

# INTRODUCTION

## RATIONING OF HEALTH CARE: INEVITABLE AND DESIRABLE

RICHARD D. LAMM†

### INTRODUCTION

Americans find certain issues in public policy much easier to ignore than to confront. The necessity of rationing health care is one such issue. Because Americans believe that access to health care is a basic right,<sup>1</sup> we, as a society, have avoided facing the hard fact that it is not feasible to provide, on demand, all needed medical procedures to every individual who could potentially benefit from them. Unlimited needs, or at least unlimited perceived needs, eventually outstrip limited resources. For this reason, we have avoided open discussions about rationing; it inevitably would become clear to all engaged in such a discussion that rationing entails denying individuals some measure of health care that otherwise would benefit them. Rationing is felt to be unfair, unethical, and potentially discriminatory.

Every health care provider knows that we already ration health care. Much has been written about the thirty-five to thirty-seven million Americans who have no health insurance and the approximately thirty million others who have inadequate insurance. Upon consideration, we cannot deny that we already ration by price, geography, and a number of other means. We tell each other, however, that this is "indirect rationing" and apparently we find it morally easier to accept indirect rationing than "direct rationing." A sin of omission is easier to live with than a sin of commission.

### I. BETTER HEALTH THROUGH RATIONING

A more positive case for rationing can readily be made: We can have better health through rationing. Today, the United States has the worst form of rationing—rationing by excluding people from the health care system entirely. A society will not be able to move

---

† Governor of Colorado January 1975 to January 1987. Director, Center for Public Policy & Contemporary Issues, University of Denver.

<sup>1</sup> See ROBERT H. BLANK, *RATIONING MEDICINE* 5 (1988).

towards maximizing the health care that it provides to its citizens until it fully confronts the issues involved in rationing.

First, we must recognize the dilemma that while our resources as a nation are finite, our health demands are infinite. A recent study observed: "The appetite for health care is infinitely expandable, since it is almost always possible to secure some small benefit by additional treatment."<sup>2</sup> There is a limit to the amount of resources society can devote to health care, the study adds, which means that we simply cannot provide all services to all who would benefit.<sup>3</sup> Similarly, an English study stated: "[F]inance is finite; caring knows no bounds."<sup>4</sup> We will not get health care spending under control until we accept this reality.

The pattern of health care expenditures in the United States is clearly unsustainable. The federal government's health care outlays are growing at two to two-and-one-half times the rate of inflation.<sup>5</sup> Increasingly, our society is recognizing that the genius of American medicine has invented more health care than we can afford to deliver. An aging society that is the world's largest debtor nation and whose economic growth is only one-third of historic rates must set priorities.

Recently, a French study asked how much it would cost to give all the health care that is "beneficial" to each citizen. The answer was five-and-one-half times the French gross national product.<sup>6</sup> If that number is indicative of how much such health care would cost in other countries, then no modern society can afford to give all the health care that is "beneficial." Medical "need" is an infinitely expandable concept. We need what is available, and in a creative and inventive society such as our own, there is no end to what we can do to treat aging bodies. It is becoming increasingly obvious that the genius of American medicine has outpaced our ability to pay. A recent publication noted that:

Modern men and women of medicine now have the capability to spend unlimited resources in heroic and sometimes vain attempts to extend life . . . [S]uch changes pose a serious dilemma to

---

<sup>2</sup> Reinhard Priester, *TAKING VALUES SERIOUSLY: A VALUES FRAMEWORK FOR THE U.S. HEALTH CARE SYSTEM* 29 (1992).

<sup>3</sup> *See id.*

<sup>4</sup> *HEALTH CARE PROVISION UNDER FINANCIAL CONSTRAINT* 1 (T. B. Binns & Mary Firth eds., 1988).

<sup>5</sup> *See U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES* 95 tbl. 141, 467 tbl. 756 (1990).

<sup>6</sup> *See The Slide Toward Auschwitz*, *RELIGION & SOC'Y REP.* Jan. 1991, at 6, 7.

society. A dilemma so new that neither our social, legal and religious institutions, nor our health care providers or consumers, have developed a satisfactory way of coping. How do we as a nation balance our beliefs in the individual choice and values in health care against our community priorities and resources?<sup>7</sup>

Just as the individual family must make choices within a budget, our national family must also make choices concerning what we can and cannot afford. Increasing efficiency and ending waste alone will not solve our health care problems. Rationing is the price we must pay for our creative success. It is the ugly child of the marriage of our creative and inventive society and our rather uniquely American (albeit abstract) desire to have an egalitarian society that denies the poor nothing that is available to the rich.

