6. WHAT NEEDS TO BE DONE? AND NOT DONE?

22 August 2026

A look back to recapitulate

Chapter 1, ostensibly written in 2035, described why and how the U.S. won affordable medical security for all. It argued that the crises outside and inside health care propelled reform.

Chapter 2 asserted that affordable, high-quality health care for all is the easiest problem to resolve in the U.S. It countered the notion that large-scale wholesale attention to social determinants of life would cut health care costs. Indeed, it is politically and financially impossible to address those social factors without getting health care costs under control—and that, in turn, is impossible without blasting loose much of the health care spending that' currently wasted, covering everyone, and reforming both caregiver configuration and payment methods.

Chapter 3 documented that assertion by showing that the U.S. spends far more per person than other rich democracies to give less care to fewer people while suffering inferior health outcomes. It showed that the U.S. – rich democracy gap on all of these measures has widened over the past five decades, even as real U.S. per person spending rose five-fold. And it offered evidence that up to one-half of yearly health spending is wasted on unnecessary or low-value clinical care, high administrative costs, high prices, and theft.

Chapter 4 asserted that competitive free markets don't and can't operate in health care.

And chapter 5 argued that government in the U.S. has generally not been able to do what it could do competently in health care—make a few strategic decisions well. Instead, it chooses or is obliged to do many things it cannot do competently.

Anarchy reigns over U.S. health care owing to the failures of the market and government.

Role reversal

U.S. health care generally relies on market forces—non-public decisions—in hopes of containing cost, configuring caregivers, and organizing and delivering care. It generally relies on governments mainly for three things. First, to finance coverage for people who can't—or whose employers can't—afford it. Second, to occasionally threaten anti-trust litigation to boost competition. Third, to enact laws and promulgate regulations to mitigate various unacceptable harms resulting from reliance on market forces.

Some good things have resulted from this mix of reliance on markets and governments. Many Americans receive appropriate, high-quality, timely, and effective care.

And many bad things have resulted.
- ✓ High costs and enormous waste.
- ✓ Caregiver addiction to more money for business-as-usual.
- ✓ Wholesale lack of accountability.
- ✓ Financial coverage and actual provision of needed care that are very uneven.
- ✓ Inadequate primary care.
- ✓ Generally, malconfigured caregivers.
- ✓ Very uneven quality and appropriateness of care.
- ✓ Adoption of remedies that often fail, and that even worsen the problems they purported to address.
- ✓ Progress is paralyzed by entrenched political interests and by high incremental costs of improvement—improvement that always relies on still more money.

It makes sense to reverse key parts of the two roles. Governments do need to continue redistributing purchasing power through Medicare, Medicaid, CHIP, ACA subsidies, and the like.

Additionally, governments need to competently make a few strategic decisions that are either not being done at all today or are being done very badly by putative markets. These are:
a) cap and contain yearly spending,
b) assure financial coverage for each person,
c) configure caregivers to redeem the promise of financial coverage with actual care,
d) pay doctors and hospitals and other caregivers in financially neutral ways that allow both patients and payers to trust caregivers to marshal our vast but finite dollars to do as much clinical good as possible without exceeding the spending cap, and
e) raise the floor under quality and appropriateness of care in all regions and for all people.

Governments must take accountability for doing all 5 of these jobs. Developing the necessary capacity and competence will take time and planning. Political support—fervent demand, actually—for effective government responses will be forthcoming during the sort of financial crisis besetting health care that was described in chapter 1. That support will be transient—it will vanish—if governments are not prepared to demonstrate effective and visible progress early in the crisis.

At the same time, ensuring that patients get needed care—equitably and affordably—requires *establishing a self-regulating substitute* for ineluctably unavailable competitive free markets.

Balancing the financial and clinical books—capped spending and financial coverage for all

Governments may cap spending, cover everyone, and figure out effective and acceptable ways to configure and pay caregivers. Governments can establish budgets for all needed hospitals and arrange to pay all doctors and other caregivers. But how will the books be balanced? Or, better, who will balance the books? Who will ensure that financial coverage is redeemed by caregivers as actual provision of needed care—without breaking the budget?

