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LIVING WITHIN LIMITS -- PRACTICAL LESSONS AND MORAL CHOICES:

Where Economics meets Ethics

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“If bread were free, a huge quantity of it would be demanded. Because the resources used to produce bread are scarce, the actual amount of bread has to be rationed among its potential users. Not everyone can have all the bread that they could possibly want. The bread must be rationed somehow; and the price system accomplishes this in the following way: Everyone who is willing to pay the equilibrium price gets the good, and everyone who is not, does not.”

Michael L. Katz and Harvey S. Rosen, *Microeconomics*, (1991): 15.

“In open markets, prices serve a rationing function in determining how much of available quantities each consumer will get.”

Edgar K. Browning and Jacqueline M. Browning, *Microeconomic Theory and Applications*, 2nd. ed. (1986): 161.

I. What is “Rationing”?

In a discussion on the need to “ration” health care in America, it is not pedantic to inquire precisely what is meant by that politically charged word.

Dictionaries are not much help in this regard, because they remain vague. *The American Heritage Desk Dictionary*, for example, interprets the verb “to ration” as “to distribute or make available in fixed, limited amounts during periods of scarcity” or “to restrict to limited amounts.”¹ That definition may suggest purely administrative mechanisms to some, but it can also accommodate the allocation of scarce resources through market prices and ability to pay.

In economic theory and in public discourse on health policy, it seems more meaningful to interpret the word “rationing” as *any* method of allocating limited resources to unlimited wants, as is the wont of some well trained economists², though perhaps not all³. On that approach, one distinguishes between “price-rationing” and “non-price rationing”⁴ and then explores the relative merits and demerits of each approach in terms of some agreed-upon criterion of “social welfare.” In general, economists consider price-rationing as less problematic than non-price rationing, although honorable people can disagree honorably that this judgment applies to all cases.

By “price rationing” here is meant the allocation of scarce resources through the price system in a free market, on the basis of the individual’s willingness and, lest we forget, *ability to pay* the going market price for the scarce resource in question. By “non-price rationing” is meant the allocation of scarce resources through administrative mechanism – e.g., ration coupons or queues (time-prices).

¹ The American Heritage Desk Dictionary (1981): 785.

² Larry Katz, for example, is a distinguished professor of economics at Harvard University. Harvey Rosen is a Harvard trained professor of economics who recently chaired President George W. Bush’s *Council of Economic Advisors*.

³ Henry Aaron of the Brookings Institution, for one, rejects the term “price rationing” as meaningless and confusing.

⁴ In this connection, see Uwe E. Reinhardt, “Rationing Health Care: What it is, what it is not, and why we cannot avoid it,” in Stuart H. Altman and Uwe E. Reinhardt, eds. *Strategic Choices for a Changing Health System*, Chicago, Ill.: Health Administration (1996): 63-100.

It is important to clarify these definitions in the current debate on U.S. health policy, because the “free market approach” so often is sold to the public as a means to avoid “rationing.” Economists and health policy analysts who embrace a more inclusive definition of rationing – this author included – consider that statement highly misleading. On that view, it is not at all meaningless to distinguish between “price rationing” and “non-price rationing.” On the contrary, it seems dubious to tell American families with a family income of, say, \$40,000 and chronic illness in their midst that a health insurance policy with a deductible of up to \$10,500, is a way to avoid “rationing”.

Surely no one will pretend that, when switched from comprehensive insurance coverage to a health-insurance policy with a very high deductible, a family headed by two professionals each earning, say, \$150,000 or so a year and saddled with chronic illness will alter its health-care behavior in quite the same way as would a family saddled with similar chronic illness but with a family income of only \$40,000 a year. It seems more honest to admit forthrightly that the high-deductible policies now being proposed in conjunction with tax-preferred *Health Savings Accounts (HSAs)* – which by themselves favor the well-to-do financially --will have the intended or unintended consequence of rationing health care more than has hitherto been the case by income class. One can then debate the merits of that approach to overall cost containment versus alternative approaches, including sundry types of non-price rationing.

II. IS RATIONING HEALTH CARE AN IMPERATIVE FOR THE U.S.?

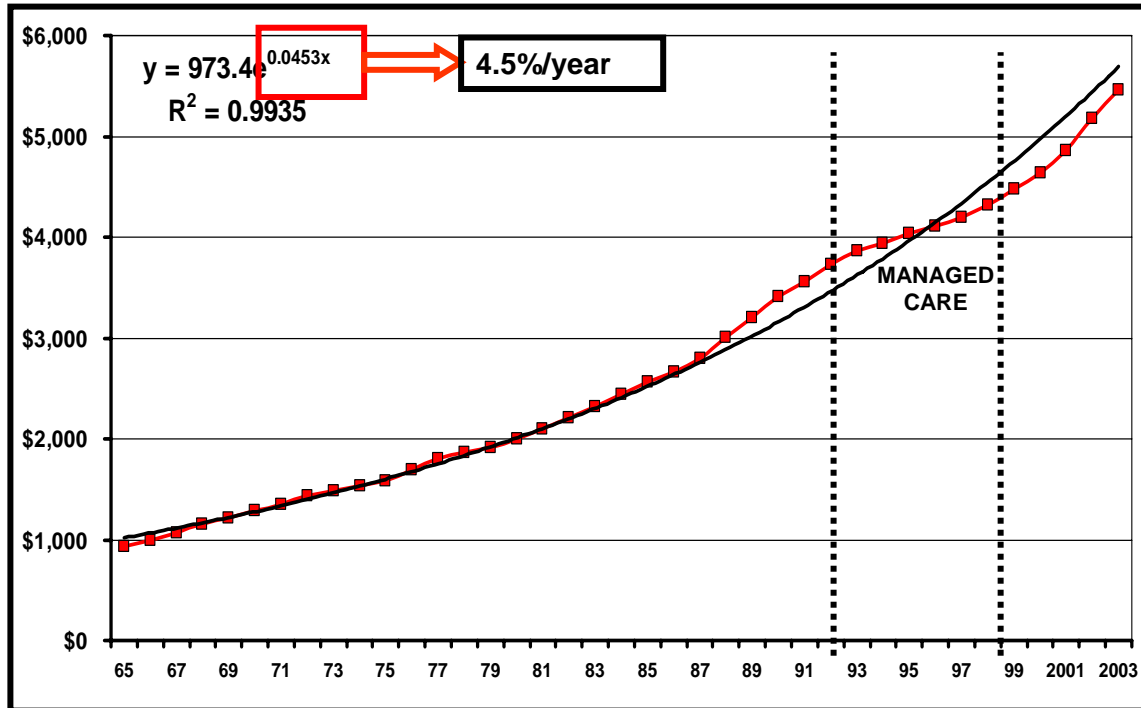
It can be asked whether the topic of “rationing” is actually of relevance to an American audience, because it may *seem* that there never has been an official policy to ration health care in this country and no such policy *seems* to be on the horizon. The answer to this question is, as usual in health policy, an unambiguous “Yes and No.”

