Health Care and the Profit Motive

Avik Roy

When it comes to health care, liberals and conservatives often seem to be living in two different worlds. To those on the left, America’s health-care system is a heartless capitalist jungle: a place where the bottom line is king, and the working poor are exploited. President Obama, for example, has accused insurance companies of holding Americans hostage in exchange for profits, and doctors of cashing in on children’s sore throats by needlessly removing their tonsils. The right, meanwhile, sees American health care as an outpost of socialism: The government distorts prices and suppresses innovation, impairing the quality and affordability of care and constraining individual autonomy. Hence Republicans’ call for less government involvement in insurance, and their complaints that heavy-handed Medicare rules are the source of our woes.

Simply put, liberals believe that health care is treated as a market commodity today but should not be, and conservatives think that health care is not treated as a market commodity but should be.

The first question raised by their disagreement is an empirical one: Does health care today actually function as a commodity, or has the market in coverage and care been hopelessly distorted by the government? The second question is both economic and moral in nature: Should health insurance be distributed by the market and subject to the profit motive? Or is it a basic right to which any citizen of a wealthy country is entitled, and which should therefore be available to all through the munificence of the state?

The second question is by far the more important and more vexing of the two. The right has long ignored it, while the left has taken its own answer for granted. This is part of why any debate over how to improve

Avik Roy is an equity research analyst in New York City.
the system inevitably reaches an impasse. To overcome that impasse, both sides must take up both of these questions directly.

PAYING FOR HEALTH CARE

In a sense, both liberals and conservatives are right to complain about our current system for financing health insurance. We experience the downsides of both the market and heavy government involvement without reaping the benefits of either.

According to the latest Congressional Budget Office figures (excluding the illegal-immigrant population), about 87% of Americans have health insurance. Most of them—about 57% of those insured—get their coverage through an employer. Another 17% are over the age of 65 and so get their coverage through Medicare, while 15% are covered by government programs for the poor (mainly Medicaid and the State Children’s Health Insurance Program). Only 10% of Americans with coverage buy their own health insurance directly, in what is commonly called the “individual market.”

This last fact is the key to understanding the peculiarly distorted character of our health-care market. Ninety percent of Americans with health insurance neither choose it on their own, nor pay for it directly. Analysts use the term “third-party payment” to describe the fact that insurers reimburse hospitals and doctors, bypassing policyholders. But in practice, the 235 million Americans with employer- or government-sponsored health coverage actually have fourth-party insurance—since they don’t even choose their insurers, let alone pay directly for care.

For most Americans, health care looks something like this: A patient purchases health insurance, or receives it from his employer. The insurer then directs the patient to use physicians in its network, with whom it has negotiated reimbursement rates. The patient is given little or no information about the comparative cost or quality of any particular doctor. The patient then visits his doctor. After an interview and an examination, the physician orders tests, procedures, or medications on the patient’s behalf. The insurance company reimburses the doctor for a large share of these costs, though it might occasionally haggle if it feels the doctor has spent too much on the patient. The patient receives a bill in the mail from the insurer for his part of the expenditure; that bill is only vaguely related to the services rendered to the patient, and is generally presented in a way that makes it impossible to decipher the relationship between services and costs.
This is no way to design a market, especially if the goal is to keep costs in check. Patients and physicians have little incentive to restrain, or even scrutinize, their consumption of medical resources. An insured patient sees little cost and much benefit in asking for an extra test; a physician sees maximal cost (in the form of litigation risk) and little benefit in refusing to provide it. In this way, the consumption of health care is divorced from the market forces that normally align cost to benefit. Such insurance is also most likely to be desired by the sick, and least likely to be desired by the healthy (what economists call “adverse selection”), making it more expensive.

Moreover, employers have different incentives than employees. They save money by buying one-size-fits-all plans in bulk, rather than allowing employees to shop around for plans that reflect their own priorities and budgets. The already weak incentives to constrain costs in a third-party system shrivel further when individuals do not even pay directly for their own insurance.

Those with privately purchased insurance — the 27 million who buy it directly, and the 150 million more who receive it through their employers — also shoulder $90 billion per year of the cost of government-funded care for the poor and elderly. Since the 85 million patients covered by Medicare and Medicaid give these programs huge negotiating power, they are able to force hospitals and doctors to offer care at below-cost prices. But these health-care providers have to make up their losses somewhere. And so they charge privately insured people more for the same care — approximately $500 per person or $1,800 per family — in order to cover the gap.

