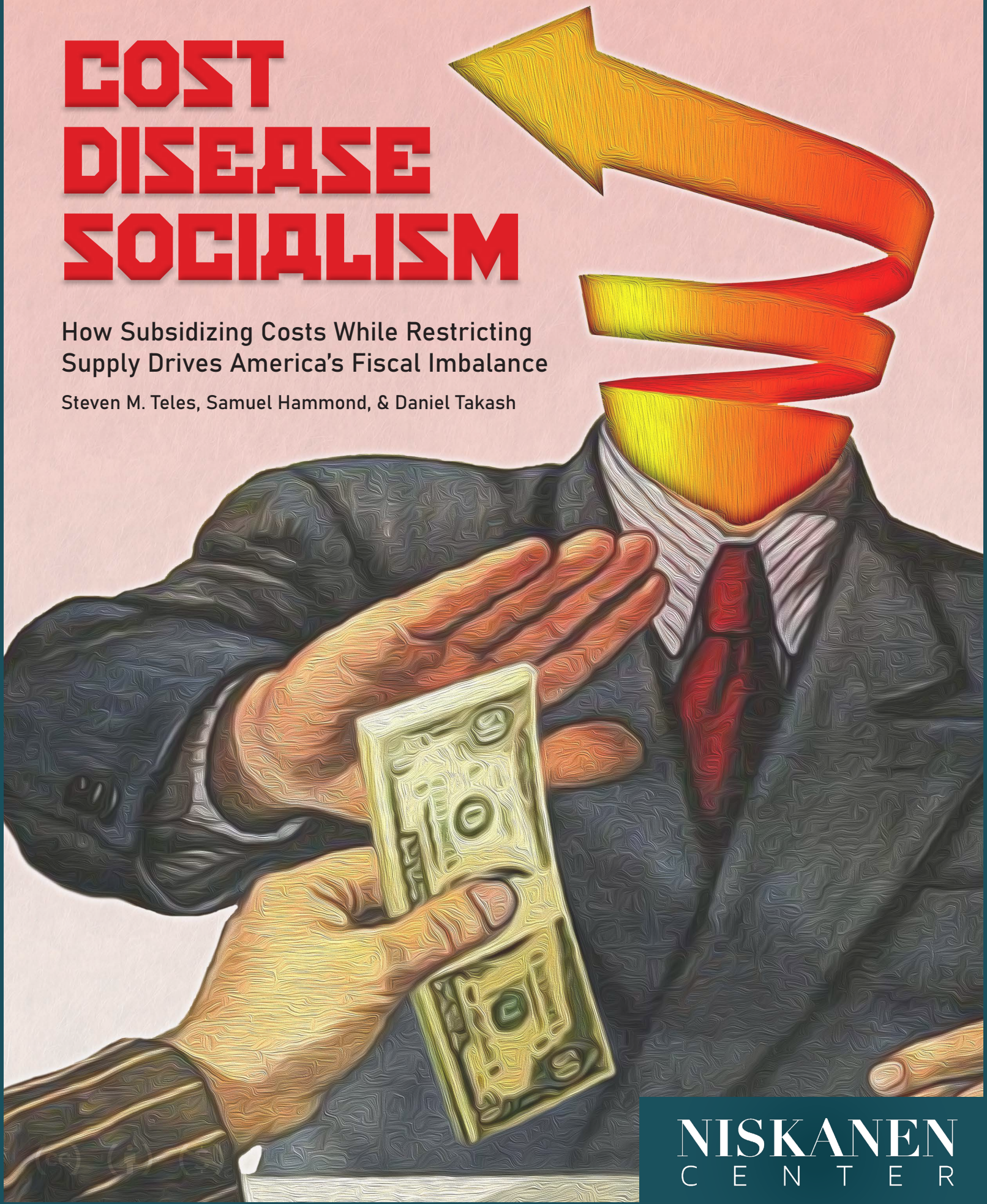
COST DISEASE SOCIALISM

How Subsidizing Costs While Restricting Supply Drives America's Fiscal Imbalance

Steven M. Teles, Samuel Hammond, & Daniel Takash



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INTRODUCTION

"Rapid productivity growth in the modern economy has led to cost trends that divide its output into two sectors, which I call 'the stagnant sector' and 'the progressive sector.'"

– William J. Baumol
The Cost Disease: Why Computers Get Cheaper and Health Care Doesn't

We are in an era of spiraling costs for core social goods — health care, housing, education, child care — which has made proposals to socialize those costs enormously compelling for many on the progressive left. This can be seen in the ideas that floated around the 2020 Democratic primary, which are a preview of coming policymaking attractions. Proposals for free college and student debt relief, Medicare for All, free or nearly free universal child care, and massive subsidies for renters in expensive cities were floated by President Biden's challengers, and continue to be at the top of the agenda of the progressive left.[1] Indeed, the current vogue for "socialism" on the left is, on closer examination, almost always about socializing these common household expenditures. The traditional socialist call to "seize the means of production" has thus been updated to something closer to "subsidize my cost of living" — a less revolutionary ambition, perhaps, but one that is no less myopic.

Soaring costs have blown a hole in the budgets of the working and the middle classes, offsetting the full benefits of a growing economy, particularly given the modest wage growth of the last four decades.[2] But simply socializing the costs and blowing an equally large hole in the federal debt is not a sustainable alternative. It is propitious, then, that the rise of "cost disease socialism" has coincided with the left's growing fluency in Modern Monetary Theory — a school of macroeconomic thought that, whatever its deeper contributions and inscrutable subtleties, has become shorthand for the view that deficits don't matter because the sovereign can always monetize its debts.[3]

1 E.g.: "How Does Bernie Pay for His Major Plans?" BernieSanders.com. https://berniesanders.com/issues/how-does-bernie-pay-his-major-plans/

2 Mark J. Perry, "Chart of the day (century?): Price changes 1997 to 2017," Capre Diem, AEIdeas, February 2, 2018. https://www.aei.org/carpe-diem/chart-of-the-day-century-price-changes-1997-to-2017/

3 Noah Smith, "Beware of Economic Theories Claiming to Explain Everything," Bloomberg Opinion, April 23, 2019. https://www.bloomberg.com/opinion/articles/2019-04-23/modern-monetary-theory-austrian-economics-deserve-skepticism

We beg to differ. Governments do not face the same budget constraints as a household, and a larger federal deficit was appropriate given the pandemic and persistently low inflation. Nonetheless, these facts do not mean that public debt and deficits can grow without limit; nor do they provide a blank check for spending as if opportunity costs have ceased to exist. Enigmatic macroeconomic theories notwithstanding, the maxim "there is no such thing as a free lunch" still holds true. Spending proposals of every kind should stand or fall according to standard principles of public finance, including the quaint notion that spending programs should ameliorate bona fide market failures.

"… we part company with those fiscal hawks who pursue backward-looking deficit reduction strategies based on budgetary gimmicks or dead-on-arrival cuts to existing entitlements."

At the same time, we part company with those fiscal hawks who pursue backward-looking deficit reduction strategies based on budgetary gimmicks or dead-on-arrival cuts to existing entitlements. An entitlement program like Social Security, for example, will be reformed one way or another given the automatic cuts that are triggered once the trust fund's assets are exhausted. At that point, if not sometime before, we fully expect some mix of the commonly proposed "fixes" to be adopted, bringing the trust fund back into actuarial balance while leaving benefit levels overwhelmingly unscathed. In fact, in contrast to most entitlement reformers, we are enthusiastic defenders of our Social Security system, and would even prefer to see its benefits enhanced. We are thus not dogmatic opponents of "entitlement programs" in the abstract; nor is our aim to downsize the fiscal footprint of the federal government, per se.[4] Administering a robust and broadly universal pensions system is a perfectly legitimate function of government for run-of-the-mill efficiency and equity reasons, and while it is important for any social insurance program to be financially sound, Social Security's "insolvency" is far more of a political crisis than a fiscal one.

Instead of looking backwards, we take a prospective approach. Cost pressures in sectors like health care, housing, child care, and higher education are creating growing, irrepressible public demands to move such costs onto public budgets. Doing so would be a mistake, in our view, because the root cause of escalating costs is overwhelmingly regulatory, rather than budgetary, in nature. Shifting costs onto the public would not only fail to fix the underlying problem; it could also make cost disease substantially worse by shielding consumers from market prices while guaranteeing overregulated sectors a source of unconditional demand. This can result in a vicious cycle in which subsidies for supply-constrained goods or services merely push up

4 Samuel Hammond, "The Case for a Free-Market Welfare State," Symposium, May 10, 2021. https://symposium.substack.com/p/the-case-for-a-free-market-welfare

prices, necessitating greater subsidies, which then push up prices, ad infinitum. Even if the cost of a particular program seems small today, spending growth linked to a particular cost-diseased sector will tend to undermine our fiscal sustainability in the long run, since by definition they are the sectors in which costs grow faster than the economy as a whole.

The regulatory roots of cost disease explain why fiscal conservatives are poorly served by strategies focused on austerity and direct budget controls. Take Medicare, which faces long-term budgetary challenges stemming from the aging U.S. population and the continued rise in costs throughout the U.S. health-care system. Total Medicare spending already accounts for 14 percent of total federal spending, and is projected to grow from 3.7 percent of gross domestic profit (GDP) today to around 6 percent of GDP by 2040.[5] Cutting benefits or moving Medicare beneficiaries onto private plans can mechanically reduce the federal government's share of the U.S.'s national health expenditure, but this risks being little more than an accounting trick — a purely nominal change in "who pays" that would do little to address the underlying sources of cost growth. Spending per enrollee has grown somewhat faster among private insurers, suggesting the real source of cost growth is at the provider level.

As an example of the underlying sources of spiraling health costs, Medicare spends nearly 7 percent of its annual budget treating kidney disease, primarily due to the high cost of dialysis treatment. At around $87,000 per patient per year, dialysis is expensive for largely regulatory reasons. As Vox's Dylan Matthews notes, "the dialysis industry is heavily consolidated, with two providers (DaVita and Fresenius) accounting for 83 percent of the market." Worse still, DaVita and Fresenius are paid per treatment — a reimbursement structure that "deters them from preparing patients for transplant and (to some extent) from offering home-based dialysis."[6] Home-based dialysis is the norm in many countries, is preferrable for most patients, and is cheaper in the long run, yet adoption has been slow in the U.S. given higher upfront costs and a payment model that is reinforced by regulatory capture.

