

The Economics of Healthcare

All of us would like to lead long, healthy lives. And given the choice, we would prefer to do so without ever having to endure the surgeon's scalpel, the nurse's needle, or the dentist's drill. Yet good health rarely comes so easily. Achieving a long, healthy life often requires the input of scarce resources, and that makes it, at least in part, an economic problem. About one out of every six dollars spent in the U.S. economy goes to some form of healthcare, including spending on physicians, nurses, dentists, hospitals, pharmaceutical drugs, and medical research scientists. Understanding the modern economy, therefore, requires an appreciation of the special economics of healthcare.



We begin this module by examining some of the economic forces that shape the healthcare system. The standard theory of how markets work is the model of supply and demand, in which buyers and sellers are guided by prices to an efficient allocation of resources. Yet, as we will see, the market for healthcare deviates from this model in many ways. These deviations often call for government policies to ensure that healthcare resources are allocated efficiently and equitably. And, indeed, in most nations, governments are deeply involved in healthcare markets.

After discussing the forces at work in healthcare markets, we look at some key facts that describe the healthcare system in the United States. The healthcare system today is very different from what it was fifty years ago, and it is also different from the healthcare systems in other nations. Recognizing these differences is important for understanding the healthcare system we have as well as for imagining systems we could have.

The proper scope of government intervention in the healthcare system is a topic of continuing political debate. We won't go into the details of that debate here. But this basic introduction to the economics of healthcare should help you become a more informed participant in what will surely be an ongoing national discussion for many years to come.

1 The Special Characteristics of the Market for Healthcare

The standard theory of how markets work is the model of supply and demand, which we studied in Chapters 4 through 7. That model has several notable features:

1. The main interested parties are the buyers and sellers in the market.
2. Buyers are good judges of what they get from sellers.
3. Buyers pay sellers directly for the goods and services being exchanged.
4. Market prices are the primary mechanism for coordinating the decisions of market participants.
5. The invisible hand, left to its own devices, leads to an efficient allocation of resources.

For many goods and services in the economy, this model offers a reasonably good description.

Yet none of these five features of the standard model reflects what goes on in the market for healthcare. Like other markets, the healthcare market has consumers (patients) and producers (doctors, nurses, etc.). But various features of this market complicate the analysis of their interactions. In particular:

1. Third parties—insurers, governments, and unwitting bystanders—often have an interest in healthcare outcomes.
2. Patients often don't know what they need and cannot evaluate the treatment they are getting.
3. Healthcare providers are often paid not by the patients but by private or government health insurance.
4. The rules established by these insurers, more than market prices, determine the allocation of resources.
5. In light of the foregoing four points, the invisible hand can't work its magic, and so the allocation of resources in the healthcare market can end up highly inefficient.

Healthcare is not the only good or service in the economy that departs from the standard model of supply, demand, and the invisible hand. (Recall our discussions of externalities and monopoly.) But healthcare may be the most important good or service that departs so radically from this benchmark. Examining the special features of this market is a good starting point for understanding why the government plays a large role in the provision of healthcare and why health policy is often complex and vexing.

1a The Prevalence of Externalities

As you may recall from Chapter 10, market outcomes may be inefficient when there are externalities. To recap: An *externality* arises when a person engages in an activity that influences the well-being of a bystander but neither pays nor receives compensation for that effect. If the impact on the bystander is adverse, it is called a *negative externality*. If it is beneficial, it is called a *positive externality*. In the presence of externalities, society's interest in a market outcome extends beyond the well-being of buyers and sellers who participate in the market to include the well-being of bystanders who are affected indirectly. Because buyers and sellers neglect the external effects of their actions when deciding how much to demand or supply, the externality can render the unregulated market outcome inefficient.

This general conclusion is crucial for understanding healthcare, because externalities in the market are so prevalent. These externalities can call for government action to remedy the market failure.

Take vaccines, for example. If one person vaccinates herself against a disease, she is less likely to catch it. But because she is less likely to catch it, she is less likely to become a carrier and infect other people. Thus, getting vaccinated conveys a positive externality. If getting vaccinated has some cost, either in money, time, or risk of adverse side effects, too few people will choose to get themselves vaccinated because they will likely ignore the positive externalities when weighing the costs and benefits. The government may remedy this problem by subsidizing the development, manufacture, and distribution of vaccines or by requiring vaccination.

Another example of an externality in the healthcare system concerns medical research. When a physician figures out a new way to treat an ailment, that information enters society's pool of medical knowledge. The benefit to other physicians and patients is a positive externality. Without government intervention, there will be too little research.

Governments respond to this externality in many ways. Sometimes, the government grants the researcher a patent on the new product, as is the case with new pharmaceutical drugs. The patent gives an incentive for research because the patent holder can profit from a temporary monopoly. The patent is said to internalize the externality. Yet this approach is not perfect because the monopoly price is higher than the marginal cost of production. As we discussed in Chapter 15, the high monopoly price reduces consumption of the patented treatment, leading to inefficiency as measured by the deadweight loss. Moreover, the high price may be particularly hard on lower-income patients.

