We have added slides with text to our original presentation to substitute for the oral presentation we could not make.
Our presentation is inspired by Drew Altman’s recent column on The Wall Street Journal blog:

The Next Big Debate in Health Care

By DREW ALTMAN
Jun 30, 2016 11:04 am ET
With 91% of the population now covered by some form of health insurance, and the coverage rate higher in some states, the next big debate in health policy could be about the adequacy of coverage. That particularly means rising payments for deductibles and their impact on family budgets and access to care. This is about not just Obamacare but also the many more people who get insurance through an employer.
Patient Spending on Deductibles Outpacing Wages

- Deductibles: 256%
- Coinsurance: 107%
- Worker Wages: 32%
- Copayments: -26%

Yearly comparison from 2004 to 2014.
Less delicately put, Drew’s question is how far the rationing of health care by income class can be pushed in this country.

Actually, this is not a new issue. We have wrestled over it for several decades now, albeit in code words.

One of us has written about it over twenty years ago, in 1995.
Turning Our Gaze From Bread And Circus Games

by Uwe E. Reinhardt

Daniel Yankelovich argues that this nation’s recent attempt at health care reform failed largely because the American public failed to “deliberate” properly on the issue. By “deliberation” Yankelovich means “mulling over” the costs and benefits of alternative choices and making tough choices, all in a serious “give-and-take” with the nation’s “leadership class.” Yankelovich places blame for the public’s failure to deliberate squarely on the shoulders of the leadership class, which, according to him, deliberated only within its own ranks.

1993-1994 was not just a technical dispute over alternative means of reaching a widely shared goal. It was a fiercely fought ideological battle over the goal itself. The nation’s leadership class was and remains deeply divided over the ethical precepts that should govern the distribution of health care.

At one end of the ideological spectrum are the pure egalitarians who would like to see health care treated as a social good to be made available to all members of society, on equal terms, regardless of a person’s ability to pay for it. This school of thought would like
When America’s leadership class sets out to debate health policy, its members invariably preface their deliberations with the mantra: “We all want the same things in health care. We are merely arguing over the means to that end.” This is utter nonsense.
The theme of these Altarum symposia has been what can be done to make our health system – especially spending thereon – “sustainable.”

There are many ways to do this, as has been demonstrated by other nations have whose level of health spending and achievement of outcome we must envy.
U.S. Health in International Perspective
Shorter Lives, Poorer Health

The United States is among the wealthiest nations in the world, but it is far from the healthiest. Although Americans’ life expectancy and health have improved over the past century, these gains have lagged behind those in other high-income countries. This health disadvantage prevails even though the United States spends far more per person on health care than any other nation. To gain a better understanding of this problem, the National Institutes of Health (NIH) asked the National Research Council and the Institute of Medicine to convene a panel of experts to investigate potential reasons for the U.S. health disadvantage and to assess its larger implications. The panel’s findings are detailed in its report, *U.S. Health in International Perspective: Shorter Lives, Poorer Health.*
Our argument in this talk will be that in the U.S. we shall seek “sustainability” by rationing more and more health care by income class, which would allow the moneyed elite to enjoy expensive and the sophisticated health care it is unwilling to help finance for everyone.

We are already well on our way to building a system supporting this goal, brick by brick, and quietly, without an open debate on the ethical dimension of the approach.
We reckon that by 2030 at the latest the new, the desired platforms for achieving the goal will largely be in place.
I. ETHICAL PERSPECTIVES ON U.S. HEALTH CARE
At the risk of oversimplifying, one can visualize the division over the distributive ethic to be observed by U.S. health care thus.
ALTERNATIVE VIEWS ON THE PROPER DISTRIBUTIVE ETHIC FOR AMERICAN HEALTH CARE:

- **U.S. Progressives**: A pure social good to be available to all on equal terms and to be financed by ability to pay.
- **U.S. Conservatives**: A private consumption good whose financing is primarily an individual responsibility.
- **Unknown**:
Although anyone can clearly and easily discern these sharply different views on the distributive social ethic of U.S. health care, Americans are invariably reluctant ever to debate them openly, because that could be divisive.

So we talk about it in code words.
AMERICANS CONFRONTING THE ETHICAL DIMENSION OF U.S. HEALTH CARE
To progressives, the very idea of rationing health care by income class is anathema – hence their penchant for a single-payer system that at least try to be egalitarian.