Avoiding these hard issues does little justice to America. Our society would *benefit* from an honest discussion of rationing. The search for the health care system that does not ration, like the search for the judge that does not err, is not only futile, but also demeaning to a thoughtful people. The worst way to deal with a problem is to ignore it.

Any solution to our health care problems will entail more than recognizing these realities. A nation does not maximize its health until it starts to ask the hard question: How do we prioritize our money to buy the most health for the most people? Buying the most health for the most people should be the standard. Modern governments historically have attempted to achieve the greatest good for the greatest number. Public spending on health care should attempt to maximize the nation's health, not individual health. We should not apologize for rationing; we should promote and advance it. We fail to explore the "opportunity costs" of limited dollars unless we admit that we cannot pay for everything and start to ask: "How do we maximize our health dollars?"

This is the brighter side of the rationing debate. Americans remember that the debate over energy conservation initially meant colder houses and less driving. The outcome of the debate, however, was not so grim; it produced better insulated houses and more efficient cars. We can achieve the same counterintuitive results with health care rationing.

In a world of limited resources, we cannot say "yes" unless we say "no." We cannot explore the best use of our resources, the so-

---

<sup>7</sup> LAURENE A. GRAIG, HEALTH OF NATIONS: AN INTERNATIONAL PERSPECTIVE ON U.S. HEALTH CARE REFORM xv (1991).

called "opportunity costs" of each dollar, unless we set priorities as to what we can afford. We must start a community dialogue about how to put our health dollars to their best use. It is an inevitable dialogue and we ought to make a virtue out of this necessity.

Many claim that all we have to do to avoid the painful question of rationing is adopt the Canadian health care system.<sup>8</sup> Others argue for a "pay or play" plan.<sup>9</sup> While structural reform in health care is needed and overdue, it will not avoid the hard question of rationing.

Oregon is a harbinger for the nation. Regardless of whether Oregon has the right answer or not, one has to admire Oregon for asking the right question. As Oregon Health Decisions explained:

It is necessary to set priorities in health care, so long as health care demands and needs exceed society's capacity, or willingness, to pay for them. Thus an "adequate" level of care may be something less than "optimal" care.

. . . .

Setting priorities and allocating resources in health care should be done explicitly and openly . . . ."<sup>10</sup>

The discussion about rationing is long overdue. Having institutionalized too much of our health care spending, we must now try to liberate our minds and ask ourselves what policies and strategies will buy the most health for our society. The United States spends 50% more on health care than our international competitors, yet our citizens are in poorer health than those in Japan, Canada, Great Britain, and other European countries.<sup>11</sup> Open discussion about rationing allows us to break out of our restricted mode of thinking and ask some hard questions. But the debate is still filled with undeveloped concepts.

<sup>8</sup> See, e.g., David U. Himmelstein et al., *A National Health Program for the United States: A Physician's Proposal*, 320 NEW ENG. J. MED. 102, 104 (1989) (arguing that in Canada, a "fee-for-service practice with negotiated fee schedules and mandatory assignment (acceptance of the assigned fee as total payment) has proved compatible with cost containment, adequate incomes for physicians, and a high level of access to and satisfaction with care on the part of patients").

<sup>9</sup> See, e.g., Joyce Frieden, *Democrats Introduce Health Care Bill*, UPI, March 5, 1992, available in LEXIS, Nexis Library, UPI file, (mentioning Democratic leader George Mitchell's "pay-or-play" health care proposal that would require all employers to provide health insurance to employees or pay into a public program).

<sup>10</sup> OREGON HEALTH DECISIONS, QUALITY OF LIFE IN ALLOCATING HEALTH CARE RESOURCES 2-3 (1988).

<sup>11</sup> See George J. Schieber et al., *Health Care Systems in Twenty-Four Countries*, HEALTH AFF., Fall 1991, at 22, 22.

