1 Management Mission Impossible

My Care Is Okay, but the System Is Broken

Americans have a layered perception of the country's medical care system, and the layers do not align. At base, their view of their own care in terms of quality, convenience, and consumer sensitivity is good: They generally like physicians and other health professionals who care for them, view the hospitals they use as satisfactory most of the time, and feel they can get care when they really need it. If we overlay this perception of individual satisfaction with the map of insurance arrangements, verdicts become somewhat darker. Consumers are not ecstatic about private insurance coverage or about the behavior of private insurance companies or their employers who generally determine those options.[1] There is still a preponderance of sentiment for having choice among different private plans rather than a single payer, though this preference is strongly influenced by political affiliation. The best one could say about the private insurance system is that it is generally decent if sometimes maddening. For the Medicare program that covers the elderly and disabled, feelings are generally more positive, but behavior suggests that most people are uncomfortable with the original government Medicare plan from 1966. They almost all modify it either by purchasing private Medigap insurance to cover cost-sharing or by opting for private Medicare Advantage plans with better coverage and lower cost.[2] Seniors love Medicare, but not enough to accept it on its own terms; they supplement, trim, and add private options. Finally, there is a third layer of perception of the American health system which is unfavorable. The system is regarded as both excessively costly and especially ineffective in improving the health of the population, especially (but not only) lower-income people and minorities. It is also regarded as unfair to lower-income people and to

[1] "Americans sour on U.S. healthcare quality." Gallup Poll Social Series: Health and Healthcare. (2023). Gallup News Service. https://news.gallup.com/poll/468176/americans-sour-healthcare-quality.aspx.

[2] Freed, M., Biniek, J. F., Damico, A., & Neuman, T. (2023). *Medicare advantage in 2023: Enrollment update and key trends*. Kaiser Family Foundation. www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/.

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those with above-average health risks. Compared to what would please people evaluating system performance for political choices, the system costs too much and does too little that is effective.

My goal in this chapter is to present an economically correct and clear picture of the system, both what we know and what we do not know. The system, I will argue, has substantial benefits as well as costs compared to the past or compared to no care. It is surely not ideal, but there is no rigorous theory and evidence on what would improve it – and "improve" itself is a subjective judgment on which so far there is no consensus. I also offer advice to those who work within it about how they can defend or at least provide reasons (but not excuses) for what happens.

The most fundamental issue is whether there is some alternative system or some set of adjustments to the current system that would do more additional good than additional harm. Be forewarned, economics will neither fuel outrage nor offer unstinting praise, in large part because the alternatives people talk about are either hypothetical or oversold. Identifying bulletproof measures of additional benefits and costs (which is what economists are supposed to be good at doing) not surprisingly turns out to be complicated, and not as yet capable of a final verdict – not even on which direction to go, much less on how far to go in some direction. But we can identify the places where there is evidence of a potential for improvement, and we can offer advice to managers (the point of this book) about the prospects and the tasks that might lead to gains.

Who Cares about Cost?

The economic perspective imagines that a good or efficient outcome is a situation in which all actions (producing a good or service, having a given person consume that good or service) which yield benefits greater than their cost should be undertaken, and no actions which yield cost greater than their benefits should be undertaken. This idea is the essence of the notion that all care which is cost-effective should be rendered, and no care should be supplied which is not cost-effective. To make this a little more concrete, imagine there is a given set of resources available to a population, and these resources (smart people, land, and physical capital) can be used to produce medical services which people value but also other things that people value. If a decision is made to divert some of those resources to medical services, what those diverted resources could have done elsewhere

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is, in a fundamental sense, the cost of the medical services. The diverted resources can be converted into a cash measure by attaching a dollar value to their use in the alternative to medical services. If we think the other use (call it "making good stuff") has a value per unit of $1 and that it takes one unit of resources to make one unit of stuff, we will have a dollar measure of the true cost of medical services.

This abstract discussion makes two important points. One is that the economic cost of anything is its value (measured by some metric) in its next best use – this is called "opportunity cost." The other is that if an economy is currently at some level of production of medical services, it will be a good thing for medical costs to be increased from that point if the value of medical services is greater than the opportunity cost – the benefits foregone from the other use. The system should be cost-effective.