To conservatives, rationing of the timeliness, amenities and quality of health care is not anathema, because we routinely apply it to other basic necessities such as food, housing, education and even the administration of justice. Why should health care be different?
Between these more extreme views on the ethics of health care is the confused, large group of citizens without firm views, at least as long as they are healthy.

They tend to slouch toward the conservative view when healthy and towards the progressive view after a bout with serious illness.
Coupled to the views on the distributive ethics of health care are views concerning the degree to which the supply side of the health care market should be allowed to extract the maximum revenue from the rest of society through their pricing policies.
A PURE SOCIAL GOOD TO BE AVAILABLE TO ALL ON EQUAL TERMS AND TO BE FINANCED BY ABILITY TO PAY

Low tolerance for aggressive pricing and therefore widespread use of price controls.

A PRIVATE CONSUMPTION GOOD WHOSE FINANCING IS PRIMARILY AN INDIVIDUAL RESPONSIBILITY

High tolerance for providers’ freedom to price aggressively and therefore rejection of price controls.
Health policy in the past 40 years basically has been a civil war between the two more extreme views on health care, although, as noted, we have debated it mainly in code words, given our reluctance to confront ethics forthrightly.

On the ground, this civil war has taken the form of a myriad of legislative skirmishes at the federal and state levels, giving victory sometimes to one side and at other times to the other side.

Overall, however, victory has gone to the conservative side.
II. BUILDING THE PLATFORM FOR RATIONING HEALTH CARE BY INCOME CLASS
So what do we need in the structure of a health system designed to ration health care by income – at least a good bit of it? We need two distinct platforms:

A. we need a platform for varying the quality of the health insurance policy by income class, and

B. we need high cost sharing by patients at point of service, to ration health care utilization when illness strikes.
If you think of it, we have been busily building these two platforms during the past 20 or so years, brick by brick.
Health insurance exchanges – public or private – are the ideal platforms for tiering the quality of health insurance by income class. ObamaCare explicitly acknowledges it with its metal tiers.

The instruments for tiering here are

- narrowness of the network of providers
- narrowness of the drug-formularies
- limits on services covered
- other features of the benefit package
The often proposed conversion of the egalitarian Medicare program from its defined benefit structure to a defined contribution structure (the premium support model) is one of the bricks for the desired platform.

Likewise, the idea to move Medicaid beneficiaries out of that defined benefit program onto the insurance exchanges can be interpreted in the same way.
Finally, the conversion of employment-based health insurance from defined benefit- to defined-contribution plans, coupled with private health insurance exchanges, is another brick in the strategy.

It will finally permit the quality of health-insurance coverage within a company to vary by income level.
B. TIERING HEALTH CARE BY INCOME CLASS AT POINT OF SERVICE

High-deductible health insurance policies are *ipso facto* an instrument for rationing health care by income class, unless the deductible were closely linked to income.

One does not need a Ph. D. in economics to realize that a low income family confronted with a high deductible will tighten its belt in health care much more than would a high income family confronting the same deductible.
As already noted, high-deductible health insurance policies are ipso facto an instrument for rationing health care by income class, unless the deductible were closely linked to income.

Similarly, under our progressive income-tax structure, the idea of tax-preferred Health Savings Accounts (HSAs) *ipso facto* makes health care for high income people cheaper than for low income people – an amazing ethical proposition.
III. U.S. HEALTH CARE CA. 2030
At this time, the gradual transformation of our health-care system into one that allows us to ration health care by income is not yet complete.

Part of the problem is that it is not yet politically correct for politicians or the policy wonks who advise them openly to state that rationing by income class is their goal.

The desired structure therefore has to be developed quietly, and so that the general voting public does not know what is happening to their health system.
Indeed, sometimes the steps toward this goal are marketed to the voting public in classic Orwellian lingo – e.g., “Consumer Directed Health Care” (CDHC) that will “enable consumers [formerly patients] to sit in the driver’s seat in health care.”

Absent solid, consumer-friendly information on binding prices and the quality of health care produced by different providers of health care – still typically the norm in the U.S. – CDHC actually has turned out to be a cruel hoax.

For the most part, CDHC has been merely an instrument to ration health care by income.
This study is forcing economists to rethink high-deductible health insurance

Updated by Sarah Kliff on October 14, 2015, 10:00 a.m. ET  @sarahkliff

sarah@vox.com

http://www.vox.com/2015/10/14/9528441/high-deductible-insurance-kolstad
“The idea was that higher deductibles would make patients become smarter shoppers: If they had to pay more of the cost, they'd likely choose something closer to the $1,529 appendectomy than the $186,955 appendectomy.

