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Abstract

The U.S. health care system is often criticized for being the most expensive in the world while delivering mediocre health outcomes. While policymakers on both the right and left agree about the need for reform, they disagree strongly about whether that reform should involve a smaller role for government or a larger role. At the same time, the U.S.' high costs and mediocre health outcomes likely are at least partly attributable to lifestyle choices that occur outside of the health care system, creating another possible avenue for intervention. This introduction to the symposium on "Free Markets and Health Care" discusses how welfare economics provides a useful tool in evaluating the appropriateness of government involvement in markets related to health and health care. The papers in the symposium provide important new evidence to help inform debates about, for instance, regulations on health care providers and insurers, health insurance expansions, and policies designed to influence health behaviors.

Keywords: Free markets, health, health care, market failure, government failure, welfare economics

JEL Codes: I11, I12, I13, I18

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I. Introduction

The U.S. spends far more on health care than every other country in the world, with health care expenditures accounting for 18% of GDP compared to 13% in the next-highest country and 10% on average across OECD nations. At the same time, the U.S. fares worse than the OECD average in terms of life expectancy and avoidable deaths (Gunja, 2023). These facts serve as the motivation for calls for health care reform on both sides of the political aisle. However, whereas Republicans generally argue that the problem is too much government, Democrats often feel that the problem is too little. Both arguments are possible because the U.S. health care system represents a complex amalgamation of private markets and government intervention that is unique in the developed world. For instance, while health care is mostly provided by the private sector and the majority of people have private health insurance, these markets face extensive regulations. Moreover, non-profits play a major role in the delivery of hospital services, and public insurance – which tends to cover disproportionately high-risk individuals like the poor and elderly – pays almost half of medical bills (American Medical Association, 2024). This heavy involvement of both private markets and government leads some people to argue that free markets do not work in health care, while others argue that they have never truly been tried.

Complicating the matter further is the fact that high costs and mediocre health outcomes need not solely be the fault of the health care system. They could also be attributable to unhealthy choices such as overeating, sedentary lifestyles, and substance use. Perhaps most notably, the U.S. has the world's highest obesity rate, which contributes to high rates of chronic diseases like diabetes, heart disease, and cancer (Gunja, 2023). The role of risky behaviors leads to additional public policy questions such as whether the government should tax or regulate unhealthy goods.

II. Welfare Economics and Health Care

Neoclassical welfare economics provides a useful starting place for evaluating the appropriate role for government in markets related to health. Critically, what matters is not necessarily *which*

outcomes occurred, but instead *why* they occurred. According to the first fundamental theorem of welfare economics, free markets lead to efficient outcomes as long as certain assumptions hold – namely, no market power, no externalities, and perfect information. Therefore, the relevant question for policy is not, for instance, what a country's life expectancy is, but instead whether it is shortened by any instances of market power, externalities, or imperfect information. If no such instances can be identified, government intervention is not justified on efficiency grounds. If such instances *can* be identified, the next question is whether these inefficiencies are due to inherent features of the market (market failure) or government policies (government failure). If government failure is the culprit, the prescription would generally be to undo the offending policy, unless the policy was necessary to rectify an even more serious problem. If market failure is to blame, then appropriately targeted intervention – i.e. one that aims to address the specific failure – can improve efficiency. For example, the remedy for imperfect information would be to ensure the provision of the information, not to tax or ban the product in question.

To illustrate, high health care expenditures reflect a combination of high prices and quantities, but are these always bad? Suppose Americans simply have a stronger demand for medical care than residents of other countries, either because of preferences or income. This higher demand naturally leads to higher prices and quantities. Addressing this situation by, for instance, imposing price ceilings would indeed lower prices, but – as any economics major would know – it would lead to shortages and ultimately reduce social welfare. Relatedly, single-payer health care systems are often credited with reigning in health care costs, but what matters from a welfare economics perspective is *how* they lower these costs. They generally do so by exploiting monopsony power, as the single payer – the government – sets the fees and imposes limits on their increases. In other words, the government creates market power for itself – a textbook example of inefficiency due to government failure. Strictly speaking, this means that the highly celebrated cost savings from single-payer insurance actually represents

inefficiency rather than efficiency when viewed through the lens of welfare economics. The long wait times that tend to be associated with single-payer systems speak to this.

