactics, complicated contractual arrangements, sharing of profits across different providers, and other factors that have little to do with the marginal cost of a service. Individuals cannot purchase

[14] This difference is also true, although smaller, for lower-income households, where, in addition to the income tax, their marginal dollar is also subject to the payroll tax.

goods directly at a reasonable price, limiting the incentives for cost control. Some services are over-supplied and others are rationed and considerable effort is spent at gaming the system. The cross-effects among all of these different arrangements are nearly impossible to understand, making the consequences of reform unpredictable.

4.3 Restriction in supply

Several important restrictions to the supply of health care raise prices and lower service. The most salient is the limited number of medical doctors. There are 2.5 practicing doctors in the U.S. per 1000 people. The average in the OECD is 3.2. The reason is that there are 6.6 medical graduates in the U.S. per 100.000 people, while the average in the OECD is 10.6. This lower supply means, as any textbook in microeconomics would predict, that medical doctors' wages are higher than what they could be. The average U.S. physician makes 5.5 as much as the average worker while the average Swiss doctor makes only 2.1 times as much. While there are other reasons to account for these differences in relative wages, the limited supply of doctors is a prominent one.[15] Medical schools, if allowed, could train a substantially larger number of students without a significant reduction in quality.

Other important limitations to the supply of health care include:

1. Around 36 states have certificate of need programs that impose regulatory approval for the expansion of medical facilities or major capital projects.

2. Insurance regulations at the state level have precluded the appearance of a national insurance market, reducing competition. This problem is particularly serious in small states and in rural areas.

3. The government has not enforced anti-trust legislation vigorously enough in the health care sector. In particular, the McCarranFerguson Act shields insurance companies from anti-trust litigation.

4. Abusive malpractice suits have led to defensive practice and excessive litigations costs. For example, Daniel Kessler and Mark McClellan have calculated that defensive treatments with minimal health benefits have increased the costs of heart disease among elderly Medicare beneficiaries between 3 to 7 percent.[16]

5 Health Care in the U.S.: Current Reforms

Not surprisingly, the problems of the U.S. health care system outlined in the previous section have led to a major reform with the Patient Protection and Affordable Care Act (PPACA)

[15] Uwe Reinhardt, Peter Hussey and Gerard Anderson (2002). "Cross-National Comparisons of Health Systems Using OECD Data, 1999." *Health Affairs* 21(3): 169-181.

[16] Daniel Kessler and Mark McClellan (2002). "Malpractice Law and Health Care Reform: Optimal Liability Policy in an Era of Managed Care." *Journal of Public Economics* 84(2): 175-197.

of 2010. The PPACA is not totally without merit. It imposes an excise tax on high-cost health plans that compensates for some of the worst consequences of the tax deductions, it creates health exchanges that increase competition, and it advances the idea that cost must be controlled and adverse selection in the insurance market reduced. However, the PPACA has failed at addressing important problems and will probably exacerbate many others, increasing the danger of a move to a single-payer, government-run system in the middle run.

While I would not try to analyze the shortcomings of the reform (which would require a whole chapter by itself), I will note that:

1. The cost control measures in the PPACA are insufficient because the underlying problem of misaligned incentives has not changed. In fact, by lowering out-of-pocket payments in some cases, it may worsen it. The actual cost control measures, based on administrative decisions, are bound to be resented by the public and create strong political forces against their enforcement.

2. The phase-out of private insurance subsidies will generate effective marginal taxes as high as 80 percent for some families, with large negative consequences for labor supply and human capital accumulation.

3. Additional regulation will create the demand for additional regulation as the problems of the former are likely to be interpreted as failures of the remaining market aspects of the system.

4. The dependence of some health care regulation on the size of the firm's work force will create distortions in the size distribution of firms and in their growth. This phenomenon is well-known in Europe, where collective bargaining regulations also depend on the firm size.[17]

6 Health Care in the U.S.: Proposals

Given the problems with the PPACA, what *can* we do about the health care system in the U.S.? The word *can* could be understood in two ways: *can* as in what one could do given control of the presidency and both houses of Congress or *can* as in what is feasible given the actual structure of the U.S. electorate, the two political parties we have, and the interest groups we endure. I will focus on the first meaning of *can*: I will not worry about whether or not the proposals would ever get 60 votes in the Senate to break a filibuster. I am an economist, not a politician, and I will leave it to someone else to figure it out how to gather the required votes. But knowing where the final goal lies is important to avoid getting lost in the daily partisan debate. I would not propose, however, ideas so far away from the mainstream that there is no course of events whereby they could be enacted. There is enough prudence in me to prevent that.