A. The *2½% Rule of U.S. Health Spending*

From a bird's-eye view it would appear that the only practical limit to health spending in the United States during the past four decades has been the health-care sector's inability or unwillingness to claim an even larger fraction of the GDP than it did. For some reason, the sector has contented itself, or mysteriously been made to content itself through forces not well understood, with the famous *2½% Rule of U.S. Health Spending* according to which, on average, though not every single year, over the past four decades the U.S. health-care sector has succeeded in growing about 2½ percentage point faster per year than the rest of the GDP (see Figures 1 and 2 overleaf).

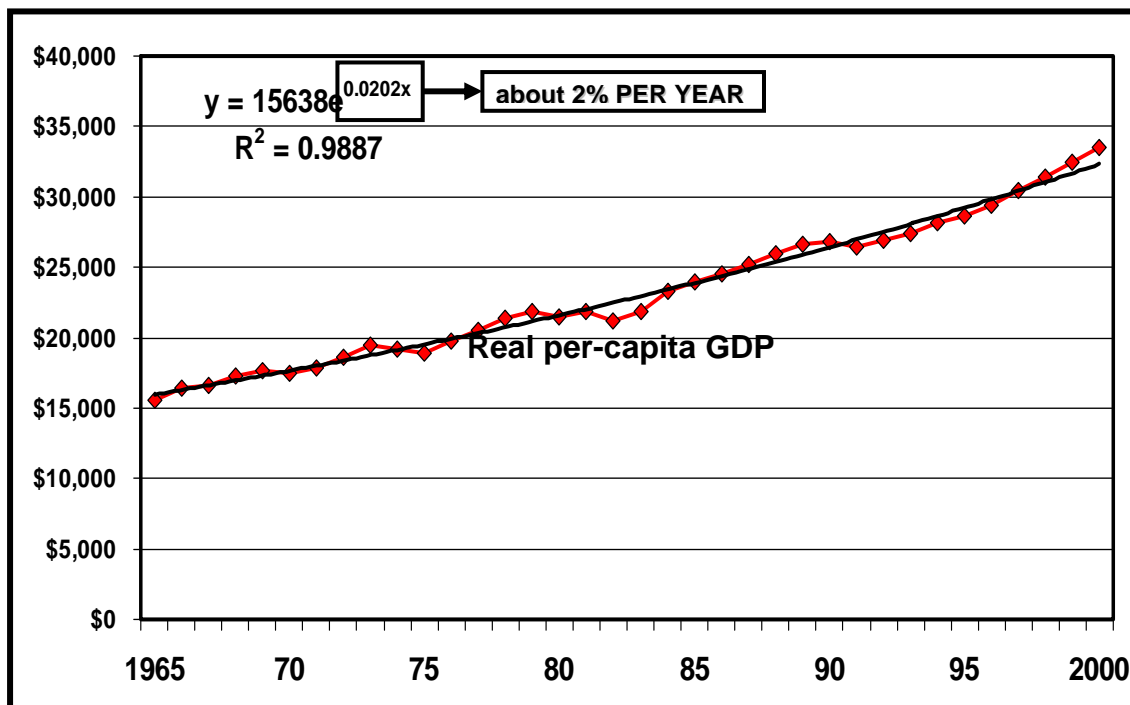
Whatever force kept the *2½% Rule of U.S. Health Spending* at that level, rather than at 3 or 4 percentage points, it has begotten a health system in which few if any well-insured Americans would be likely to have experienced the rationing of health care, even in the era of managed care. There have been few if any barriers to access to available health care resources for such Americans. Whatever limits to “more health care” they may have faced has been the speed at which new human or physical resources were put in place by the health-care sector.

**FIGURE 1 -- TOTAL REAL HEALTH SPENDING PER CAPITA 1965 – 2004
IN CONSTANT YEAR 2000 DOLLARS (GDP DEFLATOR)**



SOURCE: CMS website and President's Economic Report to Congress, 2004.

**FIGURE 2 -- TIME PATH OF REAL (INFLATION ADJUSTED) GDP PER CAPITA
UNITED STATES, 1965-2000**



SOURCE: Economic Report of the President 2002: Tables B4 and B34.

The only Americans who would have felt rationed out of desired health care somehow would be some of the nation's millions of uninsured, or Medicaid and TRICARE beneficiaries unable to find physicians willing to treat them at these programs' low fees, or elderly Americans unable to afford with their own resources prescription drugs or other health-care goods and services not covered by Medicare.

For all other Americans the very word "rationing" in health care is still entirely alien and, if uttered, conjures up fears topped only by the words "Al Qaeda."

B. Can America "Afford" the 2½% Rule of U.S. Health Spending?

The 2½% Rule of U.S. Health Spending has long driven the forecasts by the actuaries of the Centers of Medicare and Medicare Services (CMS), who now predict on the strength of that rule that, by 2015, total national health spending in the U.S. will absorb 20% of U.S. GDP, up from 16.5% in 2006.⁵ It can be calculated that, if the 2½% Rule continues to rule U.S. health sector for the next four decades, as it has in the past, the U.S. health sector will absorb roughly 37% of projected GDP by 2050. (Fortunately, it is mathematically impossible for health spending ever to absorb exactly 100% of GDP. It can only asymptotically approach that level, sometime in the next millennium.)

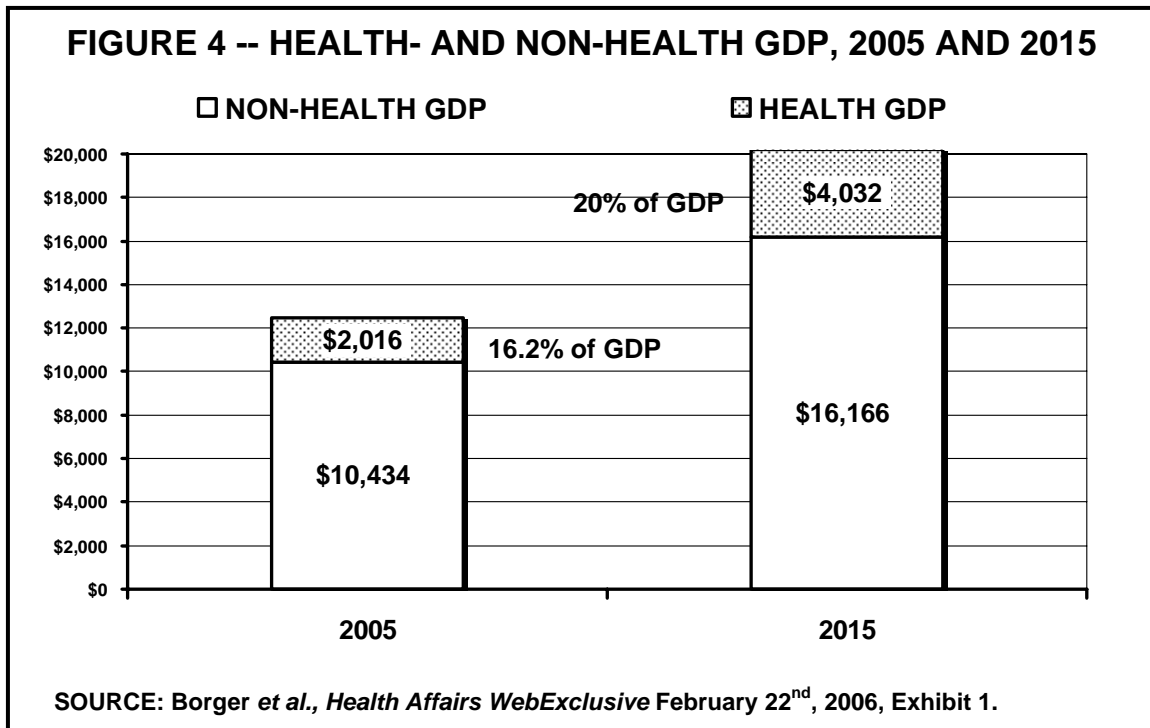
Can the U.S. actually "afford" such health spending, that is, is the 2½% Rule actually "sustainable," as the *nouvelle mot* among politicians goes?

