Documentation
UNHPC

Conservatoire national des arts et métiers

CYCLE DE CONFÉRENCES de Joseph White

Case Western Reserve University, Cleveland, Ohio, professeur invité du Cnam

La réforme de santé du président Obama : les États-Unis sont-ils en train d'abandonner le modèle américain ?

The U.S. Health Care Reform : Is the U.S. Abandoning the American Model ?

http://culture.cnam.fr/

Lundi 31 janvier 2011 - 17h30
Conservatoire national des arts et métiers Amphi Paul-Painlevé, 292 rue Saint-Martin, Paris IIIe
Cnam, École Management et société - Chaire d'Économie et de gestion des services de santé

Texte et traduction : CNAM - Mise en page : UNHPC

Joseph White

Elève d'Aaron Wildavsky, Joseph White est un spécialiste des politiques de santé et de retraite. À l'instar de son maître, une grande partie de ses travaux se focalise sur la manière dont les gouvernements financent leurs politiques de santé, mais aussi sur les efforts qui doivent être consentis afin que celles-ci gagnent en efficacité. Ses travaux comparent les politiques de santé dans les démocraties industrielles développées, avec une attention particulière pour les rôles de l'"État" et du "marché".

For decades the United States has been the great exception : the only advanced industrial democracy that does not organize a system of care or insurance for nearly all citizens.

In 2010 about 50 million residents were uninsured. That is over 16% of the population. More than one in five Americans of working age do not have insurance.

Yet the United States spends much, much more money on health care than any other country does. It spends over one sixth of its economy, and the next closest economy spends only a ninth.

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into law. The political battle about the law was bitter and even vicious. At many times it seemed as if no law would pass. The law that did pass disappointed many of its advocates. It will be implemented, if it is implemented, over a long period of time, and it is not expected to create universal coverage.

Yet the opponents describe it as radical change. And, from any point of view, a law that is expected to eventually expand insurance to more than 30 million people, at a cost of well over $100 billion per year, should count as an important public policy. It could be the largest single policy change in what Americans call a liberal direction, a move to the left, since the 1960s.

Pendant des décennies, les États-Unis ont fait figure de grande exception parmi les pays riches : la seule démocratie industrialisée qui n'organise pas de système de soins ou d'assurance-maladie pour tous ses citoyens.

En 2010, environ 50 millions d'habitants n'étaient pas assurés. Ceci représente plus de 16% de la population. Plus d'un Américain sur cinq en âge de travailler n'est pas assuré.

Et pourtant, les États-Unis dépensent bien plus d'argent pour les soins de santé que n'importe quel autre pays. Ils y dépensent plus d'1/6 de leur économie, quand le pays en deuxième position ne dépense qu'1/9 de son économie en soins de santé.

Le 23 mars 2010, le président Obama signe la loi pour la protection des patients et les soins abordables (Affordable Care Act – ACA). La loi déçut un grand nombre de ses partisans. Sa mise en vigueur, si jamais elle a lieu, durera longtemps, et il n'est pas prévu qu'elle crée une couverture universelle.

Pourtant ses opposants la décrivent comme un changement radical. Quel que soit le point de vue, il est évident qu'une loi qui est supposée étendre l'assurance-maladie à plus de 30 millions de personnes, avec un coût dépassant les 100 milliards de dollars par an, devrait être considérée comme une politique d'ordre public importante.

Overview of the Talk

So I am here today to talk about this major event in the politics of that very large country across the Atlantic, the world's hegemonic power, which provides a model of modernity for some and a spectre of fear for others. I want to try to shed some light on three topics.

- First, what would this legislation do ? In particular, how will it change American health care ?
- Second, what does this legislation tell us about American politics ?
- And third, what does it tell us about one of the main questions about the future of the industrialized world? One of the not-so-hidden conflicts is between American and European ideas about the good society. One of the key questions within that is the extent of social protection, the welfare state, as opposed to the market. So it seems worthwhile to ask whether the legislation is an example of Americans saying their own model is flawed.

As I consider these questions, I will move back and forth, between politics and policy. Those are the same word in French, la politique, but distinct in English. By Policy I mean what government does. By Politics, I mean how government decides what it will do, or try to do.

I will begin by describing some of the politics of health care reform in particular and of current American politics in general. Next, I will define in what ways there has been an international standard, a norm about how health care systems operate ; and therefore in what ways the United States has been exceptional. So that will provide the basis for my description of how the Affordable Care Act, as it is called, reforms the U.S. health care system.

I will conclude by summarizing why I believe the legislation moves the U.S. closer to what other countries do. The United States is much more divided over the principle of solidarity than is true in most other countries. Yet this law is, for the moment, a victory for solidarity. In other ways, however, the law does not move away from the American model of the modern state. In the U.S., belief in markets is greater, and distrust of direct government action also much greater, than in most other countries. The business community in particular is much more hostile to the state. And the weaknesses of the Obama reform reflect those attitudes.

American Politics and the Politics of Health Care Reform

Lets begin with beliefs, with ideology. The entire industrialized world has shared some basic trends in recent years. On social issues, such as social equality among groups of people, societies have moved to the left. On economic issues, such as the role of government and markets in the economy, they moved to the right. Or, at least, talked about moving to the right.

The United States is no exception, but these developments have sharpened ideological conflict for three reasons.

First ; the reaction against breaking down traditional social values has been stronger in the United States. Christian conservatives have become a very strong force in the Republican party. The religious dimension of party conflict makes that conflict more intense.

Synthèse de la conférence

Mon but est d'évaluer dans quelle mesure la réforme de santé d'Obama, en rendant les États-Unis moins exceptionnels, suggérerait que les modèles d'économie politique américain et européen, et spécialement les modèles de protection sociale, convergent. Je vais soutenir que la loi Obama rapproche les États-Unis des normes internationales pour ce qui est de la solidarité, malgré le fait que le pays connaisse de grandes divisions sur ce principe par rapport à d'autres pays. Néanmoins, il existe également des facteurs importants qui font que cette loi ne s'éloigne pas beaucoup du modèle économique et politique américain.

Les positions politiques et la réforme de santé américaine

Ces dernières années, les États-Unis, tout comme d'autres pays, ont connu un mouvement de l'opinion politique vers la gauche pour certaines questions, tel que le comportement envers l'homosexualité, mais aussi vers la droite, pour les questions concernant les rapports entre le marché et l'État. A la différence des autres pays cependant, aux États-Unis le conflit idéologique est plus virulent.

Second, in the past regional differences meant that the two main parties, were not ideologically consistent. Democrats from the southern states tended to be more conservative than many Republicans from states like New York, Pennsylvania and California. Since the 1960s, American party politics has nationalized. Conservative southern Democrats almost all became Republicans ; Liberal northern Republicans became Democrats. Therefore each party is much more united by ideology than before.

