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Making Sense of the Health-Care Reform Debate

Robert Hockett

Much of the confusion over the health-care debate can possibly be minimized, writes this law professor in an essay that goes to first principles, if we recognize that health insurance is much like a public utility. He makes a fresh if philosophical case for his argument that is well worth reading. The result is more clarity about what the health-care debate is all about and what direction a solution should take.

OST OF THOSE ENGAGED IN THE 2009 HEALTH-CARE REFORM DEBATE have been inexplicit and unsystematic about the insurancetheoretic premises of their arguments. It should therefore be helpful to call back to mind some of the apparently forgotten "basics" of insurance and social insurance, as both theoretical and practical disciplines. By reminding ourselves of these fundamentals, we will better understand what is at stake in the current debate, as well as what the protagonists are driving at in their more obscure moments. More important, we will be better equipped to judge among alternative proposed plans.

In what follows, I first lay out systematically those fundamentals of insurance that are most relevant to the current health-care reform debate, as well as the market failures to which insurance is always

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structurally prone. Then I explain how those failures are intensified when what we wish to insure against is catastrophic loss of health.

The upshot of the discussion is that the challenges to which health insurance is inherently prone render it a classic candidate for what has venerably been called "social insurance"—the category under which fall social security, Medicare, Medicaid, AFDC (Aid to Families with Dependent Children), and like programs that have long enjoyed broad popular support. I am careful to distinguish this phrase—"social insurance"—from the other "social" word with which demagogues now are extravagantly conflating it—"socialism." Finally, I indicate how much more sensible some proposals look than others when viewed as what they are: would-be solutions to a classic social insurance problem.

Insurance: How It Works, When It Works, When It Does Not

You might not know it, if you listen to the present debate over health-care reform as conducted in the mass media, but there is actually a well-developed theory of insurance. There is also a sophisticated understanding of how insurance works in the proverbial "real world." Rudiments of the subject were familiar to the biblical Joseph and Pharaoh, as well as to Thales, the ancient Greek philosopher who apparently designed the first "futures" contract—as it happens, for olives, ahead of a harvest that Thales expected to come up short. Much of the most interesting work done by contemporary economists as celebrated as Akerlof, Arrow, Borch, and Stiglitz, moreover, has been devoted to insurance and cognate subjects.¹

The fundamental idea behind insurance is deceptively simple. Bad things happen to good people, who often can do little or nothing to prevent them. Many of these things, moreover, occur "at random" so far as their individual victims are concerned, though with surprisingly predictable regularity so far as their frequency among the larger population is concerned. We know, in other words, that these catastrophes are highly likely to befall some but not all of us, through no

fault of our own. We just do not know whom. And because we do not know whom, we know it is possible that anyone—you, I, or someone in whose shoes you or I might have stood—might be the next faultless victim. Inasmuch as none of us knows who *will* be next, while each of us knows that she or he *might* be next, we are all risk-bearers. And we are in a sense "all alike," or "all one," in the face of these risks: It can happen to any of us. We are "in it" together.

Insurance is simply the time-honored means by which we *act* together to *address*—to "pool"—these risks we all face and to do so as fairly and efficiently as possible.

Assume that you are a farmer and so am I. Say there are a hundred of us farmers, in fact. Each of us owns a barn and must have that barn in order to farm; our barns are our principal capital outlays. Say we also know that, in general, one in every hundred barns catches fire and burns every year, notwithstanding the best efforts of each of us to prevent fires in our barns. Now if each of us acts entirely alone, it will be tempting for each of us to attempt to set aside money, up to the value of our barns, to ensure that we are able to replace our barns should they burn. After all, if you lose your barn to next year's fire, you are wiped out. So you will want to be prepared in order to avoid that contingency. And if you act alone, you will have to do all the preparing yourself.

But that is inefficient: There is only a 1 percent chance that your barn will burn. Yet you are trying to set aside—under the mattress, so to speak—the full value of your barn, and that is an awful lot of money doing nothing. Should you set aside only 1 percent of the value of your barn, then, since that is the expected value of your possible loss? That does not seem satisfactory either. For if your barn does burn, you will lack 99 percent of what you need to replace it, while the 1 percent you have set aside will have been set aside unproductively, since it is not enough to replace the barn anyway.

And this, of course, is why insurance was developed. Instead of each of us acting alone, we act together. We cooperate—we jointly pool our several risks. We notice that there are one hundred of us, we realize that this means that one of us will lose her barn, we also realize that

we do not know who the unlucky farmer will be, and so we jointly chip into one pool one hundred contributions that aggregate to the value of one barn. If each of us chips in 1 percent, the full risk will be covered, each of us will have paid in her fair share, and each will accordingly be fully covered against the risk of a lost barn, leaving the other 99 percent of the value of her barn free for investment in more seed or equipment or whatever.

Now notice that this arrangement is not only efficient but fair: We not only minimize the amount that has to be set aside to provide against risk, we also apportion the shared risk-burden equally: Everyone puts in the same, and everyone has equal—which in this case is to say full—coverage against the risk of losing her livelihood. (I am, of course, assuming here that all barns are alike for the sake of simplicity.) Fairness and efficiency often run together like this in insurance markets, a fact that doubtless accounts for the attractiveness of insurance-reminiscent "veiled choice" scenarios in the writings of some justice theorists.² Below, I will address forces that sometimes prise apart the two attributes further.

Now while our barn parable is of course highly stylized and simplified, it nevertheless carries within it all central features of insurance theory and practice as developed by economists and actuaries. The best way to show this is by simply summarizing what these people have singled out as the basic prerequisites to smoothly functioning insurance arrangements, referring back to the parable of the barns along the way. I will also emphasize the flip sides of these requisites the forms of market failure to which insurance is prone.

Event Independence

The first requisite to well-functioning insurance arrangements typically singled out by theorists and practitioners is that the contingencies against which people wish to insure—what we call "insured events"—be as statistically "independent" of one another as is practicable.³ The contrary of independence is "covariance." Whether my barn burns must be independent of whether your barn burns. The catastrophe that is a burning barn must not be "contagious." A sweeping prairie fire of the sort that could take out all of our barns in one go will be harder to insure against than will, say, more discrete, lightning-caused fires. Indeed, if the would-be pool is to be limited to those who inhabit the prairie in question, we will not be able to insure against such fires at all.

Risk-pooling works only when risks actually eventuate only for some, rather than all, in the risk pool. If our risks are not independent but instead covary, it means that the risk in question tends to occur in wavelike fashion, hitting most or all whenever it hits one. In such case the logic of pooling breaks down. There are no unaffected parties to cross-compensate affected parties. This is why it has been historically difficult, for example, to insure against floods. "When it rains, it pours." When water levels rise in a particular vicinity, they tend to soak all in that vicinity, meaning that there are no lucky winners to compensate unlucky losers—at least not until insurance pools grow large enough to embrace contributors from multiple vicinities.

Note that there is an *affirmative* lesson in this last observation in addition to the negative one: All else equal, you get greater independence and less covariance among insured events—hence better-functioning insurance arrangements—as you enlarge the insurance pool. That is part of why real-world insurance companies tend to grow larger and larger, with more and more diversified pools of policyholders. Insurance arrangements, in short, tend to enjoy "scale" or "network" effects, meaning in turn that they bear "natural monopoly" characteristics. But more of this below in connection with the market failures to which insurance is prone.