"Affordability": A remarkable fact is that, for at least the next decade, the U.S. GDP actually can easily absorb these health spending trends without reductions in the supply of non-health goods and services, as is shown in Figure 4. In 2005, total U.S. GDP was \$12.45 trillion, of which \$2 trillion or 16.2% was absorbed by the health care sector. Current projections are that, by the year 2015, total U.S. GDP will be \$20.2 trillion, of which about \$4 trillion or 20% will be absorbed by health care. This will leave a total of about \$5.7 trillion additional non-health GDP more in 2015 than was available in 2005. Adjustment for inflation would change these numbers somewhat, but would not invalidate the general point made here.

Only after 2030 or so will the availability of non-health goods and services gradually begin to shrink, not only as a fraction of GDP, but also in absolute quantities.⁶ Whether even such an enormous allocation of GDP to health care could be justified, however, is not at all a matter of "affordability", a word that are not really useful in this context. It would depend strictly on the *value* such spending would yield society, in its eyes. Indeed, it does not take much imagination to conjure up scenarios under which such health spending might well be deemed worth it by the bulk of the U.S. population. The issue in health care is not "affordability," but "benefits vs. opportunity costs" and, as will be mentioned further on, the politics of sharing, that is, political "sustainability."

⁵ Christine Borger, Sheila Smith, Christopher Truffer, Sean Keehan, Andrea Sisko, John Poisal, and M. Kent Clemens, "Health Spending Projections Through 2015: Changes On The Horizon" *Health Affairs*, March/April 2006; 25(2): w61-w73.

⁶ Michael E. Chernew, Richard A. Hirth, and David M. Cutler, "Increased Spending On Health Care: How Much Can The United States Afford?" *Health Affairs*, July/August 2003; 22(4): 15-25.



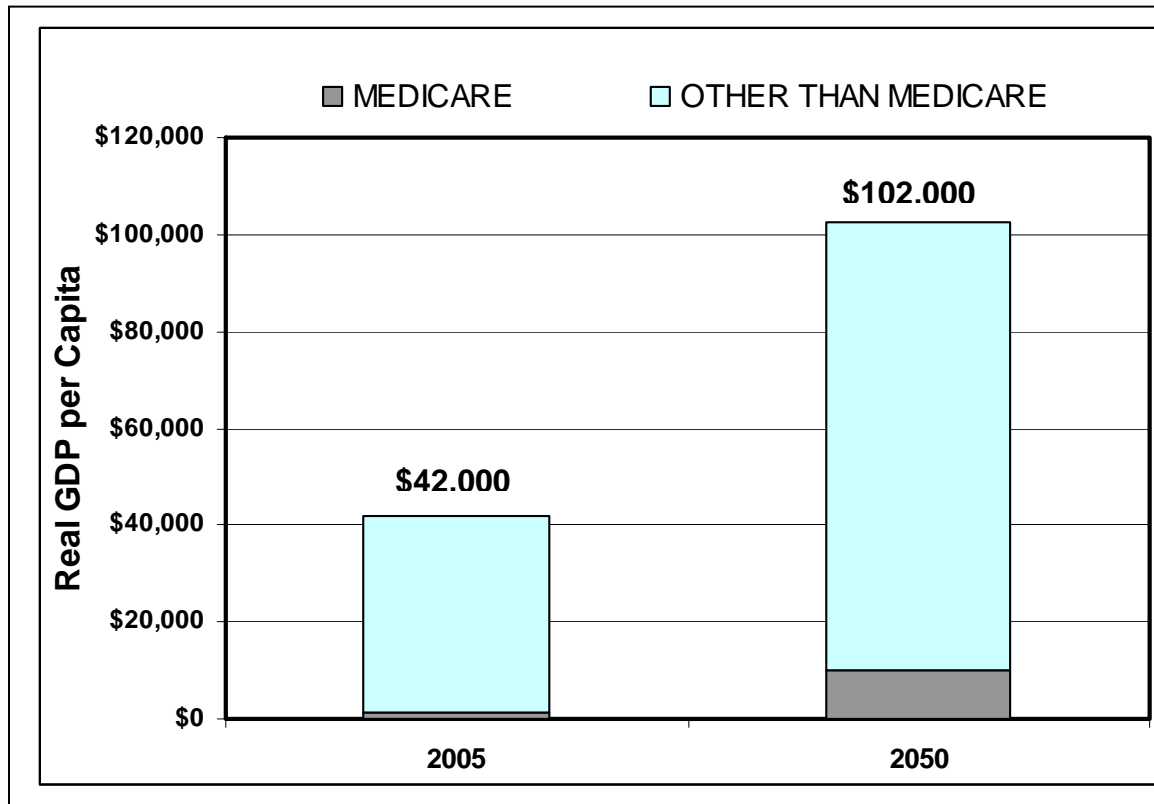
What has been said here about U.S. health spending overall also applies to the Medicare program, which is now almost axiomatically held to be “unsustainable.”

The Trustees of the Medicare Trust Fund project in their 2004 report, unless “restructured” (whatever that may mean), by 2050 Parts A, B and D of Medicare will absorb close to 10% of U.S. GDP, compared with only 3.5% in 2004 (see Figure 6). On the surface that projection may be daunting. How could the nation’s GDP in 2050 absorb an outlay of 10% for Medicare alone, let alone other health spending?

The key to the answer is future economic growth. It was noted earlier that real (inflation-adjusted GDP) per capita in the U.S. has risen on average by about 2% per year during the past four decades. If that rate of growth were sustained in the future, then real GDP per capita will rise from about \$42,000 in 2005 to about \$102,000 by 2050. Even if 10% of that GDP were set aside for Medicare, it would still leave \$92,000 of non-Medicare GDP in 2050, compared to only \$40,000 in 2005. (See Figure 5 overleaf). It would hardly break the back of people living in 2050.

Of course, the gradual aging of the population might slow down the growth of real GDP per capita in the future. Suppose, then, real GDP per capita grew only at 1.5% per year from now until 2050. Total real GDP per capita would then be \$82,000 by 2050. Even that amount should be more than adequate to absorb projected Medicare spending and still leave over much more non-Medicare GDP per capita than Americans enjoyed, on average, in 2005.