Third, the American Republicans have become a truly radical party. Some of the other conservative parties in the English-speaking world are fairly close, but the U.S. Republicans are unique in, for example, the strength of their belief that taxes are evil. We could see the extent of the change in the recent debate. In June of 2009 two former Republican leaders of the United States Senate, Howard Baker and Bob Dole, joined former Senate Democratic leader Tom Daschle and proposed a health care reform approach that was not so different from the law that passed. Dole was the Republican nominee for President in 1996. No current Republican member of Congress supported them.

As part of the worldwide trend, the law the Democrats supported is significantly more conservative than Democrats proposed in previous efforts to create National Health Insurance, such as 1993-94 and 1973-74. As part of the American trend, Republicans are determined to repeal the law, and it does not have broad public support. So we certainly cannot say that passing health care reform means that U.S. opinion has become more like European opinion.

Why, then, did the law pass ? It passed because, in another way, U.S. politics is becoming more like European politics. Party matters more in legislation than it used to. That does not mean party leaders can count on their legislators to vote the party line. It does mean that more legislators support their party's position more of the time than at any point in the past 130 years.

In the past, even if the Democrats had majorities, they could not get enough support within that majority to pass legislation. That was the question this time as well, because almost all of the legislators who are not comfortable with either party's core positions are Democrats. There is no good term for their views, so conservative Democrats will have to do. The politics of health care reform was essentially a fight for these legislators. The bill was the bill that could get enough of their votes to pass. Many of these legislators had to worry that voting for reform, even a fairly moderate reform, would provoke a strong conservative backlash in their constituencies. But about half of them eventually voted for reform.

One reason is, the Republicans made such wild accusations against the plan, and against the Democrats, that even conservative Democrats did not want to let the Republicans win by defeating the bill. But a political judgment was more important. Democrats suffered a massive defeat, by American standards, in the congressional election of 1994. They believe one reason was that failure to pass anything when President Clinton tried to pass health care reform made the party look incompetent – and that voters who did not like reform blamed them

Le parti républicain américain s'est véritablement transformé en un parti de droite radical. Les démocrates, malgré leurs divisions, comptent bien moins de membres qui se sentiraient à l'aise chez les républicains.

Suivant le courant mondial, la nouvelle loi est clairement plus conservatrice que ce que les démocrates avaient proposé lors des tentatives précédentes visant à créer une couverture maladie nationale, comme en 1993-94 et en 1973-74. Fidèles à la tradition américaine, les républicains sont déterminés à faire abroger la loi, laquelle ne rencontre pas un large soutien public. Ainsi, il est difficile de dire que le vote de la réforme de la santé signifie de manière certaine que l'opinion américaine se soit rapprochée de l'opinion européenne, en matière d'État-providence moderne.

Alors, pourquoi cette loi est-t-elle passée ? Elle est passée car aujourd'hui, plus qu'hier, les partis ont plus de poids dans la législation. Au fur et à mesure qu'ils sont devenus plus cohérents, ils sont devenus plus unis, acquérant ainsi une importance plus grande dans les élections. Lorsque le président Obama fit de la réforme de la santé le point central de ses deux premières années de mandat, les démocrates se sont souvenus de ce qui s'était passé quand le président Clinton avait fait de même. La réforme avait échoué et les démocrates avaient perdu le contrôle du Congrès aux élections suivantes. Ils en conclurent que certains membres avaient été tenus responsables de la tentative de réforme, quand bien même ils avaient voté contre elle ; et l'image de marque du parti en pâtit car le parti apparut comme inefficace. Les démocrates conservateurs qui n'étaient pas sûrs de leur vote décidèrent qu'ils étaient en danger quoi qu'ils fassent. Ils essayèrent donc de négocier une loi qui soit la plus proche possible de leurs préférences réelles. Environ la moitié d'entre eux votèrent pour la loi en espérant qu'ils pourraient l'expliquer à leurs électeurs.

for trying even though it did not pass. In 2009, President Obama did to conservative Democrats the same thing that President Clinton did : he made health care reform the key issue of his presidency, so a big part of the party label. They could only lose either way. They could support reform and anger some voters in their districts. Or they could oppose the bill, make themselves look like members of a party that was incompetent, and so also look bad in their districts.

What conservative Democrats did, logically enough, was try to negotiate a bill that was close to their preferences. About half of them voted for it and hoped they could explain it to their voters. The result is, the bill is closer to their views than to the views of most Democrats. The actual policy options in the U.S. range from very conservative Republicans to the right wing of the Democratic party.

Social Protections for Health Care in Other Countries and the United States

So now lets return to policy, and the difference between health care policies in other rich democracies and the United States. I wrote a book about this 15 years ago, in which I tried to define what I called the "international standard" of health care policies, and how the U.S. was different.

- All other countries had found ways to ensure that virtually all citizens had access to a level of health care coverage that met their nation's definition of decency. This always included medical and hospital services.

In the United States, however, about 15% of the population did not have insurance at any given time. And a larger percentage would go without insurance at some point over two years. So coverage was and is unreliable, as well as low. The numbers are a bit worse now.

- Citizens were compelled to contribute to other countries' systems. The only exceptions were for higher incomes in Germany, the Netherlands, and Switzerland. But in each of these countries the laws about insurance premiums gave people with higher incomes strong incentives to buy insurance, and higher income people could afford the costs, so almost all of them bought it.

The U.S. story is and was more complicated. All taxpayers contribute to the costs of Medicare, a government medical and hospital insurance program for people who are elderly or disabled. It is sort of the Canadian system for old people, and the largest health insurance fund in the world.

All taxpayers pay for Medicaid, which provides insurance for poor children, mothers, and pregnant women. It also provides some benefits that are not covered by Medicare for Medicare beneficiaries who cannot afford them. Medicaid is jointly funded by the national and state governments, though more by the national government. The national government establishes minimum standards for benefits and for who is eligible, but states can be more generous, and the national government then helps pay for the extra benefits.

In these ways the U.S. already has its versions of the two most expensive sets of subsidies in any country, for the poor and the old. But people who are not eligible for Medicare or Medicaid either get insurance by buying it

Les protections sociales des systèmes de santé dans les autres pays et aux États- Unis

Les politiques de santé comprennent le financement, c'est-à-dire la manière dont les patients obtiennent l'argent pour les soins et dont les fournisseurs de soins sont payés, et la livraison de ces soins, l'organisation des services. Les systèmes nationaux varient sur les deux dimensions, mais il y a des différences fondamentales de mode de financement des soins chez toutes les démocraties riches, tant en Europe qu'ailleurs (par exemple, en Australie, au Canada et au Japon), par rapport aux États-Unis.