It is perhaps harder to argue that mediocre health outcomes are socially desirable, but it is still possible. Health represents one component of utility, but not the only component. People routinely make choices that are not the best for their health, presumably because the consumption value of that choice – whether it be eating junk food, drinking alcohol, having unprotected sex, speeding, skydiving, etc. – outweighs the added health risk. In the case of medical care, health would be presumably maximized by everyone having a full range of screenings on a daily basis, but no one argues that such intensive treatment would be socially desirable. Again, what matters from a welfare economics perspective is not what the population-wide health outcomes are *per se*, but *why* they occurred. If mediocre health outcomes are merely the result of fully informed consumers deciding that they enjoy their pizza, beer, and cigarettes enough to be worth the health consequences, then welfare economics would not object. In that case, paternalistic policies such as "sin taxes" might improve population health, but would do so in a way that *worsens* social welfare.

With all that said, it is important to not view each policy in insolation. Economic arguments for market failures in health care are numerous and date back to Arrow (1963). For instance, the information asymmetry between physicians and patients is a textbook example of the principal-agent agent problem. This creates the potential for induced demand for medical care, where the individuals selling the service have the ability to leverage their information advantage to sell consumers on low-marginal-value care. Asymmetric information in insurance markets takes a different form, with consumers knowing more about their risk levels than insurers. This can lead to adverse selection and an uninsured rate much higher than the efficient level, opening the door for the government to impose regulations or mandates or provide insurance directly. At the same time, the pooling of health care risks brought about by insurance leads to negative externalities, as purchases made by one member of the

pool are ultimately paid by others in the form of higher premiums, or taxes in the case of public insurance. This is a phenomenon known as moral hazard. Additionally, the market for health care delivery features barriers to entry that give market power to incumbent providers. These barriers result from both inherent features of a highly skilled and specialized industry, such as the need for training and the purchase of expensive facilities and equipment, as well as government actions such as licensing requirements and certificate-of-need laws.

While there are numerous other possible market and government failures in health care, these examples are sufficient to make an important point: policies that would be inappropriate if implemented in isolation in an efficient market can become desirable when viewed in conjunction with the other distortions. For example, government fee setting does not necessarily make matters worse if it is in response to other failures making prices inefficiently high. Induced demand, moral hazard, and barriers to entry all push in the direction of excessively high prices, and government fee-setting could theoretically be desirable if it counteracts these forces. Of course, *how* the government sets fees is vitally important, and with such a heavily distorted price signal in the market, it is difficult if not impossible to identify what prices *should* be and to set them accordingly. Moreover, policymakers may face stronger incentives to reward special interests in their price setting than to aim for economic efficiency.

Similarly, if smoking rates are excessively high because of the externality of secondhand smoke, or if obesity rates are excessively high because of imperfect nutritional information, or if people generally engage in excessively risky behaviors because of pooled health care costs, paternalistic policies could be welfare improving. Again, though, identifying how intensively to intervene is easier said than done, both because of political pressures and the difficulty of identifying what the efficient levels of risky behaviors actually are.

If all that is not complicated enough, the second fundamental theorem of welfare economics opens the door for another justification for policy intervention: redistribution, or equity. Put simply, we as a society may prefer a somewhat smaller but more evenly distributed economic pie to a larger but less equal pie. Redistribution and equity tend to be particularly important considerations when it comes to health because high-quality health care is more likely to be seen as a fundamental human right than other products or services. Equity provides another rationale for public or heavily subsidized health insurance, among other policies.

