Health Economics: Where Have We Been and Where Are We Going? (No, We're Not There Yet – But Don't Stop Asking!)

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It's been my great privilege and honor to serve as the President of ASHEcon this past year. I'd like to take a few minutes to reflect on where we have been as a field, where we're going, and what we need to do to get there.

Health economics is a relatively young field. Dating things such as the birth of a field is necessarily imprecise, but I think it's safe to say that health economics began in the early 1960s, with work by people like Ken Arrow, Vic Fuchs, Herb Klarman, and Dorothy Rice (although there were some earlier forays, such as Milton Friedman and Simon Kuznets' work on excess returns to medical education and Reuben Kessel's paper on price discrimination in medicine). Nonetheless, I think health economics didn't really begin to emerge as a field until the later 1960s/early 1970s, when people like Patricia Danzon, Mike Grossman, Will Manning, Joe Newhouse, Mark Pauly, Chuck Phelps, and Frank Sloan started to work in the area.

Even so, when I came out of grad school in the early 1980s, while there was high quality work being done in the area, honestly there wasn't much going on. Few PhD students were writing dissertations in health economics (I think my cohort consisted roughly of David Dranove, Paul Gertler, Tom Getzen, Deborah Haas-Wilson, and Shelley White-Means – a pretty great group, but very small), there were no conferences, no real health economics association, no health economics textbooks, and the economics discipline was rather dubious about health economics research – it often wasn't taken seriously, and it was very hard to publish a health economics paper as such in a top economics journal – it had to say something more "general" about economics, otherwise it was regarded as "special," and of limited interest. Moreover, the makeup of health economics reflected the makeup of economics at the time – there were very few women or people of color in the field.

Theory played a greater role in health economics, as did explicit theory-derived modeling in empirical analyses. In addition, while health economics has always had a substantial empirical component, the data available for analysis were much more limited than they are today, and computing power was much, much lower.

Things have vastly changed in health economics since those times, and much for the better. The field is vibrant and growing. The presence of all of you at this conference, and

the high quality of the work you are doing, attests to that. There are so many scientific meetings and conferences in health economics it would be impossible to attend all of them and get anything else done. Health economics research is published in the top general interest journals in economics, the top field journals in industrial organization, labor economics, and public finance (and other fields), and we have four (at least) field journals in health economics, including ASHEcon's own journal, the American Journal of Health Economics (let me express my thanks to the editor, Tom Buchmueller, his co-editors Marianne Bitler, Keith Marzilli Ericson, and Mireille Jacobson, and the editorial board and all of the reviewers for working so hard to make this a first rate scientific journal). Health economists are in editorial positions at the top journals in the discipline and hold prominent positions in economics professional associations. Moreover, health economics and health economists are part of policy discussions in every branch and every level of government. Health economists even publish in medical journals and serve as editors!

In many ways, the field has arrived. We are very successful – we are larger, we are taken seriously, we have attracted energetic new people with fresh perspectives to the field – so take a moment to pat yourselves on the back.

While we have been very successful (I do sometimes have to pinch myself), that doesn't mean that we're there yet. We still have work to do.

While I think we have made progress at making health economics more diverse and inclusive, we still have a long way to go. This is important for the science that we do – we need multiple perspectives and insights to find where to look, formulate questions, and derive fresh, innovative approaches. It's also important to provide opportunities for everyone – we want people thinking about economics or beginning their careers in economics to think of health economics as a hot field, and one that's hot for everyone – where they will be welcomed and supported and have a scientific free hand. I want to thank ASHEcon's terrific diversity committee: co-chairs Kitt Carpenter and Darrel Gaskin, and members Marcus Dillender, Jevay Grooms, Kandice Kapinos, Victoria Perez, and Patrick Richard for all of their hard work to advance diversity in health economics. We've done some important things, like our Diversity Scholars program (I want to welcome all of our terrific diversity scholars who are here for the conference), and have new initiatives in store. This is an area where we need ongoing emphasis and progress to get to where we want to be.

In addition, while we have made tremendous strides in the science of health economics, I believe we are capable of even more progress, and need to focus on doing so. We have taken an increasingly empirical focus as data have become better and more plentiful, and computers have become ever more powerful. This is natural and appropriate. However, I think we need new thinking (and rethinking) about economic theory in order to move the science forward. Let me be clear – by economic theory I mean how we think about the world, the lens we use to view phenomena, and to formulate and test questions. This isn't necessarily highly mathematical (those of you for whom the mere mention of Mas-Colell, Whinston, and Green invokes dread can now breathe a sigh of relief).

First, we need to be clear about the economic phenomena we think we are observing when we do empirical work, and use the insights from our thinking about these phenomena (yes, this is economic theory) to formulate research designs and testing. We may end up using program evaluation econometric approaches, reduced form econometric approaches (from a model), structural econometric approaches, experimental economics approaches (or others), but we need economic theory to tell us what we're testing, how to test it, and what to make of what we've got once we have our estimates in hand. Just to be clear, I'm not here to rekindle the econometrics wars between program evaluation and structural approaches, as entertaining as that might be (it's a false dichotomy anyway). What matters is the right tool for the right job, but whatever the tool, our expertise and comparative advantage is economics, and we should use it.

Second, we need new economic theory to enable us to tackle some of the pressing problems in health economics. These include, but are not limited to, public health/epidemiology, consumer choice, and health disparities. I believe that for each of these economics can provide important insights that give use traction on these problems, but we need new theory.

There has been some work by economists on public health/epidemiology, but not nearly enough (check out the session on "The Future of Health economics – Covid-19 and Beyond" tomorrow at 2:30). If we're going to make contributions as economists to understanding epidemics and developing policies for them, we're going to need to work on our conceptual framework. To do that we're going to need to talk to, and work with, people who have expertise in this area, including epidemiologists, sociologists, and others.

The same applies to consumer choice. There has been a lot of excellent work over the last few years, particularly in analyzing insurance choice, but also in how consumers respond to information about providers, that reveals that consumers don't respond to information and incentives as received economic theory predicts. We need to dig in to understand this behavior and then to build up from that new models of socially optimal insurance coverage. As a result we may very likely need to rethink our understanding of what constitutes optimal insurance.

Health disparities, with some exceptions, have not received enough attention from economists. We are going to have to expand and modify economic theory to understand the sources of disparities and have something useful to say. This means not only accounting for racism, but having a new economic theory(ies) of racism.

In addressing these and other issues we are going to have to think hard, and in new, creative ways. We will need to understand and incorporate insights from a variety of other areas, and not restrict ourselves to solely talking to each other.

While these are all big challenges, they are also exciting opportunities. Health and health care are a fundamental part of the economy, and of economic science. This gives us the opportunity as health economists to not only contribute to our own field, but to act as leaders in advancing economic science generally. I look forward to being on this important journey together with all of you (or "yinz," as we say in Pittsburgh).

Let me conclude on a broader note. We are a welcoming, supportive field. Let's continue and amplify that. Take the time to meet someone new in a session or one of the networking rooms and get to know them a little bit. Established people - think about how you can connect with people who are at the beginning of their careers and help and support them. People beginning your careers - don't hesitate to contact people further along, and reach out to each other for information and support.

Most importantly, let's also bear in mind, that as much as we love economics and ASHEcon, there's more to life than what we do professionally. Enjoy the conference, but take time for yourself and the people in your life. Do a little good, and show a little kindness to others. These are investments that yield rich, ongoing dividends. Thank you, and be well.