Figure 5 – Medicare’s Share in Real GDP per Capita in 2005 and 2050
Assuming real GDP per capita growth at 1.5% per year

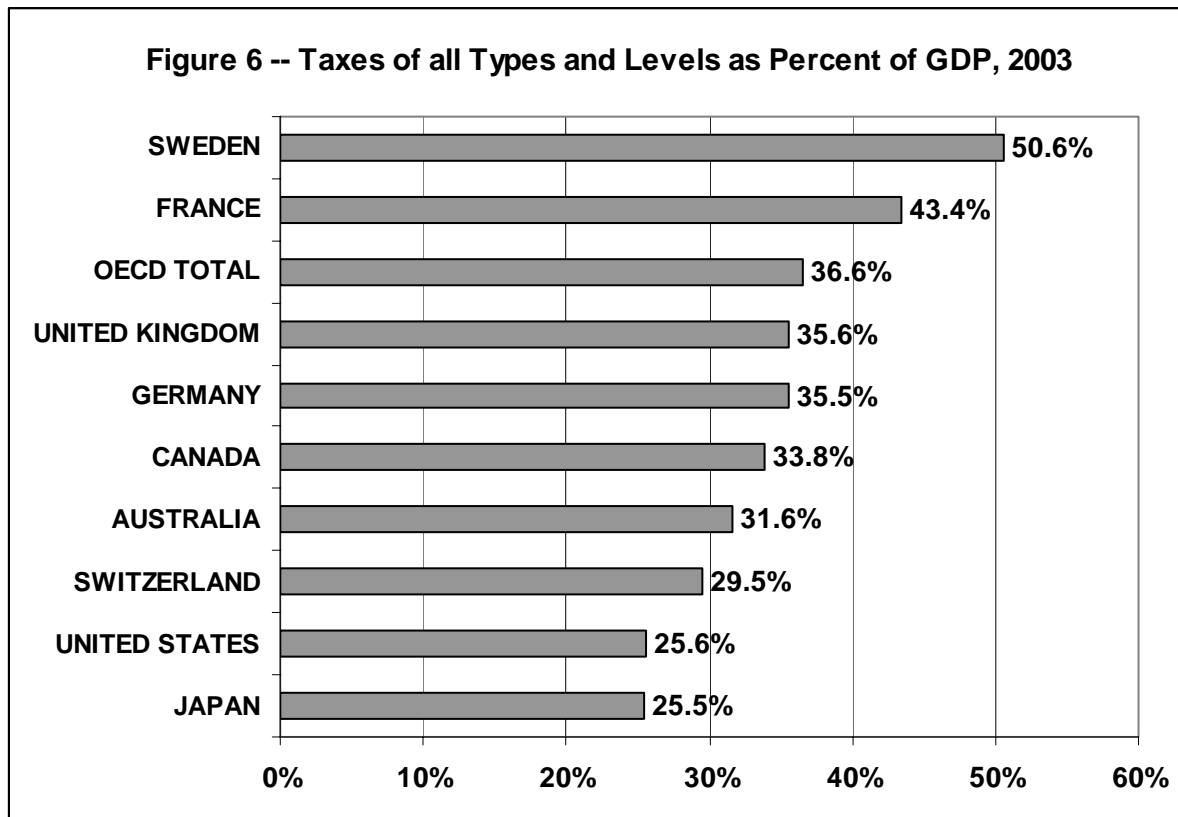


The Political Economy of Sharing: The word “sustainability” does take on meaning in the context of the political economy of *sharing*, that is, in connection with the question whether Americans in roughly the upper third of the nation’s income distribution will be *willing* to pay the added taxes needed to help supplement the health-care budgets of Americans in the lower third of the income distribution, if all Americans are to have roughly the same access to available health care.

Here it must be noted that, along with Japan, the United States now has the lowest ratio of all taxes of all types, at all government levels, to GDP in the OECD. By international standards, the U.S. can hardly be judged to be overtaxed (see Figure 6 overleaf).

The political economy of sharing is often styled as one of macro-economic growth. In fact, it is really one of social ethics. In economic theory, high taxes are only indirectly linked to macro-economic growth, and even there without great certainty.⁷

⁷ The issue is whether higher taxes stunt the overall economic growth of GDP. Although many opponents of taxes take it for granted that it does, the fairly large, rigorous economic research literature is far less conclusive on the linkage between overall taxation and economic growth. Furthermore, as is so often the case in modern economics, that research literature seems to have roots in different camps of economists, each situated on different segments of the ideological spectrum.



SOURCE: www.OECD.org/document/15/0,2340,en_2649_32427_35472591_1_1_1_137427,00.html

Even so, whether judged mainly ethical or mainly macro-economic, the issue of added taxes to subsidize health care is politically challenging in a nation in which tax cuts have come to be viewed as the solution to virtually all social and economic problems, and in which the willingness by upper-income Americans to share their good fortunes with families in the lower-third of the income distribution appears to have reached its limit, in spite of the relatively low levels of taxation enjoyed by Americans.

C. Pricing Low-Income Americans out of Health Care

The CMS actuaries currently project that per-capita health spending in the U.S. will grow at an average annual compound rate of 6.3% over the next decade, from \$6683 in 2005 to \$12,320 in 2015. That figure, however, includes many items other than personal health care proper. More relevant for our purposes is the projected growth of premiums for employment-based health insurance.

According to the latest *Employer Benefit Survey* conducted annually by the *Henry J. Kaiser Family Foundation*,⁸ the group health-insurance premiums paid by employers on behalf of their

⁸ The Henry J. Kaiser Family Foundation, *Employer-Benefit Annual Survey 2005*, <http://www.kff.org/insurance/7315/upload/7315.pdf>.

employees increased at rates in excess of 10% during 2001-2004 (13.91% in 2003) and at 9.2% during 2005. These averages, however, obscure from view the wide variation of premium increases around these averages. The 2004 Kaiser survey of employers revealed that for many smaller business firms, premiums are still rising at rates in the mid teens or even exceeding 20%. According to the same survey, workers' earnings during this decade have increased at annual rates below 3%.

According to the *Milliman Medical Index*⁹, the average total spending on personal health care for a "typical American family of four" with employment-based health insurance coverage, averaged over all such families, healthy or not, and including premiums paid by either employer or employee, along with out-of-pocket spending for health care by employees, was \$12,214. That figure can be viewed as the actuarial average cost of keeping a typical American family of four in health care as Americans have come to expect it. The figure dovetails nicely with the finding from the Kaiser Foundation survey of employers, according to which the employer- and employee-paid premium for "family coverage," averaged over all plans in 2005, was \$10,880, with only a small variation in the average premium of particular types of plans about this overall average for all plans.

Finally, according to the U.S. Census Bureau, roughly one third of American families have a family income below \$40,000¹⁰ or so, and a quarter of all workers are reported to work at wages below \$20,000.¹¹

Putting these facts and trends together suggests an emerging scenario during the coming decade in which the gross wages of low-income American workers -- the source of financing for all employer- and employee-paid fringe benefits, taxes and the employees' take-home pay -- will be just too small a donkey to carry the much more rapidly increasing load of health care for the families of such workers. Even at a premium growth rate of only 8% for the next decade, for example, a family health insurance policy that now costs \$10,000 will cost \$21,000 ten years hence, while a gross wage base of, say, \$30,000 will have grown to only about \$40,000 at current trends in wage increases.