This can't be a job for a competitive free market to perform. It is broken in health care. Indeed, market failure should compel governments to buy out owners' equity in for-profit caregivers and insurers, and convert them to non-profit ownership.

Payers' regulatory micro-management of doctors' clinical decisions has failed. It has been a costly nightmare for insurance bureaucrats. It wastes doctors' time and forces them to employ clerks and programmers to fight with insurers' clerks and programmers.

Only doctors can competently balance the books. Their decisions about how to diagnose and treat us determine how the great bulk of health dollars are actually spent. The methods and rates by which we pay doctors must be crafted with eyes toward liberating, empowering, and trusting doctors to be altruistic fiduciaries when spending the dollars they control. Doctors decide how to diagnose and treat us. Their decisions control how almost 90 percent of the health dollar is spent. To cut clinical and administrative waste, our nation must find ways to trust doctors' professional decisions.

That relies, first, on financial neutrality: doctors can't be better or worse off, personally, by giving more, less, or different care. Doctors working in hospitals should be paid mainly by salary, the most common method in other rich democracies. Doctors working in ambulatory care could be paid by fees—if they are calibrated to win a target income for a dedicated doctor. Financial incentives to induce doctors' behavior change must be abandoned.

Second, this means paying doctors well—and in ways that lead them to stop thinking about their own incomes when they go to work each day.

Third, it relies on orienting doctors toward altruism, toward doing as much good as possible with the clinical time and money available. This is partly a matter of recruiting medical students and partly a matter of establishing the profession of medicine as a public service. With doctors as clinical and financial fiduciaries, not as economic actors.

Similarly, hospitals and other institutional caregivers need budgets, fixed in advance. That money—and budgets for meds—must be allocated by doctors. They must spend it all, each year. Doctors can't benefit financially from under- or over-spending. Their incomes can't be affected by their clinical decisions. The latter must be guided only by what patients need, what care is useful, and how much money is available.

Doctors will need much better information on who needs what care—what care works for various patients. They will need much better information on the costs of care they contemplate.

At the same time, hospitals' trustees and executives will support doctors' care for patients and will share aspects of fiduciary management of their institutions' budgets. Chapters 9 and 10 address these and related matters. Hospital trustees and executives would help carve up the hospital's overall budget among cardiology, orthopedics, oncology, and other clinical services.

Hospital managers would update doctors on actual versus budgeted spending, by clinical department. They'd also analyze incremental (marginal) costs of various services and provide that information to doctors. Doctors would then compare incremental costs against clinical benefits of different ways to treat various patients.

Initially, individual doctors in each clinical service will disagree about methods of diagnosis and treatment. Over time, though, the realities of capped hospital and pharma budgets—and of doctors' own financial neutrality—will move doctors toward greater agreement on clinical paths for various patients.

Better care for all Americans requires cutting clinical waste, the largest of the 4 types of waste. Doing so requires ensuring that all people seeking care receive high-value/low cost care. It requires ceasing to give low-value/high-cost care.

For the vast array of care falling between these 2 extremes, spending money carefully requires better evidence and agreement on which types of patients need which medical services. Spending $5.6 trillion in Medicare, Medicaid, private insurance, and OOP dollars in 2025 needs to rest on better science. (If medicine is mainly an art, perhaps it should be financed from the shrinking budget of the National Endowment for the Arts.)

Inside health care, anarchy means less care at greater cost for fewer people— who don't live as long as their counterparts in other rich democracies. It means that up to one- half of health spending is wasted.

Anarchy undermines medical security by raising insurance premiums, boosting out-of-pocket costs, engendering surprise bills, undermining primary care, closing the hospitals that are among those most needed, denying dental care or long-term care or mental health services to many who need them, and making meds unaffordable.

Anarchy undermines medical security and thereby worsens the lives of many Americans who previously suffered financial, family, or physical insecurity.

Anarchy invites health care theft and gaming, and then glorifies the resulting profits even though they were earned without honor.