Cost Estimability

The second requisite for well-functioning insurance arrangements is the so-called verifiability and probable-cost measurability—in sum, the "estimability"—of insured events' occurrence and associated harm.⁴ In the burning barn parable, I assumed that we know one barn in a hundred will burn each year, and that we know both when a barn

burns and what it costs to replace a burnt barn. I assumed, that is, a specific probability distribution and a specific cost associated with the would-be insured event that is a barn's burning. In the absence of such knowledge, we would not know how much to set aside, or how much to require that each member of the pool chip in. In modern insurance parlance, that is just to say that those who seek insurance would not know how much coverage to seek, while those who manage the pooled funds would not know how much in the way of premiums to assess. This requirement is as stark in the case of a market arrangement as it is in the case of some nonmarket or hybrid arrangement. Workably rational markets require rationally priceable products.

It is worth noting in connection with this estimability requirement that here, too, as in the case of event independence, the broadening of insurance pools tends to enhance the workability of insurance. The reason is that we tend to acquire better statistical knowledge both of the costs occasioned by insured events and of their likelihoods, as we widen the field of those whose risks we insure: a straightforward consequence of the "law of large numbers." So in respect to this requisite, too, there is a tendency for insurance pools to enjoy economies of scale: All else equal, the more who take part in insurance arrangements, the more feasible and efficient insurance becomes. But again, more of this below, particularly since all else is not always equal.

Symmetric Information

The third requisite to a well-functioning insurance arrangement is that there be a reasonable degree of "informational symmetry" between insurers and insureds.⁵ The contrary condition—asymmetric information or informational asymmetry—for its part comes in two particularly well-known flavors: what we call *adverse selection* in the one case, and *moral hazard* in the other.

Roughly speaking, the first—adverse selection—refers to cases in which those seeking insurance are feared to know something about their own vulnerability that providers of insurance do not—knowledge that might be what prompts the seeker to seek insurance in the first

place. Where prospective insurers reasonably have this fear, they tend to shy away from providing, which is to say that they tend in the direction of offering no insurance at all. Voluntary insurance *markets*, in particular, accordingly tend to break down in these cases.

To return to the barn story, suppose that ten of us have formed an insurance pool of the sort previously described. Now an eleventh farmer, who refrained from joining our pool before, asks to join. Hmm, we wonder, why the change of heart? Does he know something we do not—for example, that one his many children, whose identity he cannot seem to ascertain, has taken to smoking in secret in the barn—which might account for his sudden interest in seeking to join our insurance pool? The more difficult it is for us to find answers to such questions, the more reasonable our fears will be, and the more economically rational it will look for us to decline membership in the pool to this prospective new member. We will fear there is a conscious "selection bias," operating "adversely," in the "market" that we have been asked to expand to this eleventh farmer.

How do we address this problem? One way is to render the insurance contingent upon certain warranties required of those seeking insurance-guarantees that there is no "hidden defect" of which the would-be insured but not the insurer is aware. In effect, this is to quarantine the sorts of possible information that worry us and yet elude our capacities to ascertain: we "symmetricalize" salient information between insurer and insured by holding that what we cannot ascertain simply shall not qualify for insurance. Another, complementary way to address adverse selection is to require that all prospective insured parties join insurance pools, so that no suspicions need attach to the act of seeking enrollment in the insurance pool. In effect, this is to take away reasons for fearing asymmetric information by eliminating what would have been a plausible inference concerning the motives of those seeking insurance. Which of these means of addressing adverse selection is best-imposing warranties or imposing insurance itself upon all—rides upon further considerations to be addressed below.

The second flavor of asymmetric information tending to block successful insurance arrangements, moral hazard, comprises cases in which

insureds grow psychologically or financially complacent about risks in virtue of their insurance itself, and in consequence act (or omit) in manners tending to heighten the probability that the insured risks will eventuate. In our barn story, for example, some of us might refrain from taking measures to protect our own barns-not stocking them with water buckets or fire extinguishers, for example—precisely because being insured makes us feel safer. This is probably the most familiar pathology afflicting insurance markets, tending to drive up premiums over time when it is not possible simply to refuse to render insurance. Nearly as familiar are the principal, albeit imperfect means developed over time to mitigate moral hazard—"merit rating," "bonus-malus pricing," deductibles, and copayments. The first two, notwithstanding the technical ring of the terms, simply involve higher charges to people who have poor track records-boosting premium rates for smokers or for drivers who have caused accidents, for example. The second two involve ensuring that some cost will remain borne by the insured even when insured events occur, so that there will be at least some disincentive against willfully or carelessly occasioning the events.

You might have noticed, from what I have just said, that moral hazard is one impediment to well-functioning insurance arrangements that does not seem to be addressable simply by broadening risk pools. The only means we have for addressing moral hazard is attempting to ensure, so to speak, greater morality—greater responsibility or accountability—on the part of insured parties. You likely will also have noticed, however, that all of the impediments to well-functioning insurance arrangements *other* than moral hazard *can* be met in large part by broadening insurance pools. In general, that is, the more of us with barns who take part in the risk-pooling arrangement I have just imagined, the more efficiently we are able to provide against risk, particularly if we have warded off adverse selection effects by in effect *mandatorily* "selecting" *everyone*. For then we have minimized the risks of covariance, nonpriceability, and one of the two principal forms of asymmetric information, even if we have not eliminated them altogether.

The fact that pool-broadening mitigates or eliminates most of the impediments to efficient insurance arrangements has one particularly

important consequence for public policy: Insurance enjoys large economies of scale, also known as "increasing returns." And that means it bears a defining characteristic of what economists long have called "natural monopolies"—the sorts of firm that often have to be either heavily regulated or publicly provided, as utilities. This takes us straight from the subject of insurance to that of social insurance. But on the way there, we should take stock of the ways in which human health, in particular, interacts with the requisites to well-functioning insurance. For these tend to intensify the forms of market failure to which insurance arrangements are prone.

Health Insurance: Why It Is More Daunting Than Other Kinds of Insurance

The burning barn parable by which I described the requisites to wellfunctioning insurance was, again, highly stylized. For one thing, it treated all barns as being more or less alike, simply constructed, equally valued, and subject to one and the same basic risk—immolation. For another thing, the parable implicitly assumed that we have all freely chosen to be farmers for whom barns are important investments, rather than having been forced into that condition. This assumption proves important for reasons that soon will become clear. Finally, the barn parable involved only . . . well, barns. The loss against which insurance is sought is loss of a material object and perhaps even a critical contributor to a livelihood, but it is merely a material loss all the same. It bears less "existential" import than would the loss of one's limbs, one's organs, one's healthy functioning, or like attributes of one's loved ones. Health insurance critically differs from barn insurance along all of these dimensions.