Our fourth-party insurance system was obviously not designed from motives of efficiency or fairness. Rather, it was the unintended outgrowth of World War II economic policy. Prior to the war, health insurance was rare: Health technology was in its infancy, and most medical care still took place in patients’ homes. But in 1929, a group of teachers in Dallas — spurred on by their increased need for hospital services — came together and signed an agreement with Baylor University Hospital under which the teachers would pay $6 a year in exchange for 21 days of hospitalization. The plan grew to cover additional employee groups in Dallas; eventually the American Hospital Association encouraged other hospitals to adopt similar plans. Hospitals liked the idea because it gave them more predictable income streams and ensured that their bills were paid;
beneficiaries, meanwhile, enjoyed the advantages of insurance. Thus the Blue Cross system was born.

The system offered several advantages to both patients and providers. The AHA required that Blue Cross-branded plans allow beneficiaries to freely choose their doctors and hospitals. Blue Cross plans charged sick and healthy people similar premiums (what actuaries call “community rating”). And because they were organized as non-profit corporations, insurers enjoyed tax-exempt status and were freed from certain insurance regulations that would have required them to keep assets in reserve against potential claims.

Soon physicians began establishing similar plans for their own services under the Blue Shield label. Both Blue Cross and Blue Shield plans served a significant number of low-income patients—but the secret of their success was covering large populations of healthy, employed workers. As a result, the plans were able to build a large pool of clients who did not often require expensive care; the savings from these patients went toward covering the costs of those who did need frequent or expensive care. For-profit insurers came to notice the success of Blue Cross and Blue Shield, and began to enter the health-insurance market. They did not have community-rating rules, and so could attract healthier clients with lower premiums. A serious health-insurance sector began to emerge.

The connection between health insurance and employment was first forged in the midst of World War II, as a result of the Economic Stabilization Act of 1942. With most young American men off to war, the government was concerned that employers would rapidly raise wages to attract the shrinking labor pool, thereby contributing to inflation and other economic problems. But while the 1942 law placed significant constraints on employers’ ability to raise wages, it did not restrict their ability to increase benefits. Employers took advantage of this loophole to introduce ever more generous health insurance as a fringe benefit—in lieu of the prohibited higher wages—to compete for the best workers.

In 1943, a federal court ruling asserted that direct payments by employers to insurers did not count as taxable employee income—meaning that any amount of an employee’s overall compensation dedicated to providing health insurance rather than direct cash wages would not be taxed. This, of course, created an enormous financial incentive for employer-provided coverage. The Internal Revenue Code reinforced this incentive in 1954 by explicitly exempting employer-sponsored health
benefits from taxation — and employer-provided health coverage soon became a routine benefit.

Over the years, employer-sponsored fourth-party insurance brought health-care coverage to hundreds of millions of Americans. But the tax exemption for employer-sponsored plans also created massive problems that have endured to this day. For one thing, employer-sponsored insurance makes many workers reluctant to leave unsatisfactory jobs for fear of losing their coverage. Those who fall ill while between jobs are burdened with the additional concern that a new insurance company might refuse to accept them, or raise their premiums beyond what they can afford. Insurers also face less competition and are less consumer-oriented, since they are at less risk of losing their customers. And, as noted above, because workers do not choose their own insurance, they are less likely to have plans that suit their needs.

Moreover, because employer-sponsored insurance is tax exempt, employers have a major incentive to provide generous benefit packages. For example, a worker who pays federal and state income taxes at a combined rate of 30% will receive $7,000 for every $10,000 his employer provides in gross salary. But the same employee will receive $10,000 in benefits for every $10,000 his employer spends on health insurance — a 43% improvement.

Similar inefficiencies are fomented by government-run fourth-party insurance. Medicare and Medicaid are both designed in ways that encourage excess expenditures. Medicare pays providers on a fee-for-service basis that rewards doctors for doling out more and more care and resources. Medicaid costs, meanwhile, are shared by the states and the federal government in a way that makes limits on spending grossly unappealing to state politicians (since they bear the full political burden of cuts, but only part of the financial burden of spending). By significantly boosting demand for health care, the perverse incentives in these government programs end up increasing costs for everyone.