[17] Luis Garicano, Claire LeLarge, and John Van Reenen (2013), "Firm Size Distortions and the Productivity Distribution: Evidence from France." *NBER Working Paper 18841.*

Among the main proposals, and skipping many of the technical details in the interest of concision, I would highlight:

1. The elimination of the tax deductibility of health insurance and the move toward a system of individual portable insurance for unforeseeable contingencies plus health-savings accounts (HSAs). The government should not discourage employer-sponsored health coverage (once, of course, its tax treatment is put on a common ground with other health insurances). It may be the case that the market, on its own, will discover that this is an efficient way to provide health care and we should not prevent this discovery from happening (although I do not think this will be case: few employees get car insurance through their firm).

2. The introduction of vouchers for the purchase of health insurance. The federal government would define a minimum health insurance package that includes catastrophic coverage, high-deductibles (possibly capped by income levels), is transferable, and has guaranteed renewal. Health insurance companies would be certified to offer such a package at an actuarially fair price and at the national level. The federal government would offer a voucher to each individual to purchase such insurance.[18] Such a voucher, while respecting individual freedom (nobody would be forced to buy health insurance), would induce a nearly universal take-up rate and eliminate the worst consequences of *adverse selection* in the insurance market.[19] The basic voucher could be complemented by special additions in cases where extra care is required (such as chronic conditions). It is better to separate these conditions to allow for a cleaner pricing system.

3. Enhancing the role of HSAs, which should be the normal way to pay for preventive and routine health care.

4. The voucher system plus additional credits to top off the HSAs of lower-income households could be a substitute for Medicaid and other similar programs.

5. Medicare should add more cost control measures, including higher (means-tested) co-payments. Also, Medicare should move toward result-based payments (hospital and doctors will be paid according to their results in improving patients health) and away from input-based payments (hospitals and doctors are paid for services they provide). This would be particularly useful in improving preventive care.

6. The deregulation of the insurance markets to increase competition and technology adoption. In particular, insurance markets should become national, and aside from the minimum health insurance package, insurance companies should have as much freedom as possible to offer individual plans.

[18] Technically, the voucher could be a refundable credit in the income tax. For example, if the voucher is for $1000 and the tax liability is $2500, the household would pay $1500. If the tax liability is only $400, the household would receive $600 from the federal government.

[19] The government would need, in the short run, to educate the public about the system. Low take-up rates are already a problem in Medicaid and the State Children's Health Insurance Program. Also, some financial adjustments would be required to equilibrate the ex-post different pools of consumers across insurance providers.

7. The enforcement of anti-trust regulation for all participants in the market, while allowing for mergers of hospitals when economies of scale are at stake.

8. Increasing the number of medical doctors, both through a higher number of medical school graduates and through targeted immigration. The Accreditation Council for Graduate Medical Education should limit itself to quality control, and not engage in quantity control.

9. The modification of malpractice regulation to return to a system that ensures liability but prevents abuse. In particular, caps on non-economic damages and widespread (and enforceable) mediation outside the courts are promising avenues of reform.

10. The acceleration in the adoption of new technologies that save costs through a number of regulatory changes. Among those, the repeal of the certificate of needs programs, the elimination of barriers to entry in the health care sector, and the relaxation of medical practice statutes restrictions on to how to organize health care provision (for example, allowing a better management and coordination of specialist care). In particular, specialized providers should face fewer restrictions on their activities.

11. The distribution of information among patients about health care options, treatments, and the quality of providers. Health care providers should also have access to better clinical guidelines, success rates, and medical errors through integrated databases. These databases should be protected from abuse by plaintiffs in medical malpractice suits who would like to use them as discovery tools. Also, the use of "big data" may help in identifying and correcting hot spots of medical expenditure and high-cost patients.

12. A redesign of the support for basic research and development to maximize its impact in the long run.

This long list of proposals must be completed with a note of humility. Designing a better and fairer health system is a daunting challenge. When faced with this challenge, I cannot but remember what F.A. Hayek wrote in his last book *The Fatal Conscience*: "The curious task of economics is to demonstrate to men how little they really know about what they imagine they can design." Even though I am more sanguine than Hayek about our prospects for reform, we may err and have to adjust our policies along the way. Or, simply, as society and technology change, we may also need to let institutions respond.

7 Concluding Remarks

I am not the bearer of good news for those who have tired of the debate about health care reform over the last five years. The health care system is bound to become a permanent focus of the policy discussion. Demographics and technological improvements will ensure that.

Economics tells us that we can do better. Distributive justice demands from us that we do better. A judicious combination of market forces, regulation, and transfers can provide us

with more efficient health care for all at a cheaper price. More important, the failure to fix the current problems and the refusal to accept the existence of those problems shown by many who claim to defend freedom means that we risk a backlash against markets in the near future. In particular, the move to a universal single-payer system looms on the horizon. Because, as Edmund Burke reminded us in 1790, "A state without the means of some change is without the means of its conservation."