The last point means that there is no special reason to want to have low-cost medical services; it all depends on what you get for the money. It also means that using medical services to improve health outcomes or consumer satisfaction needs to provide not just positive benefits but benefits larger than their opportunity cost. Some beneficial care will be foregone in an efficient outcome – but those who might have benefited from it may complain.

What Managers Should Say: Take One

This last point is the key for managers who need to respond to general claims about high or out-of-control medical spending. The first step is to change the conversation away from spending or cost per se and talk about value for money. In any other industry, rising revenues (and their usual complements, rising employment and rising profits) are regarded as a good thing, contributing to GDP growth and increasing opportunities for good investment. In healthcare, rising spending in and of itself is not necessarily a bad thing – it is bad only if it is not accompanied by a concomitant rise in what we are getting for that spending. But rising medical spending is almost always felt to be a bad thing.

The positive if theoretical economic view has some evidence behind it. Studies show that, despite their cost, innovations in pharmaceuticals have added high-value health outcomes for the American (and the global) population. Macro studies show that rising real incomes will prompt consumers to spend much of the increment on improvements in health that are worth it to

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them.[3] They will not, in the modern era, want to spend on more potatoes or more salt (or even that much more meat). And relatively high US medical care spending has not so far been shown to deter either economic growth or beneficial international trade.

One implication of this economic view is that the indicator of the performance of or burden from a country's health system most often cited by journalists and others, the fraction of GDP spent on medical care, is one of the most misleading measures ever developed. For one thing, if people in healthcare muddle through this year just like they did last year, but GDP tanks, the burden measure will leap but with no blame owed to the healthcare sector. More seriously, without knowing the value of whatever improvements in healthcare that are associated with an increase in spending, and without knowing the value of other parts of GDP that might have been displaced, you cannot even tell from changes in this measure if things are getting better or worse.

There is, it should be obvious, no intrinsic merit in slow growth of medical spending – it all depends on how much good the growth does. That is, evaluation depends on value. It is ironic that an organization created to lobby for better value and measurement of value in healthcare – "The Health Care Transformation Task Force," with representation from major insurers and other worthy groups – has as one of its missions making sure that "the growth in health care costs should ideally be at or below the growth of GDP."[4] What if somebody invents something costly that cures cancer? Perhaps only economists have a basis for saying that cost should not be the highest priority.

What about Other Countries?

A common topic of discussion compares the American healthcare and insurance system with those in other countries.[5] If the US and the UK are two countries linked only by a common language, matching the US against Singapore or Spain is even harder; culture matters. Still, in anticipation of

[3] Hall, R. E., & Jones, C. I. (2007). The value of life and the rise in health spending. *The Quarterly Journal of Economics*, *122*(1), 39–72.

[4] Guiding principles. Health Care Transformation Task Force. https://hcttf.org/about-us/guiding-principles/.

[5] Emanuel, E. J. (2020). *Which country has the world's best health care?* Hachette UK; Reid, T. R. (2010). *The healing of America: A global quest for better, cheaper, and fairer health care*. Penguin.

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what we will be able to say with some confidence in the following chapters, here is my opinion about variation in spending and its causes after several decades of exploring many systems: To begin with, the share of this country's labor resources used to provide medical care in the US is about the same as in the Scandinavian countries, Germany, France, and Australia, but larger than in the rest of Europe. From that pool of inputs, medical care in the US does not displace a larger share than in many other countries. (I will explain why spending varies so much more in Box 1.1.) Differences in health outcomes across middle-class countries are not large and are not explainable by differences in their healthcare delivery or financing systems; culture matters, and poverty kills. So do racism and the uneven distribution of wealth, a more serious issue in the US than in most other developed countries. Still, we can come away with some nuggets from comparisons: We will know that many different arrangements are possible and that the main difference in spending or outcomes depends on income. Beyond that, we will see what we can see.

Box 1.1 Theory: How to use exchange rates to correct cross-national comparisons of medical care spending

It is widely believed that US healthcare expenditures per capita are higher than those anywhere else in the world, even compared to other developed countries. But how do we know that? We know what spending per capita is in the US; it was $11,600 in 2019, the most recent pre-Covid year for which we have data on a large sample of countries. Take Japan as a comparator. For the same year, we know that healthcare spending per capita in Japan was about 660,000 Japanese yen. Obviously, we cannot compare yen to US dollars. To do that, we need an exchange rate – how many yen are equivalent in purchasing power to $1?