Another approach to dealing with the positive externality from medical research is for the government to subsidize the research—and indeed it does. The annual budget of the National Institutes of Health, which funds medical research, is over \$30 billion, or about \$100 per person. This policy requires taxation to raise the necessary funds, and taxation entails deadweight losses of

its own. But if the externalities from the funded research exceed the cost of the research, including the deadweight losses, overall welfare can increase.

1b The Difficulty of Monitoring Quality

In most markets, consumers know what they want, and after a transaction is completed, they can judge whether they are happy with what they got. Healthcare is different. When you get sick, you may not know what the best treatment is. You rely on the advice of a physician, who has years of specialized training. And even with hindsight, you cannot reliably judge for yourself whether the treatment the physician offered you was the right one. Sometimes state-of-the-art medicine fails to improve a patient's health. And given the natural restorative power of the human body, the wrong treatment can sometimes appear to work.

The inability of healthcare consumers to monitor the quality of the product they are buying leads to various regulations. Most important, the government requires physicians, dentists, nurses, and other health professionals to have licenses to practice. These licenses are granted only after an individual attends an approved school and passes rigorous tests. Those caught practicing without a license can be imprisoned. Similarly, the Food and Drug Administration (FDA) oversees the testing and release of new pharmaceutical drugs to make sure they are safe and effective.

In addition to government regulation, the medical profession monitors itself by accrediting medical schools, promoting best practices, and establishing professional norms of behavior. A physician's advice is supposed to be based entirely on the patient's best interest, not on the physician's personal gain. When patients accept the advice, they rely on a degree of trust, which is often fostered by long-term relationships between doctor and patient.

Suspicious about the standard economic motive of self-interest and the role of trust in healthcare relationships may explain the prevalence of nonprofit hospitals. In some ways, hospitals are like hotels, but while most hotels are for-profit businesses, most hospitals are run by the government or established as nonprofit entities. When consumers are not able to judge the quality of the product they are buying, they may be more willing to trust an institution that is not set up primarily to enrich its owners.

To be sure, these public and private regulations of healthcare have their critics. For example, some economists have argued that there are too many hurdles to opening new medical schools. They suggest that the medical profession acts like a monopoly: By restricting the number of doctors, it drives up doctors' salaries and consumers' healthcare costs. Other economists have argued that the FDA is too slow in approving new drugs. Some patients who might have benefited from experimental treatments are forced to go without them. The proper balance between protecting public safety and giving people the freedom to make their own healthcare decisions is a subject of ongoing debate.

1c The Insurance Market and Its Imperfections

Because people don't know when they are going to get sick or what kind of medical treatments they will need, spending on healthcare is unpredictable. This uncertainty, and how people respond to it, is a key reason why we have the health institutions that we do.

risk aversion
a dislike of uncertainty

The Value of Insurance Most people are **risk averse**. That is, they dislike uncertainty. Imagine that you face a choice between a certain income of \$100,000 and

a 50-50 chance of income of \$50,000 or \$150,000. The two options offer the same average income, but the second is riskier. If you prefer the certain \$100,000, you are risk averse.

The same behavior arises from the randomness of health spending. Suppose that some disease affects 2 percent of the population and that everyone is equally likely to be stricken. Treatment costs \$30,000. In this case, the expected cost of healthcare is 2 percent of \$30,000, which is \$600. If people are risk averse, they prefer to pay \$600 with certainty over a 2 percent chance of having to pay \$30,000.

Giving people this option is the purpose of insurance. The general feature of insurance contracts is that a person facing a risk pays a fee (called a *premium*) to an insurance company, which in return agrees to accept all or part of the risk. There are many types of insurance. Car insurance covers the risk that you will be in an auto accident, fire insurance covers the risk that your house will burn down, and health insurance covers the risk that you will need an expensive medical treatment. In our example, a health insurance company can charge a premium of \$600 (or slightly more to make a profit) in exchange for promising to cover the cost of the \$30,000 treatment for the 2 percent of its customers who get the disease.

Markets for insurance are useful in reducing risk, but two problems hamper their ability to do so fully and efficiently.

Moral Hazard The first problem that impedes the operation of insurance markets is **moral hazard**: When people have insurance to cover their spending on healthcare, they have less incentive to engage in behavior that will keep that spending to a reasonable level. For example, if patients don't have to pay for each visit to a doctor, they may go too quickly when they experience minor symptoms (a runny nose, an achy finger). Similarly, physicians may be more likely to order tests of dubious value when they know an insurance company is picking up the tab.

Health insurance companies try to reduce the problem of moral hazard by finding ways to encourage people to act more responsibly. For instance, rather than picking up the entire cost of a visit to a physician, they may charge patients *co-pays* of, say, \$20 per visit to deter patients from making unnecessary visits. Similarly, insurance companies may have strict rules about the circumstances under which they will cover the cost of certain tests that physicians order.