For one thing, the human organism is just dazzlingly complex. And so, accordingly, are the kinds and severities of malady to which it is vulnerable. The etiologies, cures, partial cures, and suitable treatments of the bewildering array of maladies to which we are prone are maddeningly difficult to develop firm knowledge about. Far more always seems to remain mysterious than to be sorted out once and for all. (Cancer, of course, comes to mind.) It is often difficult even to determine when particular clusters of symptoms are attributable to a single well-defined "disease," let alone to determine how to predict statistical incidences and cures for such harms. (Autoimmune disease here comes to mind.) Moreover, many diseases are, of course, contagious, and even strike in the form of wavelike epidemics. (There is a new flu that might come to mind here.) All of this means, of course, that both event independence and estimability—the first two requisites to well-functioning insurance arrangements described above—are harder to come by when it is health rather than barns that we aim to insure. Health insurance, in other words, is even more prone to market failures occasioned by nonestimability and covariance than are most other forms of insurance.

For another thing, many threats to human health are not attributable even remotely to choice in the way that threats to the barn of a farmer might be. Most harm to health appears to be at least partly, and in many cases almost wholly, attributable to genetic predispositions that afflict people differently. You might be born very vulnerable to Crone's disease or breast cancer, I to lupus or psoriasis, and a mutual friend to no particular ailments at all. Where our statistical likelihoods are especially high, there might be literally nothing that we can do to avoid being struck by these illnesses. That fact interacts with the symmetric information requisite to well-functioning insurance arrangements in several morally critical ways.

If, for example, you know of your own predisposition to an illness and a prospective insurer does not, and yet you cannot do anything to prevent that illness's eventuating, is it really fair or otherwise desirable that you be made to disclose this information to an insurer who might deny coverage upon learning it? If, by the same token, an insurer insists upon genetically screening you and then denies coverage on the basis of what she learns, does it really make sense to claim that her doing this is simply a means of ensuring "fair"—that is, symmetric—access to your genetic information, or "efficient"—i.e., afflicted-excluding—insurance by means of "risk-classification" that "screens" you out of the pool?

What these questions highlight is that *symmetric* information, per the third requisite to well-functioning insurance markets, is per se *justly shared* information only when it is information concerning things that afflicted people can do something about. Where the information is instead about things they cannot do anything about—things like their own genetic endowments—symmetric information is fair only when accompanied by what might be called symmetric *entitlement* or symmetric *action:* allowing prospective insurers no more ability to "walk away" from prospective insureds' faultless misfortune than those prospective insureds themselves have. I will have more to say on this presently.

Finally, people's health is much closer to who they are—and indeed to the *fact* that they are, that they are living—than are their barns. And this, too, renders health insurance more morally and economically fraught than barn insurance. For one thing, of course, it is much harder to talk and argue about, without being overcome by fear, dread, and like emotions, than is barn insurance. And, of course, we see some of this in the current debates over health-care reform—anxieties about "end-of-life counseling," "death panels," "pulling the plug on Grandma," and so forth.

But for another thing—returning now to the requisites to well-functioning insurance arrangements catalogued above—the profound "existential" significance of our health renders health insurance uniquely vulnerable to a particular species of *combined estimability and moral hazard problem:* namely, a seemingly irresistible temptation to say "yes" to any new test, drug, or treatment option that looks like it might offer even a marginal improvement in the likelihood that life will be saved or health restored. We balk, in other words, at the thought of conducting ordinary "cost-benefit analyses" when it comes to treating, hence insuring against, life-threatening illness or poor health. After all, we are inclined to say, life and good health are "priceless." But if that is literally so, then they are uninsurable, too. For, as we have noted already, markets do not work without prices, and market substitutes will not work without price substitutes.

These extra challenges posed to insurance by risks that confront

life, limb, and health simply heighten most forms of market failure—failures of the requisites to insurance catalogued above, as well as of long-term competition—to which insurance is always vulnerable. That takes us straight to the theory of market failure and our time-honored means of addressing it—regulation and social insurance.

Social Insurance: When It Is Called For, What It Is, and What It Is Not

While we seem to be hearing the word "socialism" a lot these days, none of those using the term in the health-care debate seems to know, or at any rate care, what it means. For its users are talking about something entirely different—something long familiar and widely supported both in the United States and other industrial societies since the late nineteenth century. They are talking about social insurance. Social insurance shares something in common with socialism, as the shared root "social" in both terms suggests. But by this standard it also shares something in common with social science, "social capital," and, of course, social security. Social insurance is no more to be confused with socialism than are the common good, the common law, the community, or communication to be confused with communism. We will do well to sort this out quickly before we proceed.

It Is Not "Socialism" (Not That There Would Need to Be Anything Wrong with That)

"Socialism" denotes a system of political economy distinguished from other such systems by reference to *ownership:* The socialist economy is one in which the state holds property rights in a significant number of those instrumentalities or institutions that supply goods and services that people require and are willing to pay for.⁶ National economies obviously can be "more" or "less" socialist, according as the state holds more or less in the way of ownership rights in the mentioned instrumentalities and institutions. The state can hold more or less in the way of those ownership rights, in turn, either by holding more or

fewer shares in such instrumentalities or institutions, or by holding such shares in more or fewer such instrumentalities or institutions themselves.

Along the dimension of shares, Mexico owns all shares of that country's sole petroleum company, Pemex. So petroleum production is fully socialized in Mexico. China, by contrast, owns a controlling interest in, but not all, of its own state petroleum company, Sinopec. So petroleum production is largely, though not fully, socialized in China. China as a whole is nevertheless more "socialist" than is Mexico, because it owns large stakes in many more firms than just Sinopec, while the Mexican state is less heavily invested in most firms that operate there. The United States, for its part, owns no shares in the petroleum companies incorporated or operating within its territorial jurisdiction. So petroleum production is not socialized at all in the United States. Nor, for that matter, is much else. So the United States can be said to be "more capitalist" than those countries.

By contrast, the supply of national defense services in Mexico, China, and the United States is provided nearly entirely by the state in all three countries. That means that Mexico, China, and the United States all enjoy socialized national defense. Essentially the same holds true of national intelligence services, "homeland security," police forces, fire departments, environmental and consumer protection agencies, and other such public services. *All* national economies are at least *partly* "socialist" in this sense. Government itself, after all, is not privately owned or provided (or so we hope!). So the interesting question is not *whether*, but *how much* in the way of required or desired services, as well as *which* such services, are publicly rather than privately provided.

Which Goods and Services Tend to Go Public, Even in Capitalist Societies?

Which goods or services tend most often—perhaps even necessarily—to be publicly provided or procured, even in the least "socialist" of

societies? Which goods and services, in other words, seem to be in some sense inherently "social"? As it happens, economists have developed a pretty good understanding of this question, just as they have of insurance.7 And these two systems of understanding—those of "public goods" and necessary regulation on the one hand, insurance on the other—come together in the theory and practice of what is called "social insurance."

One answer to the question of which goods or services tend necessarily to be publicly provided or procured is that they are the "public goods." These are those goods and services that tend to be undersupplied by private actors, owing to that particular form of market failure known as "nonexcludability." And some forms of insurance, it turns out, are public goods in this sense. I return to that below.

An additional answer to the question of which goods or services tend to be publicly provided—or, in the somewhat more relaxed alternative, to be carefully publicly regulated in their private provision—is that it is those whose production enjoys increasing returns and hence tend to natural monopoly. Supply of these goods and services is subject to another form of market failure—a form we noted above to loom over insurance itself in consequence of the scale economies of risk pooling. A bit more on each of these two forms of market failure will now be in order.

