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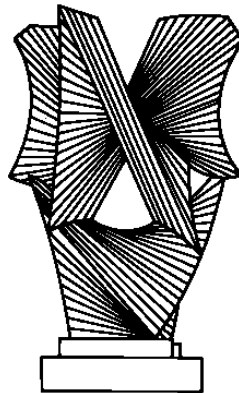
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VOICE VERSUS EXIT IN HEALTH CARE POLICY

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Voice Versus Exit in Health Care Policy

M. Todd Henderson

Abstract: This essay uses the recent controversy over President Obama's mandate that insurance companies provide generous birth control coverage to explore larger issues about the optimal locus of health care decision making. Mandates may be justified in some instances, but they sacrifice choice and local variation and perhaps lead to worse social outcomes. The key question for policy makers is whether market processes or rule by expert is more likely to strike the right balance of choice and mandate.

Key Words: law and economics, federalism, health care policy, birth control

(*Pathology Case Reviews* 2012;17: 167–171)

Georgetown University law student Sandra Fluke briefly was the center of the health care debate in this country when she testified before Congress in favor of President Obama's proposal to require insurance companies to provide generous benefits for birth control costs. Some religious institutions, like churches, hospitals, universities, and charities, criticized the proposal on grounds of religious freedom. Ms Fluke characterized the issue as one of respect and fair treatment for women, citing examples of bad outcomes that allegedly flowed to individuals denied insurance coverage for birth control. Name-calling and exaggerated claims of doom and gloom then gripped both sides. This essay uses the debate about birth control to explore some larger issues about health care policy in the United States, most of which were lost in the firestorm about religion and feminism.

WHO PAYS FOR BIRTH CONTROL?

Putting aside the (large and important) issues of religious conscience and the First Amendment, the issue is a simple one: who should pay for birth control? At first blush, one might reasonably conclude that the individual consuming the birth control should pay for it. In a capitalist economy, most individuals pay for the things they consume. If the average person wants cable television, the money for it must come out of his or her pocket, not someone else's. To be sure, there are subsidies for the very poor, like food stamp programs, but even the worst off in our society generally bear most of the costs of recurring monthly expenses. This is especially true for rather trivial expenses, like birth control (about \$10 per month for a generic prescription). This is not to say that there is no one who cannot afford birth control, clearly there is. The big question is whether this should be paid for via health insurance or some other means. Insurance seems like an odd fit for a small, predictably recurring expense like birth control. Insurance is usually thought of as a risk-sharing mechanism for *unforeseeable* expenses. I insure my car against loss but not the costs I incur to refill it with fuel each week.

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Although we might expect most individuals to pay for their own birth control, most insurance companies cover birth control, and the president has proposed that all be required to do so—why? There are several possibilities. Importantly, each of them is simply a reflection of the aggregated desires of individuals in the common pool—that is, the insured. Insurance companies provide services their customers value in a way that tries to maximize the value of the business; governments try to do the same for the welfare of society as a whole.

Obviously, those who plan to use birth control would want an insurance company to subsidize the purchase price by making others who were not planning to use it pay some or all of the price. Everyone likes getting something for nothing. But whether they can get it depends on the number of people wanting to use birth control, the number of people not wanting to, and the ability of insurance companies to create viable businesses for just the latter group. For instance, if nonusers are not a separable insurance pool and users are important customers, then a cross-subsidy might arise. In addition, the nonusers may not object to paying for users' birth control because the additional costs to them will be trivial, so long as the ratio of users to nonusers is not too high. Most nonusers (eg, men) probably do not even know whether their insurance plan covers birth control; those who do may be married and, therefore, effectively a user from an economic standpoint.

But there is a reason even nonusers of birth control might be willing to pay for birth control for others: doing so may be cheaper than not doing so, given that the insurance will likely cover the medical costs of not using birth control. Babies are more expensive than their prophylaxes. Covering birth control may economize on total expected payments and therefore allows the insurance company to offer lower rates. This reason is about the costs of insurance for all insured, not just expected users of birth control.

Making others pay for an individual's birth control on this ground must be based on an assumption that the individual will not pay for it herself out of her own funds. This is an economically irrational decision if one does not want a baby or would experience negative health consequences as a result of not using birth control. But individuals might overweight a current expenditure and discount future ones (eg, childrearing) and therefore consume less than the optimal amount of birth control. If others in the same insurance pool believe birth control will be underconsumed, for whatever reason, if not covered by insurance, then they would agree to pay for someone else's birth control to lower their own premiums. This is true whether or not one expects to consume birth control in the future. And it should, as a purely economic matter, be independent of one's views about the propriety of birth control. But perhaps those who are opposed to birth control would be happy to pay for the costs of not using it, even at a high level, given that they put such a negative value on paying for the birth control and such a high value on producing any children.