Adverse Selection The second problem that impedes the operation of insurance markets is **adverse selection**: If customers differ in their relevant attributes (such as whether they have a chronic disease) and those differences are known to customers but not observable by insurers, the mix of people who choose to buy insurance may be especially expensive to insure. In particular, people with greater hidden health problems are more likely to buy health insurance than are healthy people. As a result, for an insurance company to cover its costs, the price of health insurance must reflect the cost of a sicker-than-average person. Even people with average health may see the high price and decide to go without insurance. As people drop coverage, the insurance market fails to achieve its purpose of eliminating the financial risk from illness.

Adverse selection can lead to a phenomenon called the *death spiral*. Suppose that, because a person's health profile is private information, insurance companies must charge everyone the same price. At first, it might seem to make sense for a company to base the price of insurance on the health characteristics of the average person in the population. But after it does so, the healthiest people may decide that insurance is not worth the cost and drop out of the insured pool. With a sicker

moral hazard

the tendency of a person who is imperfectly monitored to engage in dishonest or otherwise undesirable behavior

adverse selection

the tendency for the mix of unobserved attributes to become undesirable from the standpoint of an uninformed party

group of customers than expected, the company has higher costs and therefore has to raise the price of insurance. The higher price now induces the next healthiest group of people to drop insurance coverage, which drives up the cost and price again. As this process continues, more people drop coverage, the insured pool gets less healthy, and the price keeps rising. In the end, the insurance market may disappear.

The problem of adverse selection has been central in the debate over health policy. For example, the Affordable Care Act (signed by President Obama in 2010 and often called “Obamacare”) prevented health insurance companies from charging more to cover people with pre-existing medical conditions. This rule was enacted to help people with ongoing medical problems, but it was also a recipe for adverse selection: People with pre-existing conditions would view insurance as a better deal than those without them and, therefore, would be more likely to buy health insurance. Healthy people would have an incentive to wait until they got sick before buying insurance.

Lawmakers were aware of this problem. To combat it, the Affordable Care Act required *all* Americans to buy health insurance and imposed a financial penalty on those who did not. (It also gave subsidies to help low-income households afford insurance.) The goal of the mandate was to increase the number of healthy people buying insurance, thereby reducing the problem of adverse selection and lowering the cost of insurance. As more healthy people entered the insurance market, those without pre-existing conditions would, in effect, subsidize those with them.

Analysts differ in their views about how successful the Affordable Care Act has been in improving the healthcare market. Many people (presumably healthy ones) chose to remain uninsured and pay the penalty. One interpretation of this fact is that the penalties for not purchasing insurance were too small to prevent a significant amount of adverse selection. Yet the law has increased the number of people with health insurance, which was one of its main goals. The share of the population without insurance fell from 16 percent in 2010 to 9 percent in 2015.

1d Healthcare as a Right

Normally, when some people don’t buy a good or service, perhaps because they think it costs too much given their income, that outcome is not a major problem for society. For example, suppose that a ticket to a hit Broadway show becomes expensive and lower-income consumers choose other forms of entertainment. We may lament that good theater is not enjoyed more widely, but few would argue this rises to the level of a great injustice.

Healthcare is different. When a person gets sick, it seems wrong that a low income would be a reason to deny treatment. Healthcare, unlike a ticket to a Broadway show, is arguably a human right. This judgment goes beyond the scope of economics and is best left to political philosophers, but we should acknowledge this belief as we study the economics of healthcare.

In some ways, healthcare is like food. Food is necessary to survive, and as a society we try to ensure that everyone has the resources to get the food they need. That is the purpose of the Supplemental Nutrition Assistance Program (SNAP), formerly known as Food Stamps. There is, however, an important distinction between food and healthcare. Over time, the price of food has risen more slowly than incomes, and so affording an adequate diet has taken up a declining share of the typical household’s budget. By contrast, because the cost of state-of-the-art healthcare has risen rapidly, affording it has required an increasing share of the typical household’s budget.

Healthcare being viewed as a right, along with its rising cost, has led to a large role for the government. In many nations, such as Canada and England, the government runs the healthcare system, financed mostly by taxes. This system is sometimes called *single payer* because one entity—the government’s health service—pays all the bills.

By contrast, in the United States, most people have private health insurance, often through their employers, but the government still has a sizable presence. Medicare provides health insurance for those 65 and older; Medicaid provides health insurance for the poor; the Veterans Health Administration offers healthcare to former members of the military; and the Affordable Care Act regulates the market for private health insurance and gives insurance subsidies to many lower-income households. Whether these programs can be improved, and if so how, remain topics of debate. But there is little doubt that, with healthcare often viewed as a human right, the government will continue to play a large role in the healthcare system.

1e The Rules Governing the Healthcare Marketplace

The importance of health insurance, whether provided by private companies or the government, requires that the market for healthcare work differently than most other markets in the economy. The typical market—say, the market for ice cream—looks like panel (a) of Figure 1. The market has buyers and sellers. A seller offers a good or service at a price. A buyer who wants the item simply has to offer up the right amount of money. An exchange is made, and soon the seller is counting her profit and the buyer is enjoying his ice-cream cone.