No one in health care is accountable for anything that happens outside the building where they work. And often, not even then.

Outside health care, anarchy means that health care sponges up a few hundred billion more dollars every year—an added $1 trillion every four years.[2886] That's money that might otherwise be available to build housing and bridges, engineer clean energy, improve public education and job training, combat ingestion of dangerous chemicals and the forces that magnify their consumption, help rebuild family life, make neighborhoods safer. And finance improved national defense and its industrial infrastructure.

Up from anarchy

The seduction of markets is so powerful that many very smart people can't imagine they don't work in health care. A friend who has taught for decades at a well-known business school was astonished and a little angry when I mentioned my conviction that a competitive free market did not and could not exist in health care. He said that was like denying the reality of gravity, evolution, the theory of relativity, or the superiority of the Boston Red Sox.

A few professors at journalism schools have invited me to speak to their classes about reporting on health care. Perhaps because health care was relegated to the business section of newspapers where they had worked, these professors imbibed free market thinking about

health care. Most were outraged by assertions that health care reporters should turn their attention away from the business of health care—from profits or losses of hospitals, health insurers, or drug makers—and instead examine why costs were so high, why a hospital closed, why patient use of care was suppressed by high OOPs or narrow caregiver networks, or why family doctors were in short supply.

One prominent feature of anarchy is the constant demand it makes on the attention and energy of those enmeshed in it. Anarchy and the lure of profit frighten, excite, and exhilarate. This is one of the sense in which we speak of competition as the opiate of the managers.[2887] Like heroin, and like the South's former peculiar institution, anarchy enslaves.[2888]

Freeing ourselves from health care anarchy entails doing six strategic things.

The first is to embrace realism, not fantasy—to look at the world as it is, not as imagination, theory, or wishful thinking might dictate.

The second is to confront each problem (and its causes) as directly as possible—on its own terms. This means declining the temptation to create imaginary market mechanisms or write unenforceable but annoying public or private regulations or relocate the problem to a new venue. It means fixing things where they are.

For example, costs are contained by establishing budgets and by liberating doctors to serve all patients as well as possible with the inevitably finite dollars. Costs are not effectively or acceptably contained by payer oversight of clinical decisions,[2889] by higher OOPs, and the like. Access is enhanced by financially protecting all patients solidly, by making sure each can easily reach a trusted primary caregivers, by boosting the supply of dentists, by making sure hospitals and specialist physicians are well-configured, and the like.

The third is to recognize that U.S. health care derailed—went off the tracks—in the 1940s and 1950s when it didn't move to cover all people in ways that contained cost and that negotiated durable payment arrangements with doctors and hospitals. We didn't do those things then because we didn't have to do them. Then. So no one should be blamed for failing to do, decades ago, what was then deemed unnecessary or undesirable.

But now, we do have to do them. We have to get health care back on track. See Exhibit 6-1. Forging links among coverage for all, cost control, caregiver payment, caregiver configuration, and quality and appropriateness of care is vital to winning affordable and self-regulating health care for all. And to ending anarchy.

In a valuable commentary on different payers' prices, Ginsburg wrote:[2890]

> For decades, policy thinkers and policy makers have argued about whether competition or regulation should be the approach to constrain health care spending to what society can afford. By having chosen neither, our nation now finds itself with a much larger challenge. The magnitude of our health care affordability problem cries out for pursuing both competition and regulation.

Ginsburg proceeds to debunk efficacy of competition on two grounds: Caregiver consolidation neutralizes power of "consumer incentives" like even higher OOPs to knock down prices. And

OOPs high enough to slow use of costly new technologies (and meds) would undermine access for many.

So Ginsburg concludes that “Perhaps after all these years, the United States may slowly join the rest of the world’s high-income countries in having a public entity limit payment rates from all payers.”

But it is worth wondering whether, given the combination of Americans’ skepticism about government and caregivers’ considerable power, our nation will act effectively to limit payment rates.