Ces pays se sont assuré que pratiquement tous leurs citoyens aient accès à un niveau de couverture-maladie qui corresponde à une définition nationale de la décence. Celle- ci inclut des services médicaux et l'hospitalisation. Les personnes sont obligées de participer et de contribuer soit à des caisses d'assurance soit sur le coût des services de santé (l'Allemagne est maintenant la seule exception, et seules les personnes aux revenus plus élevés, qui ont la motivation et les revenus pour acheter une assurance, ne sont pas obligés à contribuer). Les contributions sont liées au revenu plutôt que d'être des prix fixés pour un produit : ceux qui ont moins d'argent paient moins et ceux qui en ont plus, plus.

La définition nationale de couverture-maladie nécessaire peut ne pas être consignée, ou précise. Mais la couverture ne varie pas beaucoup, même s'il existe des caisses d'assurance séparées. Quelques pays ont expérimenté avec l'idée que l'assurance- maladie est un produit pour lequel les personnes devraient avoir des goûts différents, et qu'ainsi certaines catégories de personnes achètent plus, et d'autres moins ; mais l'effet de telles mesures a été limité, sauf peut-être en Suisse.

Aux États-Unis, au contraire, l'assurance-maladie a été un produit. Des groupes spécifiques ont été subventionnés par d'autres citoyens à travers les impôts : les personnes âgées et handicapées à travers le programme national Medicare, et une partie des pauvres à travers le programme fédéral Medicaid (programme national et fédéral conjoint). Mais la plupart des personnes doivent acheter une assurance- maladie sur le marché, soit directement soit, ce qui est le cas de la vaste majorité, indirectement via leur employeur, qui achète la couverture. La couverture varie beaucoup selon la capacité à payer de l'employeur ou de l'individu. Les employeurs peuvent ne pas acheter de couverture, et les individus déci-

as individuals, receive insurance through a job, or have no insurance.

The insurance people buy as individuals or get from their employment differs from the insurance in other countries in a series of ways.

- In other countries, insurance when I began studying the issue was not viewed as a commodity for which different people have different tastes. From the commodity perspective, some people want more and some less ; sellers design different products for different people ; and products have prices. Instead, benefits were defined as a standard of social sharing. Some plans might provide a bit more, but mandatory coverage met a social standard of need.

In the United States insurance, outside of the government plans, was viewed as something for which different purchasers will have different tastes ; in part because of what they can afford. Sellers are expected to design products to meet these different tastes. Therefore much of the business of insurance involves designing different plans to fit the budgets of the different employers who are the main purchasers of coverage. And benefits vary far more in the U.S. than in other countries.

Moreover, insurers are largely allowed to charge prices, to each customer, based on possible costs to each customer. So they charge far more to people who need coverage most. There is some regulation by some states, but not very much.

- In other countries, because coverage was not a commodity, it also – with a few exceptions – was not sold at a fixed price. Instead, both health insurance systems and health service systems were financed by mandatory contributions that end up being roughly in proportion to income – to ability to pay.

In the United States, Medicare and Medicaid are not commodities bought for a price. For everyone else, however, health insurance is a commodity bought at a fixed price, which many people cannot afford. If an employer offers insurance, it usually pays a large part of the premium, but employees pay the balance. Because the charge is a flat fee, not a percentage of wages, lower-income works often conclude they cannot afford it. Therefore being offered coverage is not the same as having insurance.

Many employers do not offer insurance. This is especially true of small businesses. Insurance is much more expensive for small groups, because the costs of selling and managing insurance per person are much less for a large group. For these reasons, Americans who are self-employed, work for small businesses, have low incomes, or are young and healthy and not forced to buy coverage, are most likely to be uninsured.

When I wrote my book comparing health care systems there also were, and still are, major differences between how other countries tried to control costs and the measures used in the United States.

- All countries had two kinds of policies to limit spending. First, they limited the prices paid per service. This was done in many different ways, from government price regulation in Japan or the Netherlands to the insurers forming a cartel in Germany, to government being the single payer in Canada.

der qu'ils ne peuvent pas se le permettre financièrement, même si l'employeur couvre une partie du prix. Les assureurs vont appliquer des prix plus élevés sur des personnes ou des groupes s'ils estiment qu'ils entraînent plus de dépenses. Ainsi, en Europe, la norme est ''chacun selon sa capacité'' ; aux États-Unis, on pratique le ''chacun selon ses besoins''.

Les États-Unis sont également uniques pour la faiblesse des politiques visant à contrôler les dépenses. Les autres pays limitent les prix payés pour des services à l'aide d'une sorte de régulation du système à l'échelle. Aux États-Unis, les payeurs négocient séparément avec les prestataires de soins médicaux. Cela crée un grand nombre de variations dans les prix et les dépenses administratives, mais ne contrôle pas les prix aussi bien que les systèmes mis en place dans les autres pays. Les autres pays ont également limité les occasions pour les médecins et les hôpitaux d'accroître leur capacité de manière entrepreneuriale. Aux États-Unis, il y a peu de régulation, et donc la capacité à créer des services rentables s'accroît indépendamment des besoins réels. Enfin, et ce n'est pas la moindre des choses, la complexité du système d'assurance américain crée d'importants frais généraux. La clinique de Cleveland est énorme, comptant 2 000 médecins. Ceci est très impressionnant, tout comme le fait qu'elle compte également 1 600 commis de facturation.

In the United States, payers negotiated separately with the medical providers. In order to get some leverage on prices, each insurer has to contract only with some providers. There are many different forms and names for these arrangements, but they all share the same idea. Insurers either only let their enrollees use the hospitals and doctors with whom they have special contracts, or the insurers charge higher cost-sharing if patients use different hospitals and doctors.

This method creates a lot of administration and confusion for patients, but is much less effective than the system-wide rate-setting used in other countries. On average prices were and are much higher for the same service in the United States than in other countries. Prices are lower for Medicaid than for Medicare and for Medicare than for private insurance.

- Normal countries also have limited capital investment by medical providers, so the possibilities for doctors and hospitals to expand capacity in an entrepreneurial way. These limits could lead to supply shortages. But they also meant that equipment was used pretty efficiently. In the United States there have only been very weak efforts to limit investment. As a result, capacity for profitable services expands whether more is needed or not.
- In addition, the U.S. insurance system itself makes health care more expensive. There are extra costs for marketing ; for customizing products for each employer ; for assessing the risk of each group ; for estimating the risk of each group so the premiums to charge ; for creating and managing networks ; and for reimbursing providers at different fees for the same services. And, within hospitals and doctors' offices, dealing with so many different contracts with different terms also is expensive. The Cleveland Clinic is a huge facility, with 2000 doctors. That's very impressive, but so is the fact that they have 1600 billing clerks.
- So there are many ways that the U.S. was and is unique. Yet there is also a great deal of variation among health care systems outside the United States.