A series of reforms initiated under the Trump administration is now changing this, however. Through increased incentives for living kidney donors, experimentation with new payment models, and a push to promote home-based dialysis, the reforms are expected to realize $4.2 billion in savings each year while, through expanded transplants, averting nearly 28,000 deaths. While far afield from the usual budget control playbook, these reforms represent fiscal conservativism at its most constructive, and provide a template for how to approach many other areas of spending growth. Indeed, achieving long-run fiscal balance will likely require dozens of regulatory initiatives just like this one, some of which may likewise require an

5 See: "Budget Basics: Medicare," Peter G. Peterson Foundation, July 29, 2020. https://www.pgpf.org/budget-basics/medicare

6 Dylan Matthews, "A new Trump executive order on kidneys could save thousands of lives," Vox, July 10, 2019. https://www.vox.com/future-perfect/2019/7/10/20687507/triump-kidney-disease-transplant

upfront *increase* in spending in order to bend cost curves over the longer run.[7]

A regulatory approach to fiscal sustainability has some political upsides as well. Independent of the prospective budgetary impacts, tackling cost disease head-on would directly expand the real incomes of ordinary Americans, while making the economy as a whole more productive. Programmatic cuts, in contrast, create "losers" virtually by definition, and do nothing to alter the underlying political economy that gave rise to said programs in the first place. If fiscal conservatives in America feel like they are fighting a multi-headed hydra, in which cuts to one program are followed by the expansion of three others, this is surely a major reason why.

Rather than treating politics as an afterthought, our fiscal policy vision puts political economy front and center. In the sections that follow, we review the political economy of debt and deficits, with a special focus on the concept of cost disease. We then turn to an agenda that tackles the prospective threats to fiscal sustainability head-on, using health care, higher education, housing, and child care as case studies.

THE POLITICAL ECONOMY OF DEFICIT SPENDING

The Niskanen Center's namesake, William Niskanen, is known for bluntly rejecting the "starve the beast" theory of spending cuts.[8] Cutting taxes, Niskanen argued, does not automatically lead to spending reductions down the road. On the contrary: in the short term, deficit financing reduces the cost of government programs as experienced by the public, creating a "fiscal illusion" that increases the demand for greater spending down the road — a conjecture Niskanen went on to test empirically.[9]

The failure of the "starve the beast" strategy is now well known, and yet that did not stop Congress from passing a deficit-financed tax cut in 2017, with the promise of its being paid for by future entitlement reforms. As a result, the U.S. federal deficit surpassed a trillion dollars. This historically unprecedented level of peacetime public debt was enabled by unusually low interest rates, but also by an equally unprecedented ebb in the political clout of fiscal conservatives on both sides of the aisle — and this was all *before* the Covid-19 pandemic.

The argument for budget sustainability has always been forward-looking. As economist Herbert Stein's famous "law" puts the matter, "a trend that can't go on forever won't." And yet budget hawks have tended to fight the last battle, either by seeking politically untenable cuts to popular programs, or by insisting on procedural

7 Samuel Hammond, "Two New Bills Will Help with the Kidney Shortage. But Paying Donors Could Help Even More," Niskanen Center, July 27, 2018. https://www.niskanencenter.org/two-new-bills-will-help-with-the-kidney-shortage-but-paying-donors-could-help-even-more/

8 William A. Niskanen, "Limiting Government: The Failure Of 'Starve the Beast,'" Cato Journal, Vol. 26, No.3 (Fall 2006). https://www.cato.org/sites/cato.org/files/serials/files/cato-journal/2006/11/cj26n3-8.pdf

9 Karl Smith, "Starve the Beast is a Myth, We Shouldn't Fear It," Niskanen Center, November 20, 2017. https://www.niskanencenter.org/starve-beast-myth-shouldnt-fear/

gimmicks within the budget process that are routinely waived or easily gamed. Both these approaches fall victim to what economists call the "time inconsistency" problem, which is just a technical way of saying "today's actions, tomorrow's regrets."[10]

A deep appreciation for the political economy of debt and deficits, as captured in concepts like fiscal illusion and time consistency, can help to differentiate between those who care about fiscal sustainability and those who use fiscal sustainability as an excuse for generalized austerity. Understanding political incentives is also essential to designing budget rules that work as well in practice as they do in theory — a challenge our Niskanen Center colleague Ed Dolan took up in his 2021 report, "Rules for Sustainable Fiscal Policy."[11]

> "Independent of one's macroeconomic views, deficit financing *within the context of the budget process* is undesirable due to the way it undermines democratic accountability."

Unfortunately, the contemporary debate largely neglects the political dimension of deficit financing in favor of purely macroeconomic considerations. Consider the insolvent pension funds that the Biden administration's American Rescue Plan bailed out to the tune of $86 billion. Such a large, no-strings-attached wealth transfer to union interests was only possible due to deficit financing, which divorced the link between the bailout's benefits and its costs, thereby blunting voters' ability to evaluate the trade-off in the here and now. In contrast, the analogous union-run pensions in Denmark — Bernie Sanders' model of a socialist paradise — are fully funded by law. In fact, all the big welfare states in Scandinavia make a point of ensuring future obligations are financed and with some relationship to the beneficiary's ability to pay, including through large value added taxes. They do so not out of an austerity mindset, or to the exclusion of taxes on the rich, but rather as a crucial aspect of good and honest government, ensuring that the public gets all the government it wants and is willing to pay for — but no more.

Relieved of having to make hard choices, lawmakers are free to pursue expedient reforms that reward politically favored interests with minimal resistance. The justification for linking spending to financing is democracy, not austerity — ensuring that claims on the public fisc are fully deliberated and justified in the light of other public priorities. Looking ahead, never-ending deficit financing of new programs thus risks enabling never-ending waves of rent-seeking by providers of cost-diseased goods and services.

10 Ed Dolan, "There Will Be No End to Fiscal Chaos Without Better Budget Rules," Niskanen Center, March 18, 2019. https://www.niskanencenter.org/budget-rules-fiscal-chaos/

11 Ed Dolan, "Rules for Sustainable Fiscal Policy: Three Perspectives," Niskanen Center, January 14, 2021. https://www.niskanencenter.org/rules-for-sustainable-fiscal-policy-three-perspectives/

WHAT IS COST DISEASE, ДИЧШДЧ?

The economist William Baumol famously observed that differences in productivity growth across different parts of the economy cause the cost of goods and services in labor-intensive sectors to balloon over time. Even though string quartets are no more productive than they were in 1900, for example — one violin part still requires one violinist — the cost of assembling a quartet requires paying would-be violinists on par with the myriad more productive things they could be doing in the year 2021. Wages are thus determined not merely by the marginal productivity of labor in a given occupation but also by the opportunity cost of *not* working in higher-paying occupations that compete for the same labor.[12]

Baumol's cost disease, as it has come to be known, is the curse of any highly productive economy. The United States is no exception. Chart a graph of cost inflation over time, and labor-intensive services like health care, child care, and education all rise up and to the right.[13] Not coincidentally, these are also some of the most highly regulated and subsidized sectors of the economy. Faced with pressure to make such services more affordable without facing the whirlwind of organized provider opposition, lawmakers opt for regulations and subsidies that socialize costs from a household's point of view rather than address the underlying dynamics. At best, this merely shifts private costs onto public budgets. At worst, it exacerbates cost disease by stimulating greater demand for the affected service while reducing the market incentive to discover lower-cost alternatives.

Baumol's original framing is somewhat misleading because cost disease is not, in fact, a mechanical fact of the service economy over which we have no control. In reality, cost disease is just another term for highly differential rates of productivity growth. With new technologies and better market design, labor-intensive, non-tradable services thus have the potential to become the single greatest source of future productivity growth. Socializing such services is in that sense a double threat to fiscal sustainability, since it both grows the numerator (spending) while shrinking the denominator (GDP growth) through institutional and technological lock-in.

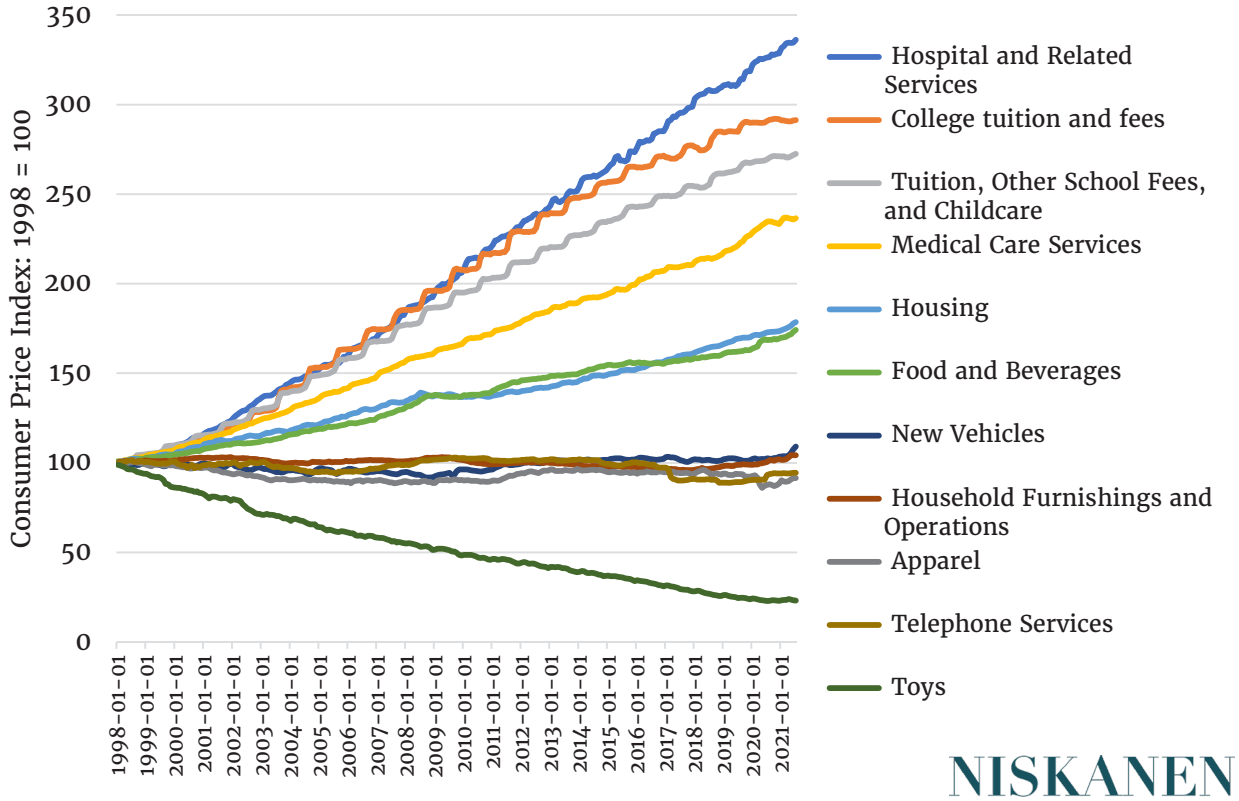
On the technological front, the wage growth sparked by industrialization contributed to the decline in domestic servants, but also to many labor-saving technologies designed to simplify various forms of housework.[14] Even the string quartet, the canonical example used by Baumol in his own writing, has in a sense undergone a productivity revolution thanks first to record players and, nowadays, to