Exhibit 6 - 1

Getting a Derailed Train Back on the Track

Unless political and financial threats to caregivers’ incomes impel them to negotiate a payment peace treaty. And unless one provision of that treaty is not merely a limit on payment rates but a guarantee of revenue. Hospitals and their doctors must be given enough money to deliver medical security for their patients and all Americans who need their care. But this must entail a pledge by caregivers to spend their vast but finite revenue effectively, efficiently, and equitably. And that requires weeding out futile care, low value care, and care whose cost is incommensurately greater than its value to patients.

The fourth is to build and negotiate trustworthy and self-regulating mechanisms inside U.S. health care. Part of the market’s appeal is its inherent ability to self-regulate. In a sense, it acts like a sail boat with a weather helm. If the human falls overboard and no hand remains on the tiller or wheel, the sail boat points into the wind. It stops; it doesn’t sail away. So the human can swim a few strokes and get back on board. See Exhibit 6 - 2.

The fifth is to seize every opportunity to bake self-regulation into U.S. health care. Overcoming anarchy requires building accountability and financial and clinical self-regulation in health care.

This entails paying all needed caregivers adequately and fairly, covering all people, configuring caregivers well, and raising the floor under low-quality care.

The sixth is to envision reforms that would actually work. Early in 2025, Berwick and colleagues advanced such visions by publishing a valuable comment on health problems and reforms, one they call "a partial roadmap for transforming the US health care system." [2891] It reasonably asserted that health spending is uncontrolled, that health care absorbs money that could better be spent on SDLs, that quality is both uneven and poor overall, and that both access to care and outcomes are inequitable.

Among the causes of these problems, they indicted weak government oversight, market failures, and profit-making. Berwick and colleagues insisted that incremental reforms are inadequate, and that reimagining health care finance and delivery—"transformational change"—is essential.

They do propose valuable reforms. Prominent among these are affordable and comprehensive financial coverage for all, solid primary care, a culture of continuous quality improvement driven by data, demanding "transparency and organizational accountability… as foundations for accountability," and "robust governance and accountability measures…."

Important though it is, the work of Berwick and colleagues is incomplete in some respects and flawed in a few others.

Their proposal lacks a transmission to link the grounded wheels of problems to the engine of reform. It lacks a political story. Berwick and colleagues wrote that "Any large-scale change will have to be driven by a set of bold aims replacing the inertia and self-satisfaction of the status quo, agreed on by public and private stakeholders, and fully aligned with the sentiments of the public."

But, as Berwick and colleagues doubtless well know, aims don't drive change. Dissatisfaction and crisis drive change. The authors write that "Our proposed path forward is impossible unless Americans take equally seriously the need to stamp out price gouging and waste." The authors seek cuts in prices for specialty care, lower capitation payments to MA plans, administrative simplifications, price transparency to drive "authentic competition", and outlawing profiteering. But Americans and our politicians have been putting up with all these for decades. What might drive our nation to act politically in any of these areas?

Six proposals are unlikely to work because they are badly targeted or because they conflict with elements of U.S. health care that are dysfunctional but deemed by Berwick and colleagues to be immutable. One is to incentivize outcomes via capitation payments for populations. Capitation as a perfectly reasonable approach. But, absent a functioning free market in health care, financial incentives have intensified caregivers' and payers' drives to boost incomes and profits without accountability. Reporting of outcomes can be manipulated if caregivers are motivated to do so.

A second is to prioritize social determinants of health to advance health equity. As argued in chapter 2, to demand or hope that health care—approaching one-fifth of the economy—will address and redress the many inequities and dysfunctions plaguing the remaining four-fifths of the economy in housing, nutrition, job training, criminal justice, family stability, and other sectors is to let health care off the hook while pretending that health care's resources can make wholesale dents in those many problems.

A third is to simplify financing. But simplification is impossible without confronting competing insurance companies and without negotiating peace treaties between payers and caregivers Simplifying financing requires simple and trustworthy methods of raising money, covering Americans solidly, and paying caregivers fairly.