"Natural Monopoly" Goods

As just noted, one form of market failure relevant to the case of health insurance in particular springs from the so-called "scale economies" mentioned above in connection with the requisites to well functioning insurance arrangements. Those scale effects give rise to "natural monopoly." Natural monopolies occur where network effects or scale economies are such as to render a single provider of some good or service the most efficient—that is, the least costly in terms of production—mode of provision.8 This condition tends to be found wherever current technologies render it significantly cheaper for an existing provider of some good or service to take on additional customers than it is for new providers to enter the market for those customers. The greater the extent of incumbent advantage in these cases, the greater the margin of quality superiority a challenger will have to be able to exploit if it hopes to enter the market. And with some things, that margin can be daunting.

Before the advent of wireless telephone networks, for example, it was notoriously easier for a telephone company simply to add more line to its system of telephone cable for new customers than for new providers to enter the market with their own cables. There was, after all, limited space for competing sets of telephone line to be set up in parallel. And so those who got into the act early enjoyed "first-mover advantages" enabling them to lock out competitors, simply by dint of the internal efficiencies that what they sold happened to confer upon them. In pre-wireless days, it was therefore widely accepted that the best way to handle the provision of telephone services was either to allow regional monopolies, whose prices then would be carefully regulated to prevent overcharging of customers lacking in alternatives, or to treat the telephone lines themselves as public property for the use of which competing telephone companies would have to enter competitive bids. Only in that way, it was thought, could the cost efficiencies of natural monopoly be exploited without giving rise to the dangerous market power that monopoly status conferred.

Pursuant to both regulatory strategies, moreover, participation in these naturally monopolistic markets as a provider was made contingent upon the supplier's agreeing to offer the service even to *remote* areas where the cost of provision might *not* be matched by the revenues there generated. The utility was, accordingly, treated as being indeed "public," even when provided by a private—but regulated—provider. And so things remain to this day in those industries that still rely upon "grid technologies" of the pre-wireless sort once found in telecommunications—power and light, for example, not to mention water, sewage, roads, and the like.

"Pure Public" Goods

The other form of market failure mentioned above that proves relevant to health insurance is the "free-rider problem," encountered in connection with some "public," "nonexcludable" goods and services that cannot be kept from nonpaying consumers.9 (Some roads and bridges implicate this form of market failure just as surely as they do natural monopoly.) When the armed forces defend me from invaders, they tend in so doing to defend you as well. If we financed the armed forces by passing around a voluntary collection plate, then the worry is that some of us might not contribute our fair share even while enjoying the same benefit as those who do. National defense is accordingly paradigmatic of the "pure public good"—a good that tends to be underprovided when privately financed. In such cases the remedy is public procurement or provision, financed through compulsory levies—taxes—that all citizens can be required to pay. Cognate considerations underwrite the public provision of all manner of public utility, including police protection, courts of law, and indeed law and government themselves.

When Insurance Becomes a Natural Monopoly or Pure Public Good

When does *insurance* qualify as a public utility that is best publicly procured or provided, or at least heavily regulated? What sorts of risk, in other words, might we expect to be best handled not merely by insurance, but by *social* insurance; and why might *health* risks be among them? Against the backdrop of market failure just rehearsed, the answer to these queries is found partly in those requisites to *all* well-functioning insurance arrangements discussed further above. It also is found partly in those special challenges associated with *health* insurance in particular, likewise discussed further above. Let us consider them in turn.

On the "requisites" side of the story, recall that two of the three basic obstacles to well-functioning insurance arrangements—possible covariance and inestimability of insured events—are surmounted principally by the broadening of insurance pools. More in the pool means greater capacity for cross-subsidy among insureds, and greater accuracy in the determination both of harm-costs and of probabilities. That is part of the reason that large employers are advantaged relative to smaller employers in finding affordable insurance for their employees. But the larger story here is that all of this means that insurance pooling is like network extending in the relevant respect. It enjoys vast economies of scale, hence increasing returns, hence the principal attribute of "natural monopoly." If power and light provision calls out for public provision or close public regulation, then so might insurance of some sorts.

On the "special challenges associated with health" side of the story, it is in part the third basic obstacle to well-functioning insurance arrangements—possible asymmetric information—that is most salient. And now it is with the "free riding" form of market failure that the structure of insurance interacts so as to render insurance a public good. For, note first that a principal means of avoiding the adverse-selection problem is by requiring participation by all, in order that no particular inference need be drawn from somebody's seeking to participate. But only the state has authority to require that people participate in insurance pools—as states routinely do, for example, with driver's insurance, social security, and Medicare.

It should be emphasized in this context that in requiring participation in such insurance pools, government is doing more than addressing the adverse-selection obstacle to well-functioning insurance arrangements. It is also preventing a form of free-riding—for example, that of uninsured motorists upon the coverage of insured motorists. So we now have transitioned to the other form of market failure discussed above—we have elided from the natural monopoly to the public-good rationale for social insurance.

In the latter connection, note now that *other* special challenges posed by medical care discussed above *also* implicate the public-good side of our story. Consider, for example, the observation that symmetric information can actually be a *bad* thing when would-be insurers gain access to genetic information and then deny coverage to individuals

whose health challenges stem from something over which they have no control—their genetic dispositions to illness. Our intuitive objection to this prospect—an intuition that virtually all Americans appear to share—is rooted in our sense of fairness. It seems fundamentally unjust that people with literally unavoidable maladies might simply be thrown from the rolls of insurance companies.¹⁰

But our demand for justice in such cases is a demand for a public good—arguably the public good *par excellence*. For no party acting upon private pecuniary motive alone can be confidently expected to supply justice to the victims of injustice, any more than unregulated providers of landline telephone service could in earlier times be expected to voluntarily supply telephone service to remote areas. And yet the case for compulsory supply here is much greater than it would have been there, inasmuch as people choose to remain in remote areas but do not choose to be genetically disposed to illness.

Moreover, just as it would seem unjust to permit the denial of insurance to those born with predispositions to illness, so would it seem unjust to saddle some insurers with more of the costs involved in compensating those born with risky genes than others. And that could conceivably happen if, say, we simply prohibited discrimination on the basis of genetic information or preexisting conditions. Arguably, then, the compensation of those who suffer through no fault of their own is something that all of us, not merely some of us, have a responsibility for. (Any one of us might turn out to be such a sufferer.) And that is just another way of saying again that insurance against these kinds of risks—risks that no individual is at fault for—is a public good. Justice, which is again what we are talking about here, is the *ultimate* public good.

Another public good that health insurance, along with some other forms of insurance like unemployment and retirement insurance, might be expected to provide comes in the form of so-called "factor mobility." The idea here is that when workers feel confident in moving from one locality or company to another, without worrying that in leaving one they might lose some irreplaceable form of insurance, factors of production—in this case, workers—are able more readily to

move to those places where they will add most value. That in turn conduces to greater growth in the larger economy. But this means that, in the absence of publicly provided insurance of these kinds, there will be a tendency for workers to stay put with firms or in localities where either insurance or substitute forms of social support are available. And that in turn means that large firms and extended families—firms that employ many workers and families that stay put in ancestral regions—tend to enjoy natural advantages over smaller firms and new localities in attracting labor. That is a drag on growth.