For those with idiosyncratically strong preferences about sexual matters of others, whether for religious or other reasons, they can find out whether various insurance plans cover birth control and then choose accordingly. If there are sufficiently large numbers of such people, they could form an actuarially significant

pool such that the plan could exclude payment for birth control. And, in any event, the prices of insurance should reflect individuals' willingness to pay for the basket of services offered. If there are individuals who do not want to pay for birth control, the price they pay for insurance may be higher because there may be more births or other medical costs that result. The price difference between two plans, one of which offers birth control and one that does not, should reflect the value of this idiosyncratic preference. Choices should be priced by the market. In a reasonably functioning market—that is, one with competition and information available to purchasers—those who do not want to cover birth control should bear the costs of that decision.

The reason for government involvement is to remedy any market failure. So far, we have seen two possibilities. First, if individuals are too poor to afford birth control or are irrational (ie, not making smart economic decisions in the long run), they may underconsume birth control relative to their private and the social optimum. Second, if the market is not providing insurance alternatives such that preferences are priced, then individuals may find themselves either coerced into a plan that does not offer them what they want or those who have idiosyncratic preferences about others' sexual behaviors might not have to bear the full costs of those preferences.

In the first case, the solution is to lower the cost for individuals by having other people pay. If the problem is purely one of money, then this can be done easily by taxing rich people and giving money to poor people. Milton Friedman called this approach a “negative income tax,” meaning direct payments to individuals to get them to at least a minimum income level. The idea would be to guarantee income and then harness the power of individuals acting in markets to deliver the socially optimal level and type of goods and services. This assumes that, with the money, poor people would make rational decisions—for example, pay \$10 per month for birth control to avoid having to drop out of school or leave work and bear the huge costs of (unwanted) child rearing. Of course, if the assumption is that poor people are irrational, then this approach might not work. In that case, a better approach might be to artificially lower the cost through an insurance mandate to cover birth control. Note two things about this approach, however. First, it still assumes some rationality. A mandate that insurance companies offer it does not compel that individuals consume it. Second, unless tied to an income level, the result is not just a subsidy from nonusers to poor users, but to *all* users.

The second type of market failure could be the lack of competition or the ability of some to externalize costs onto others. Pollution is the classic case. If a factory does not have to pay for the environmental damage it inflicts on a local stream, the factory will produce more than the socially optimal level. Effective environmental regulation is about forcing the factory to pay all of its costs and therefore optimize output. Without law, either command-and-control regulation of outputs or lawsuits by injured parties, we would privilege those firms or individuals who are best at making other people pay, not those who are the most efficient producers.

This logic obtains for both users and nonusers of birth control. If women do not use birth control but can make others in the insurance pool pay for their child birth and other associated costs of child rearing, then they will engage in an inefficient level of production, just like the polluting factory. On the other hand, nonusers with idiosyncratic preferences—that is, those who discount these child-related costs because they value highly the control over others' sexual practices or value babies highly—will only make sensible decisions if the costs of this approach are fully born by them.

The best approach to this problem is to create a robust competitive market where insurance companies offer a variety of baskets of services. If there is only a single insurance company in a particular location, all people desiring insurance have no choice but to accept the basket offered by that company. For some, it will be optimal; for others, it will not, and the losses suffered by this group in terms of their satisfaction will be gained by others in the insurance pool or the insurance company. It is for this reason that some health care reform advocates have focused on the ability of insurance firms to sell across state lines and other reforms that would increase market competition.

We have seen so far that there may be a compelling case for either private or public cross-subsidization of birth control. However, there is a big difference between the logic and the practical effect of insurance company cross-subsidies and government-mandated ones.

WHO DECIDES?

Governments and insurance companies both offer risk-sharing pools. In theory, citizens pay taxes that subsidize others to make everyone better off; insured individuals pay premiums that improve the welfare of others in the insurance pool. Two things are notable. First, government mandates will, by definition, have the potential to reduce social welfare in that they tolerate fewer choices. Imagine there are 100 individuals buying insurance. Half the people prefer a plan that covers birth control and half do not, whether it is for moral, ethical, or economic reasons. If these two groups create a viable risk pool, we can imagine insurance policies tailored to deliver to them their preferences. A government mandate would necessarily make half the people (the ones who prefer no coverage) worse off, while not necessarily improving the welfare of the other half.