## II. EXPLORING THE RATIONING DEBATE

### A. *What Level of Care Should We Use to Judge Whether We Should Ration?*

The rationing debate has yet to address the level of care to be used as a yardstick in judging denial. Some authors talk about "appropriate care," others about "necessary care," and still others discuss "basic health care." Clearly, these are different standards. Should we provide only "medically necessary" services<sup>12</sup> or, do we ration by denying something that is beneficial, but not absolutely necessary? Does "appropriate care" mean everything that is both necessary *and* beneficial? These are not idle semantic games. The differences between expansive definitions and constricted definitions could be tens of billions of dollars. Some "beneficial" services are marginal and do not fall under the category of "necessary" under most definitions. This is an issue that at this time can be raised, but not solved. It forms the nucleus of an important future debate.

### B. *Who Rations?*

There are four possible players who could ration medicine: (1) consumers; (2) health providers; (3) bureaucrats and managers; and (4) politicians through public policy. All four have some role in rationing. The principal role, however, should be played by politicians through public policy.

#### 1. Consumers

Consumers of health care can play a role in rationing by creating living wills, providing advanced directives, or by just staying away from the system. Consumers limit the amount of health care services that they demand. Recently, there has been an explosion in the number of living wills, medical powers of attorney, and advanced directives. We increasingly find that most people do not want all available medical services if those services produce an unfavorable outcome.<sup>13</sup> The consumer purposely limits the

---

<sup>12</sup> See Arnold S. Relman, *Is Rationing Inevitable?*, 322 NEW ENG. J. MED. 1809, 1810 (1990).

<sup>13</sup> See WALTER M. BORTZ II, WE LIVE TOO SHORT AND DIE TOO LONG 251-54 (1991) (finding increasing levels of support for euthanasia among both physicians and the general public); DANIEL CALLAHAN, WHAT KIND OF LIFE 225 (1990) (noting that

amount of health care and exercises personal autonomy by saying "no." The consumer also rations "by deciding not to transform a legitimate need into an actual and effective demand, for example, a genuinely sick person deciding not to visit the doctor."<sup>14</sup> The British National Health Service has found that many needs within the community do not translate into demands for services by individuals because of their free choice.<sup>15</sup> We should also note that consumers, as voters, will play a crucial role as the health policy debate matures, since the preference of the majority will ultimately prevail.

## 2. Health Providers

To what extent should doctors ration? We should not use doctors as the primary rationing agent; at the same time, however, society should not set priorities and allocate limited health care resources without the benefit of physicians' insight. As one scholar, Dr. David Hadorn, observes: "Physicians and other health care professionals are the only members of society with a broad enough perspective to estimate and compare the quality of life effects of different medical treatments."<sup>16</sup> He also urges that physicians not do this alone.<sup>17</sup> He advocates a process that includes patients and the general public "because the general citizenry collectively pays for health care (e.g., through taxes and insurance premiums) and is collectively at risk for needing health care."<sup>18</sup>

Physicians correctly ask, "Does my participation in deciding how to allocate limited health care resources trample on my sworn duty to my patients?" It must be understood that the nature of medicine forces doctors to meet the demands of competing obligations. A doctor at a patient's bedside must be the patient's advocate. But that role does not preclude a doctor from fulfilling the duty to help

---

the percentage of Americans favoring active euthanasia rose from 37% in 1973 to 61% in 1985); DANIEL CALLAHAN, *SETTING LIMITS* 175-76 (1987) (analyzing the patient's right to self-determination). The desire for limits is seen in the success of Humphry's book, *Final Exit*. See DEREK HUMPHRY, *FINAL EXIT: THE PRACTICALITIES OF SELF-DELIVERANCE AND ASSISTED SUICIDE FOR THE DYING* (1991).

<sup>14</sup> KEN JUDGE, *RATIONING SOCIAL SERVICES: A STUDY OF RESOURCE ALLOCATION AND THE PERSONAL SOCIAL SERVICES* 6 (1978).

<sup>15</sup> See *id.* at 5-6.

<sup>16</sup> David Hadorn, *Health Care Effectiveness Research & Public Policy* (1988) (unpublished grant proposal).