The easy way to do this would be to use the published rate, averaged over the year, at which yen could be bought with or sold for dollars – approximately what you would see as a tourist if you exchanged your greenbacks for yen (minus commission). Economists do not do it the easy way, because this "spot" exchange rate bounces around and can be affected by the monetary authorities in different countries – their interest rate policies, their accommodation to government budget deficits, and so on – which have nothing to do with healthcare. Instead, what is usually used is the "purchasing power parity" (PPP) exchange rate. That is supposed to reflect (averaged over a year) what it would cost to purchase a typical basket of goods and services in one country compared to another.

If the hypothetical basket cost $1 in the US and 150 yen in Japan, the PPP exchange rate would be $1 = 150 yen – or each yen is worth 2/3 of a cent. That is what is used to convert Japanese healthcare spending in yen into dollars, and the conclusion is that such spending per capita in Japan is much lower (at $4,400 per capita using this figure) than in the US. The PPP standard is sometimes called the "Big Mac" standard because, both in theory and

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in practice, it is pretty close to the comparison of what it costs to buy a hamburger and fries in the currency of most countries – and a hamburger is a hamburger. (As I write this, the cost of a Big Mac in Japan is about 600 yen – equivalent to a little over $4 at the round number of 150 yen per dollar, a pretty good deal given recent US food inflation. If you are going to order carry out, you might prefer to order from the Osaka branch, but then you would really have to wait and pay a big tip for Door Dash.)

However, a hamburger is not a doctor visit, a hospital admission, or a bottle of pills. This uncontroversial observation matters if the relative price of healthcare (compared to a Big Mac meal) is different in the countries you are trying to compare. The problem is that, as far as we can tell, in most countries, healthcare is priced much lower relative to a hamburger meal or a basket of goods than in the US. If you had to pay for a doctor visit in the US, you would have to give up many more Big Macs than in Japan. You might have to give up 20 Big Macs in the US – which would translate into 3,000 yen at the Big Mac rate – but only 10 hamburgers in Japan, which would cut the yen price in half. So, if we translate the yen price of healthcare in Japan using the healthcare PPP rate (75) rather than the usual Big Mac rate (150), we will get a much higher number of dollars.

I picked Japan because by the usual PPP measure it has a much lower level of spending than in the US and because it also has very low medical care prices relative to other prices in Japan (such as apartment rent or even food). Using the medical care rather than the all-commodities exchange rate, Chris Conover has shown that the dollar measure of medical spending in Japan is approximately doubled, from 38% to 75% of US spending per capita.[6]

If you are a manager, you can at least use this argument to confuse your critics. It is a more technically correct version of the slogan, "It's the prices, stupid": Medical spending is higher in the US because we pay doctors, hospitals and their employees, and drug companies more for comparable products than other countries do. Later in this book I will offer what economists think are some of the reasons why.

What Managers Can Say: Take Two

This is supposed to be enough economic theory to move critics away from useless cross-country comparisons. But within the US, medical spending has been rising, in most years more rapidly than GDP. So how can a manager defend an industry that absorbs an ever-larger share of spending? Zoological insults abound: "you are custodians of a rathole down which unlimited resources are being poured, feeding the tapeworm that is eating away at our international competitiveness." The most fundamental (though not the snappiest) comeback has already been proffered: Look at the benefits from better healthcare and tell me they aren't worth the money. Then there is

[6] Conover, C. J. (2012). *The American health economy illustrated.* American Enterprise Institute (AEI) Press.

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a divide and conquer strategy: Much of the growing spending represents higher payments to workers in healthcare – do you begrudge nurses their raises? That still leaves out some suppliers who are viewed less favorably: the owners of drug firm stock or your friendly neighborhood urologist (though they are mostly Americans too).

But these ripostes do not answer the feeling that almost if not all of the progress in health outcomes could be achieved at lower cost, and not all of those groups who have collected more money deserve it. At this point we can at least get down to cases – what can practically be done to remove waste and excessive payments, or (the mirror image of healthcare costs) to cut health worker wages, jobs, and wage growth – if that is what you want to do? I would argue that there is not a long list of practical changes, and most of the items on the usual list are a little soft in terms of evidence of mattering enough to matter. Chapter 13 deals with this issue in more detail, but the best summary here is that controlling medical spending or its growth is a challenge, not something easy to do right before your very eyes; it is a challenge to find something that will reduce inefficiency in ways guaranteed to do more good than harm. That discovery process is what we try to do every day, and we even use economics to help guide us. Then take your lumps.