Some provide government health services, and some use insurance. In Canada the mainline insurance allows no cost-sharing ; in France or Japan the cost-sharing can be 30%. They all cover doctors and hospitals in a universal way, but coverage of other services varies substantially. Systems can be quite centralized or quite decentralized. They can have one insurance fund in a geographic area, or many. They allow different roles for complementary and supplementary private insurance. In some countries doctors must charge the regulated price ; in others some or all can charge more.

The delivery of health care also varies. In some general practitioners are gatekeepers to specialists, and in some not. Both the ratio of GPs to specialists and the skills expected from GPs vary. In some systems specialists have practices both inside and outside hospitals ; in others hospital doctors do not have separate ambulatory practices. In some systems doctors, especially GPs, are especially likely to practice with teams of other caregivers, such as nurses ; in others most doctors practice alone.

I say all this to remind people that "solidarity" for health care, or social protection from the risks of illness, can

take many forms. Only certain provisions should count as the core of the health care welfare state.

I should also emphasize that there have been some modest changes over time. Overall, however, I do not think there had been nearly as much change as talk about change.

To summarize then, the key differences between health care in the U.S. and the international standard have been as follows. In other countries, but not the U.S. :

- All or nearly all citizens received a high level of coverage.
- Coverage and contributions were mandatory at least for the lower 2/3 of the income distribution, and very strongly encouraged for everyone else.
- Contributions were roughly in proportion to income, and were contributions to a system rather than purchase of a commodity.
- Benefits within the guarantee varied very little, though there could be modest differences
- Cost controls were arranged and enforced on a system-wide basis. This is as opposed to expecting each individual payer to find a way to control its costs.
- Medical organizations' ability to invest in search of profit was significantly limited.

These are the major criteria I will use to assess the new U.S. legislation.

What Are The Important Parts of the Affordable Care Act ?

Overview. The most important parts of the law are not scheduled to be implemented until 2014, and even then some will phase in over a few years. So we are talking about changes that probably will not happen if the Republicans win in 2012. Nevertheless, for now, the legislation that President Obama won last March, with so much drama and controversy, moves the United States towards international norms because it extends government support for buying insurance, creating what, in other countries, would be enough spending to make insurance close to universal. To do this, it makes participation in insurance more of an obligation and contributions more proportional to income, for some people.

BUT big differences remain. For the working age population, the new law does not move far enough away from treating insurance as a commodity. Therefore benefits are not made nearly as standard as in other countries. And, most important, the bill does nothing to move the United States towards international methods of cost control. Those methods do not seem satisfactory in any country. But I can tell you now, as I will discuss in my third conference, that doing without them is much worse! The costs, not the other aspects of the design, are the main reason coverage will not be universal.

The new law patches holes in the pre-existing four-part structure of Medicare, Medicaid, large- employer insurance that was mostly OK, and small-group and individual insurance that was mostly bad. There were two political reasons why the bill patched up the old structure rather than replacing it : money, and fear.

States were already contributing towards the costs of Medicaid. Employers were already paying most of the

Les principales dispositions de la loi pour les soins abordables

Synthèse. Si les républicains n'abrogent pas la loi, celle-ci rapprochera les États-Unis des normes internationales, en étendant l'aide gouvernementale à l'achat d'assurance- maladie, en rendant la participation à l'assurance-maladie plus obligatoire et les contributions plus proportionnelles aux revenus, pour certaines catégories. Malgré cela, cette loi restera encore bien en-deçà des mesures internationales de contrôle des coûts, ce qui rendra la couverture moins complète.

De nouvelles obligations pour les individus, les assureurs et quelques employeurs

La loi fait de l'assurance-maladie une obligation dans le sens où elle demande à la majorité des citoyens d'en obtenir une. Il y a des exceptions, en cas d'objection religieuse, et si ‘'la couverture qualifiée'' coûte plus que 8% du revenu d'un ménage (ce qui arrivera certainement). Sinon, les personnes qui n'achètent pas d'assurance- maladie devront payer une amende qui variera en 2016 entre 700$ et 1 200$ par ménage.

La loi cherche également à limiter certaines pratiques des assureurs qui rendent la couverture-maladie moins abordable, comme la discrimination aux dépens de personnes malades. La plupart des ces règlements seront applicables dans les nouvelles ‘'Bourses'' que je décris plus loin ; mais entre autres, la loi exige qu'un pourcentage minimum des primes soit dépensé en soins médicaux et que les assureurs n'annulent pas des polices d'assurance après que quelqu'un tombe malade.

Le mandat et les règlements ont sans doute des imperfections, mais ils ne sont pas en principe si différents des systèmes en vigueur aux Pays-Bas et en Suisse (qui ont, eux aussi, leurs problèmes).

bill for most Americans' coverage. There are good reasons to reduce both the state and employer roles in American health insurance -- but then the state and employer money would have had to be replaced. And that could only mean higher national government spending and taxes. Since politicians want to raise taxes as little as possible, maintaining the other funding from states and employers was a natural priority.

In addition, Democrats concluded from the debate over the Clinton health care reform that voters who had insurance they liked had been frightened by charges that the government would change it. So they decided that, this time, they had to tell people that they would change the insurance currently provided by employers very little.

Since the bill builds on the four kinds of coverage that existed before the debate, the best way to understand it is to look at what it does to each part.

Medicare. Lets begin with Medicare, the national government insurance for the elderly and disabled. No changes in the law were needed to cover this population. Instead, the Medicare changes attempt to save money. These savings are expected to pay some of the costs of coverage for other people, so are part of how the bill expands coverage without increasing the budget deficit. The law also has some modest expansions in the Medicare program's extremely strange drug benefit. That's one of those provisions that would take too long to explain and I'm not sure you would believe me, anyway.

Basically, the law doesn't change how Medicare fits into American health insurance as a whole. Medicare has always used its large market share to enforce lower fees, and it will do a bit more of that.

The Individual Mandate. The heart of the new law is how it will change insurance for everyone else. And that begins by creating what in the health reform business is called an individual mandate. As in the Netherlands or Switzerland, by 2014 all citizens will be required to obtain qualifying insurance coverage. They could get it from Medicaid, through their employer, or by buying insurance through new institutions called health insurance exchanges.

Now, the term "individual mandate" is a bit deceptive. It's a *mandate* because people do have a *choice*. In other systems people just have coverage due to being a citizen, or having a job. They don't get to choose, so they do not have to be ordered to obtain insurance. An individual mandate means people are penalized if they do not get insurance. So it depends on both enforcement – keeping track of whether people sign up – and how the costs and benefits of complying compare to the costs of the penalty.