The problem here stems, once again, from the pooling economies already discussed. It is cheaper for a large firm to insure workers because it has many of them, meaning it has a large pool and enjoys bargaining power vis-à-vis insurers to boot. Small businesses, by contrast, lack these advantages. And since small businesses tend to be the chief sources of innovation and growth in our economy, allowing them to be disadvantaged relative to larger firms operates as a drag upon innovation and growth. There will accordingly tend to be widespread benefits-indeed, public goods-conferred upon the larger economy, stemming both from the freeing up of labor to move to its most value-adding uses, and from the elimination of pooling advantages enjoyed by large firms over small businesses, where necessary forms of insurance such as health insurance are publicly rather than privately provided. That is a part of the reason, for example, that Bismarck first introduced national health insurance and other forms of social insurance—unemployment and pension insurance—in nineteenth-century Germany. The aim was to jumpstart economic development by removing a major impediment to factor mobility.¹²

A related point relevant to the U.S. case is that all chief economic competitors of the United States have long since followed Germany's early example. They tend to treat certain forms of insurance—notably including health insurance—as public goods, and in consequence either afford maximal pooling in the form of "single payer" plans or directly provide health care itself. This means that non-American firms enjoy a decisive advantage, with respect to labor costs, over their American competitors, even as non-American economies enjoy

a leg up on labor mobility in consequence. This in turn means that there is yet another sense in which the provision of some forms of insurance—including health insurance—at the public rather than private level would be in the nature of a public good. No private party can provide this advantage to the U.S. economy as a whole. Only the public itself, as a whole, operating through its agent—its democratically elected government—is able to supply that.

The foregoing considerations jointly explain why the particular forms of insurance that we or our counterpart nations tend to treat as "social insurance" are those we have chosen. The chief forms, as suggested a moment ago, are retirement insurance, unemployment insurance, and health insurance. In all three cases we handle supply partly through direct public provision, and partly through tax-favored private provision. But in the health field the public component is thus far underdeveloped in the United States as compared to its competing counterpart nations, and the current debate is at bottom a debate over how best to fill that gap.

Retirement insurance in the United States takes the forms of both social security, which sets a floor below which no elderly citizen's income will fall, and tax-favored retirement-savings plans such as the popular 401(k). Unemployment insurance, especially in times of significant economic dislocation, takes the form of direct payments available for brief periods as laid-off workers seek new jobs, job training programs, food stamps, reduced taxation at the low end, and related programs. Both of these forms of social insurance are complex in their constituent parts and their functioning. In particular, they are subject to significant moral hazard challenges. It is in consequence of that fact that the government plays any role at all, for it possesses maximal authority to police and enforce the terms of the insurance "contract." It is also why the role to which the government limits itself is that of supplying a minimal safety net, in effect imposing a form of deductible or coinsurance upon beneficiaries.

There is a sense in which our government affords a form of social health insurance that is similar, in the respects just noted, to those forms of retirement and unemployment insurance that it provides. It affords single-payer health insurance (more on which qualification presently) to the old and the infirm or impoverished, in effect providing a manner of minimal "safety net" for those in extremis. It also does so for government employees and veterans—in the latter case even providing the care itself. As it happens, however, the means by which this net is provided are much more inefficient than necessary, and it could readily be broadened to include more than those who are in extremis. That is especially clear when we compare U.S. health expenses and health outcomes with those of all other developed countries.

Rather than separately reprise the many widely cited comparisons between the United States and other developed countries, however, I conclude this discussion by showing how all the principal "issues" now under discussion in the current U.S. debate grow more intelligible by reference to the insurance, health insurance, and social insurance considerations outlined above. Cross-country comparisons find their way into some of this discussion.

The Current Debate and Competing Proposals in Light of the Foregoing

All of the perceived problems with our national "system" of health insurance grow more comprehensible when viewed against the backdrop of the theory and practice of insurance and social insurance reprised above. So are the multiple proposals on offer right now for addressing them. Let us break it down, ill by ill and proposal by proposal.

The Pathologies

All the perceived ills that are agreed to afflict our present system of health-care insurance and finance grow comprehensible against the backdrop of insurance and social insurance fundamentals laid out above. In particular, they all turn out to be traceable at least in part,

if not in full, to the combined effects wrought by insurance's "natural monopoly" characteristics and "moral hazard" vulnerabilities, as intensified by the moral and emotional stakes involved when it is health that we aim to insure.

Noncompetition, Health-Care Costs, and Health Insurance Costs

Probably the chief dysfunction regularly cited by critics of our current health-care and health insurance regime is its set of "spiraling" costs. Parties on all sides of the current debate seem agreed on the following statistics. The United States currently spends at least 150 percent more per capita than any other industrial country on health care. Health-care costs represent one-sixth of our economy now and are projected to reach about one-fifth by 2015. These costs have been rising at about three times the general inflation rate for some time now, and consequently are now more than double what they were only ten years ago. Health insurance premium rates have risen even more rapidly, being up now more than 120 percent what they were ten years ago, as compared to wage and salary rises of only 40 percent over the same interval. Further, it is estimated that each American citizen in effect pays \$1,000 per year to cover emergency room care provided to the uninsured, as this form of access constitutes our principal "safety net" offered to those who either cannot or do not pay for regular health insurance.¹³

It is not difficult to appreciate why the foregoing might be true, against the backdrop of the insurance discussion above. For the fact is that health insurance in the United States shows the effects of precisely those "natural monopoly" attributes of insurance discussed above. Those attributes combine with the "moral hazard" vulnerabilities to which all insurance, and health insurance especially, are prey, in a manner that generates growing costs and growing exclusion of less wealthy citizens from insured status. While other causes are at work here as well, few are likely to be as critical as this one.

What are the mechanics? First, a small number of health insurance companies dominate in all state and regional insurance markets in the

United States. Competition, all sides to the current debate agree, is sorely lacking. Once again numbers are telling: There are only three states in the United States where the two largest health insurers control less than 50 percent of the market. In twenty-five states, the two largest insurers control 50–70 percent of the market; in twelve states, the top two control 70–80 percent of the market; and in another ten they control 80–100 percent. In seven states, moreover, the largest insurer controls 75 percent or more of the market. ¹⁴ The pooling economies of insurance discussed above, of course, account for this market power, and the latter in turn accounts for spiraling costs.

As it happens, however, the noncompetition problem in the United States is even worse than might have been anticipated on the basis of pooling economies alone. For the problem is accentuated by a peculiar feature of our national law: the McCarran-Ferguson Act, enacted by Congress over sixty years ago, both exempts insurance companies from federal antitrust law and consigns the right to regulate insurance in all other respects to the states. That means in turn that small numbers of health insurers not only quickly come to dominate markets within states without falling afoul of antitrust law, they also are slowed in their capacity to grow even larger, across states, which could enable them to enjoy yet greater economies of scale that might, at least in theory, result in savings that could be passed on to customers. The law here, in other words, leaves us with the worst of both worlds.