While a strong theoretical rationale for a particular policy intervention is a good start, it is only a start. Empirical evidence, obtained through rigorous econometric methods designed to disentangle correlation from causality, is necessary to determine if the policy is working as intended and if it has had any unintended consequences. Costs are obviously another important consideration, and economic principles are also helpful in evaluating those, as the economic concept of opportunity cost tells us to consider the value of the best foregone alternative when evaluating whether a particular choice. Given multiple solutions to a particular market failure, priority should be given to the lowest-cost (or highest-revenue) option, all else equal. Structural econometric modeling can be used to quantify welfare effects more precisely under certain assumptions, but theory combined with reduced-form evidence can still make progress towards understanding the direction of these effects.

III. Symposium Papers

The above discussion makes clear, if nothing else, that the debate over the relative merits of free markets versus government intervention in health and health care is complicated and multifaceted. There is not a single answer to the question of whether there should be more or less government; rather, the answer is context-specific and depends on the presence of market or government failures, whether there is a compelling equity-based rationale for action, and the effectiveness and costs of possible solutions. The papers in this symposium, which I co-edited with Aaron Yelowitz, make

important contributions to our understanding of a wide range of health policy issues, ranging from regulations related to health care delivery, expansions of insurance coverage, and non-medical determinants of health.

Regulations Related to Health Care Delivery

The first three papers in the symposium evaluate impacts of regulations related to health care delivery in the U.S. First, Chen and Dills study telemedicine parity laws, which require private insurers to cover medical care provided remotely. At a glance, offering options for care that reduce transaction costs, especially in cases where physical examination would not influence diagnosis or treatment decisions, seems worthwhile. However, mandating insurance coverage would only be necessary if there are reasons to expect that private markets would otherwise underprovide telehealth services. This is not an easy question to answer. Insurers, whose incentive is to keep costs down, make decisions on behalf of patients, whose incentive is to overconsume low-value care if they are responsible for only a small portion of the bill – perhaps especially so if visiting the doctor is as easy as opening an app on one's phone. Given the possible incentives for inefficient behavior on both sides, telehealth could be either overprovided or underprovided in the absence of regulation. One way to indirectly assess which of these is the case is to examine effects on health outcomes, particularly extreme ones like mortality. If telehealth parity laws save lives, then at least some of the additional medical care they are inducing is high-value, helping to rule out moral hazard. Accordingly, Chen and Dills find that parity laws decrease mortality rates, particularly for ischemic heart disease.

The next two papers relate to occupational licensing, which fits into the broader debate about barriers to entry in health care. Presumably some barriers to entry, such as education and training, are necessary, since one would not want to visit a doctor who was a lawyer last week. However, whether licensing requirements (on top of education and training) are needed to ensure adequate quality of care

is less clear. If they are not, then their presence would push barriers to entry beyond the efficient level, leading to higher prices and longer wait times.

Yelowitz and Ingram's study examines occupational licensing for emergency medical technicians alongside the positive demand-side shock from the Affordable Care Act's (ACA's) health insurance expansions. They find evidence that, while the ACA's demand-side shock increased entry by 18 percentage points, stringent occupational licensing requirements offset essentially that entire effect. In other words, licensing regulations inhibited the ability for quantity supplied to adjust to keep up with demand.

Bhai and Mitchell's paper examines a different aspect of occupational licensing: scope-of-practice laws. Expanding the range of services physician assistants and nurse practitioners are allowed to perform would reduce barriers to entry and increase supply, presumably bringing down prices and helping to alleviate shortages. On the other hand, if quality of care suffers, the net effect on welfare could be negative. Bhai and Mitchell find that reforms allowing nurse practitioners independent practice authority increase parental assessments of children's health, implying that the gains from increased access outweigh any potential reductions in average quality of care.