Both the Dutch and Swiss have had some problems with their own mandates. The difficulties will be greater in the U.S. because insurance is so much more expensive so the cost of insurance, if you do not want it, is greater. So the government either has to pay a very large part of the cost, or have very large penalties, in order to make sure that people obey. Bigger subsidies, because of their effects on the budget, and bigger penalties are less popular than smaller subsidies and penalties. The combination of subsidies and penalties in the new law, therefore, will not suffice to fully enforce the mandate.

Un troisième ensemble de conditions cherche à encourager les employeurs de plus de 50 personnes à fournir, ou à continuer de fournir une assurance-maladie. A partir de 2014, ces employeurs devront offrir une assurance-maladie qui répond à certaines normes, ou bien payer une pénalité d'environ 2 000$ pour chacun de leurs employés à temps plein qui achète une assurance et reçoit des subventions gouvernementales via les bourses d'assurance que je décris plus loin. Cette mesure ne s'applique pas à des employeurs de moins de 50 personnes, en partie pour des raisons politiques : ils constituent un groupe d'intérêt très puissant, particulièrement influent chez les démocrates conservateurs qui opérèrent le revirement législatif durant la bataille pour l'adoption de la loi. Mais les raisons en sont aussi réelles : à cause de l'échelle économique, il est bien plus efficace d'acheter une assurance-maladie pour des grands que pour de petits groupes.

The penalties will be phased in between 2014 and 2016. By 2016 families that do not get insurance will be expected to pay a minimum of just under $700 per year or 2.5% of their income, up to a maximum of just under $2100. The minimum and maximum will then increase each year with the cost of living.

Whether these penalties will get people to enroll will depend on the coverage for which they are eligible. Logically, people who are eligible for Medicaid should have very strong incentives to sign up. For some others, it will depend on the costs of insurance. There will be people for whom premiums could be $20,000 or more, compared to a penalty of $2100. Therefore the mandate will not apply to anyone for whom the lowest cost plan that they could buy would cost more than 8 percent of their income.

It is important to remember the individual mandate as we turn to the other parts of the bill. Lets begin with the part that is expected to change least but would still cover the largest part of the population : the coverage provided by employers.

Employer-Sponsored Insurance. About 150 million Americans currently receive insurance through their employers, and one of the goals of the bill is to make sure there are still about 150 million getting insurance that way in 2019.

When employers provide insurance, the government indirectly subsidizes the expense because it does not tax the insurance like other income, even though it has value to the employee. The average value of this subsidy in 2004 was about $2000 per employee, and of course is more now. This tax break is controversial among American economists, and some liberal economists believe it is unfair because the break on a certain value of insurance is greater for people who have higher incomes and so are in higher tax brackets.

This criticism, though conventional wisdom, is wrong in many ways. I will discuss why in the question period if anyone wishes. For now, the key point is that **the law preserves the tax break because politicians did not want to put more of health care on the government's budget, or scare voters who worry about losing their own insurance**. But they planned to cut back on it a bit, slowly, with a new tax. This gave them an argument about how the law would reduce spending in the long run, and was fervently praised by many health economists.

Beginning in 2018, the law would set caps on how much employers spend on insurance in dollar terms. If an employer pays too much, the insurer would pay an excise tax of 40 cents for every dollar of coverage over the limit. This is a very strong incentive to keep spending within the limit. Eminent economists claimed that "health care experts," by which they meant economists, "unanimously,"which means the majority that agreed with them, supported it. In fact, the excise tax is an awful idea.

Here's the problem. It is perfectly normal to say that we, as a nation or society, want to support some set of benefits. Then people can buy the rest as a commodity. That's what every other system does. So it would be very sensible to define a benefit package and say that employers could provide coverage within that package tax free. And if employees wanted more, the employers

could be the purchasing agent but employees would have to pay with their own income, after paying their taxes.

But that's not what this new tax would do. It limits the amount of employer payments, not what they pay for. **On average**, the limit would allow quite good coverage, in 2018. But spending for the same package will vary dramatically with the demographics of the group being covered, what kind of work they do, and the costs of medical care in their communities. So it will penalize groups of employees who are older, have more dangerous jobs, or live in places where medical care costs more. The law does allow some adjustments according to the ages of employees and for certain occupations. And the tax was delayed until 2018 because liberals were so angry that some of them might have voted against the bill without those changes. But these provisions still do not keep the tax from being fundamentally unfair. And it could reduce coverage over time because the cost level that triggers the penalty is expected to rise more slowly than actual costs.

So the excise tax represents both a practical failing and a failure of principle. The practical problem is, it threatens to make employer-sponsored insurance less adequate for people who need it most. The problem in principle is that it violates the basic principle of social sharing, which is that sharing should be based on a sense of what citizens should have in common. Instead, the excise tax treats insurance as a commodity, to be judged by its price instead of its content.

In spite of these aspects of the excise tax, the politicians who wrote the law definitely wanted to maintain employer coverage. But they recognized that small employers are not the right size for risk pooling and pay much more for their coverage. And that small employers are a powerful political force which helped defeat Clinton's reform. So the bill was designed to continue employer sponsorship of coverage especially for larger groups – defined, in the law, as more than 50 employees.

The law will require, in 2014, that employers with more than 50 employees either offer insurance that meets certain standards or pay a penalty of about $2000 for each of their full time employees who purchases insurance and gets government subsidies through the insurance exchanges I will describe shortly. Employers normally pay far more than $2000 per employee now, but the penalty will reduce the benefit, to employers, of dropping coverage at any given point in time. In addition, the individual mandate will encourage some of the employees who are offered coverage but do not accept it now to pay the premiums, rather than the penalties.

These measures are expected to mostly offset the decline in employer-sponsored insurance that would otherwise occur as employers sought to avoid rising costs, and as the coverage expansions in the law provide new alternatives for small businesses and individuals.

So, finally, we get to the ways the law would actually expand health insurance in the United States!

Medicaid. Half of the new coverage in the law will come from expanding Medicaid, the program for poor people. It does that by making more people eligible, and having the federal government pay almost the entire extra cost. The law makes adults who do not have children eligible, and says all states must cover all poor people

with incomes below 138% of the federal government's definition of poverty.

States will not be required to give the childless adults who become eligible the same benefits currently available for mothers and children. However, the benefits should be better than what most workers get now. Some low wage workers with families may choose Medicaid over what their employers offer. There will still be a lot of variation between states' Medicaid programs, because some states cover more benefits and people with higher incomes now. The law has provisions that are meant to keep states which currently cover more people from cutting back.