In this way, federal tax policy and federal entitlement programs combine to radically distort the health-insurance market. The results are predictable: Health-care costs have been galloping out of control, rising by an average of 7% in each of the last ten years — far faster than price and wage inflation — and eating up an increasing portion of Americans’ incomes (not to mention the federal budget). This cost explosion also puts health insurance out of the reach of a growing number of
American families—the people who do not qualify for government health entitlements, do not receive coverage from an employer, and cannot afford to purchase insurance on the individual market. And because the individual market is effectively home only to those excluded from fourth-party coverage, it is plagued by its own inefficiencies and high prices.

All of this means that conservatives are right to argue that government policy badly distorts the health-care market, and that government bears a great deal of responsibility for the problem of rising costs. Yet it also means liberals are right to observe that, in the absence of a universal safety net, many Americans are left to fend for themselves without access to coverage.

Both sides agree that the system we have makes no sense and requires reform. But each side also accuses the other of blindness to its preferred way of thinking about health care. Conservatives say liberal programs are economically senseless, while liberals say conservative policies are morally ruthless. Settling their dispute—and deciding whose vision should guide our health-care policy—requires us to determine whether the question of how to structure our health-care system is fundamentally an economic or a moral one.

**Can There Be a Health-Care Market?**

Of course, American liberals do not simply ignore economics when thinking about health care. Indeed, they often argue that the structure of health-care delivery contravenes market economics, and must be repaired—if not replaced—by government action. We should not think of health care in market terms, their argument goes, because the very nature of health care defies normal market forces.

The seminal expression of this argument was put forth by Stanford University economist and Nobel laureate Kenneth Arrow. In 1963, the Ford Foundation approached Arrow—then known as a leading economic theoretician—about applying his ideas to the practical problems of health, education, and welfare. In December of that year, Arrow published his thoughts in the *American Economic Review*, in an essay entitled “Uncertainty and the Welfare Economics of Medical Care.” Arrow argued that health care is different from traditional market commodities in several important ways, and enumerated the elements of the health-care system that, in his view, distort the normal functioning of market forces.
We can organize these distortions into five categories. First, people’s needs and demands for medical services are unpredictable and therefore differ from other basic expenses such as food and clothing, and yet access to health care is more critical than access to many consumer goods. Second, there are daunting barriers to entry in health care: Physicians must be licensed in order to practice, and in order to gain licensure they must endure years of expensive training. As a result, the sale — and therefore consumption — of medical services is constrained by the limited number of new doctors produced each year.

Third, health care requires meaningful trust between doctor and patient, far more than the typical market relationship. A patient cannot test-drive a surgical procedure before undergoing it; if the procedure fails, or has adverse consequences, he is stuck with the outcome. The patient must trust that the surgeon knows what he is doing. And if the surgeon does not, the consequences for the patient could include serious injury or death — outcomes for which there is no complete economic remedy (even if the prospect of lawsuits helps make doctors more cautious).

Fourth, there are significant asymmetries of information in health care. Medical knowledge is complicated; the physician usually knows much more than the patient about the treatment of a disease. Therefore, the buyer of medical services is at a serious disadvantage relative to the seller. It is difficult for patients to make independent, informed decisions about their care — and third-party insurers know even less than patients about the particulars of each case.

And fifth, there are distortions in the method of payment. Patients pay for health care after, not before, it is received, and frequently pay indirectly for their care via insurers. Because patients don’t see the bill until after the non-refundable “product” has been “consumed” — and because there is virtually no transparency about costs — patients are rarely able to shop around for a medical service based on price.

For all of these reasons, Arrow argued that a free market in health insurance cannot function effectively, and agreed with what he called his era’s “general social consensus…that the laissez-faire solution for medicine [is] intolerable.” But he also believed that health insurance is necessary to protect people from financial ruin and medical catastrophe. “It follows,” he concluded, “that the government should undertake insurance in those cases where this market, for whatever reason, has failed to emerge.”
Arrow’s essay is still read widely today, and is credited by many as having invented the field of health economics. His observations remain at the heart of the left’s objections to privately financed health care. Princeton economist and New York Times columnist Paul Krugman, with characteristic bluster, wrote recently that “ever since Kenneth Arrow’s seminal paper, [economists have known] that the standard competitive market model just doesn’t work for health care...to act all wide-eyed and innocent about these problems at this late date is either remarkably ignorant or simply disingenuous.”

