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"Summary of article by Nicholas Barr: Economic Theory and the Welfare State: A Survey and Interpretation"

This article surveys the literature on the welfare state in economic theory, presents data on the nature and extent of the welfare state in ten developed countries, and analyzes two areas in detail -- cash payments to individuals, and financing systems for health care. This summary emphasizes the author's discussion of economic theory, with only brief treatment of the more empirical and detailed sections.

DEFINITION AND GOALS OF THE WELFARE STATE

The term "welfare state" is used as a shorthand for the state's activities in providing cash benefits, health care, education, and food, housing, and other welfare services. Such activities grew rapidly in the 1960s and 1970s, and by 1980 accounted for 12% to 28% of gross domestic product (GDP) in many developed countries. There are many institutional and political variations in the nature of the welfare state from one country to another; one of the most important is the distinction between residual and universal welfare states. A residual welfare state provides means-tested "safety net" programs for the poor, as in the U.S.; a universal welfare state provides services for all socioeconomic groups, as in Germany.

Academic and political discussion of the welfare state mentions a broad range of objectives, including economic efficiency, poverty relief, reduction in inequality, promotion of dignity and social solidarity, and administrative efficiency. Some of these are hard to define; some are inherently in conflict with each other, raising fundamental normative choices.

MARKET FAILURES AND SOCIAL INSURANCE

Public intervention in a market economy is often justified as a response to market failure. Traditional categories of market failure are only slightly relevant to the welfare state. Income externalities can provide a basis for intervention; if the rich have a preference for redistribution to the poor, then voluntary transfers may be less efficient than government programs when the numbers of individuals are large. Merit goods that are believed to involve important positive externalities, such as education or sanitation, may be most efficiently provided by the public sector. Such arguments, however, justify at most a residual welfare state with a handful of universal services and infrastructure programs. They do not explain why so many countries have gone much farther.

More important are a newer category of market failures, typically due to information problems faced by both consumers and insurers. Consumers may have imperfect information about the quality of the product, or about its price; the information problems are severe in health care, sharply reducing the efficiency of the market. Even if consumers are well informed, they may not be able to buy what they want in the area of social services and insurance; three additional problems limit the ability of the private sector to provide the insurance coverage that consumers want.

The first is adverse selection: if an insurer cannot distinguish low and high risk customers, it will offer pooled insurance rates based on the average risk. However, if individuals know their own level of risk, low-risk groups can opt out and find cheaper alternative coverage or self-insurance, leaving the original insurer with a riskier than average population. An analogous problem arises in other cases of asymmetric information, such as used car markets, and limits the extent and efficiency of transactions in those markets.

The second insurance problem is moral hazard: if individuals know they are insured, take too few precautions; and, when making claims, they will use resources inefficiently. As an example of the latter problem, if medical care is fully insured, neither doctors nor patients have any incentive to avoid excessive consumption.

A final insurance problem concerns unpredictable probabilities, such as the likelihood of inflation eroding the value of pensions, or probabilities that approach certainty, such as the need for treatment of the chronically or congenitally ill. While most people would like to insure themselves against such events, private insurance is clearly impossible.

Social insurance schemes, with compulsory, universal membership, can overcome some of these problems. Adverse selection does not arise if everyone is compelled to have the same public sector insurance. The social contract, which is less specific than a private one, can provide some protection (perhaps changing over time) against such diverse risks as future inflation or congenital illness. Universal benefits, unrelated to any insurance premiums -- such as family benefits in many countries, and Canadian, Swedish, and British health care -- perform a similar function to universal insurance coverage.

CASH BENEFITS

Unemployment compensation faces many of the insurance problems mentioned above. Adverse selection can arise, since workers can sometimes conceal their likelihood of voluntary future unemployment. Moral hazard exists because any compensation makes unemployment less unattractive. Probabilities of unemployment, for many groups of workers, are unpredictable and/or quite high at times. Thus private sector unemployment insurance is essentially unknown, aside from specialized programs for low-risk groups (e.g., mortgage protection policies, keeping up homeowners' monthly payments in case of unemployment).

Retirement pensions are offered by the private sector, but they are unable to insure against the important risk of unanticipated inflation after retirement. No one knows the probability distribution of future inflation rates, and if a high rate occurs, it affects everyone at once; both

these factors make it impossible to sell inflation insurance. Only the public sector can provide this much-desired form of insurance. Large and growing expenditures are required, particularly in view of the aging of the population of developed countries.