What is the result? It is much what theory would have predicted: Insurers facing little competition are able to, and do, charge high rates to their customers, in effect setting their rates in keeping with classic monopoly or oligopoly pricing models. That renders health insurance unavailable to people at the middle-to-low end of the income spectrum. Meanwhile, those who can and do afford insurance face little incentive to keep their health costs low, precisely because they are insured. (Here is where "moral hazard" kicks in.) As their costs rise, so do those of insurers, who over time pass these along to customers, rendering insurance yet more expensive and more difficult to retain for more and more people. And so the vicious spiral continues. More on this below, when we turn to proposed solutions.

Rising Numbers of Uninsured and "Unsure" Insured

As would be expected in the world of spiraling costs just described, the ranks of those in the United States without health insurance are large and growing in number, and this, too, is a principal concern shared by most parties to the current debate. Again the numbers are telling. The United States has by far the largest numbers and percentage of uninsured citizens in all the industrialized world. Nearly one-sixth of U.S. citizens—about 47 million—lack health insurance. A little over 10 percent of Americans under the age of eighteen are among them. Slightly under 20 percent of Americans from eighteen to sixty-five are among them. And surprisingly, about 2 percent even of those over sixty-five lack health insurance. All these numbers represent dramatic deterioration over the past several decades, a fact that feeds into a related "issue"—the growing insecurity of insurance even among those who now have it.¹⁶

The insecurity of existing insurance among the presently insured takes a number of forms. One form has already been suggested—that, as costs continue to grow, more and more are thrown off the rolls. Another form is the lack of portability of insurance among most Americans, from company to company or place to place. That form interacts with yet another—the propensity of insurance companies to deny coverage for "preexisting" health conditions.

These forms of insecurity among even the already insured, like the lack of insurance itself, constitute both moral and economic problems. The most obvious moral problem is associated with denials of coverage for preexistent conditions. For, as we noted above, harm for which you are not responsible is not harm with which you can justly be saddled. Another moral problem associated with missing or insecure insurance stems from the fact that there are certain degrees of desperation to which a decent society just does not allow its citizens to fall. If all other industrialized nations—nearly none of which are as wealthy as we—are able to provide secure health insurance coverage to literally all of their citizens, it seems obscene that we have not figured out how to do the same, and are even now watching as more and more lose the little coverage they had.

As for the economic problems to which lack of secure insurance

gives rise, there are at least two very obvious ones. I alluded to one earlier: lack of portability operates as a drag upon factor mobility. Another is more general in its operation: People who lack secure health insurance tend to be more cautious not only about moving, but also about spending. Liquidity preference and hoarding are not helpful in an economy that is struggling, as ours is post-crisis, to find its way out of recession.

Projected Worsening by the "Age Wave"

Finally, the foregoing difficulties afflicting our present system of health-care insurance are apt to continue to intensify, especially as the U.S. population ages. It is widely appreciated that the "baby boom" generation is now beginning to enter retirement and that the many health challenges associated with aging are set to balloon among Americans. At the same time there are comparatively fewer Americans in the lower age brackets to finance care for the aging via our "pay as you go" system of Medicare. Against this backdrop, even health-care and health insurance costs that rose at the same rate as the general rate of inflation would constitute a serious national problem. Costs rising at three times that rate will be simply unsustainable. All parties to the present debate seem to agree that they threaten to bankrupt the nation.17

The Proposed Cures

All the proposed remedies to our present ills currently under discussion grow more intelligible against the backdrop of the ills themselves as just characterized—and hence even more intelligible against the backdrop of those *insurance basics*, by which I have just characterized the ills.

The "No Denials for Preexisting Conditions" Denial

One measure that seemingly all parties to the present debate agree upon is a flat prohibition on denials of coverage for preexisting conditions.¹⁸ As ugly as the present debate has been at some points, this agreement is something to be celebrated. It indicates broad consensus to the effect that a significant injustice is no longer to be legally tolerated, hence that justice for those who are ill through no fault of their own is a public good deserving of public assurance. It bears noting, however, that in order for this prohibition itself not to operate as an injustice on companies disproportionately approached by persons with preexisting conditions, agreement on further proposals—among them those discussed below—will have to be forthcoming as well. In other words, proper health insurance reform must be suitably *comprehensive* health insurance reform. It is a package deal.

The Requirement That Uninsured Citizens Obtain Insurance

As noted above, the principal feature of our current health "safety net," such as it is, is a long-standing requirement that emergency rooms afford treatment to all who enter their doors irrespective of insured status. In return, the government compensates emergency care givers—meaning that at least this much health insurance is in effect publicly guaranteed to all. But this operates as an inefficient method of insuring. The reason is that *emergency room* treatment is very *expensive* treatment. Here, then, is a significant source of high—and avoidable—costs.

Presumably for this reason, there is wide agreement that at least some manner of requirement should be imposed upon those who either are able to *afford* health insurance, or who with public assistance would be, to *purchase* it.¹⁹ The idea here is very simple. If you can afford insurance but do not purchase it, you are among those who impose an avoidable cost upon others—a cost to the tune, as noted above, of \$1,000 per annum upon each American. Because most seem agreed on the principal operative in this requirement, most disagreement associated with it centers on how best to *render* health insurance affordable to those who presently lack it only because they cannot afford it. That takes us to the next, and by far most contested, set of competing proposals.

"Exchanges," "Public Options," "Co-ops," and "Single Payer"

Easily the most controversial real question—as distinguished from such hoax-questions as those concerning "government rationing" and "death panels"—in the current health-care reform debate concerns how best to address the problem of noncompetition between health insurance providers. This problem, as noted above, is significantly at the root of the rising costs and rising ranks of uninsured and insecurely insured problems considered above. Unfortunately, however, we have yet to explicitly recognize, in the public debate itself, the fundamental "natural monopoly" origin of this cluster of ills. Were we to do so, we would be much better able to make sense of the current fracas over "exchanges," "public options," "health-care cooperatives," and even the presently dormant "single payer" option. We would also be much better able to assess what is more likely to work.

Most parties to the present debate agree that exchanges might be a good idea, regardless of whether they are supplemented by a public option or by co-ops.²⁰ (Single-payer health care, by contrast, would render the idea of an exchange otiose.) The idea here is to standardize the modes in which certain categories of essential information provided by insurance providers is presented. Then consumers would be able to compare what is offered by companies in their vicinities within these categories, and thus make intelligent comparisons. As things presently stand, consumers hoping to "shop" between competing insurance plans—few as these are—are faced with proverbial "apples and oranges" comparisons owing to the dissimilar ways in which companies categorize relevant data. Exchanges, then, would offer something analogous to what the public stock exchanges have long offered in comparison to older-style "over the counter" markets in corporate debt and equity.

While no one apparently objects to the proposal to institute insurance exchanges, there is significant disagreement over whether they would *suffice* to address our ills. While those who charge that they would not have been regrettably unclear about why that is so, the underlying reason would be this: Owing to the natural monopoly characteristics of health-risk pooling elaborated on above, health

insurance markets are apt to be dominated by a very small number of very large firms even if prospective customers are more able to compare what is on offer from allegedly competing oligopolists. Since a nonprofit public, "single-payer" option such as "Medicare for all" is off the table right now, the "public option" has turned out to be the proposed cure for the oligopoly ill that has drawn the most attention. It has also, unsurprisingly, drawn the most ire from incumbent insurance firms and the politicians they bankroll.