12 Alex Tabarrok, "The Baumol Effect," Marginal Revolution, May 31, 2019. https://marginalrevolution.com/marginalrevolution/2019/05/the-baumol-effect.html

13 Eric Helland and Alex Tabarrok, "Why Are the Prices So D*mn High? Health, Education and the Baumol Effect," Mercatus Center, 2019. https://www.mercatus.org/system/files/helland-tabarrok_why-are-the-prices-so-damn-high_v1.pdf

14 Ester Bloom, "The Decline of Domestic Help," The Atlantic, September 23, 2015. https://www.theatlantic.com/business/archive/2015/09/decline-domestic-help-maid/406798/

Figure 1: Cost inflation in labor-intensive services



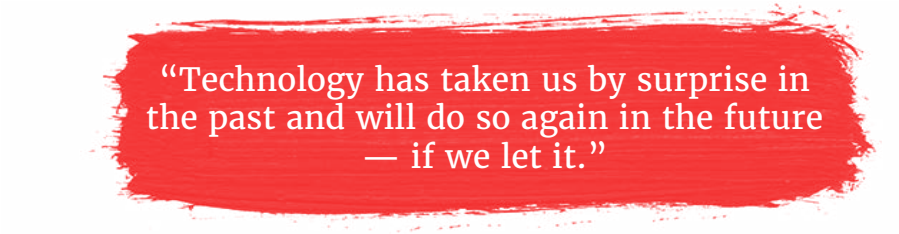
Source: FRED CPI for all urban consumers (Monthly, Not Seasonally Adjusted)

digital streaming services.[15] The London Symphony Orchestra receives seven million monthly listens on Spotify alone, which represents approximately seven million more listeners than it could ever hope to reach through in-person performances. We're fortunate, then, that employing a maid and attending a symphony were not considered as essential to daily life as health care or education. Had they been, they may very well have been subsidized and regulated far in excess of any public policy rationale, creating long-term public liabilities while forestalling technological progress, all in the name of maintaining their middle-class affordability.

In other cases, cost disease isn't eliminated so much as managed and adapted to through institutional evolution and reorganization. Growing wages, urbanization, and expanded labor market opportunities for women in the twentieth century led many rural schoolhouses to become cost-prohibitive, resulting in their steady amalgamation under consolidated education systems. Rather than reduce the labor cost of teachers, per se, schools adapted by pooling resources, standardizing curricula, extracting efficiencies through economies of scale, and taking advantage of transportation technologies like busing. Larger class sizes and impersonal bureaucracies came with their own costs, of course, but such trade-offs were unavoidable in lieu of actual

15 Tyler Cowen, "Why I Do Not Believe in the Cost-Disease," Journal of Cultural Economics, 20: 207-214, 1996. https://d101vc9winf8ln.cloudfront.net/documents/27978/original/10.1007_s10824-005-7214-1.pdf?1523464843

improvements in the labor productivity of educators. Perhaps one day progress in artificial intelligence (AI) and online education will combine to create the AI teacher to end all teachers. At a marginal cost of 6 cents per kilowatt hour, that is, the cost of electricity, an AI teacher would enable school systems to re-localize, if not be leapfrogged by homeschooling AI tutors. If that sounds fantastical, simply treat "AI tutor" as a stand-in — a limiting case — for any innovation that does for schooling what Spotify did for the symphony. Whether or not new, technology-enabled models of K-12 education can be made to work at scale, institutional adaptability and experimentation will remain essential to managing, and ultimately transcending, educational cost disease in the long run. Technology has taken us by surprise in the past and will do so again in the future — if we let it.



Lastly, it is important to keep in mind that many areas of cost growth are not technically examples of Baumol's cost disease at all. Strictly speaking, Baumol's theory of cost disease refers to sectors typified by definitionally labor-intensive production — a string quartet is not a quartet without four musicians. The dilemma of genuine cost disease (hence the "disease") arises from the fact that we humans are the only input to production. One person's cost is thus another person's compensation — a dynamic that worsens as productivity growth makes all non-diseased goods and services abundant, and thus a relatively smaller share of one's overall budget.

Nevertheless, for the purposes of this paper it is worth relaxing Baumol's definition of cost disease to include other areas of spiraling cost growth such as housing. Much like other "diseased" sectors, the high cost of rent in many U.S. cities is a function of regulations that restrict supply and limit housing innovation, leading to a demand for subsidies or additional regulations like rent control. Unlike genuine cost disease, however, rents show up in the national accounts as a form of profit, not labor income, and as such there is no inherent incompatibility in a high-wage, low-rent economy. On the contrary, the construction of substantially more housing would allow workers to live and work in areas where they can demand a higher wage.[16]

To give a more general definition of cost disease, then, we look to what these labor-intensive services and housing have in common: intrinsically high demand combined with structurally constrained supply. Unlike the preference for apples over oranges, our consumption of education, child care, health care, and housing is largely

16 See: Brink Lindsey and Samuel Hammond, "Reduce Regulatory Barriers to New Housing" in "Faster Growth, Fairer Growth: Policies for a High Road, High Performance Economy," Niskanen Center, October 5, 2020. https://www.niskanencenter.org/faster_fairer/liberating_the_captured_economy.html#Reduce_Barriers_to_New_Housing

nonnegotiable. There may be different *kinds* of child care (family-based versus center-based, say), but if you have children, there is simply no substitute for child care, per se. Cost-diseased goods and services can thus be said to have intrinsically inelastic demand by dint of their relative non-substitutability. Unlike necessities such as food or water, however, supply is constrained by structural factors, whether due to a mode of production that is inherently resistant to productivity growth or, as in the case of housing, due to the interaction between the regulatory environment and the intrinsic scarcity of land.

It should not be a surprise that relatively non-substitutable goods find their way onto public budgets. In a democratic society, it is hard to argue that such goods should be allocated exclusively by ability to pay. Politically, however, this compelling claim can serve as a very effective cloak for protecting the producers of these goods. As we will see in the following sections, putting constant pressure on these producers on the regulatory side is essential to reconciling legitimate demands for access to core services with reasonable budgetary control.

HEALTH CARE

The enormous and growing cost of health care in the United States makes it a natural starting point for understanding the linkages between cost disease and fiscal sustainability. In 2019, national expenditures on health care amounted to $3.8 trillion, or 17.7 percent of GDP, which is more than double the Organisation for Economic Co-operation and Development (OECD) average of 8.8 percent of GDP.[17]

Private health insurance accounts for roughly one-third of U.S. health-care consumption, with the remainder provided through Medicare (22.2 percent), Medicaid and CHIP (17.7 percent), out-of-pocket spending (11.3 percent), and other miscellaneous payers and programs like the Veterans Affairs (VA) and Indian Health Services.[18] The large majority of U.S. health-care spending is therefore publicly financed in one way or another, with the federal government playing an outsized role. This includes nominally private, employer-sponsored insurance (ESI), which is subsidized through tax expenditures that, in 2019, cost the federal government $273 billion, or roughly one-third the total budget for Medicaid.[19] The philosophical debate about *whether* the government should be involved in health care is thus long over. The question that remains is whether universal coverage can be achieved in a way

17 Rabah Kamal, Giorlando Ramirez, and Cynthia Cox, "How does health spending in the U.S. compare to other countries?" Peterson-KFF Health System Tracker, December 23, 2020. https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#item-spendingcomparison__recent-years__average-annual-growth-rate-in-health-consumption-expenditures-per-capita

18 National Health Expenditure Accounts (2019).

19 Joint Committee on Taxation. 2020. "Estimates of Federal Tax Expenditures for Fiscal Years 2019–2023." JCX-55-19. Washington, DC: Joint Committee on Taxation. https://www.jct.gov/publications.html?func=startdown&id=5238

that expands access while *reducing* total health-care expenditure over the long run.

The question of "who pays" can have important consequences for the growth in health-care costs. Exempting employer-paid premiums for health insurance from federal income and payroll taxes, for example, is well known to incentivize compensation in the form of health insurance benefits, particularly for employees in high-income tax brackets.[20] Replacing the ESI exclusion with a fixed, per-employee tax credit would help eliminate this bias; however, related proposals like the Cadillac Tax have tended to face fierce opposition.[21] Similar "demand-side" reforms are possible on the public-payer side as well, from "value-based" reimbursement models in Medicare, to replacing the matching grants used to fund Medicaid with per capita block grants that avoid rewarding the highest-spending states. Canada, for example, finances its "single payer" health-care system with per capita block grants to provinces indexed to nominal GDP growth.[22] This has helped to control cost disease by putting the onus on the provinces to fund health-care expenditure growth in excess of the growth rate of the overall economy.