The market for healthcare looks more like panel (b). The provider (the seller of medical services) is not paid directly by the patient (the buyer). Instead, the patient pays money to an insurer in the form of either a premium (if the insurer is a private company) or taxes (if the insurer is the government). The insurer uses this money to compensate the provider, who in turn provides medical services to the patient.

This process requires three sets of rules to guide behavior. The first set determines the financing—that is, who pays for the insurance and how much they pay. If the

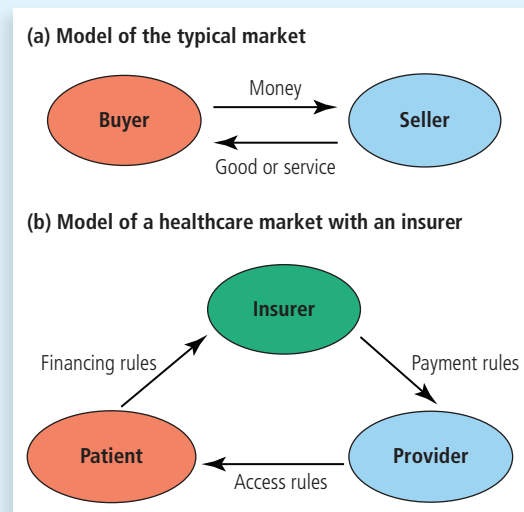


FIGURE 1

How an Insurer Changes a Market

In a typical market, shown in panel (a), a seller delivers a good or service to a buyer, who in exchange pays the seller a market-determined price. In a healthcare market, shown in panel (b), the provider delivers healthcare to the patient, but the provider is paid by an insurer (either the government or a private company). This arrangement requires rules for financing, access, and payment.

insurer is the government, paying for healthcare becomes part of designing the tax system. If the insurer is a private company, healthcare is financed by the price that health insurance purchasers pay for their coverage. The price is set in the insurance market, which (like other markets) bases price on costs. In many cases, however, state and federal governments regulate the market for private insurance. For example, they may limit the extent to which companies can charge different prices based on age, sex, and pre-existing conditions. Thus, even when the financing of healthcare occurs between a patient and a private insurer, it is still shaped by public policy.

The second set of rules determines a patient's access to healthcare. As we have discussed, because insured patients do not pay the marginal cost of each medical service they consume, there is the possibility of overuse. To mitigate this problem of moral hazard, the insurer (whether the government or a private firm) has rules to limit access to when it makes sense. In other words, these rules ration the use of medical services based on estimated costs and benefits. For example, a patient may be able to get a routine check-up no more than once a year, may have access to only a limited number of doctors, or may need a referral from a general practitioner before making an appointment with a more expensive specialist. Such access rules are necessary because, once people have insurance to pick up the cost, market prices are no longer giving them the right signals about how to allocate scarce resources.

The third set of rules determines the payments from insurers to providers. These rules establish both what an insurer will pay for and how much they will pay. Treatment prices influence which treatments providers guide patients toward. Insurers may deem some treatments too expensive, too experimental, or insufficiently valuable to pay for them at all. In such cases, providers will often not offer patients the services. Sometimes, however, providers will offer the services only if the patient pays the full cost of the treatment (as is often true with cosmetic procedures). In this case, the market for healthcare reverts from panel (b) in Figure 1 to the more typical market in panel (a).

The rules regarding financing, access, and payment are related, and together they shape the kind of healthcare system a nation has. For nations with a government-run system, these rules are set by public policy. For nations with more private insurance, such as the United States, these rules are set by insurance companies as they compete for customers, subject to various government regulations.

2 Key Facts about the Healthcare System

Now that we understand the main economic forces at work, let's look at some data that describe the U.S. healthcare system. We first examine what we get from it, as measured by how long people live. We then see how much healthcare costs us, how much other nations pay, and how we pay the bill.

2a People Are Living Longer

We start with some good news: People are living longer than ever before. Figure 2 shows life expectancy over time in the United States. Life expectancy measures how long people born today would live, on average, if they faced current mortality rates at every age. You can see that it has increased substantially over time. Life expectancy in 1900 was just 47.3 years. It increased to 68.2 years in 1950 and to 78.8 years in 2015.