Employers will initially try to respond to the emerging premium squeeze by shifting more and more of the cost of the health care of their employees out of insurance premiums and into out-of-pocket spending by the employees themselves. The instrument for this shift will be what is euphemistically marketed now as *Consumer Directed Health Care*, which are code words for "health insurance policies with very high deductibles, coupled with so-called Health Savings Accounts (HSAs) into which employers can make deposits that are not counted as the employee's taxable income, or into which employees themselves can make tax deductible deposits to defray out-of-pocket spending."

At this stage, the words *Consumer Directed Health Care* can fairly be called a clever marketing euphemism, because very few Americans now have access to the basic information envisaged by the economic theory of competitive markets. Where in the communities in which members of this audience live can they get adequate, reliable information on the prices and the

⁹ Milliman Medical Index (MMI), http://www.milliman.com/research_resources/healthcare/Milliman_Medical_Index_Final.pdf

¹⁰ U.S. Department of Commerce, Bureau of the Census, Bureau of the Census website <http://ferret.bls.census.gov/macro/032003/faminc>. The number in 2002 was \$35,000, not \$40,000 (my rough estimate).

¹¹ *Business Week*, May 4, 2005: 58. The number on 2004 was \$18,000.

quality of services of individual providers of health care in their communities? Bold promises aside, it is far from clear when such information will be available to them, for similar promises were made in the past decade and eventually broken.¹²

Ultimately, many business firms, or large ones with a predominantly unskilled workforce, are likely to drop employer-provided health insurance altogether, thus feeding the growing pool of uninsured Americans in the decade ahead. American taxpayers then face the choice either of

(a) stepping up to the government’s cashiers window, there to pay higher taxes for the purposes of subsidizing the health care of low-income Americans, or

(b) asking policymakers to devise an algorithm that price-rations health care in America more and more by price and ability to pay, that is, by income class.

The coming decade will reveal which route this nation will choose, because the choice set forth above will be upon the nation within this coming decade.

D. Rationing under “Consumer Directed” Health Care

Option (b) above, that is price-rationing by income class, is readily implemented with the so-called “HSA” strategy, which is another shortcut term for “health insurance policies with very high deductibles (up to \$10,500 per family), coupled with tax-preferred *Health Savings Accounts* (HSAs).” The implications of that approach for the rationing health care and for the distributive ethic of the American health system can be summarized as follows:

1. The tax-preference accorded the HSAs has long been inherent in the tax-preference accorded employer-provided healthcare. It is now to be extended to all Americans, provided that they purchase high-deductible health insurance policies. That makes the idea almost seem fair from one perspective¹³. At the same time, the permanent adoption of this tax preference will complete and permanently cement in place a tacit acceptance of the idea that, on an after-tax basis, health care in America should be *cheaper* in absolute dollars for high-income Americans (facing high marginal tax rates) than for low-income Americans (facing lower marginal taxes). One can wonder how many Americans would judge this “fair.”

2. Unless the maximum loss to which American families will be exposed under the construct of high-deductible health insurance policies (HDHI) and HSAs is made to rise with family income, the construct will naturally delegate the bulk of

¹² The national Blue Cross and Blue Shield Association, for example, had announced with great fanfare a website *RxIntelligence™* which promised to provide “all stakeholders” in health care with information on the cost-effectiveness of alternative prescriptions drugs in therapeutic groupings. That website is now defunct, less than half a decade after it had been launched.

¹³ From that perspective, the tax preference would appear fairer still if it were granted to all Americans, regardless of whether or not they purchased the high-deductible policies politicians now wish them to purchase.

the task of cost containment in health care to families in the lower half of the income distributions. In other words, the intended or unintended effect of the HDHI-HSA construct is to ration health care substantially by price and ability to pay, that is, to ration health care by income class.

3. Relative to the more comprehensive health insurance to which the bulk of Americans have become accustomed, the HDHI-HSA construct inexorably shifts more of the financial burden of health care out of the budgets of chronically healthy Americans and into the budgets of chronically sick Americans who account for over half of total national health spending.

One should not reject this distributive ethic inherent in the HDHI+HSAs construct out of hand. On the other hand, it is eminently fair to remind the proponents of HDHI+HSAs that it represents a major shift in the distributive ethic for our nation's health system, and that such a shift should be debated openly and forthrightly. After all, one wonders whether this ethic and the style of rationing it envisages conforms at all to the ethical values one might discover among the American population.

III. Analytic Ways to Think about “Rationing” in Health Care

A health-care system offers the rest of society the ability to wrestle “better health” from nature's course, given the life style of the population. Practically, health-services researchers have come to measure the fuzzy term “better health” by the metric of the QALY, which stands for “quality-adjusted life years.”¹⁴ At least conceptually, added QALYs are achieved even if physical life expectancy is not changed, merely by changing the quality of life of an unchanged life expectancy. Although the metric QALY remains controversial among ethicists¹⁵, it is widely used by health-services researchers and by policy makers inspired by them.

A. Non-Medical Producers of QALYs

As is well known among health-services researchers, if added QALYs really were society's overarching objective, then added QALYs could also be achieved, and often at lower monetary cost, simply by changing the life styles of the population.

As was reported only recently by James Banks *et. al* in the *Journal of the American Medical Association*, for example, the life style of Americans – including possibly the much heavier work load assumed by Americans and the many risks visited upon the Americans that are mitigated or eliminated in other societies through social insurance of various types – are not particularly conducive to good health.¹⁶

¹⁴ One very intuitive of several ways to construct QALYs is to describe carefully to a set of respondents in a survey a particular health status and then to ask them how many years in *perfect* health the respondents would equate to living in the described poorer health status for, say, 10 years. If the respondents answer, say, 8, then 10 years in the poor health status would be scored as 8 QALYs.