Medicaid expansion is a large part of the bill because Medicaid is cheap. It doesn't pay hospitals and doctors and drug companies as well as other insurers, so more people can be covered for a given amount of dollars. Because of the payment differences, however, there are some access issues. It is hard to say whether having more people in Medicaid will make healthcare providers more or less willing to see them.

Health Insurance Exchanges and Reform of the Individual and Small Group Markets

The law's most important initiatives fix the part of the system that worked worst. That is the insurance available to individuals and workers who work for small companies – defined as up to 50 workers. The law creates a version of the markets that exist in the Netherlands or Switzerland, but only for a small part of the population – expected to be about 20 million people. What will actually happen depends on whether the law succeeds in maintaining employer- sponsored insurance. If employers abandon health insurance in spite of the penalties, there will be a lot more people in the new market for individual insurance!

The federal government will sponsor, though states will help administer, health insurance exchanges. Exchanges will cover entire states or parts of states, according to decisions made by state governments. Insurers will be required to sell their products through these exchanges. They will have to sell their products at set prices, adjusted only for age, geography and tobacco use, to anyone who is eligible to buy through the exchange. This, along with the individual mandate, will be a big improvement on the current market.

In addition, individuals and families who buy insurance through the exchange will be eligible for government support if their incomes are no more than four times the federal government's definition of poverty. That definition varies with family size, of course. In 2014, subsidies are expected to be available up to an income of

Extensions de couverture-maladie : le programme Medicaid et les subventions via les bourses

L'extension de l'éligibilité à Medicaid, ce programme distinct pour les pauvres, va alimenter la moitié des nouvelles couvertures-maladie. Ce programme a beaucoup de défauts, mais il fournit de manière équitable une large gamme de prestations de manière relativement peu chère, si les patients réussissent à trouver un médecin qui les prend en charge. Le gouvernement national paiera les coûts supplémentaires. Les programmes Medicaid des différents États fédéraux continueront à ne pas être identiques, étant donné que certains couvrent plus de prestations et des personnes dont les revenus sont plus élevés.

Le reste de la nouvelle couverture, et le changement le plus important du système actuel, viendra de la réforme de l'assurance-maladie qui est proposée aux individus et aux travailleurs qui travaillent pour de petites compagnies de moins de 50 employés. La loi crée une version des marchés tels qu'ils existent aux Pays-Bas ou en Suisse, mais uniquement pour les familles sans employeur, ou bien dont l'employeur choisit de payer la pénalité plutôt que d'acheter l'assurance-maladie.

Le gouvernement national va financer des bourses d'assurance-maladie, pendant que les États l'aideront à les administrer. Les assureurs devront vendre leurs produits à travers ces bourses à des prix définis, qui seront ajustés uniquement sur l'âge, la taille de la famille, la localité et l'usage de tabac. Les prestations ne seront pas standardisées, mais tous les plans d'assurance devront avoir des valeurs actuarielles comparables : un pourcentage du coût prévu des prestations ''essentielles''. Les couvertures s'échelonneront depuis la couverture ''catastrophique'' (avec une franchise élevée, uniquement pour les personnes jeunes) jusqu'à des couvertures de 60% (bronze plan), 70% (silver plan), 80% (gold plan) et 90% (platinum plan) des coûts.

Les individus et les familles qui achètent une assurance-maladie via ces bourses seront éligibles pour un soutien gouvernemental si leurs revenus ne dépassent pas de quatre fois la définition de la pauvreté établie par le gouvernement fédéral. En 2014, il est prévu que les subventions soient disponibles pour les familles de quatre

$88,000, about 65,000 euros, for a family of four or more. Before we look at the amounts of the subsidies, however, we should look at what's being subsidized. That brings us back to the benefits.

First, the Secretary of Health and Human Services is supposed to define a package of "essential benefits." Then there will be five levels of coverage for those benefits. It seems likely that the big national insurers and Blue Cross plans will be in almost all markets, and will offer plans at each level. So enrollees will have lots of "choice" between insurance products.

The first level will be "catastrophic coverage," for costs only above a fairly high deductible. This would be available only for people up to the age of 30 or who are exempt from the mandate for some reason. The idea here is to make sure that there is a plan that would not cost much more than the penalty, and so could get the young, healthy people to obey the mandate.

Everybody else in the exchange will be allowed to buy, and insurers allowed to sell, four levels of benefits : "bronze," "silver," "gold" and "platinum." More precious metals are better benefits. They will be defined by their actuarial value : what percentage of the costs of the essential benefits they are estimated to cover, on average. That means that plans at the same level could have quite different provisions : for instance, one might have higher cost-sharing for drugs and the other higher cost-sharing for physician visits.

The second lowest level, silver, would cover 70% of the value of the essential benefits. People who buy insurance through the exchange will be eligible for subsidies, depending on their income, to help them with the price of the second-least expensive "silver" plan within that person's exchange. They would not get subsidies to buy a more extensive plan, and would save money by buying a cheaper plan.

Covering 70% of "essential" benefits is less than the norm for current employer-sponsored insurance. Most American workers currently have coverage for a bit more than 80% of the expected standard. So this is another way in which the reform does not provide as much protection as is common in Europe and Japan. Poorer people are especially unlikely to be able to afford the costsharing in the silver plan.

Therefore, the subsidy structure is especially complicated. There are subsidies for both premiums and cost-sharing. The premium subsidies are designed to limit a family's payment to a percentage of income. That percentage ranges from 2 percent, for families that would be eligible for Medicaid but prefer the exchange ; up to 4% of income at 150% of the poverty level, just over 8% at 250% of poverty, and 9.5% of income between 300 and 400% of poverty. Over the line, the subsidies stop. But the cost-sharing subsidies mean that coverage below 200% of the poverty level should be much better than the silver plan, and very slightly better between 200 and 250%.

Unlike in other countries, except Switzerland, premiums will be allowed to vary with age and family size, as well as local costs. However, except for single people, most of the variation due to age and local costs will be eliminated by the caps on payments as a percentage of income. For example, in 2014 a family of 4 with a 55 year-old head of household and a $50,000 or $75,000 or

membres ou plus dont le revenu ne dépasse pas les 88 000$, soit 65 000€.

Bien que dans les bourses, l'assurance-maladie sera vendue à un prix fixe, les règles des subventions signifient que la plupart des personnes qui ont plus qu'une couverture individuelle paieront un pourcentage de leur revenu – jusqu'à ce qu'ils dépassent le revenu éligible pour une subvention. La subvention standard, cependant, correspondra à un niveau assez bas de couverture-maladie : le coût d'un silver plan, qui couvrirait seulement le 70% des prestations ''de base''. Étant donné qu'il serait très difficile pour les personnes qui ont moins d'argent, de payer un partage de coûts, la loi prévoit d'autres subventions pour le partage des coûts, qui seront très importants pour les ménages dont les revenus se trouvent à 200% sous le seuil de pauvreté.