<sup>17</sup> See *id.*

<sup>18</sup> See *id.*

society set health care priorities. Physicians can fight for individual patients and yet still advocate, in other contexts, that particular treatments are futile. In the same way, a lawyer can defend a client in a capital case and yet advocate the death penalty. Priorities must be set, and the expertise and experience of physicians are necessary to help accomplish this task.

### 3. Bureaucrats and Managers

In countries with national health care systems, bureaucrats and managers play a role in rationing. It has been observed: "They are continually involved in making financial allocations, both independently and in conjunction with politicians, and also in supervising and guiding a good deal of service rationing."<sup>19</sup> Judging by the large public support for these systems wherever they exist, we must assume that these managers do their jobs well. They are held accountable to both politicians and the public and, absent incidents of flagrant abuse, are rarely the subject of criticism.

### 4. Politicians

While all of the above will play a role in rationing, a major part of the rationing decision must ultimately be worked out through the political process. Health care is no longer merely a commodity purchased by individuals. Government already funds approximately 40% of all health care spending.<sup>20</sup> Even if this amount remains static, community values must be expressed through the political system. Increasingly, however, health care is being thought of as a social good to be financed or guaranteed through government. The Internal Revenue Code provides for tax exemption of health benefits,<sup>21</sup> and government regulates the health care system in a myriad of ways.<sup>22</sup> States regulate health insurance<sup>23</sup> and Congress has adopted diagnosis-related groups and relative value scales

---

<sup>19</sup> JUDGE, *supra* note 14, at 6.

<sup>20</sup> See DEAN CODDINGTON ET AL., *THE CRISIS IN HEALTH CARE: COSTS, CHOICES AND STRATEGIES* 88 (1990).

<sup>21</sup> See HENRY J. AARON, *SERIOUS AND UNSTABLE CONDITION: FINANCING AMERICA'S HEALTH CARE* 66-68 (1991).

<sup>22</sup> See *id.* at 68-72.

<sup>23</sup> See *id.* at 68-69.

to reimburse physicians.<sup>24</sup> The federal government funds a massive amount of research.<sup>25</sup>

Government is deeply involved in health care in these ways and more, and it is thus appropriate that it reflect community values in a policy area that it has so much influence on. It is too late for government to stand back and say "Who me?" Government controls so many aspects of health care that it cannot avoid its role as rationer. When resources are limited relative to needs, government must allocate those scarce resources. Resources spent on one patient means fewer resources available for others with medical needs. Government in these circumstances unavoidably must decide the common good.

### C. *Forms of Rationing*

Societies ration in a number of ways. Once we admit that we must set priorities, we must inevitably recognize the need to explore the means of rationing scarce resources. There are four basic methods of rationing: (1) price; (2) quantity; (3) chance; and (4) prioritization.

The United States rations chiefly by price. In rural America, access may be limited by lack of availability, but the primary rationing method in this country is by price. Great Britain rations by setting limits on quantity. Everybody does not get everything, but all get access to good basic health care. Philosophers love to talk about chance (i.e., rationing by lottery), but to my knowledge it has never been tried and, in my opinion, is impractical. What is left to be explored is rationing by prioritization. Such a system is designed to allow us to buy the most health for our dollars.

Some experts suggest that rationing systems can be characterized as either "first-dollar" systems or "last-dollar" systems:

One might argue that *first-dollar* rationing is the principal form of rationing in this country; that is, our public programs are more likely to limit an individual's access to basic services by not paying for the initial costs of care (either because of a lack of coverage for basic services or because of high deductibles and coinsurance), even though more expensive, tertiary care is often covered. For instance . . . the lack of Medicare coverage for outpatient prescription drugs and the low physician reimbursement rates under

---

<sup>24</sup> See *id.* at 69-72.

<sup>25</sup> See *id.* at 72-73.



Medicaid serve to ration basic services for many elderly and poor people. For individuals without insurance coverage, access to basic services is also rationed. Ironically, those with tertiary care needs, such as renal dialysis or organ transplantation, are more likely to find some coverage through a combination of Medicaid, Medicare, and public hospitals.