Of course, if there is a large number of individuals who desire coverage (whether or not they can pay) who are unable to sort into these two policies, then a mandate might make sense. This would only be true, if the gains to the people who get the coverage are greater than the losses to the people who harmed by providing it. (This could be the case, for example, if society puts a low value on individuals trying to control others' birth control choices.) The point is simply that government mandates tolerate less local variation, which leads to fewer choices and potential destruction of social welfare. The government could mandate all cable companies to show only PBS, and this would likely make some people better off, but it would make many more worse off. Less ambitiously, the government could simply require all cable companies to carry PBS regardless of demand. But this cross-subsidy from watchers of PBS to nonwatchers would be justified only if the PBS watchers would be otherwise unable to watch PBS *and* the gain from doing so exceeded the cost of the cross-subsidy.

The important takeaway here, however, is that any decision, by either a government or an insurance company, to create a cross-subsidy is based on an *imperfect* assessment of whether or not the transfer is in fact welfare enhancing. But there is a big difference along this dimension between governments and insurance companies. Governments make one-size-fits-all decisions based on the opinions of experts, whereas markets operate based on the tacit knowledge of hundreds of millions of individual actors. While command-and-control can make sense in some cases, what Friedrich Hayek called the “knowledge problem” will plague any attempts to answer complicated questions based on limited information available to experts. We will return to this issue in a moment.

But there is another problem that is revealed starkly by the birth control flap. That difference has to do with what Albert O.

Hirschman called the choice between “voice” and “exit.”¹ Individuals have these two choices to influence the world around them. First, individuals can exercise “voice,” that is, some direct control over the goods or services they are offered. Voting, whether it is for representation or directly on an issue, is the classic manifestation of voice. Individuals, say parents in a school district, can vote for individuals to represent their interests on the school board or they can vote directly on a particular spending or curriculum issue. This is representative versus direct democracy, and there are arguments for both in various contexts.

Second, individuals can “exit,” that is, express their preferences about a particular policy offered by a particular institution by choosing to have their desires satisfied elsewhere. Customer choice is the classic manifestation of exit. If one has a bad meal at a restaurant, one does not try to get the chef replaced or seek input into the recipes used; one simply goes to another restaurant. Although this seems a silly example, exit is the primary way we shape our lives. Voice is the exception and only used in cases in which exit is unavailable or very costly.

The interplay between voice and exit is crucial to understanding how the birth control controversy implicates larger issues in health policy. In other contexts, we see that voice and exit work as rough substitutes for each other. Where individuals have lots of exit options, then we do not expect them to exercise much voice. Individuals will not demand it and we will not observe it in practice. The restaurant example above shows this point, but it is an easy case. Consider instead a case in which the individuals exercising voice or exit are not just customers but owners of the institution in question.

Corporate America is such a place. Holders of shares in large American corporations have very little power over how those firms operate, although shareholders literally own the company. Shareholders elect the board of directors, which governs the firm, but these elections are more like elections in North Korea than North Dakota. Board members are handpicked by the CEO and are very rarely replaced. Shareholders also do not have much, if any, say on corporate policies or decisions. Why is there so little voice for corporate owners?

The reason is that exit costs are so low. Ownership stakes in firms are readily transferable at extremely low cost. Shares of large companies are traded in highly liquid public markets, like the New York Stock Exchange, and shares can be sold online through discount brokers, like E-Trade, for a few dollars per trade. In addition, there is no market for any particular stock; there is just a market for the risk-return tradeoff offered by each stock, for which there is an infinite number of alternative combinations. Therefore, stocks look like restaurants. The rational thing for a shareholder in a company that makes a bad decision to do is to sell the stock and buy another company instead. This can be done for less than \$10, compared with the enormous expense and uncertainty involved in trying to change corporate policy.

Some companies, however, do not trade in liquid markets, and therefore, selling shares is much more costly. Small, closely held firms are in this group because ownership is usually concentrated in a family, and there are restrictions on who can sell, when, and how much. As such, we would expect, and do see, much more active roles in governance played by the shareholders in these firms. These shareholders *demand* voice because the costs of exit are high.