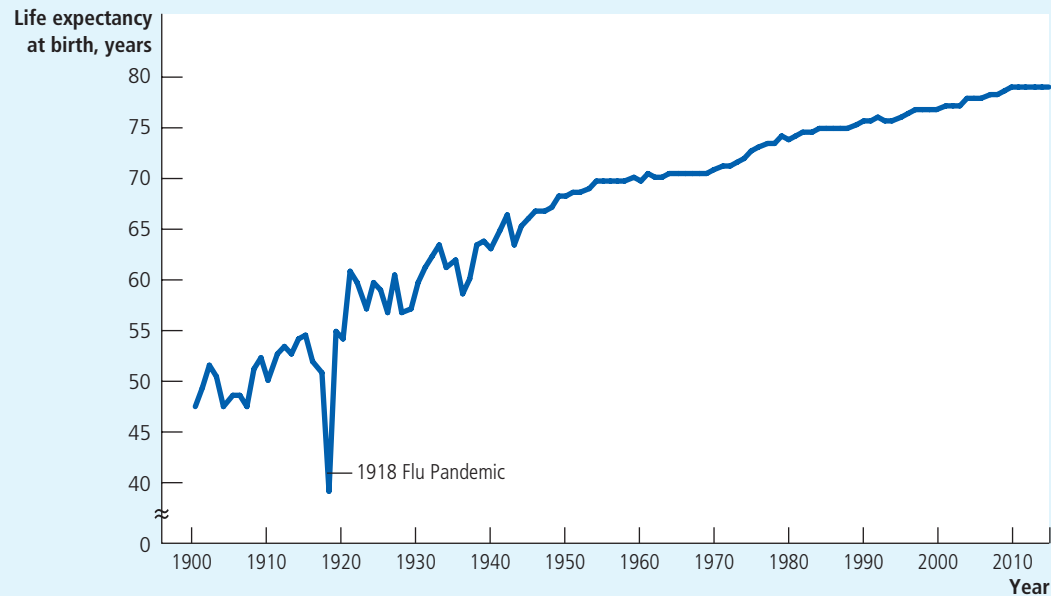
A large part of the increase in life expectancy is due to a decline in infant mortality. At the beginning of the twentieth century, about 10 percent of children died before the age of one. Today, the infant mortality rate is less than 0.6 percent.

The number of years a person can expect to live has increased substantially over time.

Source: Centers for Disease Control and Prevention.

FIGURE 2

U.S. Life Expectancy



Much of the credit for the increase in life expectancy goes to advances in medical technology. Physicians now know more about how to prevent disease and how to treat medical problems when they arise. But other developments play a role as well. For example, improvements in sanitation—specifically, the availability of clean water and the adequate disposal of sewage—has reduced the spread of disease. In addition, the rate of fatalities from car accidents is now half what it was in 1950. Credit for this change goes to advances in automotive safety, such as seat belts and air bags.

2b Healthcare Spending Is a Growing Share of the Economy

Figure 3 shows healthcare spending in the United States as a percentage of GDP (a measure of the economy's total income). Health spending has risen from 5 percent of GDP in 1960 to 18 percent in 2015, and there is no sign that this increase is about to stop.

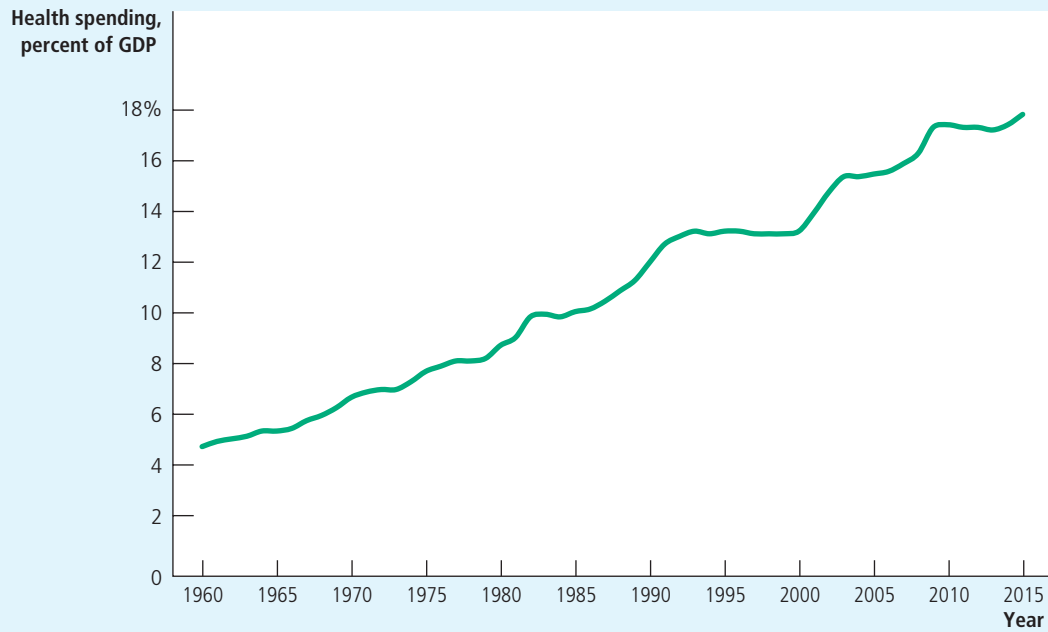
What explains this trend? Several forces are at work.

