

On Roses and Rationing: The Economics of Health Care Access

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Abstract

Health care in the United States has always been rationed. Such rationing is both an economic reality and a social responsibility. This paper argues that while the concept is typically renamed in order to make managed care somewhat more palatable, rationing remains a fundamental tenet of the U.S. health care system. An analysis of literature in the fields of managed care and social work ethics is used as the basis for a discussion of this rationing and of social workers' role in its wake. Health care rationing – and its current iteration, managed care – are shown to be neither good nor bad, but rather tools to be managed carefully by social workers. Simple suggestions are offered for social workers' effective intervention in the health care delivery system.

Introduction

Health care in the United States has always been rationed. Rationing implies a controlled limitation of what is needed for survival that most people are loathe to consider as a component of the health care delivery system. It sounds so terribly un-American. This article will argue that social workers have historically participated in seeking more equitable rationing of scarce resources within a capitalist system (Specht & Courtney, 1994), and in securing the best possible outcomes for both individual clients and the communities of which they are a part. In most regards, health care resources are not conceptually different; medical interventions are scarce and choices regarding their allocation will be made by patients and the health care system itself at myriad points. The difference lies in the fact that when health care is being rationed it is effectively implied that some American lives are deemed more expendable than others. Social workers must be actively involved in identifying the issues, in defining the variables, and supporting their clients – here also patients – in navigating a complex system of care.

Certainly, rationing's pejorative connotation has necessitated its being renamed. But like the proverbial rose, rationing is rationing regardless of what it is called. And rationing has been called many things. To explore the notion of rationing it is

instructive to consider some of those things by which the American public has come to accept what they might believe they would never condone: the “rationing” of health care. Of the roughly 120 terms in the glossary found in one U.S. health care system text, 75% could easily be redefined using the word “rationing,” although that word is nowhere to be found (Jonas, 2003). Some of the more obvious and often used euphemisms include the following:

- *Gatekeeping* refers to any operation that monitors (and restricts) access to care (Jonas, 2001, p. 70; Mechanic, 2001).
- *Utilization* reviews are economic analyses of health care choices (Davidson & Davidson, 1998).
- *Diagnosis-Related Groups* (DRGs) are 468 Reagan-era formulas to determine at what level medical care is reimbursed (Moniz & Gorin, 2003).
- *Managed Care* by virtually all definitions is at its core rationing (Allbrecht, 2001; Eastman & Eastman, 1997; Jonas, 2003; Kapp, 2001; Rosenberg, 1998; Vandivort-Warren, 1998).

Rationing can be conceptualized as an economic reality or a social responsibility. When the discussion is of health care rationing, the two intersect. In other words, it is useful for the purposes of this discussion to review “Economics 101” as well as “Social Work 101.”

On Economics 101

Americans have a reputation for trying to live life without limits. Cars are big. Homes are big. Business is big. Health care is both big business and a big social and economic problem. This problem emanates from basic economic principles of supply and demand and limited resources. In terms of health care on both macro levels (national policy where social workers might serve as lobbyists, advisors and expert witnesses) and micro levels (management practice and individual choice where social workers most routinely find themselves in agency and health care casework), the principles of supply and demand

assert that in a free market the quantity of a commodity depends upon the demand for that commodity. Here the commodity is health care. This would be simply a descriptive formula if it were not for the intervening reality of limited resources. Most of the U.S. health care system operates in a free market economy where profit is the primary motive driving the industry. In this free market economy, the price of a commodity (health care) will rise until the demand for that commodity is sated. Where the commodity is a luxury item like designer shoes or a substitutable item like a tastier loaf of bread, this again would be simply a descriptive formula. But when the commodity is health care and, therefore, effectively means human lives, the discussion must move beyond description. Given the reality that *everyone* eventually experiences a health care need, eventually the resources of the system *will* be allocated according to formulae explicit or implicit. This allocation is rationing.

Even in this land of big and plenty there will *never* be enough health care to stave off illness and death. Technology has limits. One of those limits is dollar cost (Abraham, 1993). With pharmaceutical companies advertising that they will be able to cure all ills (Lown, 1999; National Association of Pharmaceutical Companies, 2003) and physicians untrained to confront death (Kapp, 2001), the American public is naturally loathe to accept that some things cannot be cured and that death is inevitable. Some suggest that there *should* be limits on certain radically expensive interventions of limited efficacy (Abraham, 1993; Callahan, 1999). Yet most admit that if the patient in question were dear to them they would feel otherwise. Given limited resources, all parties within the national health care system must make choices about how to allocate the health care resources that they control.