Indirect Policy Implications

The next two papers do not evaluate the impacts of specific policies but have indirect policy implications. Ruseski and Matti examine geographic clustering in health care services using data from Phoenix Yelp reviews. This study relates to debates about whether physicians should be nudged (e.g. through subsidies) to locate in underserved areas. The argument for intervention in location decisions is largely equity-based; if health care is a fundamental human right, it follows that not only should there be some form of universal health insurance coverage, but people should also not be so far from medical providers that access is impeded. This issue is particularly salient in low-income urban communities where residents might rely on public transportation, as well as rural areas with insufficient numbers of

residents to support local health care providers. Matti and Ruseski find that general practitioners are more widely dispersed than specialists, with specialists being more likely to cluster around hospitals. There is an efficiency rationale for this equilibrium, as specialists need convenient access to hospitals to perform procedures. However, these results also point to potential access challenges for people who do not live close to hospitals.

Collier and Williams' study contributes to our understanding of optimal insurance plan offerings. They examine data from a large employer than offers only two insurance plan options and find that a large number of people still make plan choices that are clearly suboptimal in terms of both out-of-pocket costs and expected utility. This paper fits into the behavioral economics literatures on choice overload, limited attention, and limited cognitive bandwidth, which together suggest that more choice is not always better. The fact that clear mistakes occur with only two plan choices implies that choice overload can occur with even a small number of options if the choice is complex. Does such a phenomenon necessitate policy intervention? If the reason for the mistakes is imperfect information, there is a market-failure rationale. However, such an explanation seems too simplistic, since employers already provide detailed information on insurance options. A clearer rationale relates to the more controversial concept of internalities, in which people – whether due to an inability to understand the information, limited attention span, or time-inconsistent preferences – systematically make choices that are not utility-maximizing. In effect, they impose an externality on their future selves. Any interventions should aim to rectify the source of the internality, such as by providing information in a simpler, easily digestible form. More extreme responses like imposing restrictions on the number of choices may do more harm than good. Moreover, it is unclear whether such policies should be implemented by the government instead of the employer.

Health Insurance Expansions

The next three studies estimate impacts of government interventions designed to increase health insurance coverage. The ACA, signed in 2010 with most major components taking effect in 2014, deployed several policy levers in an effort to achieve nearly universal health insurance coverage in the U.S. The law provides an excellent illustration of the "whack-a-mole" nature of policymaking. Its starting place was an equity motivation: concern over people with pre-existing conditions having coverage denied or dropped or being priced out of the non-group insurance market. The ACA addressed this problem by prohibiting these practices and requiring modified community rating of premiums, only allowing limited variation by age and smoking status. Realizing that doing this in isolation would lead to adverse selection and destroy the non-group market, the ACA included a mandate for individuals to have coverage or face a tax penalty, thereby keeping "good risks" in the pool to offset "bad risks". However, stopping there would require young and healthy people to buy a product they did not want at an inflated price that they might not be able to afford. This led to generous income-based subsidies, delivered through a government-run Health Insurance Marketplace. The ACA also included a Medicaid expansion in an effort to cover low-income individuals. Realizing that these additional paths to coverage would disincentivize employers from providing it, the law included a mandate for firms with 50 or more employees to offer coverage, and also prohibited individuals with access to employer-sponsored insurance (ESI) from purchasing subsidized Marketplace coverage.

The paper by Lennon focuses on the effect of the ACA on the availability of employer-sponsored health insurance (ESI). Since nearly all large companies already offered ESI before the ACA, Lennon uses their workers as a control group and examines impacts on workers at smaller firms (under 250 employees). He finds that the ACA increased the likelihood of workers at smaller firms reporting ESI being available by 5.2 percentage points. However, he does not find evidence of an increase in the

probability of taking up ESI coverage. Instead, employees newly eligible for ESI are disproportionately low-wage and appear to have taken up Medicaid instead – an example of crowd-out.

As discussed previously, increases in health care utilization from insurance expansions need not be welfare-improving due to moral hazard, and one way to indirectly shed light on the extent of moral hazard is to test for improvements in health. Hoodin et al.'s paper examines the impact of the ACA's Medicaid expansion on self-reported health outcomes, with an emphasis on those with chronic conditions. They find that health improvements were larger for those with chronic conditions than those without them, but the difference was not statistically significant.