First, some medical care, such as a doctor's visit, is a personal service, much like a barber's haircut or a teacher's lesson. Economist William Baumol pointed out long ago that for many providers of personal services, productivity does not change much over time. But as the rest of the economy experiences technological progress, labor productivity and overall wages increase. Those supplying personal services will come to expect rising wages along with the rest of the labor force. Yet without much productivity growth in those sectors, the only way to give these service providers higher wages is for the prices of their services (adjusted for overall inflation) to increase. In other words, when overall productivity

FIGURE 3**Health Spending as a Share of GDP: Changes over Time**

The percentage of the U.S. national income devoted to healthcare has increased over time.

Source: Center for Medicare & Medicaid Services.



is rising, a symptom of being a sector with low productivity growth is increasing costs and prices. This phenomenon is called *Baumol's cost disease*. And if the demand for the services of these sectors is price inelastic, as it is for healthcare, spending on those services will increase as well.

Second, while there have been significant advances in medical technology, many of these advances, rather than being cost-saving, have increased spending. In the past, physicians had little treatment for many diseases. Bed rest and wait-and-see (and leeches!) were sometimes the best they could offer. Today, we have more options for treatment. These new treatments extend and enhance the quality of life, but they are often expensive.

Third, changes in the population may have increased the demand for healthcare. In particular, as social norms for women have evolved, birth rates have fallen. Fifty years ago, the average woman had about three children over her lifetime, compared with about two children today. This fall in birth rates, along with rising life expectancy, has altered the relative sizes of various age groups. The share of the U.S. population 65 years or older increased from 9 percent in 1960 to 15 percent in 2015. Because the elderly consume more healthcare than the young, an older population leads to greater healthcare spending.

Fourth, over time, society has become richer, and that change may have increased the share of spending on healthcare. Average income per person, adjusted for inflation, is today more than three times what it was in 1960. As incomes rise, we spend more on many things, but we don't increase spending on all items proportionately. How we choose to spend the extra income depends on preferences. For example, as incomes increase, the share of spending on food declines

because the marginal value of consuming more calories declines rapidly. By contrast, the marginal value of years of life declines slowly and so, as we get richer, we may spend a higher fraction of our budget on healthcare. In other words, healthcare may be a good with an income elasticity greater than one. Estimates based on international comparisons put this elasticity at about 1.3.

In light of these four forces, the increasing share of health spending in the economy may be inevitable. In and of itself, higher healthcare spending is not necessarily a problem. But it does mean that the policy challenges of this sector will loom larger over time.

2c Healthcare Spending Is Especially High in the United States

Figure 4 shows healthcare spending as a percentage of GDP for seven major developed nations. One striking fact is that the United States spends an especially high fraction of its GDP on healthcare. Most developed nations spend 9 to 12 percent of GDP on healthcare, while the United States spends more than 17 percent.

Critics of the U.S. healthcare system use this comparison to argue that the United States is uniquely inefficient. They point out that life expectancy is higher in some nations that pay less for healthcare, such as Canada, France, and Japan. They sometimes suggest that greater reliance on government rather than private health insurance, as is the case in most other nations, could lower costs without adversely affecting health outcomes.

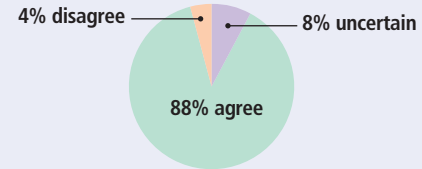


ASK THE EXPERTS

Baumol's Cost Disease

“Because labor markets across different sectors are connected, rising productivity in manufacturing leads the cost of labor-intensive services—such as education and health care—to rise.”

What do economists say?



Source: IGM Economic Experts Panel, May 16, 2017.