Decision makers include the federal government whose allowance of extraordinary spending has not proven to increase the quality of U.S. health care (Bottles, 2000; Reay, 1999). There are currently 281 million Americans (Jonas, 2003), almost 50 million of whom are uninsured and another roughly equal number are underinsured (Karger & Stoesz, 2002). There are some 1,000 managed care organizations whose benefit plans effectively serve as health care proxies (Agrawal, 1998; Mechanic, 1999). The employers who contract for their services are also economic decision makers. Hospitals and physicians - who some argue are the ones to render the ultimate

decisions (Agrawal, 1998) - and consumer groups which include social workers, complete the cast of characters within the health care system (Keigher, 1997). Some believe that the best option is interdisciplinary collaboration (Abrahamson & Mizrahi, 1996; Keigher, 1997). Others conclude that the solution is to entrust more decision-making to those receiving care - to the patient (Havas, 1998; McBride, 1997). Of course, there remain millions who are not privileged to make those decisions by virtue of living without health insurance in this country.

If the complexities of the national health care system could ever be reduced to a single notion, that notion would be *access*. Access can be understood in myriad ways. The two broadest conceptualizations are access to a particular facet of medical care and access of a particular population to any care at all. For reasons stemming from the basic elements of economics discussed earlier, access by any definition is as it has always been - limited. Even quality of care cannot be logically considered absent access to that care. Of what use is a state-of-the-art imaging center to a population whose managed care plan severely restricts use of that technology? And what impact will a public aid clinic boast if it is located far from public transportation routes within its catchment area? Ultimately every combination and permutation of resource allocation is made for the purpose of rendering health care accessible. It is rationed. It always has been. It always will be.

Havas (1998) identifies managed care as "what happens on the way to not providing a national health care policy" (p.75), and others would certainly agree that the reactive quilting that constitutes what we refer to as the U.S. health care system is far from systematic (Albrecht, 2001; Kohn, Hasty & Henderson, 2002; Lown, 1999). Many point out that managed care is simply a new name for an old reality. Now, however, an ever-increasing proportion of middle class Americans are confronting the limitations of health care for the first time and politicizing widespread discontent (Friedman, 1997; Havas, 1998; Lown, 1999; Mechanic, 1999). Still, in a free market economy, "one person's rationing is another person's income" (Friedman, 1997). This, after all, is in part why managed care companies came to exist. And given their existence, Siskind (1998) describes managed care organizations as an "insurmountable opportunity" that we might do well to learn to work within. Others argue eloquently that managed care is

ethically flawed (Davidson & Davidson, 1996; Galambos, 1999). Buchanan (1998) asserts that rationing is not conducted according to principles of justice despite his conviction that the notion of rationing itself is tenable. Rosenthal and Newhouse (2002) concur. To others, rationing is construed as beyond tenable and the reasonable basis for what is conceived as “sustainable health care” (Callahan, 2001; Jameton & Pierce, 2001). One enlightened physician points out that “[w]hen death is the inevitable result of a chronic and incurable disease, it is often kinder not to impede it with heroic measures but to manage its approach with common sense and compassion” (Lown, 1999).

On Social Work 101

The World Health Organization (1946) definition of health is oft-quoted perhaps because of the eloquence of its charge: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (p.100). Whatever health is understood to include as “well-being,” it is certainly the absence of disease or infirmity. But it is naïve to think that *anyone* privileged to live very long will escape disease or infirmity. As sure as birth and death, these are part of the human experience. It is the role of social workers to support people as they manage *all* of life.

On a personal economic level, health management impacts social workers in terms of their remuneration. That means that there is some new attention being given to the mechanics of social workers competing in the health care marketplace (Gibelman & Whiting, 1999). On a broad level, the NASW Code of Ethics charges social workers to minister to the disenfranchised (NASW, 1996). In this country, the disenfranchised are invariably either without health insurance or without adequate health insurance. More specifically, the tenets of managed care impact social work ethics in terms of confidentiality, informed consent, self-determination, fiduciary responsibility, and the primacy of the individual over the system such that they coalesce to resemble a Venn diagram on steroids (Davidson, Davidson & Keigher, 1999; Eastman & Eastman, 1997; Galambos, 1999; NASW, 1996; Schneider, Hyer & Luptak, 2001). Each social worker must frame their professional practice and allocate their finite resources within that practice. This is yet another illustration of how health care

rationing impacts the social work community.

When the NASW Code of Ethics (NASW, 1996) addresses cultural competence, it is understood to refer to the ability to understand the community which informs clients and in which those clients, in turn, live and move and have their being. But in the same way that rationing has been broadened in this paper, it is useful to expand social workers’ concept of culture. Health care is characterized by a unique and increasingly complex culture. The same caveats that the NASW codified regarding communities of heritage might well be extended to include communities of health. We are unlikely to be able to effectively serve clients with meaningful interventions if we are not committed to influencing the policies which impact their communities (Davidson & Davidson, 1998; Reamer, 1998). Social workers are unlikely to be influential policy makers or social advocates if we are not also cultural insiders.