Ce pourcentage de revenus payés augmentera rapidement, de 2% pour les familles qui seraient éligibles pour Medicaid mais préfèrent la bourse ; à 4% du revenu pour les familles se trouvant à 150% du seuil de pauvreté ; environ 8% pour les familles se trouvant à 250% du seuil de pauvreté et à 9,5% des revenus pour 300 à 400% du seuil de pauvreté. Juste sous le seuil de 200%, les inscrits au programme paieront 6% du revenu familial, mais les subventions de partage de coûts signifieront que les prestations couvrent 87% des coûts prévus. Ce n'est pas fameux, mais pas si mal non plus. Les plus grands problèmes d'accessibilité et d'égalité concerneront les personnes qui se situent au dessus de ce seuil, lorsqu'ils seront assez malades pour qu'ils participent de manière significative au partage des coûts ; les personnes qui se trouvent au-dessus du seuil de subventionnement seront également concernées. En 2014, une famille de 4 personnes, dont le chef du ménage est âgé de 55 ans et a un revenu annuel de 100 000$, vivant dans une zone de coût élevé, devra payer environ 24 000$ pour un silver plan ; c'est 15 000$ de plus qu'une famille de 4 personnes, avec le même revenu, mais vivant dans une zone de coût bas et dont le chef de ménage est âgé de 30 ans.

Si tout cela vous semble extrêmement compliqué et difficile à gérer, vous avez raison. C'est le résultat d'une tentative désespérée de combiner les méthodes du marché et une sorte d'équité. Heureusement, la plupart des personnes dont les revenus sont trop élevés pour avoir droit aux subventions via la bourse aux assurances sont déjà assurés via leurs employeurs. En ce moment, on compte seulement 5 millions d'Américains – moins de 2% de la population, et sans compter les personnes âgées - dont la famille a des revenus au-dessus du seuil de subvention et qui n'ont pas d'assurance-maladie. Mais cela signifie simplement que ce projet va échouer, à moins qu'il ne s'attache à préserver l'assurance-maladie financée par les employeurs.

Contrôle des coûts, ou pas ?

Malheureusement, cette loi ne fait pratiquement rien pour aider les employeurs à contrôler leurs dépenses, si ce n'est en réduisant les prestations. Elle ne crée pas non plus un système de fixation des prix, de restrictions ou d'investissements à grande échelle, ou encore la moindre simplification administrative qui explique les coûts plus bas dans les autres pays riches.

$90,000 income in a high-cost area is expected to pay the same premium, after subsidy, as a family of four with the same income but a 30-year-old head of household in a low cost area. But, as often happens in systems with income-related subsidies, there are perverse effects at the income level where the subsidies stop. These are called “threshold effects,” and the threshold effect in this reform is huge. If the same two families had incomes of $95,000, just over the income at which subsidies stop, the older head of household in the higher cost area is expected, by the best current estimates, to pay almost $15,000 more than the younger family in the lower cost area.. The good news is, the mandate will not apply to them. The bad news is, they probably will not be able to afford insurance even if they want it.

If this seems a bit crazy, well, that’s true too. But I don’t want to give the impression that these problems with the Exchanges make them fatally flawed. The law should be compared to what the U.S. does now. From that perspective, the exchanges would be an improvement for the vast majority citizens eligible for them

Marketing through the exchanges will eliminate some of the extra costs for small groups. The subsidies will help most of the people who are uninsured. And most of the people whose incomes make them ineligible for subsidies through the exchange are already insured through their employers. Only about five million Americans right now – less than two percent of the non-elderly population – are in families with incomes above the subsidy level and do not have health insurance.

I have told a very complicated story. It is time to do some final analysis and draw some conclusions.

What Does It All Mean ? Implications and Conclusions

The main forms of insurance expansion in the new law are both flawed. Medicaid has access problems both because some providers do not want Medicaid patients and because state governments, seeking to limit spending, often do not try very hard to find people who are eligible and sign them up. Insurance through the exchanges will be very complicated and confusing. The benefits in the silver package are relatively weak, and some people still will not be able to afford coverage at all.

But it is important to understand that this is NOT because Americans are particularly ungenerous or unkind – at least to the extent that generosity can be judged by use of government to help people who need help. The American voter already contributes for the two most expensive groups, the elderly and the poor. Even before the Obama reform is implemented, even in 2008, the United States was above the average level of public spending on health care among members of the OECD. Let me repeat that : as a share of the domestic economy, public spending on health care is higher in the United States than in all but a few other countries. Only Sweden, New Zealand, Germany, France, Denmark and Austria spent more. The U.S. was in the same range as Canada and Belgium, and above all other countries.

The new law would commit the U.S. public to subsidies for about two thirds of the nation – everyone who is elderly or has an income below 400% of poverty. These subsidies could be very large, even if they are inadequate! An average family of four with an average income in a community with average costs {all medians}

Quel est le sens de tout cela ? Conséquences et Conclusions

Les formes principales de l’expansion de l’assurance-maladie inscrites dans la nouvelle loi sont défectueuses à bien des égards. Les subventions dans le système de bourses seront importantes, mais dans certains cas elles ne sont toujours pas satisfaisantes. Les prestations également seront assez étriquées et déroutantes.

Pourtant, ce n’est PAS parce que les Américains seraient particulièrement avares ou méchants. En 2008, bien avant la réforme, les États-Unis comptaient parmi les pays de l’OCDE dédiant la plus grande proportion de leur économie aux dépenses publiques pour la santé. Les États-Unis se trouvaient au même niveau que le Canada et la Belgique, et seules la Suède, la Nouvelle-Zélande, l’Allemagne, la France, le Danemark et l’Autriche dépensaient plus. Beaucoup de dépenses en santé étaient socialisées. La nouvelle loi ajoute un engagement du secteur public américain à diriger ses subventions vers pratiquement les 2/3 de la nation : les personnes âgées et tous ceux dont le revenu ne dépasse pas 400% du seuil de pauvreté. Une famille de 4 personnes typique devrait s’attendre à recevoir en 2014, via la bourse d’assurances, une subvention entre 9 000$ et 10 000$.

is expected to receive a subsidy, in 2014, of between nine and ten thousand dollars. Many people would get more, through Medicare or Medicaid or the exchanges if they have lower incomes or higher local costs. And these subsidies do not include the off-budget support for employer-sponsored insurance.