The basic idea behind the "public option" is that a public provider of insurance, unencumbered by the requirement of making shareholders happy by increasing profits at the expense of insured customers with no other options, would be able to improve existing insurance markets in two ways. First, it would do so by making insurance available more cheaply both to the presently uninsured and to any presently insured who are stuck with their present arrangements owing to noncompetitive state markets. Second, by virtue of that first feature, the public option would help by presenting incumbents with a serious competitor more beholden to health-care recipients than to shareholders in search of profits. That would in turn induce even private providers to render better service at lower prices, and hence reap profits by becoming more efficient rather than by poorly serving customers who lack other options.

While incumbents and their agents in Congress have, unsurprisingly, objected to the specter of serious competition from a public provider, their putative arguments against the "public option" thus far have been remarkably implausible. Indeed, they have been self-contradictory. On the one hand, these opponents complain that a public provider would enjoy an unfair leg up on private providers by dint of its soft budget constraint, and thus "unfairly" out-compete them. A government-run plan, in other words, could operate at a loss and still operate, thanks to the government's tax power. Incumbents say these things, however, as if unaware that a requirement of *budget neutrality* has been written into any legislation establishing a public provider. They (and the recent PricewaterhouseCoopers study they bankrolled) cynically ignore, in other words, the fact that operating

at a fiscal loss has been prohibited by the instituting legislation itself. Incumbents also proffer their anti-public argument as if unaware that private schools, colleges, and universities, as well as mailing and shipping companies, all do perfectly well in markets that also include *public* schools, colleges, and universities, as well as the U.S. Postal Service.

It also bears noting that opponents of the public option in other moments argue that a public provider would constitute a bloated and inefficient "bureaucracy" likely to "come between patients and their doctors." They make this claim as if they were unaware that it contradicts the first one. For would a hopelessly inefficient public plan, prohibited from operating at a loss, really be able to outcompete a putatively efficient private one rendered "lean and mean" by the disciplining effects of private markets? These critics also lay the inefficiency charge as if unaware that Medicare and Medicaid currently operate much more efficiently—at shockingly lower cost—than do private insurance companies. They also do so as if unaware that it is actually *private* insurers, never public ones, that are constantly castigated for "coming between patients and their doctors," as any insurer aiming to counteract moral hazard must do.

It is difficult, then, to credit the now familiar arguments against the public option with good faith. The only apparently good-faith concerns raised with the public option raised thus far have been directed not to the merits of the public option as such, but to strategic considerations made relevant by the bad-faith arguments heard from opponents. They have focused, in other words, on what best to do as a *political* matter in view of some successes enjoyed by sectional interests in manipulating some members of an already frightened and bewildered public with outright fabrications about "death panels," unrecouped costs, African-American Nazi presidents, and similar nonsense.

It is against this backdrop that the "health-care *cooperatives*" idea proffered by some professed "moderates" is best understood. (Proponents of single payer say it is the public option that is the actual "moderate" compromise.) The co-op idea, in a nutshell, is in effect to return to a scenario not unlike that of our homespun burning barn

parable presented at the beginning of this article. The government would somehow provide institutional means through which presently uninsured people, along with others who are dissatisfied with their present insurance arrangements, could come together and pool health risks in the way that the farmers in our parable did. How it would do that remains vague at present, and that is likely no accident. For to describe more specifically what role a government instrumentality would play in facilitating this form of pooling is to describe something that looks a lot like a . . . public option.

The problem with the co-op idea is subtle, but damning. First, you will recall that the burning barn parable involved individuals who were more or less identically situated, in close proximity to one another within a single locality. I deliberately stacked the deck, in other words, to suggest that the parties had more or less homogeneous interests and were able to meet and decide and administer things together as a more or less cohesive community. But as groups of people grow larger, and the occupations and interests and demographic and other characteristics of those people grow correspondingly more diverse, the folksy New England town meeting image of communities deciding things together and acting as one quickly fades as a plausible image of how things work. Any pool large enough to surmount the event independence, cost-estimate ability, and adverse selection challenges observed above to face workable health insurance arrangements will be much too large to make decisions and operate in the manner of a small college faculty or New England town meeting. It will also be too large to avoid the presence and operation of severe conflicts of interest among diverse constituents. That means that ultimately it will have to vest quotidian decision-making and administrative authority in some sort of board, which will in turn institute a managerial hierarchy.

The "co-op," in other words, if it is to be large enough to surmount the classic obstacles that always stand in the way of efficient insurance arrangements, will take on the attributes of a corporation—a corporate insurance company. Then, if that company-like entity is provided, sponsored, or administered by the government as contemplated by those now advocating co-ops, it becomes indistinguishable from the

public option. If, on the other hand the government withdraws once the sufficiently large co-op is up and running, the co-op will face enormous pressure to go corporate and seek external capitalization from outside investors rather than remaining a standard-form co-op. It will, that is, come to be owned not by its customers, but by external shareholders.

Why? Because buyer and seller co-ops work in the long run only when the buyers or sellers of their products who own them are homogeneous in respect of their interests in the firm. If all those who would own Ocean Spray are growers of fungible cranberries, who have no interest in Ocean Spray other than as a buyer of their cranberries, then their owning and operating Ocean Spray will have some hope of working in the long run. Members of that agricultural sellers' co-op, which is what Ocean Spray in fact is, will be able to apportion their voting rights in proportion to their patronage—the quantity of more or less fungible cranberries they grow and sell to it. The firm will in consequence face no significant internal governance difficulties. It more or less closely resembles, in other words, the picture presented in our barn parable.

Where the would-be members of a *health* co-op are concerned, however, matters stand very differently. For what these diverse people's coverage needs are, and what they seek from the firm, and what their demographic features and other interests are, all will tend to vary dramatically—much more than those of cranberry farmers qua cranberry farmers. Under such circumstances, what always occurs is "demutualization," whereby the firm converts from a commodity co-op to a "capital co-op"—a publicly traded corporation, owned by more homogeneous equity contributors rather than by heterogeneous customers with, say, radically differing health profiles. This is, of course, precisely what happened to what used to be the most famous insurance co-op in America—Blue Cross and Blue Shield.²² It is also what happened in the life insurance industry in the twentieth century, and to the "mutual benefit societies" of the nineteenth century. And it is why nowadays you only find noncorporate co-ops in sectors like cranberry production.²³

The co-op idea now being floated by some "moderate" Democrats in the Senate, then, is at best a means of offering the public option without using that word that seems to exercise hysterical Republicans—"public." At worst it offers simply another private insurance company ultimately destined to be swallowed by some other private firm or firms in an industry where scale economies naturally conduce to monopoly or oligopoly.

What, then, about the one option presently said to be not on the table—"single payer" health care, or even "national health care"? As it happens, little need be said here about how well or otherwise such arrangements "would" work; multiple examples are operating out there in the proverbial real world for all to see. Every single industrialized country other than the United States offers one or another of these systems, and every one of them scores better than does the United States on all metrics of comparative health-care performance. That seems unlikely to be a mere accident.