But are Professor Arrow’s critiques still pertinent today? Much has changed since 1963, after all. Scientific and technological breakthroughs have transformed medical treatment and the delivery of care. Unpredictability, as an economic principle, is far less exotic today than it was in the 1960s. The last five decades have witnessed a proliferation of insurance products addressing all sorts of unpredictability: traveler’s insurance, home-owner’s insurance, extended warranties, overdraft protection, and even malpractice insurance. And very few industries today enjoy no barriers to entry; many dynamic sectors and industries now involve work that requires extensive training and credentialing.

While it is fair of Arrow to observe that trust is especially important in health care — after all, in medicine, a patient is literally putting his life in someone else’s hands — trust is a component of a great many other commercial transactions. There is no way to fully compensate a baby who suffers birth defects due to a botched delivery, but neither can one make whole the victims of an airplane crash or defective car brakes. Nevertheless, modern markets still prove remarkably capable of assigning appropriate prices to goods and services, even when a great deal of trust is necessary.

There are certainly daunting asymmetries of information in health care, but these have diminished substantially in recent years. Because of the internet, patients now have mountains of information at their fingertips — and physicians commonly remark that their patients know about new medications before they do. Message boards and patient websites allow people with certain diseases to compare notes and experiences with others; this has been a special boon to those suffering from less common disorders, or diseases with a social stigma, for which a local support group is not always available. Insurers, too, are growing
more informed: The digitization of patient records, while still in its early stages, offers greater insight into how physicians are managing their patients.

Government has also played a constructive role on the information front. For instance, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 authorized the Centers for Medicare and Medicaid Services to increase reimbursement rates to hospitals that reported their performance data and met certain performance targets. Enticed by the extra funding, nearly all hospitals now participate in the reporting program — and a government web site (hospitalcompare.hhs.gov) makes the data available to consumers. Another government web site (clinicaltrials.gov) allows patients with difficult-to-manage diseases to learn about, and enroll in, clinical trials for novel therapies. Such transparency is a critical component of well-functioning markets, and also of quality health-care systems.

And so we are left with Arrow’s final objection: that third-party health insurance cannot be made to function as an efficient market commodity. This may well be true — many people across the political spectrum certainly agree with it. But while Arrow recommends correcting this problem with government-sponsored fourth-party insurance, some today instead advocate a move toward what has come to be known as “consumer-driven health care” to address the same concern.

The phrase was coined in the 1990s by Regina Herzlinger, a Harvard Business School professor, to describe health plans that combine third-party insurance against catastrophic medical costs with tax-free savings accounts for direct spending on chronic and routine health care. The concept took off seven years ago, when President George W. Bush signed the 2003 Medicare Modernization Act. The new law defined the parameters of eligible consumer-driven plans, called high-deductible health plans, and empowered banks to create and manage tax-free health savings accounts (HSAs).

In a traditional, comprehensive insurance plan, an individual pays a monthly premium, say $400, in order to gain reimbursement for nearly all health-care expenses. Under such a plan, patients will usually pay a small fee for medications — called a co-pay, and typically in the neighborhood of $10 to $40 — and possibly also a certain minimum annual amount in health expenditures called a deductible (typically ranging up to $1,000) and a percentage of any expenses above the deductible, called co-insurance.
In our employer-based insurance system, insurers are incentivized to make their plans as generous as possible—offering lower co-pays, deductibles, and co-insurance ratios, but charging higher premiums. The structuring of such plans has a lot to do with why health care eats up so much of the U.S. economy: If someone else is paying most of the bill, workers have every incentive to get as much out of their plans as they can—choosing the fanciest health-care options, and going in for all of the extras, even if the costs are astronomical.

Consumer-driven health care seeks to change these incentives. In a typical high-deductible health plan, the deductible is at least $1,200 for an individual, and total annual out-of-pocket expenditures (excluding premiums) are capped at $5,950 per person. As the coverage is less generous than a traditional plan, the premiums are lower. For instance, a 40-year-old single man would save $1,500 a year in premiums by purchasing a consumer-driven plan instead of a traditional, low-deductible plan. (A family would save twice that amount.) Critically, an individual with a consumer-driven plan in 2010 could place $3,050 per year into a tax-free health savings account (the amount goes up to $6,150 for a family plan). This money can be spent on any health costs—and so can go toward covering the plan’s deductible, its premium, or paying for unexpected health-related expenses. If the money is not spent in 2010, it can be saved and rolled over for medical expenses in following years. Moreover, these savings can be invested—just as with individual retirement accounts—harnessing the power of compound interest. In short order, a healthy individual or family could save enough in an HSA to meet their deductible and co-insurance requirements.