A fourth is to seek authentic competition. How is that possible when health care fails to satisfy even one of the seven requirements of genuine free market competition?

A fifth is to outlaw profiteering. That would require setting levels of profit deemed acceptable, demanding honest reporting of costs and revenues, and deeply auditing those financial reports. Creating and enforcing this level of monitoring is daunting. Without free markets to legitimize profit-seeking, profit ceases to be an outward sign of inner financial grace—efficiency, innovation, and delivering needed care.

A sixth is to demand higher spending on primary care and on boosting Medicaid prices. It is very hard to identify the financial aquifer from which these added financial infusions would be pumped, or which politicians might vote to tap them. U.S. health care is unaffordable today. Therefore increased spending on primary care must be directly financed by cutting waste. And leveling Medicaid prices upward must be financed by leveling private insurance prices downward.

The proposal from Berwick and colleagues is well-intentioned and forward-looking. But its definition of pragmatism requires both retaining competing private insurers to cover workers through the job, and expanding government regulation of a market. It does not seem to contemplate broadly and deeply reshaping how money is raised, how revenue is capped, how caregivers are paid, or how clinical and financial accountability are woven deeply into U.S. health care. That definition of pragmatism would condemn reform efforts to addressing more symptoms than causes, discrediting those efforts themselves and those that might actually work.

The chapters that follow—numbers 7 through 17—sketch integrated reforms that include many proposed by Berwick and colleagues, but that rest on a different notion of what's pragmatic and politically feasible. These chapters offer integrated ways to cover all Americans, contain costs, organize and deliver care, pay caregivers, win primary care for each of us, configure needed hospitals, improve long-term care and mental health care, win affordable meds for all while providing greater incentives for innovation, and raise the floor under health care quality and appropriateness.

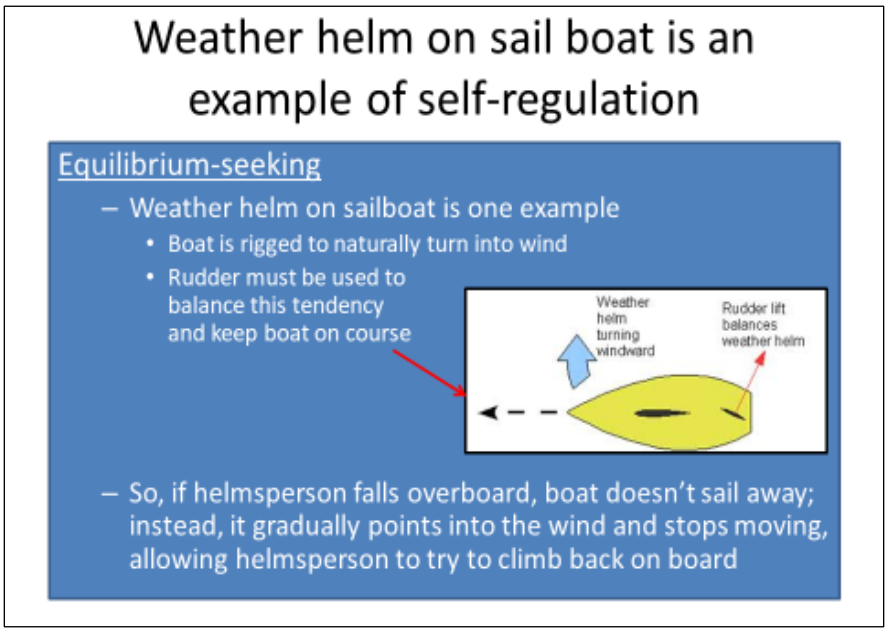
How to undertake all six of the approaches to overcoming anarchy just discussed? The *first* element is to recognize that doctors' decisions about whether or how to diagnose and treat individual patients commit or control some 87 cents on the personal health care dollar. Doctors and labs they order account for 21 cents. Inpatient and outpatient hospital care, nursing home and home health care, meds, and all the other services only doctors can control account for 66 cents. This leaves only 13 cents for dental care, over-the-counter meds and supplies, equipment, and the rest.