The study by Koumpias et al. turns back the clock before the ACA and investigates the mortality effects of state Medicaid expansions for adults in the 1990s and 2000s. Recent work has documented decreases in mortality from the ACA, but Koumpias et al. ask whether similar results are observed for other health insurance expansions that occurred without the same levels of fanfare and outreach. They find no evidence that any of eight substantial state-level Medicaid expansions reduce all-cause, healthcare-amenable, non-healthcare-amenable, or HIV-related mortality. This is the case regardless of whether the states are examined separately or pooled together.

Non-Medical Policies

Of course, health can be influenced by numerous policies that are not intended to directly influence the health care sector. These include interventions related to risky health behaviors, but also some policies that on the surface appear to have nothing to do with health. One such example is the minimum wage, which can have health effects by influencing employment status and income. The study by Clemens and Wither adds another way in which increasing the minimum wage could influence health, which is by affecting eligibility for Medicaid. Since Medicaid eligibility is inherently all-or-nothing, small increases in income can render someone ineligible on the margin. Clemens and Wither first show that, in the absence of labor market frictions, workers who receive a minimum wage increase can retain

Medicaid eligibility by making small adjustments to work hours. However, with frictions, workers can face a choice between leaving their job or losing Medicaid. Their empirical results are consistent with low-wage workers facing substantial frictions, implying that being the beneficiary of a minimum wage increase can actually leave someone worse off.

The symposium's final two papers focus on risky behaviors. Tchernis et al. revisit the widely studied question of whether quitting smoking leads to weight gain. The existing literature has reached paradoxical conclusions, with descriptive medical studies consistently showing weight gain after smoking cessation but quasi-experimental economics studies finding a relationship between cigarette taxes and weight that implies an effect in the opposite direction. Tchernis et al. implement a novel econometric method and show that accounting for misreporting of smoking can flip the sign and yield estimates in line with the descriptive medical evidence. These results have implications for optimal cigarette taxes and other anti-smoking policies. If exogenously inducing individuals to quit smoking has the unintended consequence of contributing to obesity, then the welfare gains form such policies are smaller (or the losses greater) than they would be otherwise. More generally, considering spillovers to other types of health behaviors is vital when evaluating policies intended to influence one behavior.

Pesko and Cooper make the same point in a different way by showing that indoor vaping restrictions *increase* infant mortality. This seemingly paradoxical result can be explained by the substitutability of e-cigarettes and traditional combustible cigarettes (which are generally considered more harmful) observed in numerous other studies. If mothers are induced to switch from vaping to smoking by indoor vaping restrictions, as opposed to quitting tobacco use completely, then infant health outcomes can worsen rather than improve. Again, viewing single behaviors in isolation can lead to inappropriate policy conclusions.

IV. Conclusion

In the midst of debate about a Republican alternative to the ACA, President Trump remarked, "Nobody knew health care could be so complicated" (Liptak, 2017). I humbly suggest that health economists might disagree. The complexity surrounding appropriate health care policy stems in part from the size and complexity of the health care industry, but also in part from how substantially the sector deviates from the assumptions made in standard economic models. Barriers to entry, externalities, and imperfect information abound in health care, sometimes from inherent features of the market and sometimes from distortionary public policies. While some distortionary policies are inevitably explained by public-choice-style misaligned incentives facing policymakers, others result from well-intentioned solutions to problems that create new problems. In an environment with so many interconnected parts, even incremental change is difficult – to say nothing of major system-wide reforms.

All hope is not lost, however. As Tom Hanks' character said in *A League of their Own*, "The hard is what makes it great" (Fagan, 2019). Opportunities abound for scholars well-trained in the intricacies of the health care system, the insights of welfare economics, and cutting-edge econometric methods to help inform intelligent policy design. The papers in this symposium advance debates along a number of fronts, and my hope is that they inspire more economists to join the conversation.

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