What Managers Should Do

The purpose of this book is to help managers address economic challenges that occur in this environment by offering insights from health and medical economics research – and the economic view of the world in general. My argument is that economic problems require economic solutions (rather than slogans or outrage). Not all challenges that arise from the current environment can be addressed, but many can – and knowledge of which others are still open cases can help managers avoid jumping into action too soon or seeming too defensive. It is sometimes said that the US healthcare system is a nonsystem; it is also sometimes said it is a system perfectly crafted (by someone) to produce the outcomes it does. The second observation is closer to the truth but fails to recognize that systemic relationships can and do develop organically. There always is an invisible hand – though sometimes it can be all thumbs. But tracing these relationships to their consequences and then back to their causes is what economists are supposed to be good at doing, so I will offer up what we have so far, in the hope that it can both explain and guide.

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My approach here differs from the usual books that explain health economics, mostly to economists or economics students. They do not tell managers things they did not already know – while my hope is to do just that. Most of management, everybody knows, is a combination of personal attention and common sense; I am going to assume my readers already have that. What I can add is both theory and evidence from health economics, which tells you things beyond (or counter to) common sense (and surely beyond the much-maligned conventional wisdom). Some points are counterintuitive – cost-shifting cannot happen in a world of profit-maximizing firms, better health insurance is not always good for you, nonprofit hospitals are no different from investor-owned ones. Often the message is counsel of caution when what people need to know to make the best decisions does not exist (despite widely accepted conclusions), so you need to hedge your bets. And sometimes economics does agree with common sense even when it is uncomfortable to say so (e.g., physicians perform differently based on economic incentives).

My hope is to supply punchlines that not only are clear (hard for an economist) but that also pay off for managers in terms of insights they would not otherwise have, assumptions they would otherwise make, and conclusions that might otherwise follow the crowd. I am not bold enough to imagine that this book will be a version of *Freakonomics* meets health economics, but I do hope to surprise a little, reassure some, and warn a lot.[7]

The most fundamental idea in welfare economics is that the best situation in any part of the economy is for activity to be carried to the point where the benefit from doing more of it just equals the cost of doing so. The mantra in economics is that "marginal benefit should equal marginal cost." This is common sense personified and simplified: If you can get more benefit than cost by doing more of something, you should do more of it – whereas if you get positive benefit but it is less than cost, you should do less. Obviously doing less, or stopping altogether, is what you should do if you get zero or negative benefit (harm) from more of some activity.

This self-evident truth has actually gotten a lot of play in health economics. As a theoretical concept, one can think of an economy starting with no resources devoted to healthcare and adding more. Up to a point, the improved health from doing so will be large enough to cover the cost, but

[7] Levitt, S. D., & Dubner, S. J. (2005). *Freakonomics: A rogue economist explores the hidden side of everything*. William Morrow & Co.

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there will eventually (and often quickly) be diminishing returns, so marginal benefit (though positive) falls as more is done. Beyond some point, more resources devoted to care may do almost no good for the health of the population getting them – this is the famous law of diminishing returns, rechristened for health economics as "flat of the curve" (that plots health outcomes as a function of inputs) before going over the top and hitting the range where excess care actually can make people sick. Where to stop adding inputs (say, to improve the quality of care)? Not at the top or flat where more inputs have a cost but do little good, but at a lower level of spending where the additional health benefit is just worth the additional real resource cost. For most services we do not need this belaboring of common sense, but for health care we need an antidote to slogans like "the best possible health outcomes" – and this is it.

One reason why this idea has gotten so much play is partly because many observers feel that, as a whole, the US healthcare system may be at the flat of the curve, where more spent on care does almost no good. What has gotten less play among the general public (though well known to economists) is that an ideal system should stop adding resources well before the flat of the curve is reached. The awkward implication of this conclusion is that it is not economically efficient for a system to maximize health – precisely because the maximum (the peak of the mountain) occurs, as any climber can tell you, at the top where it is flat. The same kind of debunking applies to slogans about the "maximum possible quality of care" or the "maximum prevention of disease." All are foolish goals.