In other countries, such as Great Britain, *last-dollar* rationing might be a more apt description for the means of controlling expenditures. In such a system, based on universal coverage, access to very high-cost services is impeded whereas the initial, or first-dollar, costs of basic care are covered. Thus, although access to primary physician care is open to all, those who are more severely ill and likely to require expensive therapies are more likely to confront rationing.<sup>26</sup>

These are never easy choices, but most experts would agree that last-dollar rationing utilizes resources in a way to maximize the public's health. There are a large number of high cost-low benefit procedures. Such procedures have marginal value. Most health policy experts agree that a society buys the most health for its resources by first funding basic health care, and if choices must be made it is best to eliminate those services of marginal value.

Experts also classify rationing methods as either formal or informal.<sup>27</sup> Formal rationing is explicit rationing of the type Oregon has put into effect. Informal rationing is unofficial and usually involves doctors or bureaucrats exercising their discretion. There appears to be a logical continuum starting at one pole with rationing by price, a formal method, and ending, at the other pole, with the informal methods of rationing by limiting quantity, or rationing by delay. Other forms of rationing, such as restricting eligibility or imposing restrictions on direct access to specialists, fall in between the two poles. Experts note that formal methods of rationing are generally governed by rules and regulations and are thus much less subject to abuse than informal methods. These rules attempt to ensure that people with similar needs are treated uniformly.<sup>28</sup>

There are no rules to informal rationing. Professional judgment and factors like delay, geography, and withholding information

---

<sup>26</sup> Jeffrey C. Merrill & Alan B. Cohen, *The Emperor's New Clothes: Unraveling the Myths About Rationing*, 24 INQUIRY 105, 106-07 (1987).

<sup>27</sup> See, e.g., PEGGY FOSTER, ACCESS TO WELFARE 12-16 (1983) (listing formal and informal rationing methods).

<sup>28</sup> See JUDGE, *supra* note 14, at 28.

often operate to deny services to needy people. How patients act or appear physically has been shown to determine, to some extent, the services they receive; this type of rationing is especially vulnerable to abuse. Some consider "rationing via public relations," where private funds are sought through the media to fund an expensive medical treatment, as another form of informal rationing.<sup>29</sup>

As we begin to prioritize health care, we, like every other country, should decide that the first priority is basic health care for all our citizens. Other countries wrestling with these priorities have emphasized public health, preventive care, and basic health care.

#### D. *Rationing By Defining Basic Health Care*

The scope of this essay does not allow for a full discussion of the various rationing methods. The current debate over the Oregon plan, however, reveals one method that is being widely discussed: defining a basic health care package. One of the key waivers Oregon is seeking from the Health Care Financing Administration would permit the state to redefine the services it provides,<sup>30</sup> essentially defining a basic health care package.

Under Oregon Senate Bill 27,<sup>31</sup> the Oregon Health Services Commission released a draft priority list of health care services intended to cover 100% of poor Oregonians, and only those services deemed to be a relatively high priority.<sup>32</sup> The first 587 priorities have been funded. They were chosen by a formula that contained three factors: (1) cost of services; (2) their anticipated effects on longevity and quality of life; and (3) the expected duration of the effects.<sup>33</sup> The purpose of the priority setting is to cover all Oregonians under the federal poverty level. "The net effect is a trade—a cutback in coverage of approximately 115 services for . . . 200000 people . . . and an addition of coverage for 587 services for 450000 people . . . ."<sup>34</sup>

<sup>29</sup> See BLANK, *supra* note 1, at 97-99.

<sup>30</sup> See David M. Eddy, *Oregon's Plan: Should It Be Approved?*, 266 JAMA 2439, 2439 (1991).

<sup>31</sup> S. 27, 65th Leg., Regular Sess., 1989 Oregon.

<sup>32</sup> See Eddy, *supra* note 30, at 2439.

<sup>33</sup> See OREGON HEALTH SERVICES COMMISSION, *PRIORITIZATION OF HEALTH SERVICES: A REPORT TO THE GOVERNOR AND LEGISLATURE 13-28* (1991) (describing the Commission's methodology of using data and values integrated into a three-step process leading to a prioritized list of health services).

<sup>34</sup> *Id.* at 2441.

Oregon earlier gave us a glimpse of the future when it decided not to fund transplants under its Medicaid program. Instead, it decided to spend the money on basic health care for the people currently outside the health care system. Oregon, like every other state, previously rationed health care by excluding people from the system. Anyone in Oregon who made more than \$7800 a year for a family of four was not eligible for Medicaid. Oregon became the first state to cover 100% of those persons living below the poverty line and the price they paid for this was no funding for a select number of high-cost, high-technology procedures. Oregon shifted from a rationing system that excluded people to a system with prioritized procedures that covers all of the poor.