Better funding models can force a degree of economizing within existing health systems. Our preferred approach is to create a universal catastrophic tier of public insurance with deductibles and other forms of cost-sharing tied to an individual's income. As Ed Dolan details in his white paper on the concept, universal catastrophic coverage would provide first dollar coverage for low-income households; however, its purpose would not be to replace the need for private insurance.[23] Rather, the program would function as a backstop for uninsured individuals and those caught between more comprehensive forms of coverage. Universal catastrophic coverage would function as social insurance against financially ruinous medical expenses, and as an implicit form of *re*insurance for private insurers who are otherwise forced to spread those costs across healthy policy holders in the form of ever-higher premiums. A universal catastrophic tier of health coverage would thus bring premiums for private supplemental insurance down dramatically, while creating a pathway to reduce fragmentation across the U.S. health-care system.

However, achieving serious spending reductions while expanding access to low-cost medical services will ultimately require supply to outstrip demand, which implies radically enhancing the productivity of the U.S. health-care sector itself. And while much attention has been paid to America's high drug prices and the profit margins

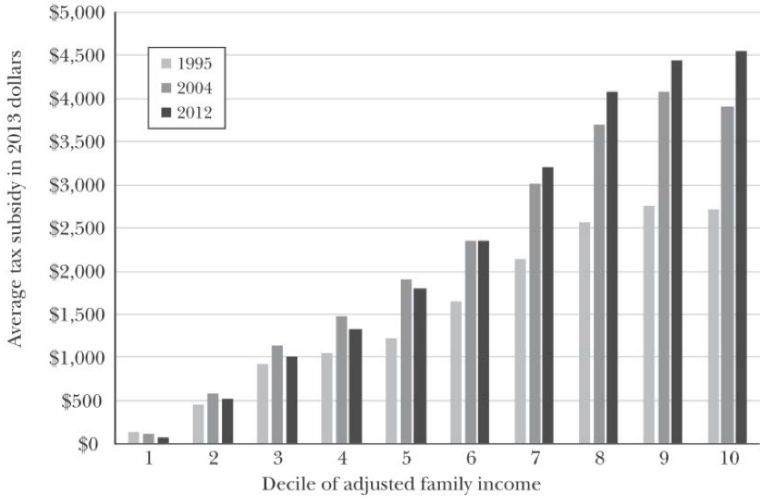
20 EconTalk, "Ed Dolan on Employer-Sponsored Health Insurance," The Library of Economics and Liberty, January 7, 2019. https://www.econtalk.org/ed-dolan-on-employer-sponsored-health-insurance/

21 Van de Water, Paul N. Center on Budget and Policy Priorities. Policymakers Shouldn't Repeal or Further Delay "Cadillac Tax." March 12, 2019. https://www.cbpp.org/blog/policymakers-shouldnt-repeal-or-further-delay-cadillac-tax

22 Samuel Hammond, "Canada Shows Medicaid Block Grants Can Work But Probably Won't," Niskanen Center, April 3, 2017. https://www.niskanencenter.org/medicaid-block-grant/

23 Ed Dolan, "Universal Catastrophic Coverage: Principles for Bipartisan Health Care Reform," Niskanen Center, June 25, 2019. https://www.niskanencenter.org/universal-catastrophic-coverage/

Figure 2: Average tax subsidy for employer-provided health insurance by decile of adjusted family income



Source: R. Kaestner and D. Lubotsky, "Health Insurance and Income Inequality," Journal of Economic Perspectives, Spring 2016. https://www.aeaweb.org/articles?id=10.1257/jep.30.2.53

and administrative duplication of private insurers, the most severe sources of health-care cost disease are at the provider level.

Consider that states that have expanded Medicaid under the Affordable Care Act (ACA) have seen substantial declines in their rates of uncompensated care, that is, services to uninsured patients that hospitals are required to provide by law.[24] Nevertheless, rather than pass on those cost savings to consumers, many hospitals have used their increased cash flow to expand high-margin services within wealthy areas that already have sufficient capacity. As Kim Bimestefer, the executive director of Colorado's Department of Health Care Policy & Financing, noted: "Hospitals had a fork in the road to either use the money coming in to lower the cost shift to employers and consumers or use the money to fuel a health care arms race. With few exceptions, they chose the latter."[25]

The propensity for hospital systems to plow savings into expensive and often duplicative services is ultimately a regulatory failure. Nonprofit hospitals, which provide the lion's share of care in the United States, have to earn sufficient revenue to cover their expenditures, but not their cost of capital. As such, any "profits" earned by nonprofit hospitals tend to be reinvested regardless of whether the capital expenditure in question is worthwhile, fueling cost growth. Indeed, overcapitalization is a well-known problem with nonprofit organizations more broadly.[26] Today, seven of the

24 Kevin Callison, et al. "Medicaid Expansion Reduced Uncompensated Care Costs At Louisiana Hospitals; May Be A Model For Other States," Health Affairs, Vol. 40, No. 3, March 2021. https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01677

25 Phil Galewitz, "Medicaid Expansion Boosts Hospital Bottom Lines — And Prices," Kaiser Health News, March 27, 2019. https://khn.org/news/medicaid-expansion-boosts-hospital-bottom-lines-and-prices/

26 Michael Fricke, "The Case Against Income Tax Exemption for Nonprofits," St. John's Law

most profitable hospitals in the U.S. operate as nonprofits, compete as aggressively as their for-profit counterparts, and, despite being required by law to demonstrate "community benefit," provide comparable levels of charity-based care.[27] Revoking these hospitals' tax exempt status in recognition that large nonprofit hospitals have outgrown their charitable origins would immediately return over $25 billion in savings to the U.S. government.[28]

Yet if tax exemptions are a blunt policy instrument, so too are blanket redesignations of an entire sector's tax status. A better way forward would thus be to modify the terms nonprofit hospitals are required to operate under to eliminate the model's most perverse side effects.[29] This includes restructuring tax exemption rules in order to promote improved resource efficiency and utilization.[30] The Internal Revenue Service (IRS) has taken steps in that direction since the passage of the ACA through stronger enforcement of community benefit rules; however, this is unlikely to go far enough.[31] Consider Canada, where hospitals are overwhelmingly structured as not-for-profits, and yet have not suffered from overcapitalization thanks to their lump-sum public funding and global budget caps.[32] Ever since the "managed care backlash" of the late 1990s, such strict hospital budgeting has fallen out of favor in the U.S. context, not least because most states passed legislation restricting the cost-cutting measures that managed care organizations could impose. One estimate suggests the backlash to managed care alone caused U.S. health-care spending as a share of GDP to increase by 2 percentage points.[33] While improved tax treatment might push hospitals to economize, more robust cost controls will ultimately require reversing the backlash to managed care and models like it.

Nonprofit hospitals pose problems for the competitiveness of U.S. health care as well. Under current law, the Federal Trade Commission (FTC) is unable to investigate

Review, Vol 89, No. 4, Winter 2015. https://scholarship.law.stjohns.edu/cgi/viewcontent.cgi?article=6735&context=lawreview

27 Cory S. Capps, Dennis W. Carlton, and Guy David, "Antitrust Treatment of Nonprofits: Should Hospitals Receive Special Care?" Economic Inquiry, Vol. 58, Issue 3, p. 1183-1199, March 4, 2020. https://onlinelibrary.wiley.com/doi/10.1111/ecin.12881

28 Sara Rosenbaum, et al. "The Value Of The Nonprofit Hospital Tax Exemption Was $24.6 Billion In 2011," Health Affairs, Vol. 34, No. 7, July 2015. https://www.healthaffairs.org/doi/10.1377/hlthaff.2014.1424

29 Bradley Herring, et al. "Comparing the Value of Nonprofit Hospitals' Tax Exemption to Their Community Benefits." Inquiry, vol. 55, February 2018. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5813653/

30 Danielle Ofri, "Why Are Nonprofit Hospitals So Highly Profitable?" New York Times, February 20, 2020. https://www.nytimes.com/2020/02/20/opinion/nonprofit-hospitals.html

31 Jeff Byers, "IRS revokes hospital nonprofit status for the first time," Healthcare Dive, August 16, 2017. https://www.healthcaredive.com/news/irs-revokes-hospital-nonprofit-status-for-the-first-time/449473/

32 Steffie Woolhandler and David Himmelstein, "Why Canadian hospitals outperform U.S. hospitals," EvidenceNetwork.ca, December 2014. http://evidencenetwork.ca/why-canadian-hospitals-outperform-u-s-hospitals/

33 Maxim L. Pinkovskiy, "The impact of the managed care backlash on health care spending," The RAND Journal of Economics 51(1):59-108, March 2020. https://onlinelibrary.wiley.com/doi/10.1111/1756-2171.12306

nonprofit hospitals for anticompetitive conduct. Instead, the FTC's authority extends only to merger reviews, for which nonprofit hospitals have tended to receive more lenience.[34] Indeed, nonprofit hospital mergers have increased significantly over the past two decades, resulting in a dramatic consolidation of the U.S. hospital sector.[35] As the FTC's acting chairwoman, Rebecca Kelly Slaughter, has noted: "One of the chief drivers of increasing healthcare expenditures is the increasing prices of healthcare services, particularly hospital prices."[36] Hospital competition has been further inhibited by a federal prohibition on new physician-owned hospitals,[37] as well as state-level "Certificate of Need" (CON) laws that empower incumbent hospitals to block new market entrants.[38] Eliminating these barriers to competition for health-care services will be essential to controlling cost disease in health care.