You can make even more trouble with economics. Another implication of what has just been said is that there are bound to be situations in which more care has positive health benefits, but not enough of such benefits to justify its cost. People talk about "necessary" care as if they knew what it meant – but is care of positive benefit but high cost "unnecessary"? Economics abhors the concept of "need": We think that people should get what they want, not just what they need. For many goods and services there are unequivocally better versions that just are not worth their cost to most people – and we do not fault them for walking away. If I do not add the lane change assist option on my new car, I will be at greater health risk but too high a cost can be a good excuse. We have a harder time living with the conclusion that even in healthcare some good must be left undone.

Managers generally have a keen awareness that some things are good but not worth doing. Healthcare managers have the difficult challenge of explaining that this is sometimes the case for what they manage. It is hard to find graceful

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language to explain why – and economists are no help with soothing words here. Sometimes you just have to say "no" and brace for the incoming. A little good news: This is not the case for most healthcare interventions, so managers need not worry about continuous complaints. But there will be some.

Getting Down to Brass Tacks and Real Inputs: Where Are All Our Smart Young People Going?

Healthcare is a labor-intensive industry; hospitals and physician practices employ many people, and even some things purchased from the outside (like clean hospital bedding) primarily use labor to produce them. Producing healthcare services does not require high heat, huge machines, or smoking chimneys. Because prices and wages vary so much over time, across the US, and across countries, rather than use that nasty percentage of GDP statistic, it is more realistic to think of the percentage of the workforce going into healthcare. Obviously, someone who works in a clinic when they could have taught in a school, sold shoes, or worked as a cook deprives the economy of the value of whatever else they might have done. The Organisation for Economic Co-operation and Development (OECD) collects data on the workforce in healthcare in different countries. That data is a little soft; the healthcare share of Sweden's workforce dropped dramatically when the government moved nursing homes from the healthcare to the housing sector in the national accounts – and Italy only counted people who worked in government hospitals. Still, what Exhibit 1.1 shows is that the US healthcare workforce share has been growing over time but is still lower than some of the other countries; our healthcare labor "cost" is not the highest in the world. The reason why our cost is the highest is

Exhibit 1.1 Percentages of labor force in medical care, 1993 and 2004

	Physicians		Nurses		Total health employment	
	1993	2004	1993	2004	1993	2004
US	0.42	0.47	1.51	1.53	6.6	7.5
Canada	0.43	0.40	2.23	NA	7.3	7.5
France	0.73	0.74	1.32	1.65	6.9	7.1
UK	0.35	0.47	1.66	1.87	5.7	6.8
Switzerland	0.51	0.64	NA	2.40	8.8 (1995)	9.9
Norway	0.53	0.68	NA	2.90	NA	10.6

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that US healthcare wages (not just the wages of physician specialists) are both high relative to other countries and high relative to the average wage in the US – compared to that ratio in other countries. The reason is, in the first instance, higher prices here, but those prices largely support higher wages – especially in the production of medical services (rather than devices and drugs).

So, if managers succeeded in reducing real healthcare costs, they would have to fire many workers – or let them leave voluntarily – and these workers would get other jobs elsewhere in the economy, doing things of greater value than what they had been doing in their healthcare jobs. That is what economic theory would say, but I personally would not try to prove that their alternative job was more valuable than healthcare – what if they became lawyers? More seriously, analysis shows that the growth in health employment in the US was largely matched by shrinkage in manufacturing employment over time – not from other service industries.[8] Did those workers who laid down their hammer and picked up their stethoscope (metaphorically speaking) jump into healthcare, or were they pushed by the hollowing out of US manufacturing employment caused by higher productivity and foreign competition? Far from depleting the manufacturing sector in the US by attracting away its workforce, the medical care sector probably provided them with a new home when foreign competition reduced the demand for their products. Had it not been for growth in good healthcare jobs, the Great Recession of 2008–10 would have had a much more harmful effect on total employment and wages for labor. No final verdict can be rendered on how these changes all worked out (compared to some other scenario) but it is clear that the "burden of healthcare costs" on the US economy is easy to overstate.

The Limits of Economics

Compared to critical views of the US healthcare sector as a drain on the economy and the welfare of citizens, health economics can offer some consolation. The true cost of medical services and goods provided has not been proven to be an unsustainable burden on the economy. The international comparisons of spending per capita (in dollars converted at the PPP exchange rate or relative to GDP) use an estimate for the US that is significantly biased upward – all because our medical prices and health

[8] Pauly, M. V., & Saxena, A. (2012). Health employment, medical spending, and long-term health reform. *CESifo Economic Studies*, *58*(1), 49–72.