The Obama legislation increases the amount and eligibility of subsidies. But it also creates the principle that all Americans should have insurance, as well as a structure that will make insurance much more accessible for most people who are not covered by their employers. The new system would also be more secure than the old one, because people who cannot get a job with an employer that sponsors insurance, or who lose such a job, will have somewhere to go.

Having all those different insurance pools may seem very strange in many countries, such as France and England. But there have been other systems with lots of different funds, and the division is actually fairly similar to the setup in Japan, though for entirely accidental reasons.

I am not saying the U.S. has embraced social protection in the same way as other countries have. I am saying the difference is smaller than it seems. Being kind and gentle, as Uwe Reinhardt has been saying for decades, is a lot more expensive and so a lot harder in the United States. We buy less social protection in part because it costs so much more.

The U.S. is more divided about solidarity, so the law could get repealed if the Republicans take power. But the difference between the Democrats' policy as enacted in 2010, and the norms in other countries, is not mainly due to beliefs about. It reflects other beliefs about the relationship between government and society.

The U.S. reform reflects the dominance of market thinking in the U.S.. And this in turn reflects differences in the role of business, the political attitudes of business interests, and perhaps the influence of the economics profession.

The reform treats health insurance, for many people, as a commodity to be purchased, even if subsidized. Although the bill will substantially increase regulation of insurers, in some ways I did not mention, it makes few changes to the process of shopping and bargaining between insurers and the employers who cover about half of Americans. Individuals in the exchanges and employers in the market are supposed to act as consumers, constrained by costs and forced to have tastes.

But the law does almost nothing to change the core dynamics that explain high costs in the United States. It does not bring payers together to counter the power of the hospitals and physician groups and drug companies. It does not provide any regulation of supply, or any limits on the mad rush of hospitals and doctors to invest in whatever service is most profitable at the moment. The difference in costs determines the other key differences. Costs are why the benefits are uncertain and in some cases inadequate. The costs explain why a normal amount of subsidies and transfers, compared to other countries, is not enough to guarantee insurance for all citizens.

Why was nothing serious done about the costs ? First, I should warn you that some people disagree with me.

Je ne dis pas que les États-Unis se soient convertis à la protection sociale telle qu'elle est en vigueur dans les autres pays. Les États-Unis connaissent plus de divisions quant à la solidarité, et la loi pourrait être abrogée si les républicains prennent le pouvoir. Mais la différence des coûts semble plus significative : le pays achète moins de protection sociale en partie à cause de son coût supérieur. Ce sont les coûts qui expliquent pourquoi les prestations offertes par le système de bourses d'assurances se trouvent à un niveau relativement bas, et pourquoi un montant normal de subventions et de transferts ne suffit pas à garantir une assurance-maladie pour tous les citoyens, en comparaison des autres pays.

Si l'on se demande pourquoi les États-Unis n'ont pas d'assurance-maladie au niveau national depuis si longtemps, la réponse est que la droite américaine, du moins pour les cent dernières années, s'en tient à une position particulièrement anti-solidaire, et que grâce à la structure politique américaine, elle a réussi à bloquer toute réforme. Mais si l'on se demande pourquoi les États-Unis permettent à l'establishment médical entrepreneurial et à l'industrie des assurances d'exploiter tout le monde - pas uniquement les pauvres, mais aussi les employeurs ; pas uniquement les démocrates, mais aussi les républicains -, la réponse serait quelque peu différente.

Nous devrions alors nous concentrer sur les américains centristes : ces démocrates conservateurs, mais aussi la presse de référence, les économistes, les organisations d'hommes d'affaires d'élite, les think tanks et les autres acteurs de la vie économique. Les acteurs centristes, qui veulent aider à assurer les gens, continuent à voir la couverture sociale comme un produit, et leur but est donc de les aider à l'acheter sur le marché. Ils ne veulent pas se mêler du marchandage entre hommes d'affaires et fournisseurs de soins.

L'attitude des entreprises américaines et de leurs intérêts constitue le facteur le plus important. Pour eux, la question clé est le pouvoir public contre le pouvoir privé. Bien qu'ils se plaignent du niveau inférieur des coûts de la santé dans les pays concurrents, les entreprises américaines n'en tirent pas les conclusions logiques. Les intérêts commerciaux n'avaient pas une position réelle dans le débat de 2009-2010 sur le contrôle des coûts – ils s'en

They have what I consider magical beliefs about cost control. I will explain why more when I discuss options for cost control in France, in my third talk. Having said that, the cost provisions in the new law do not include anything like the more effective methods in other countries because the swing legislators, the moderate or conservative Democrats, believe more in social sharing than they do in government regulation of the economy. And the key interest group, the interest group that has the biggest stake in cost control, is the interest group that is most opposed to government "interference," as they see it, with "private enterprise" and markets : business.

From a purely economic point of view, American businesses should want the government to just take over health care. Put in the Canadian system and get health care off their budgets! But business interests won't go there. They had no real cost control position in the 2009-10 debate – just some wishful thinking about how someday, maybe, health care delivery in the United States would become more efficient. The liberals wanted to lower prices by creating government insurance that could use Medicare's market power. The conservatives wanted to reduce insurance. But the people in the middle – the conservative Democrats and the employers who already provided insurance – did not want to eliminate insurance but also did not want to use the power of government to constrain private parties, such as doctors and hospitals and insurers, to control costs.

The Obama administration's health care finance system, if it survives Republican attacks, will not quite meet the international standard. But that is not because it does not represent beliefs in social protection. The problem is the broader American distrust of governmental power, and belief that markets are efficient. Many Americans do not quite believe that markets are fair. But getting them to believe government can be more efficient is more difficult.

tinrent, tout comme l'administration Obama et un grand nombre d'économistes et de chercheurs en services de santé, à la même pensée magique. Les libéraux voulaient baisser les prix en créant une assurance-maladie gouvernementale qui pourrait utiliser le pouvoir de marché de Medicare. Les conservateurs voulaient réduire l'assurance-maladie. Mais ceux qui se trouvaient au milieu – les démocrates conservateurs et les employeurs qui fournissaient déjà une assurance-maladie - ne voulaient pas éliminer l'assurance mais ne voulaient pas non plus utiliser la force du gouvernement pour obliger le secteur privé, c'est-à-dire les médecins, les hôpitaux et les assureurs, à contrôler les coûts. Après tout, les médecins, les hôpitaux et les compagnies d'assurance sont aussi des entreprises.

Le système de financement de la santé mis en place par l'administration Obama ne satisfera pas vraiment les normes internationales, même s'il réussit à survivre aux attaques républicaines. Pas parce qu'il ne croit pas à la protection sociale ; le problème le plus important est ce conflit profond, très américain, entre l'Etat et le marché, entre le gouvernement et les entreprises.