

MODELS OF RATIONING

INTRODUCTION TO RATIONING

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A good deal of the popular commentary on rationing, relying on images of the meager medical care portions that are given out abroad, portrays it as a fearsome but inevitable alternative to our present medical care arrangements. The British National Health Service ("NHS") provides the doomsayers' favorite illustration. Indeed, the prevailing conception of the NHS among hostile American critics is of "a monster, painted on a pole," a system in which patients suffer

endless waits to see overworked and undertrained staff in obsolete and undermaintained facilities. Patients may even be denied life-saving treatment if they are old or for other reasons fail to receive high enough priority for scarce services whose availability is controlled by heartless, or at least unaccountable, bureaucrats.¹

A remarkable feature of such caricatures is their incongruity with the more formal notions of rationing developed by many economists and policy analysts. Economists take a particularly benign view of "rationing," equating it with "allocation." In their view, market economies ration access to goods and services by price (ability or willingness to pay). Our present medical care system is a marketplace where private and social insurance allow both cost sharing and risk pooling, permitting allocation to those who might not otherwise have purchased goods and services at their full price. From this perspective, our present system of "rationing" is hardly a monster. If it is a monster, it is, at least, one with which we are intimately familiar.

Policy analysts exhibit less agreement about the meaning of "rationing." Most of them distinguish between *macroallocation* (referring to decisions about how resources are distributed to

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¹ Robert G. Evans, "Rationing" *Health Care: The Loaded Alternative*, FRONTIERS OF HEALTH SERV. MGMT., Fall 1987, at 31, 31.

institutions or types of services—for example, decisions about how many open heart surgery beds there will be in a region) and *microallocation* (referring to decisions about how resources are to be distributed to individuals—for example, decisions about who is to receive open heart surgery). And most would assign the label “rationing” to microallocational decision making.² But of course, “rationing” in this more restricted sense can only be a monster if health services are scarce. If there are enough to go around, there is no reason to fear microallocational rulemaking. Indeed, the proposal to cut waste by using “clinical guidelines” or “practice parameters,” which we describe in detail in our own contribution to this Symposium,³ has been immensely appealing precisely because it has been promoted as a way of making microallocational rules without denying anyone anything of benefits: It is rationing without pain.

Claims about the inevitability of rationing begin with the assumption that the present crisis has its roots in financial scarcity. From this premise it is inferred that hard choices are inevitable. We take exception to such arguments because they fail to distinguish between the “tragic choices” of true scarcity—for example, the case where there is one transplantable organ and two potential recipients⁴—and the garden variety scarcity that arises from shortcomings in existing arrangements—for instance, the case in which there is only one mammography machine and patients must book an appointment for routine screening examinations a month in advance.⁵ The failure to attend to these fundamentally different forms of scarcity leads pundits to assert that Oregon’s rationing plan is sadly inevitable because its present Medicaid budget can no longer be expanded—rather than because the state’s wealth cannot support a decent level of medical care for the poor.⁶ In making this distinction, we do not mean to imply that the politics of modifying budgetary constraints are trivial. We do mean to suggest,

² See ROBERT H. BLANK, RATIONING MEDICINE 78 (1988); Roger W. Evans, *Health Care Technology and the Inevitability of Resource Allocation and Rationing Decisions*, 249 JAMA 2047, 2048 (1983); Michael D. Reagan, *Health Care Rationing: What Does it Mean?*, 319 NEW ENG. J. MED. 1149, 1151 (1988).

³ See Jan Blustein & Theodore R. Marmor, CUTTING WASTE BY MAKING RULES: PROMISES, PITFALLS, AND REALISTIC PROSPECTS, 140 U. PA. L. REV. 1543 (1992).

⁴ See GUIDO CALABRESI & PHILIP BOBBIT, TRAGIC CHOICES 21 (1978).

⁵ See *id.* at 22.

⁶ Numerous instances of such punditry (and critics’ replies) can be found in Lawrence D. Brown, *The National Politics of Oregon’s Rationing Plan*, HEALTH AFF., Summer 1991, at 28.

however, that claims about the inevitability of rationing must be critically evaluated in light of the real facts of service availability and financial strain.

In the pages that follow, our colleagues expand on many of these issues. In so doing they will necessarily address questions of the allocation of medical resources, and some will develop models of its appropriate form. Whether termed "rationing" or, as some policy analysts, we among them, would prefer, the "microallocation of medical services," several broad issues are pertinent and important.

The first has to do with the dynamics of resource allocation in this contentious field. What methods are best suited to addressing who gets what, when, and where? There is no avoiding this question of allocation, but there is ample dispute about the right answer. What, for example, are the predictable strengths and weaknesses of such decisionmaking through government? What about doing so through market transactions? In the case of governmental allocation, what is to be said about the expected features of using administrative agencies, of depending upon courts, of relying on a mix of separate "powers?" These questions, though exceedingly controversial, are unavoidable. To the extent they have not been regularly raised in American health policy, they have been answered by default.

The second broad class of issues concerns the standards that should be applied to allocational rules by any institution. Should the relevant standards be largely professional ones: what the doctor (or nurse, or physiotherapist) thinks is appropriate? Ought organizations of medical professionals set the standards not only "for what works" but what allocational rules "make scientific sense?" Should governmental authorities control budgets alone or ought they actively engage in this setting of micro-allocational standards? What about direct public involvement in standard-setting? Is this an arena for direct democracy? That is, should there be open participation in the sense of various publics deciding what the standards ought to be, how loose or slack, and with what avenues for dispute and review?

Finally, there is the central question of to whom the contemplated rationing ought to apply. Should it be egalitarian; must the rules apply to all cases if applied to any? For example, were governments to restrict the supply of some new technology and to pay for the technology's use only when deemed professionally "necessary," should it be permissible to buy such services "in the

market?" If supplements are allowed, ought they be insurable under tax deductible private health insurance? Is there one set of rules for those covered by public plans and another for those not covered? What happens if the United States turns to universal health insurance? How "universalistic" are our rules in their application? Are there grounds for treating some groups specially? Who are they and on what basis?⁷

⁷ To make these questions less abstract, note that Canada explicitly forbade private insurance for publicly financed services when its universal program of medical insurance began. No group was permitted to "top up" payment for any particular service with private insurance. This restriction limited severely the market for "extras." It represented an egalitarian conception of health care access and an understanding of how cost containment was related to having a universal plan that was really comprehensive in its application. *See generally* ROBERT G. EVANS, *STRAINED MERCY: THE ECONOMICS OF CANADIAN HEALTH CARE* 34-52 (1984).