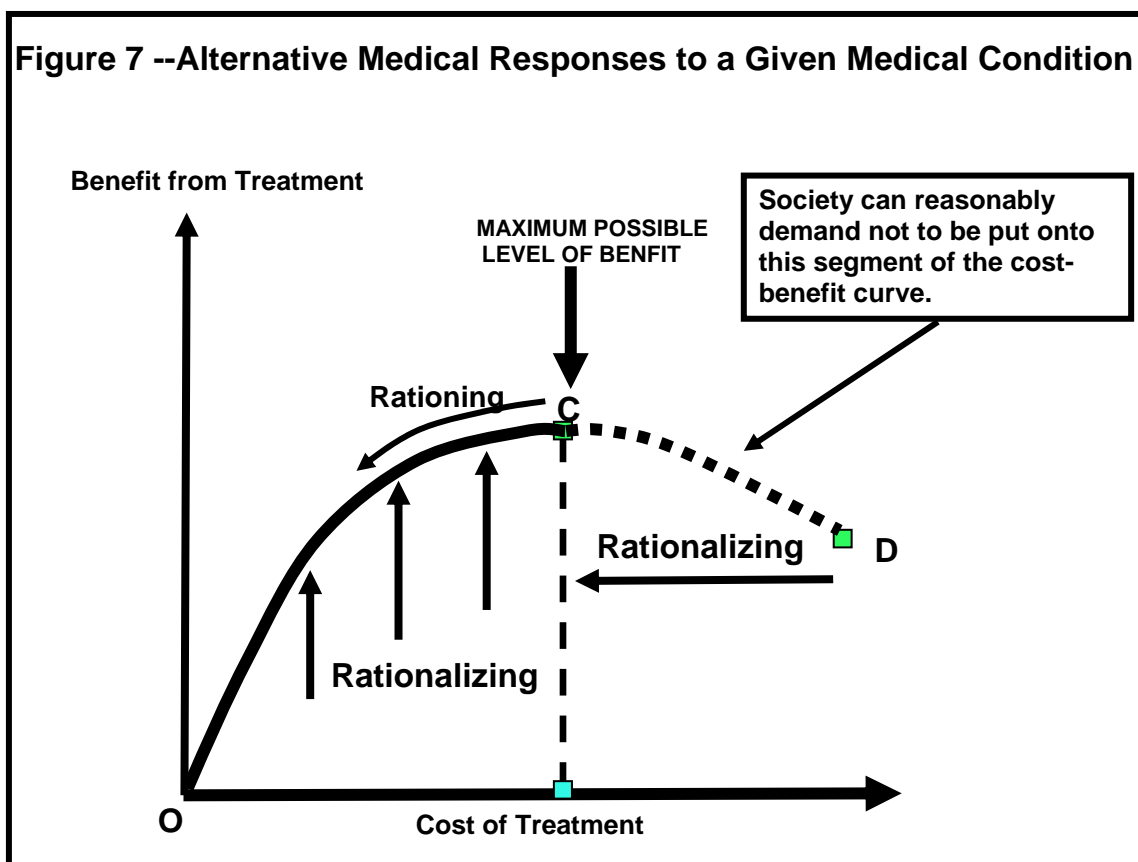
¹⁵ See, for example, John McKie, Jeff Richardson, Peter Singer and Helga Kuhse, *The Allocation of Health Care Resources: An Ethical Evaluation of the 'QALY' Approach*, Dartmouth Publishing Company/Ashgate Publishing Ltd. (1998).

¹⁶ James Banks, Michael Marmot, Zoe Oldfield and James P. Smith, “Disease and Disadvantage in the United States and England,” *Journal of the American Medical Association* 295(17), May 3, 2006: 2037-45.

Society, however, may have a strong preference for the life style, unhealthy or healthy, it has adopted and then look to its health-care sector to add to the QALYs which that life style would otherwise bestow on society. In what follows, we take the chosen life style as given and immutable.

B. Rationing vs. Rationalizing

In principle, the outright “rationing” of health care -- that is, the withholding of potentially beneficial treatments for budgetary reasons or for want of adequate physical capacity – should be deemed necessary only if all health care currently is being produced efficiently by the health sector. Getting to that efficient trade-off frontier is called “rationalizing,” which is, alas, typically equated by the providers of health care as “rationing”. When the production of health care is “rationalized,” one reduces resource use without hurting patients. Figure 7 illustrates that idea.



As is well known, the U.S. health system now is not anywhere near the efficient trade-off frontier at which genuine rationing comes into play. Just this week *Business Week's* cover (May 29, 2006) carries the headline “MEDICAL GUESSWORK: From heart surgery to prostrate care, the medical industry knows little about which treatments really work.” The article begins with a story in which David Eddy, the well known expert on cost-effectiveness in health care, demonstrated to a group of Kaiser Permanente physicians that a simple regimen of aspirin and generic

drugs to lower blood pressure and cholesterol was more effective than more expensive, conventional approaches to treating patients with diabetes. Shifting from expensive, less effective treatments to cheaper, more effective treatments certainly is not rationing although, once again, physicians and the pharmaceutical companies standing behind them may well argue that it is.

For over two decades now John Wennberg and his associates at Dartmouth University have made it abundantly clear to Congress that the monetary prices at which different regions in the United States, and different institutions within regions, produce added QALYs varies enormously across regions and institutions, in ways that have never been defended by the medical profession. Recently published empirical work by the Dartmouth researchers supports the hypothesis that there is no correlation at all between these variations in per-capita spending on health care and clinical outcomes or patient satisfaction.¹⁷ Other work has suggested that the correlation between per-capita health spending and the process-quality of care actually is negative.¹⁸

Given the widespread inefficiency suggested by Wennberg *et al.*'s work, talk of the "unsustainability" of, say, the Medicare program and of "rationing" health care more severely than it already is for at least some Americans, seems premature and misplaced. There is something truly grotesque in Congress' decades' old lack of interest in the drivers of the huge cost variances reported by Wennberg *et al.*, when so many members of Congress and their staffs have lamented for just as many years that the Medicare program is "unsustainable" and must be "restructured." "Restructuring," of course, is merely these politicians' code word for the idea that the elderly should be made to bear a larger proportion of the cost of their health care which, in turn, implies that price-rationing should be applied to at least some types of care used by the elderly.

Probably the best explanation for Congress' longstanding disinterest in the Wennberg variations is Bruce Vladeck's thesis that that Congressional policy on Medicare all along has been much less about the health care and health status of America's elderly citizens than about the distribution of tax revenues among regions of the country and among provider interest-groups.¹⁹ It leaves one cynical, but at least reassured that Congress is not totally irrational.

C. A Health System's QALY Supply Curve

The preceding remarks can be summarized, in rough and ready fashion, in Figure 8 below. In that sketch, the points above the solid curve should be thought of as regional health systems or institutions within regions that deliver added QALYs at varying degrees of cost-effectiveness, that is, incremental costs per added QALY. The solid line represents cost-effective points and, therefore, can be thought of the as the *least-cost* QALY-supply curve with which an efficient health system would confront the rest of society.