This study* is forcing economists to rethink high deductible health insurance they'd likely choose something closer to the $1,529 appendectomy than the $186,955 appendectomy. This would push the really expensive doctors to lower their prices so cheaper physicians didn't steal their business.”

* http://www.vox.com/2015/10/14/9528441/highdeductibleinsurancekolstad , 2/9
“Turns out they didn't. The new paper shows that when faced with a higher deductible, patients did not price shop for a better deal. Instead, both healthy and sick patients simply used way less health care.”
We came across the following paper that goes along with our thesis, although we do not know how authoritative these figures are.
Wealthy spending more on health care than poor and middle class, reversing trend
Medical spending per capita, by income group, adjusted for inflation

SOURCES Authors’ analysis of data from the 1963 and 1970 Surveys of Health Services Utilization and Expenditures; the 1977 and 1980 National Medical Care Utilization and Expenditure Surveys; the 1987 National Medical Expenditure Survey; and the 1996-2012 Medical Expenditure Panel Surveys. NOTES Data represent two-year moving averages for years 1996-2012. Data before 1996 are shown for the survey years only; trends between data points are interpolated. The population was divided in each survey year into income quintiles; for simplification, the middle three quintiles were combined since they followed similar trends. Online Appendix Exhibit 8 displays confidence intervals for all estimates (see Note 13 in text).
V. TOWARD “SUSTAINABILITY”
“Sustainability” is a much-mouthered word, although few people using the word actually define it. We can think of at least two distinct meanings:

A. **Economic sustainability** – the ability of the macro-economy to absorb further growth in health spending;

B. **Political sustainability** – the willingness of families in the upper-income strata to subsidize through taxes or health insurance premiums the health care of families in the lower income strata.
A. ECONOMIC SUSTAINABILITY

Because spending on health care is part of GDP, it is actually difficult to define what we mean by “economic sustainability” in health care – hence our habit of putting the word in quotation marks in this presentation.

It is not clear, for example, that more spending on, say, golf courses or breweries or restaurants will add more to future growth in real GDP per capita than would more spending on health care for hitherto underserved populations.

The issue really is what value in other activities we must give up to create more value through health care.
B. POLITICAL SUSTAINABILITY

Here the question is whether or not families in the upper income strata are willing to subsidize for the poor the same kind of health care that families in the upper-income strata would like to have for themselves.

If not, then the search is on for a health system that can ration more and more health care by income.

Our argument is that the U.S. seems to have arrived at that point at least a decade ago.
We do not, at this time, render a value judgment on the merits of this development. It is a matter of ideology and ideas of what is a just society.

But we do wish to register our amazement—indeed, almost our admiration—at the ease with which one faction of the nation’s elite has been able to further this transition – a development of which the voting public hardly seems aware (except when illness strikes).

It can be doubted that the general populace of other countries – France, Germany, the U.K., Canada – would accept this transition with such astounding equanimity.
In an honest referendum, with full knowledge of what is underfoot, the general voting public probably would not support a move to rationing more and more health care by income.

More likely the voting public would opt for a more egalitarian system, which can explain why it is not yet politically correct for politicians openly to advocate rationing health care by income.
Americans Overwhelmingly Prefer This Presidential Candidate's Healthcare Plan, Study Shows

Trump, Clinton, or Sanders: Which healthcare proposal do Americans really prefer, and how might it impact your wallet?

Sean Williams
(TMFUltraLong)
Jun 19, 2016 at 11:41AM
According to Gallup, 48% favored keeping the Affordable Care Act, while 49% opposed it. This probably comes as no big surprise, given Obamacare’s low favorability numbers since it was first signed into law in March 2010.

Some 51% of respondents favored repealing Obamacare, while 45% opposed the idea. In other words, Trump’s healthcare proposal would appear to have a little more steam than Clinton’s.

However, the overwhelming favorite was the single-payer plan offered by Bernie Sanders. Overall, 58% of respondents favored the idea, with just 37% opposing it and another 5% having no opinion.

In a separate question, Gallup asked respondents to choose between putting a single-payer system in place versus keeping Obamacare in place, and single-payer won by an even broader margin -- 64% to 32%.