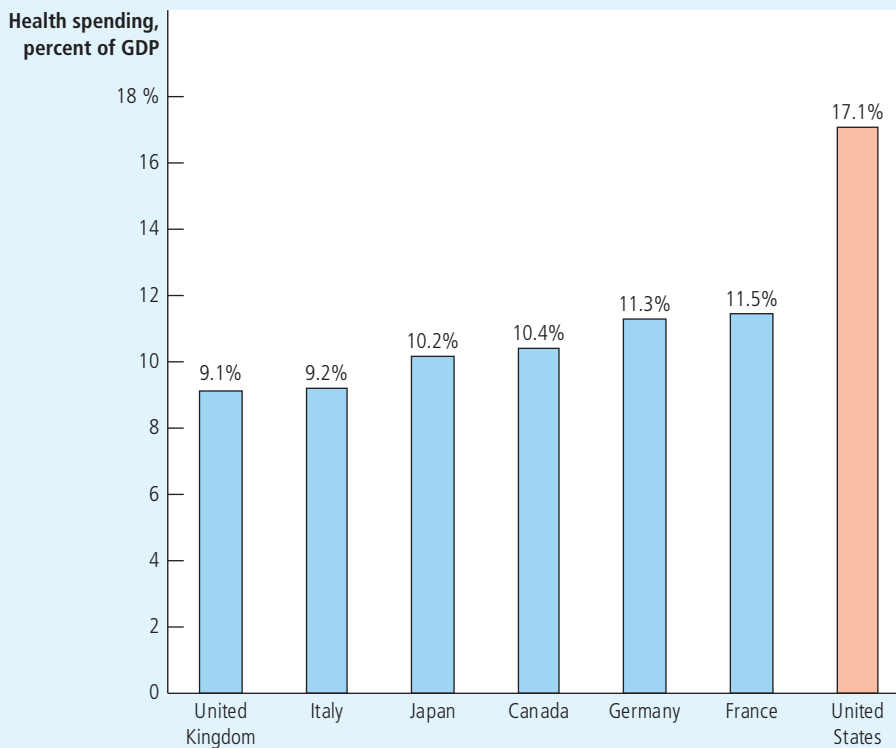


FIGURE 4

Health Spending as a Share of GDP: International Comparison

The United States spends a much larger share of its income on healthcare than do other nations.

Source: The World Bank. Data are for 2014.

Defenders of the U.S. healthcare system accept that some reforms might reduce costs, but they believe that reliable conclusions are hard to draw from the international comparisons. For example, the rate of obesity is higher in the United States than it is in the other six nations in Figure 4. Higher rates of obesity reduce life expectancy and increase health care costs. Thus, some of the international differences observed in health data do not shed light on healthcare systems but, instead, reflect differing lifestyle choices regarding diet and exercise.

One notable and widely debated difference between the United States and other nations concerns pharmaceutical pricing. Canadians on average spend about 30 percent less on drugs than Americans do (and residents of most European nations spend even less). Often, the same drug is much cheaper on the Canadian side of the border than on the American side. The reason is that Canada, with its centralized government-run health system, maintains strict controls over drug prices. Critics of the U.S. healthcare system believe that pharmaceutical companies are taking advantage of America's less centralized system by charging exorbitant prices for patented drugs. They argue that the U.S. government should follow Canada's lead and undertake more aggressive regulatory policies to reduce drug prices. Defenders of the U.S. system believe that expanding price controls into the United States would substantially reduce the incentives for pharmaceutical companies to engage in research into new drugs. Consumers would benefit from lower prices today, but they would bear the cost of a smaller range of treatments in the future.

2d Out-of-Pocket Spending Is a Declining Share of Health Expenditure

When you consume the services of a healthcare provider, such as a physician or dentist, the provider is compensated in one of two ways. Either you pay the provider directly out of your own pocket or a third party, such as a government insurance program or a private insurance company, pays the provider for you.

Figure 5 shows the percentage of spending on personal healthcare that is paid out of pocket in the United States. The percentage has declined from 56 percent in 1960 to 12 percent in 2015. Conversely, third-party payment has risen from 44 to 88 percent of health spending. Of the large amount that is *not* paid out of pocket, just over half is paid by government insurance programs, such as Medicare (the program for the elderly) and Medicaid (the program for the poor); just under half is paid by private insurance companies.

The increasing importance of health insurance is understandable. Because the need for healthcare is unpredictable, as it gets more expensive, people will seek to protect themselves from the uncertainty by obtaining insurance.

Yet many economists believe that the United States health system has become too reliant on health insurance, especially for small or routine expenditures. They believe that excessive insurance exacerbates the moral hazard problem discussed earlier and thereby drives up healthcare costs. To explain excessive insurance, they note that the U.S. income tax gives preferential treatment to employer-provided health insurance. Compensation in the form of health insurance is tax-exempt, unlike cash compensation. As a result, employees have an incentive to bargain for more generous (and thus more expensive) health insurance than they otherwise would, reducing the amount of healthcare they pay out of pocket.

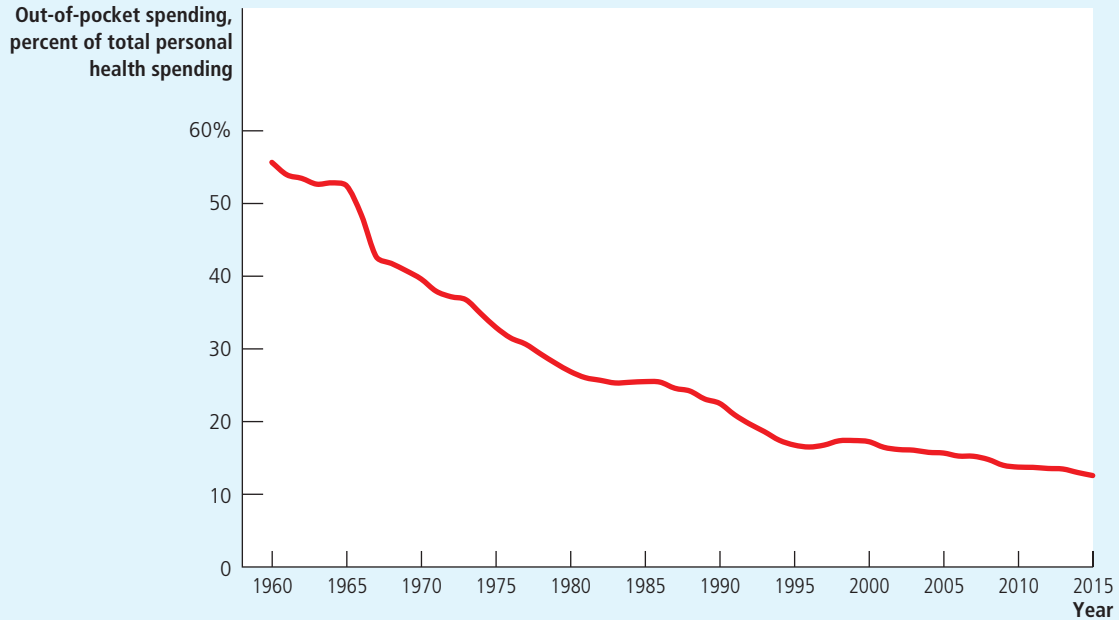
The Affordable Care Act tried to remedy this problem by levying a so-called "Cadillac tax" on especially expensive employer-provided health plans. This policy would level the playing field between paying workers in the form of cash compensation and paying them in the form of generous health insurance. That is, the tax code would no longer give an incentive for excessive insurance. The Cadillac