These consumer-driven plans benefit patients in that they are less costly than traditional insurance; the health savings accounts, meanwhile, work to the advantage of the entire system, in that they motivate patients to make pragmatic choices about the costs and benefits of medical care. Instead of automatically ordering deluxe medical care, consumers can decide for themselves: Is that extra procedure worth the money? Can I get a better price by using a different doctor or hospital? This, in turn, creates incentives for providers to compete for patients’ business, placing downward pressure on costs and upward pressure on quality. In addition, over the long term, such plans give individuals a financial incentive to lead healthy lives, as they will be spending more of their own money should they fall ill from smoking or obesity.
Opponents of these plans argue that they would lead patients—especially those with low incomes—to under-consume health care. Critics also argue that health care is too complex for individuals to make optimal choices for themselves. But neither argument holds up under examination.

It is true that consumer-driven plans can lead to less consumption than fourth-party insurance does. That is, after all, one of their salient qualities—they encourage more intelligent (and so more selective) consumer behavior. But the significantly lower premiums associated with consumer-driven plans make health care more affordable for individuals with lower incomes, and so allow them more, not less, access to the care they and their doctors decide they need. The lower premiums have the added benefit of attracting younger and healthier individuals into the risk pool, mitigating the problem of adverse selection, and thereby reducing the cost of coverage for everyone else.

And while it is true that health-care choices can be complex, 21st-century consumers are accustomed to making complex decisions. If they can choose between hundreds of models of computers and automobiles, each with its own extensive set of bells and whistles, they are certainly capable of making choices about health plans and treatments that will affect their lives far more significantly.

Consumers are voting with their pocketbooks. By January 2009, according to the U.S. Census Bureau, 8 million Americans were enrolled in HSA plans, up from 1 million in January 2006. These figures don’t even count the 6 million-plus who participate in “health reimbursement arrangement” plans, which are similar to HSAs but managed by an employer rather than an individual. (The Whole Foods employee-benefits program is a prominent example.)

Consumer-driven plans are still a small fraction of the enormous health-insurance market. But their increasing popularity at least undermines arguments against their economic viability. The left’s stronger argument—and the more significant and important one—is that it is immoral to treat health care as an economic commodity. After all, just because there can be a market in health care does not mean there should be one.

**Should There Be a Health-Care Market?**

The tension between the spirit of medicine and the spirit of the marketplace is hardly a new problem. In Book I of Plato’s *Republic*, Socrates poses
the difficult question: “Is the physician a healer of the sick or a maker of money?” The answer is necessarily both, and balancing the two is not much easier in our time than it was in Plato’s.

Indeed, the ancient ethic of the medical profession—set forth by Plato’s contemporary, the physician Hippocrates of Cos—gives doctors a moral as well as a medical role in their societies. The famous Hippocratic Oath affirms that doctors should protect the sick not only from disease but also from “harm and injustice,” and instructs physicians not to prey on patients’ vulnerability for their own gain. In ancient Greece, the oath represented a minority ethic in a world where charlatans posed as physicians to rob desperate people. Later, Roman physicians found much to admire in the Hippocratic Oath and preserved it for Christian Europe, where the code’s universal moral claims found more hospitable ground. The Christianized Hippocratic Oath became the common standard by which physicians were judged. For new doctors, swearing the Hippocratic Oath became a defining rite of passage—connecting them to generations of their predecessors in an ancient, unbroken tradition that endured into the 20th century.

Today, contrary to popular perception, few medical schools require their students to take the oath; its strict injunction against “abortive remedies,” for one, would be controversial. But its broader principle of placing the “benefit of the sick” above self-interest remains at the heart of the medical profession. It is one important reason why physicians are held in high regard by society, and why so many decent and honorable people are drawn to medical careers. Insofar as the pursuit of profit is the pursuit of self-interest, it is easy to understand why many would think that the free market has no place in medicine. Treating the sick and offering relief to those who suffer are acts of compassion and benevolence that risk being corrupted by economic calculations.