John Kitzhaber, a physician and President of the Oregon State Senate, explained the trade-off as follows:

When money is spent on one set of services it is, by definition, not available to spend on other services. Health care services must compete with all other legitimate services state government must provide. An explicit decision to allocate money for one set of services means that an implicit decision has also been made not to spend money on other services. That, in essence, constitutes the rationing of health care. State legislatures do it with every budget cycle.<sup>35</sup>

He continues passionately:

We are spending vast amounts of money on some people and virtually none on other people. We spend about three billion dollars a year on neo-natal intensive care while we deny prenatal care to hundreds of thousands of women. We spend fifty billion dollars a year on people in the last six months of their lives while we are closing pediatric clinics because we claim that we do not have the resources to keep them open. We are rationing by default.<sup>36</sup>

The reasoning adopted in Oregon is that the need to provide all people with health care coverage outweighs the desire to fund a limited set of high-technology procedures. Given information on the outcomes of health services, the debate no longer focuses on which individual is granted or denied health care services; rather, the debate now focuses on assigning priorities for funding those

---

<sup>35</sup> *Hearings on S. 27 Before the Senate Health Insurance and Bio-Ethics Comm.*, 65th Leg., Regular Sess., 1989 Oregon 16 (statement of Sen. Kitzhaber).

<sup>36</sup> *Id.* at 17.

services.<sup>37</sup> The process of rationing turns on the definition of what is covered.

We need to address what should be covered in a basic health care plan. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research confirmed society's obligation to provide all citizens with "equitable access" to an "adequate level of care."<sup>38</sup> Unlike the Oregon plan, the Commission defined medical need "as any condition for which medical treatment might be effective."<sup>39</sup> Others, however, have pointed out that the concept has to be more narrowly defined to be of any use. If we cannot pay for everything, and we cannot, the battle will likely occur over the definition of basic benefits packages. Oregon is thus a harbinger.

The situation gets even more complicated. Some commentators argue that patients' characteristics vary considerably; there are "high-benefit patients" and "low-benefit patients" and various procedures help various patients differently.<sup>40</sup> They argue that any rationing plan must give priority to high-benefit patients within each category of procedures. Not doing so would place excessive burdens on the high-benefit patients' access to truly beneficial health care. These issues are far from resolved and will not disappear.

### E. *Federalism*

Given the unsettled nature of so many of the questions in the rationing debate, it would seem desirable to maximize state innovation in these areas. Oregon has helped educate the entire nation. The historic roles of states as "laboratories of change" could, and should, be encouraged. This is one of the strengths of our federal system, and it ought to be utilized.

The federal government simply is not in a position to undertake sweeping reform. As one political scientist noted: "The federal government has made it clear that it's so broke that any of the major initiatives it would like to push in the '90s—transportation, drug wars, education reform—will be overwhelmingly state-funded

<sup>37</sup> See *id.* at 18-20.

<sup>38</sup> See PRESIDENT'S COMMISSION FOR STUDY ETHICAL PROBLEMS MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, 1 SECURING ACCESS TO HEALTH CARE 20 (1983).

<sup>39</sup> See *id.* at 19.

<sup>40</sup> See William Schwartz, AM. HOSP. ASS'N NEWS, Nov. 13, 1989, at 1, 5.

and state-directed."<sup>41</sup> This is hardly the atmosphere to in which undertake health-care reform at the federal level.

#### CONCLUSION

One of the principal challenges of any society is to adapt to new realities; it is a painful process because it often overturns institutions and entrenched values. But public policy is never static; it is always evolving. Health care in industrial societies has outlived its historic assumptions. We cannot build a functioning health care system that is based on the premise that we can do everything for everyone. Infinite medical needs soon exhaust finite resources. Once we recognize that there are limits to what we can do and spend, we will recognize that a thoughtful allocation of health resources can actually improve our national health.

---

<sup>41</sup> Neil Peirce, *The State-Federal Seesaw*, 13 HEALTH MGMT. Q. 2, 5 (1991).