The consequence for these corporations with illiquid shares and more shareholder voice is conflict. The corporate law casebooks are filled with disputes among rival owners, typically family members, squabbling intensely about the governance choices of small firms. While large, publicly traded firms rise

and fall as stock is bought and sold based on individual investor sentiment, small, closely held firms frequently find themselves in court fighting over corporate policy.

Hirschman’s logic can be extended to the political realm. One might ask, for instance, why voters seem to care more about elections for the federal government than for local governments. One reason is the relative costs of exit. Although it is expensive to move from one town or state to another, the costs of moving abroad are dramatically higher. The US annual migration rate over the past 20 years has averaged about 15%, meaning about 1 of 7 Americans moves each year.² But very few Americans emigrate to another country. Local laws impact property values and, as such, are priced by the market.³ If Illinois raises taxes dramatically, house prices will fall as people move to Texas, where house prices would rise. Although not everyone will move based on such considerations, the prices are set by marginal consumers, and enough bad laws will cause people to move. It is more difficult to avoid federal law, and therefore, it is more important to get it right.

For governments, this feature is called federalism. The chief virtue of a federalist model in which subnational states have much authority over their citizens is competition. In a famous dissenting opinion, US Supreme Court Justice Louis Brandeis described it this way: “It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”⁴ If there is uncertainty about some policy, say whether or not government should compel insurance companies to create cross-subsidies for birth control, then allowing states to experiment with different policy approaches reveals information about the costs and benefits of each. This is simply a limited market for government in the spirit of Hirschman’s duality. Massachusetts may compel birth control coverage, while Maine may prefer to stay out of the business of telling insurance companies what services they must provide. Then we watch and see what happens. Later, Massachusetts, Maine, and all the other states may take information learned from this experiment and update their preferences about what is and what is not good policy.

In contrast, a federal policy is a single experiment that compels compliance by the entire nation. Article VI, clause 2 of the US Constitution declares federal law “the supreme law of the land,” which means it trumps any state law that directly conflicts with or contradicts or impedes the purpose of federal law. While federal experimentation is possible, it is more costly to write rules governing the entire country, and change happens more slowly. As the supreme lawmaker, however, the federal government has other options, such as the ability to coerce states into experimenting. In this role, the federal government could set a target—say increasing the percentage of individuals with health insurance—and then require states to deliver that target, in whatever way they see fit, by a certain date. As leverage, the Supreme Court permits the Congress to use carrots and sticks unrelated to health care, such as the withholding of federal funds for highways, education, or the like.⁵

But what can we expect to happen if the federal government deploys the Supremacy Clause of the Constitution to make one federal policy for a particular health care issue?

TWO APPROACHES TO ALLOCATING HEALTH RESOURCES

There are two (and only two) ways to allocate all scarce resources: markets and fiat. Market allocations are made using the price mechanism. Buyers and sellers are matched at mutually beneficial terms by reducing their preferences to a single price at

which they are willing to buy or sell. The chief virtue of price is that it encourages both producers and consumers of a product or service to reveal information about the value of the goods or services in question.

Fiat, on the other hand, is a mechanism that works based on hierarchy. Those higher up in a particular hierarchy make decisions about who will do what or receive what, and these allocations are enforced by the hierarchy. At the macroeconomic level, this is the approach of planned economies, such as the former Soviet Union, which had “experts” develop 5-year plans for the allocation of all the resources in the entire Soviet economy. Gosplan, as it was known, was a state agency staffed by economists, business people, politicians, and scientists from various fields. They were charged with determining the optimal way in which everything from wheat to steel to shoes to health care would be produced and delivered.

One danger of this approach is the fact that, despite the experts’ confidence in their own views and the public’s confidence in them, experts are often wrong. In his book, *Expert Political Judgment: How Good Is It? How Can We Know?*, psychologist Philip Tetlock shows how experts often get it wrong, sometimes spectacularly so.⁶ The problem is various decision making heuristics and biases—for example, the confirmation bias, the saliency or availability heuristic, and so forth—plague experts as much as the rest of us. Experts can be subtly led to particular outcomes that confirm their hunches, which may not be correct or even supported by the data. One need only pick up the newspaper to see how scientists declare *X* one week and not-*X* the next. In the lay press, this is known as the everything-that-was-bad-for-you-is-good-for-you problem. Butter is better than margarine, drinking (in moderation) is good for you, so too is chocolate, too much exercise can kill you, and on and on and on. More concretely, a recent news story described how scientists at Amgen, Inc, failed to replicate 47 of 53 “landmark” cancer studies published “in top journals, from reputable labs.”⁷

Errors can be expected, so the question is whether an expert-driven approach is more likely to uncover them and reform them than diverse approach does. Imagine 15 scientists, politicians, and other experts tasked with making all scientific decisions or judging which scientific discoveries to implement into policy. Although such a top-down approach might have certain virtues in overcoming the irrationality of crowds in some areas of science policy (perhaps global warming is such an issue, although perhaps not), this approach probably strikes us as absurd. And yet, as we will see in a moment, it is precisely the approach to the allocation of health care resources taken by the Affordable Care Act.