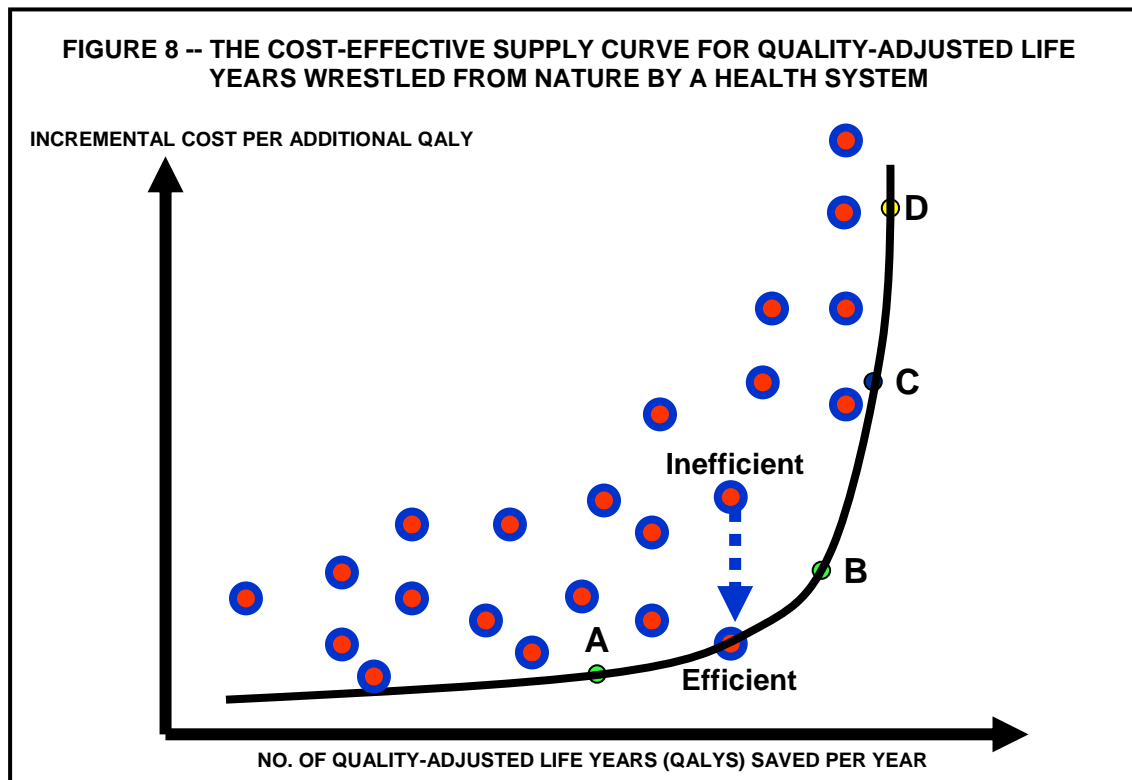
Driving the interior points in Figure 8 down towards the efficient (least-cost) QALY-supply curve is the proper task of the managers of our health system, aided by the insights from health-services research or provided by other management experts.

¹⁷ David C. Goodman, Thérèse A. Stukel, Chiang-hua Chang, and John E. Wennberg, "End-Of-Life Care At Academic Medical Centers: Implications For Future Workforce Requirements", *Health Affairs*, March/April 2006; 25(2): 521-531.

¹⁸ Katherine Baicker and Amitabh Chandra, "Medicare Spending, The Physician Workforce, And Beneficiaries' Quality Of Care," *Health Affairs* Web Exclusive, April 7, 2004.

¹⁹ B C Vladeck, "The political economy of Medicare" *Health Affairs*, January/February 1999; 18(1): 22-36.

Deciding at what price the rest of society will purchase additional QALYs from its health sector, however, is not the job of either health-care managers, health-services researchers or health policy analysts. It is, at its core, a purely political decision which, in turn, reflects the distributive ethic that society wishes to impose on its health care system.



In principle, any discussion of “rationing health care” therefore should be preceded by a forthright public debate on the distributive ethic that should drive our health system. Other nations do this routinely when they discuss health policy and health reform, rejecting out of hand proposed policies that violate the nation’s distributive ethic for health care.

Unfortunately, Americans are extremely reluctant to venture into that territory. They regard it as too “ideological” and, worse, purely “political,” acting as if either term were unsavory. Americans therefore tend to debate and implement health policy as what they think of as a series of technical fixes, letting the distributional effects from those fixes fall where they may. In other words, Americans have long treated the formulation of a social ethic as a mere by-product of technical fixes. The current reform proposals centered on high-deductible health policies (a.k.a. HSAs or “Consumer Directed Health Care”), for example, are a classic manifestation of this tendency.

III. Ethical Perspectives on the “Rationing” of Health Care

Suppose that, by some miracle, the U. S. health system had descended from its present scatter of inefficient points illustrated in Figure 5 to the efficient, least-cost QALY-supply curve.

Suppose further that there were no objections to QALYs as a compact measure of the system's output, as in fact there are.²⁰ The question then would be up to what price American society should purchase added QALYs from its health-care sector, if there were such a maximum in the first place.

Here one could think of several distinct approaches, and many hybrids in between, to wit:

- A. the free-market approach;
- B. a multi-tiered approach;
- C. a purely egalitarian approach.

Each of these approaches warrants a brief comment.

A. The Free- Market Approach

Under a purely free-market approach, without government invention, each family would have a maximum bid price at which it would be willing to purchase additional QALYs. Although personal preferences might play some role in that decision, the binding constraint would be the family's ability to pay for added QALYs. The maximum price society would pay per life year then would be the maximum bid price offered by the wealthiest persons in society.

On the free-market approach, it makes perfect economic sense for society routinely to forego the purchase of low-cost QALYs for some members of society – e.g., children in low-income families -- all the while countenancing with equanimity the acquisition of added QALYs at extraordinarily high prices for others, even for terminally ill persons. It is so because, under this approach, the social value imputed to health services would be in large measure a function of the recipient's wealth. As I have written elsewhere, a good many American economists would be willing to certify such an arrangement as "efficient" and, thus, good.²¹

Ironically, since the enthusiastic embrace of free-market doctrine by the Communist leadership of the Peoples Republic of China, that country's health system has slouched more and more towards this particular distributive ethic. By contrast, and just as ironically, the ostensibly capitalist Republic of China (Taiwan) now finances health care with a single payer system and aspires to a purely egalitarian distributive ethic for health care.

B. A Multi-Tiered Approach

Few societies actually still operate their health systems on a purely free-market approach. Instead most nations seek to provide at least some government-financed guarantees for added QALYs, within more or less fixed public budgets. Even the Peoples Republic of China, whose health system comes closest to the free-market extreme, is now desperately seeking to

²⁰ See, for example, John McKie, Jeff Richardson, Peter Singer and Helga Kuhse, *The Allocation of Health Care Resources: An Ethical Evaluation of the 'QALY' Approach*, Dartmouth Publishing Company/Ashgate Publishing Ltd. (1998).

²¹ Uwe E. Reinhardt, "Can Efficiency in Health Care be Left to the Market?" *Journal of Health Policy, Politics and Law*, 26(5), October 2001; pp. 967-92.

reestablish such a bottom tier with the limited resources available to the Chinese government through tax revenues.

In terms of Figure 8, such systems may explicitly or implicitly set a maximum price (such as points B or C on the solid QALY-supply curve) at which they are prepared to purchase added QALYs for everyone with *collective* tax- or insurance funds, but permit individuals who have the means to do so to purchase added QALYs at higher prices, with their own resources. The *National Institute for Clinical Evaluation (NICE)* of the British *National Health Service (NHS)*, for example, is said to use an upper limited £30,000 (about \$50,000) for the price at which it recommends that the NHS purchase added QALYs with tax funds²², although individual citizens in the U.K. can purchase added QALYs at higher prices with their own funds (or through private health insurance) from the country's budding private health-care sector.

In the United States, the State of Oregon under then Governor Kitzhaber had attempted a formal two-tiered approach, one for citizens entitled to the tax-financed Medicaid program, and another tier for privately insured citizens. The budget set for Medicaid by the State legislature determined the maximum price Medicaid would pay per added QALY for its beneficiaries, thus excluding from coverage some treatments or procedures that were covered by private insurance or affordable to self-paying patients.

C. The Purely Egalitarian Approach

On this approach, society would set a maximum price at which added QALYs would be purchased out of collective funds, and no one would be permitted to purchase added QALYs at higher prices with their own resources. Canada and Taiwan aspire to that approach.