Since doctors control the 87 cents, the challenge is to put it into their hands under arrangements that allow us to trust them to spend it carefully. This might be called professionalism. One

foundation for professionalism is financial neutrality, meaning that doctors don't make more or less money if they give more, less, or different care. That means abandoning hope that financial incentives (greed) can motivate doctors or to change their behavior. And embracing reliance on professionalism, financial neutrality, decency, self-respect, and putting the patient first.

Exhibit 6 – 2

A Sailboat with a Weather Helm



Doctors could still earn lots of money. Doctors who work in hospitals would probably be paid salaries. These would be set at levels high enough to attract adequate numbers of the right doctors to the places they were needed.

Doctors in ambulatory practices could be paid variously by fee-for-service, capitation, fee-for-time, salary, or combinations of these. Regardless, total income for doctors in ambulatory practice would be calibrated to get the right doctors in the right places, and to provide total remuneration deemed fair to a hard-working physician.

For all doctors, these financially neutral methods would substantially simplify the job of getting paid. All payers would pay the same sum for the same care, by the same rules, with the same quality measures, formulary, and the like. Opportunity for self-enrichment would be limited. As financially-driven mistrust between payers and doctors was cut, so would demands for paperwork fall. Almost all doctors would welcome the chance to care for patients in light of their clinical needs and the availability of effective treatments, uninfluenced by money-making pressures, insurers' demands, or fear of malpractice litigation. Core reforms in malpractice are described in chapter 15 during the discussion of quality and appropriateness of care. Cutting paperwork, payer-doctor mistrust and financial wrangling, and ending fear of malpractice

litigation would be powerful ways to persuade doctors to accept financially neutral payment methods.

A *second* foundation for self-regulation is to devise finite yearly budgets for hospitals. Doctors would shape how the budgets are spent in light of patient need, efficacy of treatments, and—unavoidably—politics that shape shares of dollars going to orthopedic surgery, oncology, cardiology, and other clinical services. Payers would press hospitals and doctors increasingly to divide hospital budgets in proportion to evidence on patient need and treatment efficacy. The trustees of non-profit and public hospitals would be asked to act as fiduciaries—to find ways to marshal inevitably finite dollars to allow doctors and other clinicians to do as much clinical good as possible.

Third, finding ways to shift for-profit entities like investor-owned hospitals, ambulatory surgery centers, and physician practices to self-regulating methods of payment will be one of the most challenging aspects of the shift to more trustworthy and self-regulating methods of payment.

Self-regulation, then, entails only a few things, though they are all big. One is a commitment to assuring medical security for all Americans. A second is a cap on spending. A third is a set of methods and levels of revenue for paying caregivers that both caregivers and payers accept—and that are commensurate with both medical security for all and respect for the cap on spending. A fourth is adequate caregiver configuration—enough caregivers in total, of the right types, and located in the right places. A fifth is to assure high-quality and appropriate care for all. The sixth is to negotiate political, clinical, financial, legal, and ethical peace treaties among payers, caregivers, investors, voters, and other stakeholders. This entails negotiating compromises that respect each party's core interests.

A look ahead

Winning medical security has three aspects—financial coverage, caregivers to redeem the promised coverage with actual care, and high-quality and appropriate services for all. Financial coverage for all requires cost control, and that requires negotiating with caregivers to find methods and levels of payment that are trustworthy and also self-regulating. Caregiving requires doctors, hospitals, and other caregivers—the right numbers and types in the right places. This means a supply of caregivers that is adequate to meet need for services—at a total cost that matches the cap on health care spending. Improving quality and appropriateness of care is perhaps the hardest aspect of medical security.

The next three chapters take up the interlocked topics of financial coverage for all people, cost control, and paying caregivers in ways that deliver needed care for all people while controlling cost. It is usually supposed that improving coverage must cost more money and that containing cost must harm coverage. This notion, though deeply engrained, is at once dangerous, stultifying, and wide open to repudiation.