Another problem with an expert-driven approach is that it can lead to complacency and dependency. The philosopher Immanuel Kant identified the problems that flow from individuals relying on the decisions of others in his essay, “Answering the Question: What Is Enlightenment?” Kant argued powerfully against paternalism and rule by expert, claiming that man could only be truly capable of achieving his full potential when freed to deploy individual human reason. He described humans, then under the tutelage of church and state paternalism as like cattle, incapable of thinking for themselves, leading to a perpetual state of immaturity and therefore abuse.

This state of unthinking and blindness is manifest as well in leaders. A well-known chestnut to demonstrate this point is the story of the Soviet ambassador to London, who, upon marveling at the abundance of a local bakery, asked to meet the man responsible for ensuring the bread supply in London. Such a question strikes capitalists as absurd, but it was perfectly sensible for someone living under Gosplan. To these people, asking

whether government should provide a particular service, like producing, distributing, and selling bread, is completely natural, as they cannot imagine it being produced, distributed, and sold without government. (Many in the United States today probably feel this about health care, where the government spends more than all but three other countries in the world.)

But experts should not be discounted entirely, despite the failure of every 5-year plan and communism in general. Markets can be inefficient in some cases, and they do not always allocate resources in socially optimal ways. Environmental externalities, as discussed above, are the obvious example—so is research in basic science, which may, for a variety of reasons, be underproduced by the market. Where market failures are identified, the question is the best way of approaching the problem. In the environmental area, there are examples of success based on both a price-based approach to regulation and a command-and-control approach. To solve the problem of acid rain in the 1970s and 1980s, the EPA developed a market for tradable emissions credits for sulfur dioxide that dramatically reduced emissions with huge social benefits. In contrast, there may be particular pollutants, such as arsenic or mercury, that experts can adjudge to be harmful beyond a certain level and which are best solved by simply banning the emission of them beyond this amount.

In health care policy, the choice between markets and experts is manifest in the policy approaches favored by our two political parties. Republican reform proposals focus on empowering individuals to make decisions (with cash subsidies for poorer individuals) that will hopefully lead society in the direction of the optimal and efficient allocation of resources. On the other hand, Democrats have enacted a top-down approach in which experts will decide about who will be able to buy what health care goods and services. The “Independent Payment Advisory Board” will consist of 15 voting members appointed by the president and confirmed by the Senate. The board will be responsible for ensuring that the growth rate of Medicare spending does not grow faster than a target rate. It will achieve this by rationing care—that is, deciding what health care procedures, devices, and drugs will be available, and to whom.

This approach can theoretically achieve reductions in spending because the board could make an assessment of various health care alternatives and decide to exclude those procedures that are not cost-effective or not supported by strong evidence. I am sure each of the readers can imagine circumstances in which such an approach could be successful and beneficial at improving health outcomes or reducing costs. But I am sure each of the readers can imagine instances in which such an approach would have or could lead to worse outcomes. The question is whether we trust these 15 people, subject to some but limited oversight, to get the answers right. (For a discussion of serious structural and constitutional issues presented by the ACA’s creation of the Independent Payment Advisory Board, see Cohen and Cannon.⁸)

The expert model is not unprecedented because it is used in other jurisdictions with some efficacy. In Germany, private health insurance is common, but an expert agency akin to our new 15-member board deems certain procedures to be unnecessary and therefore not reimbursable. The Institute for Quality and Efficiency in Health Care (Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen), which is similar to the National Institute for Health and Clinical Excellence in the United Kingdom, investigates drugs, medical devices, and all medical treatments to determine efficacy. If the treatment is deemed not cost-effective, then another group, a committee representing doctors, nurses, insurance companies, and hospitals, decides whether to authorize reimbursement.