Improving competition within the hospital sector can be complemented by reforms to expand the provision of primary care. The number of practicing physicians per person in the United States is lower than in just about any other developed country. From 1980 to the early 2000s, the prevailing wisdom was that the number of physicians within the United States should be reduced. During this period, a series of ill-judged reports by the federal government warned of an impending physician *surplus*.[39] These reports ushered in a period in which both private and public actors took actions to constrain the supply of U.S. physicians, the most significant of which was a decades-long moratorium on new medical school slots. The resulting dearth of physicians had had the effect of making U.S. health care less accessible and more costly than it otherwise would have been.[40]

Meanwhile, of the physicians that the U.S. does produce, 67 percent opt for relatively lucrative careers in specialty care, leaving the supply of primary care physicians particularly constrained.[41] This trend isn't surprising given the enormous

34 Steven Porter, "Nonprofit Hospitals and Antitrust Enforcement: Should FTC Have Jurisdiction?" Health Leaders, September 17, 2019. https://www.healthleadersmedia.com/strategy/nonprofit-hospitals-and-antitrust-enforcement-should-ftc-have-jurisdiction

35 Michael G. Vita and Seth Sacher, "The Competitive Effects of Not-for-Profit Hospital Mergers: A Case Study," FTC working paper: 226, May 1999. https://www.ftc.gov/sites/default/files/documents/reports/competitive-effects-not-profit-hospital-mergers-case-study/hospitals.pdf

36 Remarks of Commissioner Rebecca Kelly Slaughter, "Antitrust and Health Care Providers Policies to Promote Competition and Protect Patients," Center for American Progress, May 14, 2019. https://www.ftc.gov/system/files/documents/public_statements/1520570/slaughter_-_hospital_speech_5-14-19.pdf

37 Brian J. Miller, et al. "Reversing Hospital Consolidation: The Promise Of Physician-Owned Hospitals," Health Affairs Blog, April 12, 2021. https://www.healthaffairs.org/do/10.1377/hblog20210408.980640/full/

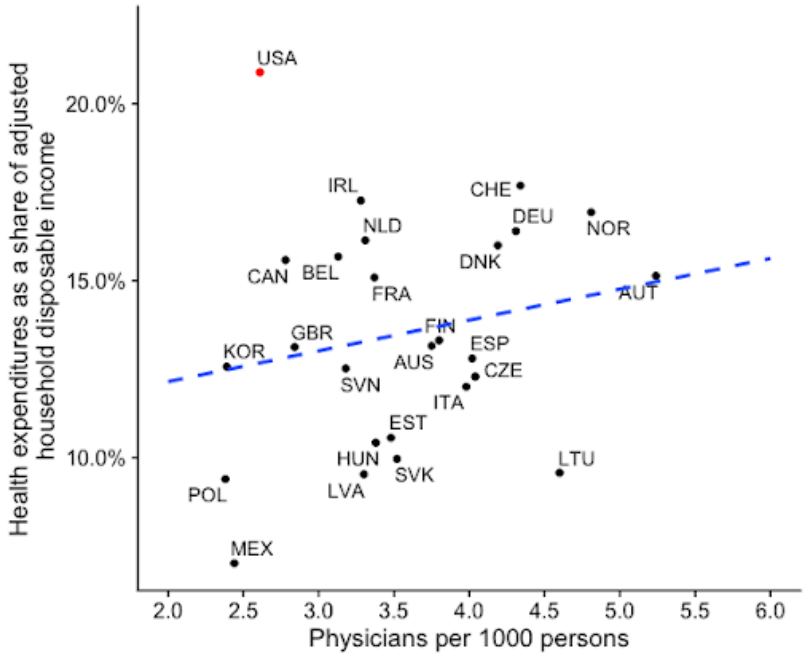
38 Matthew D. Mitchell, Elise Amez-Droz and Anna Miller (Parsons), "Phasing Out Certificate-of-Need Laws: A Menu of Options," Mercatus Center, February 25, 2020. https://www.mercatus.org/publications/healthcare/phasing-out-certificate-need-laws-menu-options

39 Robert Orr, "The Planning of U.S. Physician Shortages," Niskanen Center, September 8, 2020. https://www.niskanencenter.org/the-planning-of-u-s-physician-shortages/

40 Robert Orr, "The U.S. has much to gain from more doctors," Niskanen Center, August 4, 2021. https://www.niskanencenter.org/the-u-s-has-much-to-gain-from-more-doctors/

41 Robert Orr, "America's Reliance on Non-Physicians for Primary Care is Growing," Niskanen Center, December 18, 2019. https://www.niskanencenter.org/growing-reliance-on-non-physicians/

Figure 3: The U.S. produces too-few doctors relative to health spending



Source: Robert Orr, "The U.S. has much to gain from more doctors," Niskanen Center, August 4, 2021. https://www.niskanencenter.org/the-u-s-has-much-to-gain-from-more-doctors/

costs of medical education in the United States. Apart from Canada, the U.S. is the only wealthy country that requires prospective doctors to earn a separate four-year bachelor's degree prior to entering medical school. Accordingly, physicians in the U.S. must undergo a minimum of eight years of postsecondary education followed by three to seven years of residency training. Most of Europe, in contrast, offers consolidated six-year medical degrees.[42] Foreign doctors are thus all but shut out from practicing in the U.S., given multiple licensing requirements and the need to redo residency programs that are themselves in short supply.[43]

The scarcity of primary care physicians has resulted in a growing proportion of primary care being provided by nurse practitioners (NPs) and physician assistants (PAs). Research consistently finds that primary care provided by NPs and PAs is high quality; however, state-level "scope of practice" laws that restrict the ability of NPs and PAs to operate independently have made them imperfect substitutes for doctors.[44] In recent years, a number of states have sought to reform nurse scope of practice regulations to expand their ability to supply primary care. To date, however, all such

42 Robert Orr and Anuska Jain, "The Case for Shortening Medical Education," Niskanen Center, March 17, 2020. https://www.niskanencenter.org/the-case-for-shortening-medical-education/

43 Philip Sopher, "Doctors With Borders: How the U.S. Shuts Out Foreign Physicians," The Atlantic, November 18, 2014. https://www.theatlantic.com/health/archive/2014/11/doctors-with-borders-how-the-us-shuts-out-foreign-physicians/382723/

44 Robert Orr, "Too Little for Too Much," Milken Institute Review, January 24, 2021. https://www.milkenreview.org/articles/too-little-for-too-much

reforms have fallen short of reaching their full potential by, for example, continuing to restrict NPs' and PAs' ability to establish independent clinics, or requiring their practice to be under a doctor's supervision.[45] Further expanding nurse scope of practice would help reduce health-care costs while dramatically expanding access to primary care in rural and other underserved communities that struggle to attract physicians, particularly if paired with reforms to expand the use of telemedicine and the recognition of health-care licenses issued in other states.[46]

Looking ahead, recent projections indicate a national shortage of 122,000 physicians by 2032, with the worst shortfalls in areas that are already chronically underserved.[47] In one scenario, these shortfalls will be addressed by Congress simply throwing money at the problem, worsening cost disease and our fiscal imbalance simultaneously. A better approach would focus on undoing the above forms of regulatory capture that are undermining U.S. health-care competition and innovation in the first place.

HIGHER EDUCATION

The price of going to college in the United States keeps going up. For many Americans, especially those for whom college is critical to social mobility, there is no way to privately insure against these costs. As a result, we are faced with some very tough choices. We can simply accept that college costs will shut out a large number of American citizens, which is morally unacceptable. We can maintain the cost structure of higher education but try to keep the price paid by students and their parents down by socializing the costs. Alternatively, we can address the underlying cost structure of higher education, either alone or in conjunction with tuition supports.

Subsidizing the price of higher education without addressing the underlying costs is simply unsustainable. It is also unnecessary. The spiraling costs of higher education are not a force of nature but a consequence of a web of public policies and institutional strategies that are susceptible to reform. According to a 2017 study by economists at the New York Federal Reserve, for example, increases in subsdized student loan maximums pass-through into higher tuition costs at a rate of 60 cents on the dollar, enriching universities while inflating the cost of higher education overall.[48] While there are strong arguments for socializing more of the price of higher

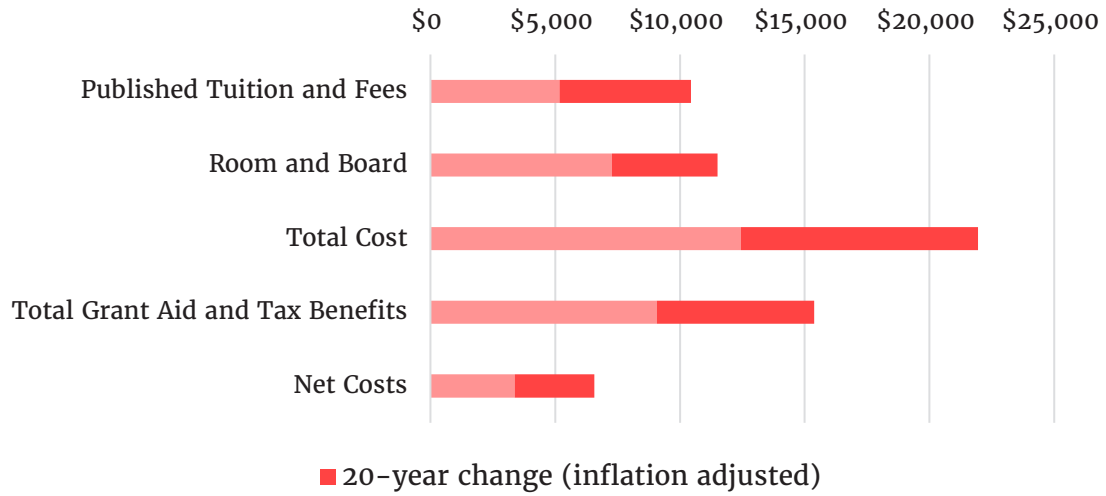
45 Robert Orr, "The US has a primary care shortage — scope of practice reform can help," The Hill, February 21, 2020. https://thehill.com/opinion/healthcare/484023-the-us-has-a-primary-care-shortage-scope-of-practice-reform-can-help

46 Robert Orr, "U.S. Health Care Licensing: Pervasive, Expensive, and Restrictive," Niskanen Center, May 12, 2020. https://www.niskanencenter.org/u-s-health-care-licensing-pervasive-expensive-and-restrictive/

47 Harris Ahmed and J. Bryan Carmody, "On the Looming Physician Shortage and Strategic Expansion of Graduate Medical Education," Cureus, 12(7):e9216, July 15, 2020. https://europepmc.org/article/med/32821567

48 David O. Lucca, Taylor Nadauld, and Karen Shen, "Credit Supply and the Rise in College Tuition:

Figure 4: Public four-year in-state tuition costs have doubled over last 20 years



Sources: College Board, Annual Survey of Colleges; Trends in Student Aid 2019; NCES, IPEDS Fall

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education, doing so without reform of costs runs the risk of simply facilitating even greater cost inflation.