Those who are intuitively suspicious of the profit motive in medicine will naturally also be suspicious of private health insurance. After all, a for-profit insurance company’s first obligation is to generate revenues in excess of expenses, not to provide unlimited care for everyone. This means pursuing economic efficiencies—up to and including denying sick people money for their care—and constantly seeking ways to boost corporate earnings. To those who advocate care for the sick regardless of economic circumstances, the business model of insurance will always grate.

That model often becomes even more irritating when it is put into practice. For example, it is in the economic interest of insurers
to scrutinize those who wait until they are sick to buy health insurance—charging new customers who are already sick more than those who are not, and even denying coverage to some prospective customers whose treatment would be especially expensive. This means, in effect, denying care to some in desperate need. Insurers also have to employ means of weeding out fraud and dishonesty, but in the process will inevitably hassle genuinely ill policyholders instead of issuing timely reimbursements. Moreover, under the American insurance system, people often lose access to health care through no apparent fault of their own—as the result of an economic downturn or the loss of a parent’s or spouse’s job.

The very notion that life-saving therapies might be available to one sick person but not another simply because the first has more money strikes our egalitarian sensibilities as unjust. Indeed, many liberals treat health care like a fundamental human right—one of the rights that governments exist to secure. As a society, we accept government control of police and fire departments, and government schools, whatever their faults, have been ubiquitous since the 19th century. We consider these public services essential to ensuring equality of opportunity and equality under the law, and have decided that everyone should therefore be entitled to them. Why, then, are treatments for deadly disease or injury not entitlements too—rather than mere commodities to be bought and sold on the market?

The question of whether health care is a right certainly deserves careful consideration and discussion. After all, it touches on some deep philosophical quandaries at the heart of the liberal-democratic order. But even if we were to answer that question with a “yes,” it should not prevent us from thinking of health care in economic terms. Positive rights as liberals understand them—rights to some good or service, rather than rights against government intrusion into our lives—require that we find ways to economize their provision. A right to some minimum degree of something does not mean a right to an unlimited supply of it: We may have universal access to education, for instance, but not every child can attend an elite private school. No matter how evenly we try to distribute goods and services we deem to be “rights,” inequalities will always exist.

Modern health care is an expensive commodity. So even if we agree that it is unjust to deny some citizens access to it, we must still recognize that money is limited—and figure out the best way to allocate
care. The moral conviction, therefore, leads back to economics. Both sides of the health-care debate share the goal of making insurance coverage and medical care more cheaply available to more people (ideally, to everyone). The difficulty arises with the questions of what to provide, and how. These are two inherently economic questions, because the problem of allocating a scarce resource is by definition an economic problem — indeed, the economic problem.

Just as America cannot afford to give a Lexus to every citizen who needs transportation, it cannot afford to give the very best health care and the latest technologies to everyone who seeks them. Someone will always need to make the difficult choice to deny a treatment option on the basis of its cost. The key questions are: Who should make the tough decisions, and by what principles? Should it be a government bureaucrat on the basis of political considerations, an insurance-company bureaucrat balancing his bottom line, or a patient weighing his personal priorities? The first option points toward a more socialized system; the second more or less to the system we have now; and the third toward a more robust individual market in health insurance, and more consumer-driven care.

These questions also help show why the case for providing health care along market principles has a moral dimension — because the market is very often the most efficient and most fair way to allocate a scarce resource. Market forces don’t have to be at odds with a patient’s welfare. Indeed, they can be highly aligned with patient interests if the market’s incentives for health-care delivery are properly structured. After all, absent certain distortions by government policy, health-care companies stand to profit most by addressing patients’ unmet medical needs.

We must also not forget that the system we have now, for all its faults, has one notable quality: Americans have more access to innovative treatments than do the citizens of any other country in the world. Thanks to for-profit pharmaceutical, biotechnology, and medical-device companies, the average American battling cancer or recovering from a stroke lives meaningfully longer than his British or Canadian counterparts, and gains quicker access to novel therapies. New technologies may be expensive at first, rewarding innovators, but they become cheaper and better over time, benefiting everyone. And yet consideration for how to preserve, let alone enhance, the pace of medical innovation has been largely absent from the concerns of the left in the health-care debate.
Naturally, the moral case for the profit motive in health care is not always the easiest case to make— but it is important to see that critics of that case often misunderstand the nature of profit in a free economy. In a speech to a joint session of Congress last September, President Obama argued that “by avoiding some of the overhead that gets eaten up at private companies by profits, [government health insurance] could provide a good deal for consumers.” But profits do not “eat up” overhead. Indeed, the opposite is true: Overhead eats up profits. This is why insurance companies are incentivized to reduce administrative costs, along with any other unnecessary expenses. The potential for profits motivates insurers to seek greater efficiency in the way they pay for health care. And if more individuals bought their own insurance—rather than having their employers do it for them—the prospect of profit would motivate more insurers, doctors, and hospitals to offer what consumers want: more options and lower prices.