According to a senior minister in the German Health Ministry, “most patients and doctors usually accept IQWiG’s recommendations.”⁹ American health care policy expert Uwe Reinhardt, who saw the IQWiG in action and marveled at its effectiveness, told critics of the Independent Payment Advisory Board: “Go to Germany, study [the IQWiG], and you will find that this really works...It’s civilized.”¹⁰

WHAT WE CAN LEARN FROM THE BIRTH CONTROL DEBATE

Can the rationing of US health care spending be civilized? This all brings us to a very public debate about birth control. It was not civilized, as the incident with a famous radio host insulting Ms Fluke clearly demonstrates. The question is why such a firestorm would arise, when in fact almost every health plan covers birth control, and most Americans have no problem with the implicit cross-subsidy?

While birth control or some other drug, device, or procedure might not be salient for most members of the common pool, be it insured persons or taxpayers, it may become so when the issue becomes political. By political, I mean that the issue is decided by majority vote, crudely speaking, such that 50% plus one of the people deciding set the rule for everyone. When the president sought to make birth control a mandatory part of all insurance plans, this was a political decision regarding health care. This is not to disparage political decisions in general but merely to point out this feature of them—that they bind those who disagree.

In contrast, apolitical or market decision making involves individuals choosing what maximizes their own interest, without impacting others. This depends on there being choices that exist to satisfy individuals’ preferences. Monopolies can undermine this result. It also depends on the choices of some individuals not harming others. If my decision to swing my fist in the air does not impact your nose, you have little ground to complain, but if it does, then certainly the law should speak loudly to set right the wrong and deter future acts of this sort.

Whether political or not, the common pool always votes. For governments, the voting is clear. For insurance companies, the choice is made individually by buyers of insurance, but their individual choices are aggregated at the firm level to produce a suite of services that will be offered. Or, looking at it another way, one can vote about what insurance plans should offer or one can vote about which insurance to buy, thus expressing a preference for what insurance plans should be offered. Again, if there are enough people who express a particular view, one way or the other, about a particular service being part of the common pool, then it will be offered by an insurance plan. In this way, the competitive forces working on insurance companies result in a more continuous satisfaction of individual preferences than the dichotomous choice presented by a political calculation. There may not be an insurance plan to satisfy everyone’s ideal basket of services and price, but there are more of these provided by the market than by political decision making.

With this as background, what I take from the birth control debate is that, while the German experience may suggest that, for that population, political decision making or expert decision making can be effective as a means of deciding who gets what medical care, such a policy is much more fraught in our country. A relatively simple, low-cost, and widely accepted practice like birth control became a firestorm when individual choice and local variation were overridden on the grounds of improving social welfare. The airwaves and print media were filled with analysis, name-calling, and hyperbole. Kitchen tables, like my own, were filled with debate about how we should vote about other peoples’ use of birth control. The reason for the intensity of the debate—

the powerful expression of voice—was the fact that exit options were dramatically limited. This was a debate about a federal rule that would apply to everyone. Hirschman predicts intense expressions of voice, just as we saw. Just imagine what the debates will look like when the stakes become, as they inevitably will, whether expensive cancer therapies, surgeries, or other procedures will be paid for, or whether more controversial matters like abortion, gender reassignment, and the like must be paid for.

We saw this in a way during the HMO boom of the early 1990s. For a period, HMOs were quite aggressive in trying to ration care based on their assessments of the efficacy of various health treatments. So-called “managed care” did what it was supposed to do: the only decade since World War II that did not see health care costs increase more rapidly than general cost of living was the 1990s. But the system was untenable because political leaders could not stomach the stories of people harmed when denied care. In addition, choice was not robust among providers and poor individuals were not given subsidies to purchase insurance. Without a flourishing market and with tragic (but perhaps rational) cases making the nightly news, the system became political and therefore died. Costs have therefore continued to skyrocket because the system is not designed to deliver efficient care. The Independent Payment Advisory Board is the purported silver bullet, but it is likely doomed by politics, and probably unreliable regardless.

When we vote with our feet and our wallets, our preferences can be satisfied, so long as there is choice and we are not imposing costs on others through our choices. When instead matters are decided by votes of experts or politicians, mistakes can be made and made in ways that necessarily are coercive. This coercion does not admit easy exit, especially if done at the federal level. The central lesson is that centralized power over complex matters risks making larger mistakes than decentralized power, admits less innovation, provides for less tailored satisfaction of preferences, and generates greater political conflict, which, ironically, may undermine the important work that the government must do to improve the world we live in.

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