Broad access to higher education is impossible without addressing its underlying cost structure. If those costs are not addressed, the public will not accept that access to those goods is beyond their reach. They will demand that the costs be taken off their books and put onto those of the government. And they will be right to do so.

Making sense of the price of higher education is a fiendishly difficult task. The first step is to appreciate that the price of higher education (what individuals actually pay) and its cost (the total resources devoted to providing it) are not the same. There is no question that the cost of American higher education is eye-wateringly high. As of 2016, the U.S. paid $31,600 per full-time student in postsecondary education, nearly twice the OECD average of $16,200. The United States pays considerably more per student in higher education than countries of roughly equal per capita income, whereas we spend only what our income would predict on primary and secondary education.

Our higher education costs, in short, are far higher than in comparable countries. Cost, of course, is not the same as price. If we want to understand the increasing price paid by most students who attend public institutions, then there is little doubt that the culprit is decreased state support. State governments are increasingly allowing tuition costs to go up, and, more subtly but also more significantly, increasing the cost of room and board, rather than increasing appropriations to higher education.

Evidence from the Expansion in Federal Student Aid Programs," Federal Reserve Bank of New York Staff Reports, no. 733, February 2017. https://www.newyorkfed.org/medialibrary/media/research/staff_reports/sr733.pdf

Allowing the sticker price of higher education to go up while providing various forms of discounting to reduce the degree to which those increases hit less advantaged students is a strategy with significant downsides. Increasing the effective price paid by students with higher familial income makes those students a premium good on college campuses. As Elizabeth Armstrong and Laura T. Hamilton have shown, the culture of flagship state universities in particular has been shaped by the need to appeal to the children of the upper middle class.[49] In addition, the search for full-tuition-paying students has increased the need to attract foreign students, in particular those from China (with consequences for the cultural dimensions of U.S. foreign policy).

Increasing price discrimination in a context of upward underlying costs of service is a kind of hamster wheel that cannot spin forever. Either universities will have to further socialize their cost structure through additional subsidy (that is, by putting those costs explicitly on the government's books) or they will need to figure out how to deliver quality education for a wider range of students at lower cost.

Baumol's theory of cost disease would seem to be an adequate explanation for why the second strategy is a nonstarter, since higher education mostly consists of humans in classrooms interacting with other humans. If we assume that higher education involves a fixed number of instructors interacting with a fixed number of students, then the parallel to Baumol's string quartet is exact. By definition the relative cost of higher education will go up, and then the only question is the distribution of costs between consumers and various sources of subsidy.

But working with the metaphor of the string quartet raises some questions. First, we might think about the venue in which the string quartet performs. How luxurious are the seats and how many are there? Can only those physically present in the venue watch (and pay for) the performance, or can those at home watch (and pay) as well? How intensely is the performing hall used (that is, do you have performances for three hours a day, or twelve, or eighteen, or is the performing hall generating income in some other way)? What is the administrative overhead of the string quartet in the form of its managers and the people who operate the performing hall? Even in the classically cost-disease-ridden occupation, there are multiple margins on which there are imaginable productivity improvements. The same thing holds for higher education.

It does not appear that our higher cost structure is mainly a function of the higher salaries of professors. While the U.S. is at the higher end of professor pay globally, it is not at the very top, and Canada, for instance, pays more per professor despite having a much lower overall cost structure. To extend our metaphor, it's not the

49 Elizabeth A. Armstrong and Laura T. Hamilton, "Paying for the Party: How College Maintains Inequality," Harvard University Press, October 2015. https://www.hup.harvard.edu/catalog.php?isbn=9780674088023

salaries we pay the performers in the string quartet that seems to be the problem.

Where American higher education really does stand out is the huge sums of money we devote to the system's administrative costs, and the much lower intensity with which we use the university's physical plant. There is little question that American universities devote considerably more of their resources to administrators, as compared to instructional employees, than they did a generation ago. According to the Delta Cost Project, the primary driver of that cost explosion is not outsized presidential or decanal salaries; rather, it is the yeomanry of higher education administration, the "mid-level professionals" doing a range of functions, from admissions to financial aid to legal compliance and in particular student services. Administrative costs are driven, therefore, by the multiplication of noninstructional functions in the modern university, rather than by exploding salaries.

"The fact that instructional costs do not appear to be the key culprit in soaring university budgets does not mean that they could not contribute significantly to making college more affordable."

American higher education uses far more physical capital per unit of education than do comparable systems in other countries. In part this is due to a spree of new construction as colleges scramble to compete for students through increasingly lavish student services.[50] It is also closely related to the organizational imperative to construct new buildings. As a recent report observes: "The arms race in facilities has gotten too far in front of reasonable expectations for revenues to support it, especially revenues from enrollment."[51] This arms race is caused, in large part, by the highly decentralized nature of U.S. higher education, with more than three thousand four-year colleges and universities alone as well as thousands of other postsecondary institutions.

The fact that instructional costs do not appear to be the key culprit in soaring university budgets does not mean that they could not contribute significantly to making college more affordable. Only a philistine would deny that there are vital, irreplaceable aspects of the higher education experience that happen live, in person, in the human relationship between an instructor and their student. But we are not very good at supporting those functions financially and finding the aspects of higher education with the potential for large economies of scale. Finding that balance, and

50 Jon Marcus, "The Paradox of New Buildings on Campus," The Atlantic, July 25, 2016. https://www.theatlantic.com/education/archive/2016/07/the-paradox-of-new-buildings-on-campus/492398/

51 Bryan C. Harvey, "State of Facilities in Higher Education," Gordian, 7th Edition, 2020. https://www.gordian.com/uploads/2020/04/V8_2020-State-of-Facilities-Report.pdf

ensuring that the really important human relationships in higher education are not simply rationed to the wealthy, is the key to controlling higher education finance.

The above analysis suggests that, if only the United States could get control of its administrative and physical plant costs, it could reduce the price paid by students without additional subsidy or reducing the resources devoted to instruction. Unfortunately, the problem is easier to solve on a spreadsheet than it is in the real world.

First, the United States is likely to see a considerable decline in the number of domestic students over the next few years, purely as a function of demographic factors. Second, it is unlikely that this decline will be compensated for by an increase in foreign students. The gap between supply and domestic (especially full-paying) demand in recent decades has been largely filled with foreign (in particular Chinese) students, but the blowback from Covid-19 and increasing international competition is likely to put a squeeze on this as well. In short, we cannot solve the cost problem in higher education by merely sweating our existing corps of administrators and stretching our physical capital stock over a larger body of students. If anything, we will have fewer students in the system in the future.

There is no easy way to deal with the problem of excess physical capital. If universities were to use their buildings more intensively, for instance, it is not obvious that they could sell off most of the excess space, since it is very asset-specific. There is not an active secondary market for classrooms and office space for professors. That suggests that if we are to rationalize this side of the cost problem, it will come by taking some institutions entirely out of the education market, and then squeezing more students into the institutions that remain. That suggests that we may need to make it easier for excess universities to exit the market entirely, rather than trying to solve the problem at the level of the individual institution. Universities with the most precarious finances — in particular, thinly endowed private institutions that are already in a death spiral of discounted tuition — should be encouraged to go bankrupt, with their physical capital redeployed for other purposes. That would allow the U.S. to get closer to the balance of physical capital per student of our fellow advanced industrial nations.

Reducing administrative costs is no walk in the park either. While there is some administrative empire-building in some institutions, most administrators are actually performing real functions. Many of them are engaged in regulatory compliance, and so reducing their number would require significantly deregulating institutions of higher education across the board, in areas from human subjects review to financial aid.[52] Another area for growth in noninstructional employees has been in student life,

52 Vanderbilt University, "The Cost of Federal Regulatory Compliance in Higher Education: A Multi-Institutional Study," October 2015. https://news.vanderbilt.edu/files/Cost-of-Federal-Regulatory-Compliance-2015.pdf

and so reducing noninstructional costs will require rethinking the actual character and administrative density of non-classroom life in American universities.

More broadly, we may simply need to increase the amount of institutional churn in the higher education sector. Once a university has attained a particular cost structure, it may just be very hard to cut it down, except at the margin. Earlier, we suggested the need for substantially more market exit for institutions of higher education, perhaps through a greater use of structured bankruptcy. We might want to aim for significantly more market exit than would be necessary just to get the same ratio of physical capital to students as similar countries. Instead, we should be aiming to repurpose even more universities for other ends, and to create space for models of higher education with radically different models of delivery.

We know how that can be done badly. A large number of private, mostly online colleges turn out to be exercises in grift and rent-seeking, designed to exploit asymmetric information and the availability of federal aid. We need to experiment with new ways of paying for higher education that better align what students need with what they are paying for. We need models that combine the parts of the existing higher education experience at well-resourced institutions that are genuinely transformative and inspiring — like small, in-person seminars connected to substantial one-on-one connections between faculty and students — with radically lower-cost forms of instruction that are susceptible to much greater scale.

That kind of hybrid experience will require new ways of paying for higher education, and will drive a significant amount of organizational creative destruction. But, combined with reduced administrative costs and more intensive use of physical capital, it could allow us to preserve what is best in American higher education, while creating a cost structure that would ensure that we can maintain access to high-quality education without ever-greater — and, in the end, futile — subsidy.