To Americans, probably the best-known example of a single-payer system is that of Canada. And it bears noting in this connection that Canada's system (a) is nearly universally applauded, yet (b) was initially resisted, before adoption in the 1980s, by sectional interests who sought to whip up hysteria by making the same claims we hear from the far right today in the United States. Probably the best-known example of *direct provision* of health-care services, to Americans at any rate, is that of the British National Health Service (NHS). It, too was resisted, upon introduction earlier in the twentieth century, by rightists—in terms that anticipated those heard from right-wing American alarmists today. And it, too, is now widely applauded—not only as fair and effective, but as a great source of national pride—by Conservative, LDP, and Labour adherents alike.²⁴

Britain's NHS recently found itself the subject of a tragicomic incident in the American debate, an incident that could not be more emblematic of the farce this debate has become: Business interests in the United States opined in the press that the renowned astrophysicist Stephen Hawking would have been deemed unfit to live had he lived under a system of health care like Britain's. Apparently

these people did not realize that Hawking, a Briton, has in fact been the beneficiary of NHS-delivered health care all of his life—a fact of which Hawking kindly apprised them this summer, while also crediting his life to the fact.²⁵ It would be good if those who now take themselves still to be struggling with George III and Parliament at their "tea parties" would consult with Hawking, or their erstwhile hero Tony Blair, or even the present head of the Conservative Party, David Cameron, about the benefits of public health care. It might be good for their health.

For purposes of this article, perhaps the most helpful observation to make about single-payer and direct provision health-care systems like those found in the rest of the developed world is this: They reflect express recognition of the most salient fact that has emerged in the discussion above. That is the fact that many forms of insurance, and health insurance in particular, tend to be very much in the nature of a public utility, precisely by dint of their "natural monopoly" and "pure public good" characteristics. For health insurance to be available on optimally just and optimally efficient terms, it will in consequence ultimately have to be treated as that form of public utility—either as a carefully regulated monopoly or as a publicly administered public good like police and fire protection. Anything else is at best "second best." Doubtless the simplest option would be a straightforward extension, to all, of something already enjoyed by many-including the members of Congress itself. That would be something that has come to be called "Medicare for all." That is what our peer nations have, and it is a large part of why their populations—as well as their economies—are healthier than ours.

Conclusion

I cannot claim in the discussion above to have "solved" the healthcare problem or offered a final conclusion to the ongoing health-care reform debate. Nor has that been my aim. I do hope, however, to have realized a more modest ambition. I hope I have shown that we can make much more sense of the present debate, as well as render the

difficulties that have occasioned it more tractable, by viewing the problems as classic insurance problems—all of them jointly constituting a classic social insurance problem. Viewed in that light, it seems much easier to appreciate why our peer nations have taken the courses they have, and what course we ought now to pursue.

Notes

- 1. See, e.g., K. J. Arrow, Essays in the Theory of Risk-Bearing (Amsterdam: North-Holland, 1971); K. Borch, Economics of Insurance (Amsterdam: North-Holland, 1991). See also George Akerlof, "The Market for 'Lemons': Quality Uncertainty and the Market Mechanism," Quarterly Journal of Economics 84, no. 3: 488–500; and Joseph Stiglitz and Andrew Weiss, "Credit Rationing in Markets with Imperfect Information," American Economic Review 71 (1981); Joseph Stiglitz and Bruce Greenwald, Towards a New Paradigm in Monetary Economics (Cambridge: Cambridge University Press, 2003).
- 2. More on the relations between justice and efficiency in Robert Hockett, "Just Insurance Through Global Macro-Hedging," University of Pennsylvania Journal of International Economic Law 25 (2004).
- 3. Ibid.; Borch, Economics of Insurance, 163-74; Emmett J. Vaughan and Therese M. Vaughan, Fundamentals of Risk and Insurance, 8th ed. (New York: Wiley, 1999); J. François Outreville, Theory and Practice of Risk and Insurance (Dordrecht: Kluwer, 1998), 131-65.
 - 4. Ibid.
- 5. See Hockett, "Just Insurance"; Borch, Economics of Insurance, 315-30; Outreville, Theory and Practice, 166-67; Vaughan and Vaughan, Fundamentals, 5-6, 21-22.
- 6. See generally Joseph Schumpeter, Capitalism, Socialism, Democracy (New York: Harper & Brothers, 1942).
- 7. The locus classicus here surely is Richard Musgrave, The Theory of Public Finance (New York: McGraw-Hill, 1959). A more contemporary treatment, accessible even to lay readers, is Joseph Stiglitz, Economics of the Public Sector, 3d ed. (New York: Norton, 2000).
- 8. See, e.g., Musgrave, Theory of Public Finance, 42-49; Stiglitz, Economics of the Public Sector, 190-98.
- 9. See, e.g., Musgrave, Theory of Public Finance; Stiglitz, Economics of the Public Sector, 127-36, 141-88.
 - 10. For more on this matter, see Hockett, "Just Insurance."
- 11. This benefit of social insurance is well discussed in Michael Graetz and Jerry Mashaw, True Security: Rethinking Social Insurance (New Haven, Yale University Press, 1999); see also Stiglitz, Economics of the Public Sector, 353-81.
 - 12. See Graetz and Mashaw, True Security.
- 13. See Sheryl Gay Stolberg, "Despite Fears, Healthcare Overhaul Is Moving Ahead," New York Times, September 9, 2009: A1.
- 14. See Catherine Arnst, "The Tight Grip of Health Insurers," Business Week, August 3, 2009: 23.

- 15. 15 U.S.C. § 1011. Absent this law, there is no question but that the insurance industry could be regulated at the federal level pursuant to the Commerce clause. Thus held the Supreme Court in 1944. See United States v. South-Eastern Underwriters Assn., 322 U.S. 533 (1944).
 - 16. See Stolberg, "Despite Fears."
 - 17. Ibid.
- 18. Ibid.; Carl Hulse and Robert Pear, "Democrats Promise to Send Health Plan to Obama," New York Times, September 9, 2009, A17.
 - 19. Ibid.
 - 20. Ibid.
- 21. An illuminating elaboration of when and why cooperatives work, and when and why they do not, is Henry Hansmann, The Ownership of Enterprise (Cambridge: Harvard University Press, 1996).
- 22. Ironically, Blue Cross Blue Shield is the most consistently encountered nearmonopolist in those concentrated state health insurance markets mentioned in the text associated with note 14. For an effectively disillusioning recent story on current health care co-ops, see Chana Joffe-Walt and Keith Seinfeld, "Senator Eyes Health Co-Ops for All 50 States," NPR Morning Edition, October 2, 2009, transcript available at www.npr.org/templates/story/story.php?storyId=113404632.
 - 23. See Hansmann, Ownership of Enterprise.
- 24. See, e.g., Vicki Barker, "Is Britain's Health System Really That Bad?," NPR Morning Edition, transcript available at www.npr.org/templates/story/story. php?storyId=111976186.
- 25. For more on this amusing episode, see Bernie Becker, "Stephen Hawking Defends Care in Britain," New York Times, available at www.npr.org/templates/ story/story.php?storyId=112807192; and http://prescriptions.blogs.nytimes. com/2009/08/12/stephen-hawking-defends-care-in-the-uk/.