In fact, however, in an increasingly global health care market, no country can ever reach pure egalitarianism, because citizens can travel to other countries, there to purchase added QALYs for themselves at higher prices. For both Canadians and citizens of Taiwan, for example, the U.S. health system has long represented an upper tier to their ostensibly one-tier health system.

IV. Is Maximizing the Number of QALYs for a given health-care budget a Proper Social Goal?

As already noted, Americans routinely, and without question, purchase some QALYs for well-insured citizens at extraordinarily high prices, all the while neglecting to purchase for other citizens – e.g., uninsured children – added QALYs that could be had at relatively low prices. That approach often is criticized. Many policy analysts appear to prefer an approach in the spirit of Benthamite Utilitarianism which drives much of the debate on health policy around the world, even

²² J. LeGrand, "Methods of Cost Containment: Some Lessons from Europe." (Mimeographed.) Paper presented at the Fourth International Health Economics Association World Congress, San Francisco (June, 2003): 6; also Devlin, N., Applebie, J. and Parkin, D., "Patients' views of explicit rationing: what are the implications for health service decision-making?" *Journal of Health Services Research Policy* (July, 2003): 183-186.

within the United States. On that approach, policy makers should seek to maximize the number of QALYs in the nation for a given level of national health spending.

Jeremy Bentham (1748-1832), after which this distributive ethic is named, would have been any American parent's dream. He studied history and Latin at age four, entered Oxford University at age 12 and graduated from there at age 15. He and John Stuart Mill (1806-1873) are widely regarded as the founders of the school of *Consequentialists* who hold that the merits or demerits of human acts – business decisions, legislation, crime and punishment – should be judged strictly by the pleasure or pain, or both, that these acts visit on human beings (or animals), rather than by some other intrinsic merit or demerit of those acts (e.g., some religious merit). Bentham called the attempt to value the total consequences of pleasure and pain of an act as the *felicific calculus*.

Bentham, Mill and their later disciples believed that the pleasure and/or pain begotten by an act could be quantified and measured as “utility” or “disutility,” which is why they are also known by the more common label of “utilitarians.” They argued that public policy – in local commerce, international trade and in the law -- should be conducted so as to *maximize the sum of utility in society*. In fact, 19th century utilitarianism furnished intellectual foundation for what we now know and teach students of economics as modern “welfare economics” or “benefit-cost analysis.”

Benthamite utilitarianism, however, inspires not only modern “welfare economics” American style, which leaves the valuation of resources and their “efficient” allocation among members of society to the interplay, in freely competitive markets, of individual preferences and ability to pay, one the one hand, and on the willingness of individuals to supply resources they own (including their own time) on the other. The Benthamite doctrine inspires also the school of so-called “extra welfarism,”²³ which accepts the idea that, in some areas of human activity, such as health care and education, central decision makers can and should make resource-allocative decisions on behalf of society, on the basis of some well understood criteria of the common good which, presumably, have broad popular support.

When extra-welfarists apply Benthamite utilitarianism to health policy, they have in mind the loosely phrased idea that some fixed overall allocation of resources for health care should be allocated among individual members of society so as to maximize the overall “health” of the population. Applied to a less fuzzy metric for health – namely, the QALY – this means that a nation's total health spending should be so allocated among members of society as to maximize the sum of QALYs that can be wrestled through health care from nature for the entire population, given its preferred life style.

Although the application of Benthamite utilitarianism to health policy may appear sensible to many at first blush, it is problematical on further thought.

For one, it violates the individualistic spirit of “economic welfarism” that is espoused by American economists and their numerous disciples among policy makers. The idea smacks of heavy-handed government regulation and, therefore, has relatively few customers on this side of the Atlantic.

Furthermore, however, as the Australian health-services researchers Jeff Richardson and John McKie²⁴ have pointed out, as was noted above, an attempt to maximize “population health” or its proxy, the sum of QALYs, for given populations can easily lead to discrimination against

²³ See, for example, Anthony J. Culyer, “The Normative Economics of Health Care Finance and Provision,” *Oxford Review of Economic Policy* 5 (1989): 34-58.

²⁴ Richardson J, McKie J 2004 ‘Empiricism, ethics and orthodox economic theory: what is the appropriate basis for decision making in the health sector’, *Social Science and Medicine*, vol. 60, pp 265-75.

severely ill individuals or older citizens for whom added QALYs tend to be more expensive than they are for younger or less severely ill persons. The authors cite a substantial body of research on the ethical preferences of citizens in a number of countries (Australia, Norway, Spain and the U.S.), according to which respondents typically would like to see added health-care resources allocated to the sickest people first, even if that entails buying QALYs at much higher prices than would be paid if those resources were allocated to less sick individuals, and even if it means that the nation does not maximize “population health” or “the sum of QALYs” for a given level of national health spending.

The authors therefore suggest that scarce health-care resources be allocated through an iterative process which they call “ethical empiricism.” Under ethical empiricism, initial ethical guidelines would be sought from the population through well designed surveys, resources would then be allocated on that initial set of ethical values, and follow-up surveys would be fielded to allow respondents to judge the ethical quality of the results of the initial allocation.

It is an ambitious proposal, and one not easily implemented. It is reasonable to conclude from the literature the authors cite, however, that a simple maximization of population health (or QALYs) on the Benthamite doctrine almost surely would violate the public’s ethical predilections. One is inclined to agree with the authors that more empirical research should be conducted to elicit just what the general public’s ethical values actually are in regard to health care. Nowhere would such research be more illuminating than in the United States.

IV. Whither American Health Care?

For long-time students of American health care, the coming decade is apt to be the most interesting one in their careers, for the country cannot much longer sweep under the rug issues that hitherto it had avoided through unfunded government mandates on private entities, through a brittle safety net for the uninsured, financed through a pin-the-tail-on-the donkey game called the “cost shift,” and by a studious avoidance by the Congress and employers of glaring inefficiencies in American health care.

Within this decade, Americans must either abandon the idea that each and every economic crisis in this country can be solved through tax cuts, and finance the health system more honestly or, alternatively, forthrightly embrace the idea that the benefits of health care, like those of education and of our system of “justice”, so called²⁵, should be rationed by market prices and ability to pay, that is, by income class.

It is, in fact, remarkable, that so far Americans have been able to uphold at least the pretense that health care in America is distributed on more or less egalitarian basis, and in many instances actually have owned up to that ethic, even for economically disadvantaged populations, when no such pretense can be maintained for our education- or “justice” systems. It has been accomplished through an arrangement that still holds physicians, hospital executives and other health-care providers to strictly egalitarian standards, even though the payment system that confronts these providers of care increasingly shouts at them that society’s valuation of their professional work varies with the socio-economic and health-insurance status of their customers.

It will be fascinating, and for many of us possibly troublesome, to observe how things will unfold in American health care in the rough and tumble of the decade ahead.

²⁵ In this connection, just Google “Tulia, Texas and Coleman” and read.

In the meantime, the reader may find it instructive to discuss with his or her colleagues the question raised in the one-page appendix to this paper. I had sent this questionnaire about a month ago to the Editorial Board of *The Wall Street Journal* who, not unexpectedly, have preferred so far not to respond.