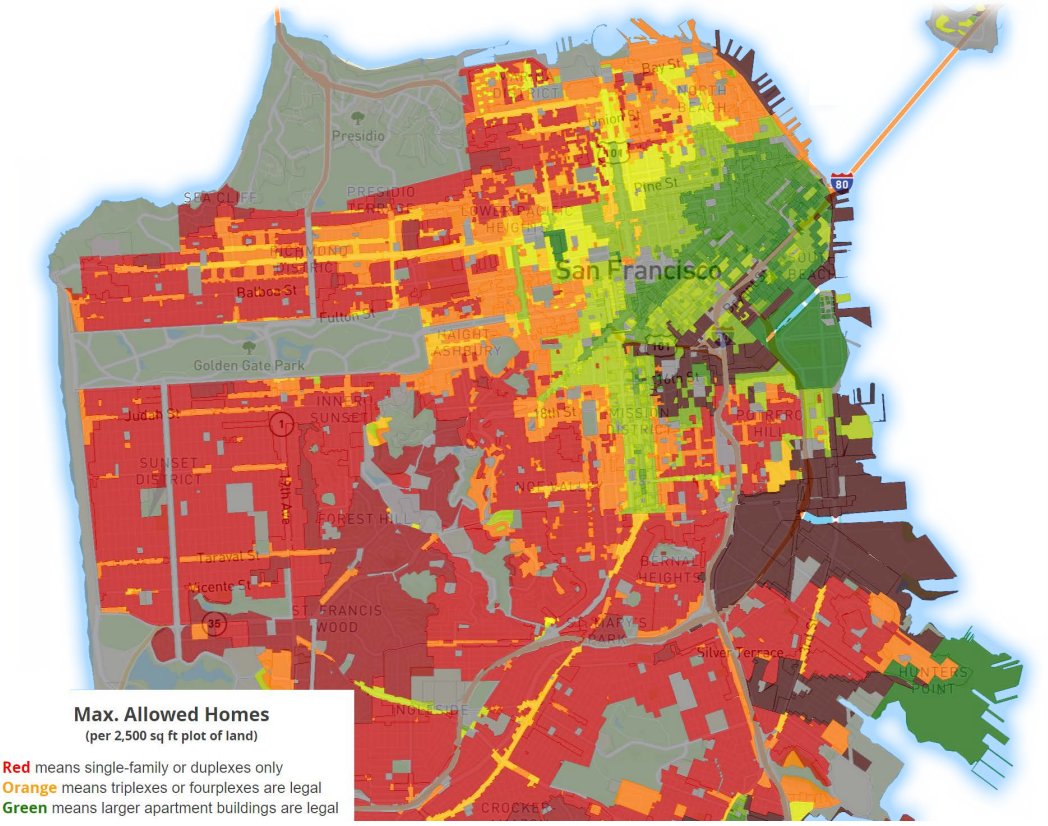
HOUSING AFFORDABILITY

Since the 1990s, housing costs in major urban areas have skyrocketed. As the economic center of gravity in the United States has shifted back to cities, they have attracted large numbers of high-skilled, high-earning people. The first wave could afford to buy houses, but as successive waves came, all available homes were purchased and they were left with only rental properties.[53]

This wouldn't necessarily be a problem if housing supply were allowed to expand as demand increased. However, housing supply has failed to keep up with growth,

53 Jacob Anbinder, "The Pandemic Disproved Urban Progressives' Theory About Gentrification," The Atlantic, January 2, 2021. https://www.theatlantic.com/ideas/archive/2021/01/anti-growth-alliance-fueled-urban-gentrification/617525/

Figure 5: Apartment buildings are illegal to build in 76% of San Francisco



Source: SFzoning.deapthoughts.com

and restrictive zoning and land-use regulations are the primary cause of the problem. A 2014 review of the literature by Joseph Gyourko and Raven Molloy found that "locations with more [land-use and zoning] regulation have higher house prices and less construction."[54]

One common objection to the construction of new housing is that such housing tends to be "luxury" housing. While the term "luxury" is misleading, it is true that these buildings tend to be newer and have amenities, such as gyms or office centers, and other features which make them attractive to higher-income residents. However, this is analogous to saying that a 2020 Honda Accord is a luxury car. It is certainly luxurious compared to a 2000 Accord, but that is a feature of its being new.

Aside from this misleading terminology, criticizing new housing developments for increasing housing costs is wrong for two reasons. First, it ignores the phenomenon of "churn" in the housing market. While newer, tonier developments may be affordable only to higher-income residents, this opens up other housing choices that would have been occupied by such residents. In an area which only has hundred-year-old

54 Joseph Gyourko and Raven Molloy, "Regulation and Housing Supply," NBER Working Paper 20536, p. 42., October 2014. https://www.nber.org/system/files/working_papers/w20536/w20536.pdf

rowhomes, these wealthier residents will outbid lower-income residents for what is available.

Second, there is compelling empirical evidence that the construction of more (by definition) newer housing *reduces* rents. One study from Germany found that a 1 percent increase in housing supply led to a reduction in monthly rents by 0.4 to 0.7 percent. In Washington, D.C., rents in Navy Yard, where housing construction has increased the supply dramatically, fell by around 8 percent from 2014 to 2018. By contrast, the Capitol Hill neighborhood, which has seen little to no increased construction despite being in the same zip code as Navy Yard, experienced a 20 percent increase in rents.[55] Liberalizing zoning regulations to allow for greater housing construction would go a long way toward slowing the growth of rents in high-cost housing markets. The housing affordability crisis is fundamentally a supply-side problem that demands a supply-side solution.

"Demand-side solutions like housing vouchers or renter tax credits — at least without seriously attacking the supply-side problem — are likely to make things worse."

Demand-side solutions like housing vouchers or renter tax credits — at least without seriously attacking the supply-side problem — are likely to make things worse. The most prominent figure to propose this policy was Senator (now Vice President) Kamala Harris with her Rent Relief Act,[56] which Senator Wyden recently revived in a slightly modified form.[57] The Act would give Americans paying more than 30 percent of their income in rent and utilities a monthly refundable tax credit equal to the excess of such a cost based on the fair market rent for the area. The credit would cover 100 percent of the excess for those making less than $25,000 per year, 75 percent for those making between $25,000 and $50,000, 50 percent for those making between $50,000 and $75,000 per year, and 25 percent for those making between $75,000 and $100,000 per year. Those making more than $100,000 per year would get nothing.

In 2019, Daniel Shoag conducted an analysis of various housing affordability measures. According to Shoag, demand-side interventions such as housing vouchers "have served as an important part of the safety net, but property owners capture a

55 Payton Chung, "A tale of two 20003s: high rises or high rents," Greater Greater Washington, July 18, 2018. https://ggwash.org/view/68373/a-tale-of-two-20003s-high-rises-or-high-rents

56 Alex Muresianu, "Senator Harris's Rent Relief Tax Credit is a Well-Intentioned Misfire," Tax Foundation, July 25, 2018. https://taxfoundation.org/senator-harriss-rent-relief-tax-credit/

57 Press Release: "Wyden Announces New Bill to End Homelessness and Ensure Affordable Housing for All," US Senate Committee on Finance, August 18, 2021.

significant share of the benefits. This problem seems especially severe in markets with inelastic supply. It therefore seems unlikely that further demand-side subsidies, such as the recent proposal to offer tax credits for rent-burdened Americans, can solve this specific problem."[58] Fundamentally, rent subsidies (as opposed to simple cash redistribution) increase demand without a corresponding increase in supply, which is a textbook formula for cost inflation. As prices go up, increasing subsidies become necessary to ensure affordability, which then create even more dollars chasing the same number of rental units.

Rent subsidies, like other forms of socializing the cost of supply-constrained goods, mostly get captured by the producers of those goods (in this case, landlords) rather than consumers. Whether it's legalizing Accessory Dwelling Units, making it easier to convert single-family housing to multi-family uses, speeding the approval of apartments, or even reinvigorating the construction of social housing, the only way off the hamster wheel of subsidy is unleashing the supply of housing of all sorts. Simply resisting the socialization of these costs is no answer — like health care, education, and (as we'll soon see) child care, those concerned about budget discipline need to focus on the microeconomic sources of strapped household budgets.

CHILD CARE

Federally funded universal child care is one of the most popular ideas on the left right now. While the various proposals differ in important ways, they share a common vision of greater federal involvement in child care, regulations that mandate worker quality, and public financing to make formal child care centers either free or heavily subsidized. Typically left off the agenda is equal recognition of home- and family-based models that remain the dominant source of child care in the United States — which surveys show most parents prefer.[59] Indeed, when American Compass asked families about their ideal child care arrangement, only upper class households (as defined by households with income above $150,000) indicated paid, full-time child care as their dominant preference.[60]

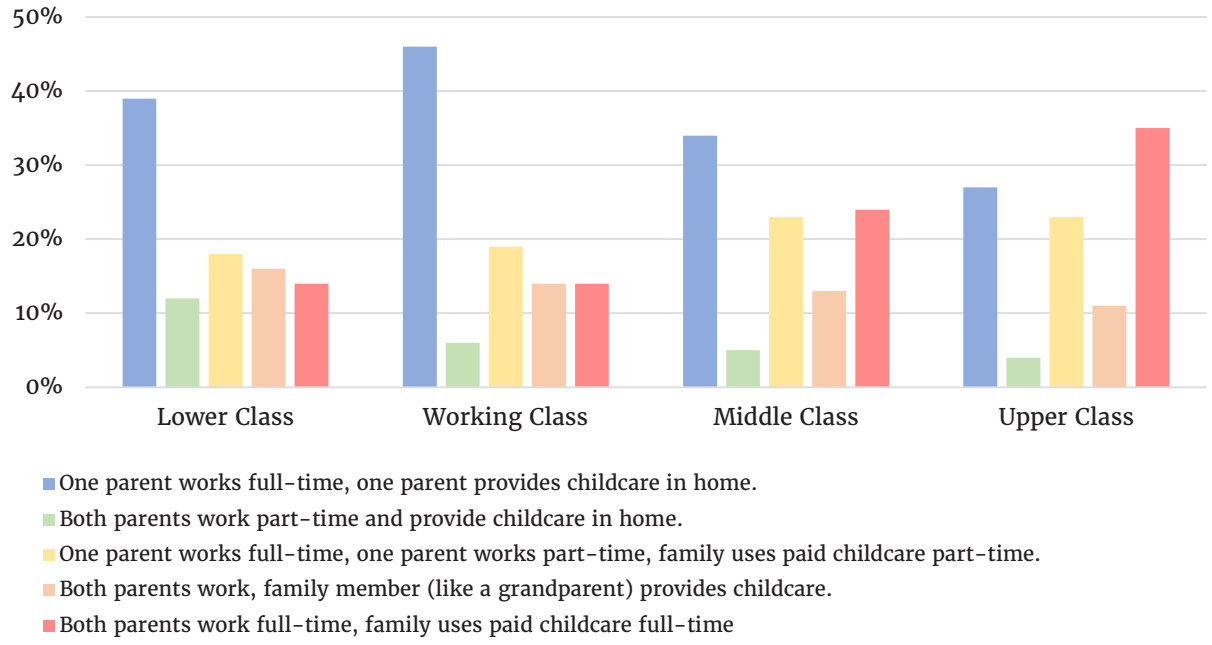
While framed as responding to a crisis of affordability, most major child care proposals are variations on subsidizing demand while restricting supply. Without addressing the root causes of rising child care costs, such approaches will merely exacerbate child care affordability by fueling cost disease. International experience