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worker wages are higher than elsewhere in the world. We could have costs relative to GDP like those of western Europe if we chose to pay not only doctors but other healthcare workers less. (The greater governmental control of healthcare in those countries permits the government to force down wages for workers in the sector.) From the viewpoint of economics, the relative burden of US medical care is much lower than comparative spending data suggests – and almost all of the difference represents payments to our fellow Americans. In their role as custodians of scarce resources, managers do not have to be so embarrassed.

These soothing words apply to marginal cost, but what about marginal benefit? The relatively poor health outcomes in the US suggest that the effectiveness of care delivered here is not high – and managers have some responsibility too, though the blame also rests on clinicians. The full answer is more to a question of epidemiological causation; the cross-national data is certainly consistent with the hypothesis that the health productivity of US medical care compares unfavorably with that in other countries – but they do not prove it. This is not primarily an economic issue, although (as we will see in this book) economists have used their statistical techniques to illuminate it.

The most obvious thing to say about the cause is that health outcomes depend on much more than formal medical care use. They are affected by socioeconomic deprivation, which can influence citizen lifestyle behaviors that also can have a large effect on health outcomes. I will deal with this issue in more detail in Chapter 15 on the social determinants of health. For the present, it is enough to note that the aggregate health outcomes in any country (such as mortality) are affected by the level and distribution of resources across various segments of the population – beyond some point more resources cannot make you immortal, but few resources can shorten your life. Both the more uneven distribution of income and wealth in the US and the stronger effects of race-related disparities cause worse health outcomes than in more homogeneous countries. The role of medical care in alleviating these disparities, even if it was taken as a positive goal in the US, has to be limited. Not all data is adverse; middle-aged men live longer in Minnesota than across the border in Manitoba, evidence either that the Canadian healthcare system is inferior to the system in some parts of the US or that much more is going on. Whatever the resolution of this question, there is no proof in the data that managers in the US are responsible for overall health outcomes. The absence of proof does not let them off the hook, but it does mean that more research is needed.

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What to Say about Healthcare Spending: Past, Present, and Future

We are used to confronting a dystopian vision of "out of control" medical spending. There is a reason for that. Using the journalist-favored measure of national health expenditures as a share of GDP, that metric has increased substantially over the last 50 years, from about 7% in 1974 (which President Nixon declared to be unsustainably high) to about 17% in 2023. For reasons which no one (including yours truly) understands, the share took a big jump after 1980,[9] as spending outpaced GDP growth thereafter by about 2%, year in and year out for decades. However, this horror story is old news; it is no longer true. The healthcare share in 2022 at 17.3% of GDP was actually lower than the recession-affected 2010 share of 17.9%. There have been some bumps since then – in 2016 when the expensive but curative treatment for hepatitis C came online, and in the COVID year of 2020 when the economy and GDP tanked, health services use actually fell but the government flooded the sector with bailout money.

Things apparently have changed lately from the old gloomy story. It is always dangerous to predict, especially about the future, but more than 10 years of stability suggest that things may have stabilized at about a 17%–18% share, still higher than anywhere else in the world but no longer growing. Here again we do not know why. We can narrate the developments – drug spending actually fell in the early 2010s as new introductions fell, physician real incomes have been falling, both Medicare and Medicaid now tell hospitals how much they will pay rather than pay what a hospital's charges or costs are, and higher deductible insurance grew. Perhaps as healthcare spending rose, in line with economic theory, citizens noted it was biting more and more into what they could spend on other things, and so as private insurance purchasers and as taxpayers for public insurance, they decided "Enough!" and conveyed that message in a subtle way. Perhaps managers actually helped.

In what follows I offer some insights on pockets of success in lowering the level of cost. I also preach the message of needing evidence of effectiveness before going ahead with new spending. I am an optimist about this sector: I think it has reached a stable level where it can support a reasonable flow of effective new treatments and other ways to improve quality of care. I am even optimistic that the adverse social determinants of health, surely one of the

[9] Frakt, A. (2018). Medical mystery: Something happened to US health spending after 1980. *New York Times*, May 14.

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main causes of poor health outcomes in the US, can finally be addressed, although doing so will require effort from agents in addition to healthcare managers. There have been (as there will doubtless continue to be) disappointments as changes which sound good do not work. Read on for an overall bright picture about what economics advises can be done to hold our own and move forward.

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