FIGURE 5

Out-of-Pocket Spending as a Share of Total Personal Health Spending

The share of U.S. personal healthcare that households pay for themselves has declined over time. The share paid by third parties—government programs and private health insurers—has increased.

Source: Center for Medicare & Medicaid Services.



tax was originally scheduled to go into effect in 2018 but has been delayed until 2020.

3 Conclusion: The Policy Debate over Healthcare

This module has introduced some of the facts and economic insights useful in understanding the market for healthcare. Most of these ideas are widely accepted by the economists who study healthcare. Despite this consensus, there is ongoing debate among U.S. policymakers about what role the government should play in the healthcare system.

Those on the political left would like to see an expanded government role. They often believe that private insurance companies are particularly inefficient and too often put profit ahead of people. Some on the left would like the government to offer people a *public option* in the healthcare system—that is, a government-run insurance program that any person can buy into instead of purchasing private insurance. Others would like to move toward a *single payer* system in which the government pays for

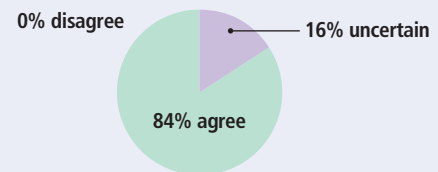


ASK THE EXPERTS

Cadillac Tax

“The ‘Cadillac tax’ on expensive employer-provided health insurance plans will reduce costly distortions in U.S. health care if it is allowed to take effect as scheduled in 2018.”

What do economists say?



Source: IGM Economic Experts Panel, May 17, 2016.

healthcare for everyone out of tax revenue, as Medicare now does for the elderly. They point to Canada as a successful model. A centralized system run by intelligent administrators, they argue, is best able to reduce administrative inefficiency, eliminate wasteful treatment, bargain with providers for lower costs, and allocate healthcare resources most equitably to where they are most needed.

Those on the political right would like to reduce government's role in the healthcare system. They acknowledge that the market for health insurance needs to be regulated, but they would like the regulation to be less heavy-handed than it is now. They believe that the best healthcare is likely to arise as private insurers and providers compete for consumers. They worry that a centralized government-run system would limit individual freedom, excessively ration care, and stifle innovation. They view Canada not as a role model but as an example of what could go wrong. Waiting times for medical procedures can be long in Canada, and those who can afford it sometimes choose not to wait and instead come to the United States for medical procedures.

The debate over health policy also needs to be understood as part of the larger debate over income inequality and the role of government. As we first discussed in Chapter 1, society faces a trade-off between equality and efficiency, and that fact looms large when discussing the provision of healthcare. Those on the political left want to provide universal health coverage to all citizens, regardless of income, either through government insurance programs or by subsidizing private insurance for low-income households. But paying for these policies requires higher taxes on higher-income households, and those taxes distort incentives and shrink the size of the economic pie. Those on the political right are more concerned about the distortionary effects of taxes and income redistribution. They advocate more limited government and lower taxes to expand the economic pie. But smaller government revenue means fewer public resources to help those who struggle to get the healthcare they need.

This debate raises hard and important questions, and this module does not try to offer up easy answers. But this introduction to healthcare economics should give you a starting point for thinking through the many issues.

KEY CONCEPTS

risk aversion, p. 4

moral hazard, p. 5

adverse selection, p. 5

QUESTIONS FOR REVIEW

1. Give two examples of externalities in the healthcare system.
2. Explain moral hazard and adverse selection in the market for health insurance.
3. Describe the three sets of rules that are necessary in a healthcare market with an insurer.
4. Give three reasons why life expectancy has been increasing over time.
5. How does spending on healthcare in the United States compare with spending 50 years ago? Give four economic forces that might help explain the trend.
6. How does healthcare spending in the United States compare with spending in other developed nations?
7. Explain the rationale for the "Cadillac tax" on expensive health insurance plans.