Coverage and cost control can—and must—cease to be adversaries but, like France and Germany, can be made into allies. A first key approach is to politically motivate cost containment by showing how coverage could be improved with the money that's saved. A second is to recognize that attaining and sustaining financial protection for all citizens requires

cost control—while cost control can be motivated by politicians' desire to avoid tax increases. The latter would rest on a new requirement that rises in health spending be financed entirely by public dollars—by higher taxes. That cuts the Nordstream-type addiction to higher private out-of-pocket payments or private insurance premium increases to finance higher health spending. The twin obligations to care for all people and to contain cost must help shape payers' negotiations with caregivers over methods and levels of payment.

After a short chapter on organization and delivery of health care, five chapters on care and caregivers follow.

Caregivers get much less attention in U.S. health policy or reform than they deserve.

Genuine access to care—medical security—and cost control must rest in part on securing the right numbers and types of caregivers in the right places.

Plastic insurance cards are meaningless unless caregivers are available, able, and willing to redeem them as actual medical services. Medical caregiving is shaped by money, politics, power, demography, geography, prestige, accident, and other forces. All need to be addressed if caregiver configuration is to better match Americans' clinical needs.

Primary care is examined first. That's because it is the most important—to protect access, to contain cost, and to promote higher-quality and more appropriate medical care.

Hospital configuration is next because it is vital to medical security when we are most vulnerable, and because effects of decades of anarchy on hospitals have been so dangerous. Because hospital care itself interacts so deeply with the physicians who give care in hospitals, the two are considered jointly.

Long-term care for elderly and disabled Americans follows, and then mental health services.

The final chapter on caregivers concerns meds. It's likely that affordable high-quality meds for all is the easiest problem to fix inside health care, but that long-term care and mental health are the hardest.

After winning financial protection for all people and then securing the right numbers and types of caregivers, in the right places—those needed to redeem the promise conferred by financial protection—the remaining task is assuring high-quality and appropriate care for all—regardless of payer, age or disability, location, race/ethnicity/religion, and other human characteristics. Improving technical quality of care and appropriateness of care should accompany efforts to ensure equitable care. Lower-income patients, for example, should not need to rely disproportionately on resident physicians in hospital ERs or on social workers in training.

Political support for greater equity will require assurances that no one will suffer degradations in quality or appropriateness. That, in turn, will require shifting the quality/appropriateness distributions in a positive direction—in part by amputating bad care and in part by shifting the remainders of both distributions in positive directions.

What should not be done—succumbing to the subtle and silent seductions

Winning medical security for all Americans while containing costs will remind us we can be both compassionate and competent.

It will be a strategic victory because it will liberate time, attention, and money to address the harder problems that plague or nation economically, socially, and even militarily.
We will never win—or even move toward—medical security for all by continuing business-as-usual.

So we should not continue down the path toward failure, bankruptcy, demoralization, and defeat.

This means ceasing to do a number of things.—

× Trying to protect or improve coverage by providing even more money. This makes health care even more expensive. It's like climbing Mt. Everest. With each thousand feet of added height, the more oxygen you need to climb higher.

× Retaining open-ended entitlement financing that pumps more money to finance business-as-usual.

× Relying on cost control mechanisms that sound good—like bribing caregivers to change behavior through financial incentives—but that don't actually contain cost.

× Imposing higher out-of-pocket costs (sickness taxes) on the weakest party in U.S. health care—individual sick, injured, or disabled Americans—in hopes of saving money by deterring use of care.

× Perpetuating policy-by-slogan—managed care, accountable care, pay-for-value, prevention, or social determinants.

× Using market language by referring to consumers, providers, players, demand, markets, incentives, profits, advertising, or choice.

× Getting enmeshed in regulatory remedies that look good but are too complicated to work in the real world—or that require high levels of enforcement, inspection, and sanctions—often exacerbating the original problem instead of remedying it. Good intentions sometimes go awry, but bad ideas usually do.

× Failing to laugh at anyone who asserts that health care profits denote efficiency, doing what consumers want, or anything other than simply amassing profits.

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