Moreover, the common image of insurance companies as rapacious profiteers simply does not match the reality. Health insurers listed in the *Fortune 500*—14 in all—registered $8.6 billion in combined profits in 2008 on a revenue base of $276 billion, achieving a profit margin of 3%. This compared unfavorably to, say, confectioners (4%), purveyors of recreational goods (4%), restaurant owners (8%), cigarette producers (17%), and brewers (26%). Nevertheless, insurers are the easy targets—because while they must make hard decisions, they are not directly answerable to the patients who bear the consequences, especially in the fourth-party model. But replacing the insurers with similarly unanswerable government bureaucrats would not solve the problem. Giving insurers the economic incentive to be more responsive to patients, though, could go a long way toward a solution.

**A FREE MARKET—WITH LIMITATIONS**

It would seem, then, that there can and should be a free market in health care—with certain limitations. What might these limitations look like? There are some instances in which we should obviously consider more than economics: Certainly no wealthy nation should allow a destitute woman who has been hit by a car to die in the street. Likewise, in a pressing emergency, catastrophic care should be provided to those who need it, and the costs can be sorted out later. Of course, we already have universal emergency care today, if only through the back
door. The Emergency Medical Treatment and Active Labor Act of 1986 requires any hospital receiving Medicare revenue—essentially every hospital in America—to treat anyone needing emergency care, irrespective of citizenship, immigration status, or financial resources. The bad news, though, is that hospitals are forced to bear most of the financial burden, and then pass the bulk of the costs on to other patients. A more organized program to cover these expenses—provided that the distinction between emergency, chronic, and routine care were reasonably well defined—would be a step forward, and would also clarify the boundaries of the free market in health insurance.

We also do not want to let the poor go without chronic and routine care—this, after all, is why Medicaid exists. The program certainly does not offer the same quality of care as most private health insurance, but it offers decent care to those who can’t afford to buy coverage. The fourth-party Medicaid system should be improved—and some state experiments, like Indiana’s utilization of consumer-driven care in its Medicaid program, can show us the way. But the medical plight of the poor is not being ignored in America, and does not cry out for a wholesale re-invention of American health insurance.

It is the case of the genuinely uninsured—people who are not poor enough to qualify for Medicaid, but who do not have access to employer-based coverage and can’t afford insurance on their own—that underlies the liberal moral argument for reform. But as we have seen, the economic problem that has left these Americans uninsured cannot simply be outlawed. It must be addressed.

At the heart of the problem is the rising cost of insurance coverage. Costs are rising because of our existing fourth-party system, driven in particular by the very health-care entitlements that liberals seek to expand. To address that problem, we need incremental reforms to bring about greater market competition. Replacing the entire system with a sweeping government program might feel good—and might seem like a way to address the moral element of the problem—but it simply would not work. Given its economic inefficiencies, it could never be a serious answer to the question of how to fix American health care.

So even if the purpose of our health-care system is both economic and moral, the solutions to its problems must be economic. They should apply market forces, including the profit motive, to curtail the growing cost of health care. As much as possible, they should place the power
to make difficult decisions into the hands of patients and their doctors. And they should liberate the forces of medical innovation to increase quality, improve affordability, and extend lives.

These reflections point us toward reforming, but preserving, our system of guaranteed catastrophic care and Medicaid for the poor, and toward developing a genuine market in health insurance — through consumer-driven health care in particular — for those who find themselves uninsured today. This hardly sorts out the fine details, of course, but it offers the general framework of a solution, and takes into account the unique character of our health-care conundrum: a moral problem with an economic dimension, and an economic problem with a moral face. We cannot solve it while ignoring either element. And if we take both seriously, we might just find that the profit motive is not the enemy of high-quality, universally accessible health care — but rather its most effective servant.