58 Daniel Shoag, "Removing Barriers to Accessing High-Productivity Places," The Hamilton Project, January 2019. https://www.hamiltonproject.org/assets/files/Shoag_PP_web_20190128.pdf

59 Wendy Wang, "Homeward Bound: The Work-Family Reset in Post-COVID America," Institute for Family Studies, August 17, 2021. https://ifstudies.org/blog/homeward-bound-the-work-family-reset-in-post-covid-america

60 "Home Building Survey Part II: Supporting Families," American Compass, February 18, 2021. https://americancompass.org/essays/home-building-survey-part-2/

Figure 6: Child care subsidies reflect upper class preferences



Source: American Compass Home Building Survey (2021); N=1,746
Question wording: "Which arrangement for paid work and childcare do you think is best for your own family while you have children under the age of 5?" OR "If you were to have children in the near future, which arrangement for paid work and childcare do you think would be best for your family while your children were under the age of 5?"

suggests universal day care, in particular, comes with significant risks, both to the well-being of children and to the freedom of parents to choose a child care model that works best for them.[61]

Like many health-care and educational services, professional child care services are relatively low-skill and labor-intensive. In normal goods markets, the long-run supply curve is typically elastic: An increase in the demand for widgets may raise the price of widgets in the short run, but in the long run firms respond to the higher price by developing more productive techniques for producing widgets and compete the price back down to a long-run equilibrium. In contrast, in a cost-diseased sector like child care, there are natural (and often legal) limits to how productive a child care worker can become, such as caps on the number of children a single worker can oversee at a time. Supply is also made less responsive through barriers to entry.[62]

Supply may nonetheless increase with a sufficiently large subsidy, but only by pulling in workers from more productive sectors through artificially higher prices and wages. You could call this approach "leaning into cost disease," and it presents

61 Matthew Yglesias, "Quebec gave all parents cheap day care — and their kids were worse off as a result," Vox, September 24, 2015. https://www.vox.com/2015/9/24/9391625/quebec-daycare-study

62 Diana Thomas and Devon Gorry, "Regulation and the Cost of Child Care," Mercatus Center Working Papers, August 17, 2015. https://www.mercatus.org/publications/regulation/regulation-and-cost-child-care

the worst of two worlds. Not only do child care costs continue to escalate but they come at the expense of the broader economy's productivity.

The effects of cost disease are not limited to making low-skill, labor-intensive services more expensive. Cost disease also affects the relative costs of different institutional arrangements, putting pressure on old economic models to adapt or go by the wayside in ways that are often hard to foresee. As discussed in the introductory section, the decline in community schools is the classic example. As teacher salaries grew commensurate with the wage growth in more productive sectors, the economics of small local schools became untenable. Over time, cost disease in education caused thousands of community schools to consolidate into larger, regional schools that take advantage of economies of scale.

These sorts of transition are always painful, but particularly so when they're put off through subsidies and various kinds of support that slow down the restructuring. A major problem with subsidies to child care providers, whether done directly or indirectly through vouchers, is thus the risk of entrenching a particularly high-cost model of child care delivery. This is why it is virtually always preferable to simply provide low-income parents with cash, giving them the choice over different care arrangements based on market prices.[63]

It is inherently difficult to predict the ways in which cost disease will change the economy. In the case of health care and education, there is increasing pressure in the direction of telemedicine and online or hybridized college courses. As more and more jobs are digitized, the ability to telecommute will continue to increase — an existing trend that the Covid-19 pandemic dramatically accelerated.[64] In a world of ubiquitous home offices, does greatly expanding the supply of external child care centers even make sense?

The question remains: How do lower-income households afford the high cost of formal child care under the status quo? The simple answer is that they don't. As it stands, more than 40 percent of children under the age of five are in regular care arrangements involving relatives, while less than 25 percent are in a formal, paid child care center. Importantly, this largely reflects parental preferences. In a 2021 survey, 47 percent of parents in the U.S. with children below the age of six stated that their ideal primary child care arrangement was a parent or close relative, irrespective of the price of the alternatives.[65]

Advocates of center-based child care nonetheless tend to treat the by-product of

63 Patrick Brown, "Child Care Pluralism: Supporting Working Families in Their Full Diversity," Niskanen Center, June 17, 2021. https://www.niskanencenter.org/child-care-pluralism-supporting-working-families-in-their-full-diversity/

64 Adam Ozimek, "The Future of Remote Work," Upwork, June 2020. https://www.upwork.com/press/releases/the-future-of-remote-work

65 Morning Consult, National Tracking Poll: Project 201263, January 2021. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2021/01/Parent-Survey.Toplines.pdf

these parental preferences — a low willingness to pay for formal child care — as evidence for the existence of a market failure. For example, a report by the Center for American Progress calls attention to "child care deserts" based on an analysis of the capacity of child care centers by zip code.[66] The analysis suffers from some serious flaws. As a simple conceptual matter, for example, the "desert" metaphor fails when more than 75 percent of parents of preschoolers say they are happy using alternative care arrangements (there are no alternatives to drinking water when dehydrated).

The use of organized child care facilities has varied erratically over the years, even as maternal employment has steadily increased. While the most recent trend has seen an increased reliance on fathers and organized day-care facilities as primary care providers, a 2013 U.S. Census report notes that "the lack of a consistent trend since 1985 in the use of specific child care arrangements for preschoolers makes it difficult to foresee which arrangements will grow or wane in popularity in the future."[67]

Parents, on the whole, state a strong preference for parental or family care over day-care centers, which does more to explain the erratic uptake of external care arrangements than cost alone. And, importantly, it's a preference that is strongest in low-income households. According to the U.S. Census:

> "Low-income parents (those making no more than $25,000 annually) have more pronounced concern about day care centers than high-income parents (those making more than $75,000 annually). Seventy-two percent of low-income parents express great concern about the possibility of neglect or lack of supervision of children, compared with 51% of high-income parents. Seventy-six percent of low-income parents are more fearful that children may suffer physical or sexual abuse in day care, compared with 49% of high-income parents."

Results like this should give pause to would-be reformers. It suggests that the drive to push young children into child care facilities reflects a bias in elite attitudes, rather than the preferences of the parents themselves.

Consider that Canada doesn't have a national child care program, yet it has a prime-age female employment rate that is nearly 6 percentage points higher than in the United States. Canada's liberal regulation of home day-care providers is part of the reason why. Only one-third of Canadian children aged four and under rely on formal day-care centers, similar to the rate in the U.S. The remainder make use of private care like family (28 percent) and home day care (31 percent). Only 11 percent of Canadian parents cite affordability or the feeling that they had only one option as the reason behind their choice of child care.

66 Rasheed Malik et al., "America's Child Care Deserts in 2018," Center for American Progress, December 6, 2018. https://www.americanprogress.org/issues/early-childhood/reports/2018/12/06/461643/americas-child-care-deserts-2018/

67 As quoted in: Samuel Hammond, "Cash is Superior to Child Care," Niskanen Center, June 26, 2017. https://www.niskanencenter.org/cash-superior-child-care/

Home day-care providers in Canada can open without a license below a certain threshold of children. In Ontario, the most populous province, the threshold is more than two children under the age of two or more than five children over the age of two (both including your own children under the age of six). Past this threshold, home day-care providers are required to register with the province and meet provincial health and safety inspections. Licensed home day-care workers are also required to pass a criminal record check and take first-aid training, but they are not required to obtain a "Registered Early Childhood Educator" designation or undergo any other form of pointless credentialling.[68]

Seen through the lens of the working parent, the pursuit of higher child care "quality" — be it in the form of stronger licensing requirements or mandatory curriculum standards — is actively counterproductive. Instead, child care choice and affordability can be tackled simultaneously by relaxing regulations on home and formal day-care centers and, in urban areas, reducing restrictions on land use that push up the price of real estate.

With appropriate cash benefits to parents and a legal framework that opens up lower-cost options, there is no argument for favoring universal child care outside of social engineering. Given a transparent price for child care, parents can — and do — make their own choices.

CONCLUSION

In these days of soaring budget deficits and rock-bottom interest rates, it may seem that the whole idea of fiscal responsibility has become passé. But maintaining a healthy relationship between revenues and spending is always important as a basic matter of democratic accountability, and wasteful spending not well calibrated to serving important public goals is always to be decried. As to the economic constraints on government borrowing, they may have been relaxed but they have not been eliminated. Stein's Law — that a trend which cannot go on forever won't — remains in force.

But fiscal responsibility *does* need to be reconceived. The conventional approach of top-down budget controls has been tried repeatedly and found wanting. The reason it hasn't worked well is that it ignores the political economy drivers of rising government spending. Accordingly, the effect has been similar to putting a lid on a boiling pot while keeping the burner on: Sooner or later, the lid will be knocked off and the pot will boil over.

Here, we offer a new conception of fiscal responsibility focused on addressing

68 Samuel Hammond, "The False Promise of Universal Child Care," Institute for Family Studies, February 28, 2019. https://ifstudies.org/blog/the-false-promise-of-universal-child-care

fiscal imbalances at their political economy roots. In our diagnosis, the fundamental problem lies in cost disease, broadly understood, across core social goods like health care, education, housing, and child care. Unless we are able to effect regulatory reforms to subdue cost disease in these sectors, public demand for socializing the cost of these core social goods will inevitably prove irresistible. But such socialization will only exacerbate cost disease over time, leading to renewed public demand for increased socialization in a dismal cycle of bloat and waste.

The challenge of fiscal responsibility in the twenty-first century is to break this vicious circle by attacking head-on the producer interests that benefit from the dysfunctional regulatory status quo. We are under no illusion that rising to this challenge will be easy: Those producer interests are powerful and well entrenched. But if we are to adequately meet public needs without politically and economically unsustainable demands on the public purse, there is no alternative.

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