There is a longstanding debate over the merits of full funding of pension liabilities, versus pay-as-you-go systems such as Social Security in the U.S. Which makes it easier to pay pensions in the future? The empirical evidence is inconclusive: countries like Sweden and Japan, with funded public pensions, have often put the resulting capital funds in relatively low-yield investments, losing much of the expected benefits of their cautious approach. Even in theory, it is not clear that pay-as-you-go pensions reduce a society's total savings; the greater pension contributions required for full funding may cause offsetting reductions in non-pension private savings.

The distributional impact of cash benefits varies widely across countries. One measure of this impact is the percentage of families who would otherwise have been poor (below 50% of median income), who were moved out of poverty by government programs. In the mid 1980s, this percentage ranged from 82% in Sweden to less than 23% in the United States. Sweden's welfare state transferred 10% of GDP to the poorest 20% of its population; in the U.S., the transfer to the poorest fifth was 5% of GDP.

MEDICAL CARE

Private markets are inefficient in health care for all the reasons discussed above. The information needed for rational decision-making is technical and often inaccessible. Adverse selection -- low-risk individuals opting out of broad insurance pools, leaving a higher-risk population behind -- is a chronic problem. Moral hazard -- overuse of medical care because it is free or subsidized -- is inescapable, though it is reduced by copayments and deductibles. People want coverage for pre-existing and congenital problems, which are uninsurable for a private insurer. The inefficiencies of the market, as predicted by theory, can be seen in the United States, the country that relies most on the private market for health care: the problems of high and rising costs, gaps in coverage, and unequal access, are all worse in the U.S. than in other developed countries.

> A hypothetical pure private market for medical care and medical insurance would be highly inefficient and also inequitable. That view is hardly controversial; what is less clear is the specification of the least bad alternative. (781)

Rapidly rising costs have affected virtually all health care systems, leading to interest in incentives for cost containment. Prospective payment systems provide payment ex ante, imposing all risk of cost increases on the medical supplier. Prospective budgets for hospitals (fixed sums per inpatient case) are now widespread in Europe. Diagnosis related groups, a more refined form of prospective payments, are used by U.S. Medicare, paying a fixed price for each of almost 500 diagnoses. Health maintenance organizations (HMOs), a rapidly growing institution in the U.S., receive a fixed annual payment from each member, and agree to provide all medical care needed by the members. All of these prospective payment systems, however, create unfortunate incentives for the providers to lower the quality and/or quantity of care supplied; and they do not address the problem of uninsurable risks.

An alternative regulatory approach sets annual national, regional, or local budgets for medical care, with payments to doctors and hospitals at fixed fees per service subject to the budget limits. Several European countries, as well as Canada and New Zealand, employ variants of this approach. Funding can be centrally administered, as in Canada, or decentralized to numerous sick funds, subject to government approval, as in Germany. The critical point is that "budget constraints of this sort control physician incomes not physician actions, leaving doctors largely autonomous in treating their patients" (787), unlike the U.S. experience with managed care.
There is a continuing need for reform of health care provision, both to increase the flow of information and to improve the structure of incentives for providers and patients. Several European countries are considering experiments with competition, less as cost containing devices than as ways to make providers more responsive to consumers.

CONCLUSION

> Many parts of the welfare state are a response to pervasive market failure, and therefore serve not only distributional and other objectives . . . but also efficiency objectives such as income smoothing and the protection of accustomed living standards in the face of uninsurable risks and capital market imperfections. (757)

The market failures that lead to welfare state measures require a two-part intervention strategy: social insurance, which makes universal coverage possible, must be combined with a regulatory regime which includes stringent financial control. While there are no perfect solutions, the search for better institutions inevitably continues.

Social insurance, unlike private insurance, charges premiums that need not be directly tied to individual risk; is such a system still insurance? The social insurance systems of the welfare state can be viewed as a contract entered voluntarily by risk-averse individuals behind John Rawls' veil of ignorance; behind the veil of ignorance, individual levels of risk are unknown. Universal benefits and assistance programs can also be seen as a form of insurance. "By offering cover prior to birth, the welfare state is acting like ex ante actuarial insurance with a long time horizon... From this perspective the nature of the welfare state is determined in part by the choice of time horizon." (795)