On Managing Care in an Era of Imbalanced Rationing: The Challenge for Medical Social Work

In advocating for individual clients as well as supporting broad policy change, some easily implemented suggestions are offered for social workers working within the health care field, or for those supporting clients in their interface with the health care system. Everything reasonable must be done to secure basic health care for clients. This demands that social workers be familiar with resources available to those who are able to navigate the systems’ labyrinth. These resources may include pharmaceutical companies which offer drugs at no cost, medical specialists who provide some pro bono services, entitlement criteria for hospital-based and free-standing clinics, as well as for ancillary services like transportation, meal delivery, and medical supplies. Additionally, social workers must resist the systemic pressure to offer less attention to the medically indigent. In the responsible use of scarce health care resources, clients must be coached in their rights to self-determination and their attendant right to opt for palliation rather than technologically intense medical care. Before a health care crisis emerges – and eventually it will – clients must be encouraged to prepare and appropriately file legal documents, such as Advance Directives and Living Wills, in order to minimize the likelihood that excessive resources will be used in end of life care.

Policy is a standard response to an issue. Here the issue is the tens of millions without health care in the U.S. The policy response may be formalized as law (like the proposed Clinton Health Plan) or embodied in the traditions of an agency (like the routine prioritization of insured patients in hospital ERs, despite the tenants of the Emergency Medical Treatment and Active Labor Act (Pear, 2003)). Programs develop within the framework of policy. Social workers serve clients with interventions in the context of those programs. For this reason alone, it behooves social workers to actively participate in the creation – or re-creation – of policy.

There will always be inequities in material wealth. Nonetheless, it is proposed that the fulcrum of rationing that balances managed care be shifted towards meeting the basic needs of the medically disadvantaged. This is not to suggest that there will ever be a *purely* socialized health care delivery system in this nation so committed to entrepreneurship and the market economy. It is to suggest that it is morally – and economically – untenable to put exorbitantly high dollar values on some American lives while others are effectively deemed expendable (Kapp, 2001; McBride, 1997; Mechanic, 2001). The U.S. Supreme Court and the State Constitutional reviews of every state in the Union have determined that health care is not a basic right (Saltzman & Furman, 1999). But the courts cannot determine what is conscionable for this wealthiest of nations, for any of us who have chosen the profession of social work, nor for how we will function under the U. S. Constitution and the health care system.

In closing, it is worth noting that rationing in health care is both addressed in the press and academic journals by those who are educated, employed and emancipated; the disenfranchised are by definition without access to the most erudite channels of communication. The discussions of rationing – whether by that name or any other – tend to assume that health care is or will be somehow more limited in this era of managed care. Their fear is that a choice of specialists or experimental treatments might be restricted. For the unemployed and oppressed, rationing might look more like immunizations for children and maintenance prescriptions for those with chronic but easily managed conditions. Managed care is neither good nor bad; care, however, can be badly managed. Likewise, rationing is neither good nor bad. Rationing is simply a technique for managing care.

Because there is no national discussion of the rationing of health care, the piecemeal approach effects a rationing without rationale. It might well be a difficult discussion, but the rightful place of rationing in the provision of U.S. healthcare, nonetheless, needs to be had. Until policy makers – be they elected officials, private businesses, managed care organizations, hospitals, agencies, social workers or outspoken individuals – address rationing with integrity, there will never be basic health care for all Americans. Without access to basic health care, the management of care will continue to be both big business and a big problem. Ultimately, that problem will be most keenly felt by the uninsured asking only the most basic of health care. By compassionate extension, social workers will feel it as well. No one will come up smelling like roses.

References

- Abraham, L. (1993). *Mama might be better off dead: The failure of health care in urban America*. Chicago: The University of Chicago Press.
- Abramson, J. Mizrahi, T. (1996). When social workers and physicians collaborate: Positive and negative interdisciplinary experiences. *Social Work, 41* (3), 270-282.
- Albrecht, G. (2001). Rationing health care to disabled people. *Sociology of Health & Illness, 23*(5), 654-677.
- Agrawal, G. (1998). Chicago hope meets the Chicago school. *Michigan Law Review, 96* (6), 1793-1825.
- Bailey, M. (2003). Managed care and the rationing problem. *Hastings Center Report, 34*-42.
- Bottles, K. (2000). Why are physicians so angry? *Physician Executive, 26* (5), 44-49.
- Buchanan, A. (1998). Managed care: rationing without justice, but not unjustly. *Journal of Health Politics, Policy and Law, 23* (4), 617-634.
- Callahan, D. (2001). *Biomedical research and health care costs: how much progress can we afford?* Retrieved August, 30, 2003 from <http://www.embl-heidelberg.de/ExternalInfo/stefanss/callahan.html>.
- Callahan, D. (1999). *False hopes: Overcoming the obstacles to sustainable, affordable medicine*. New Brunswick, New Jersey: Rutgers University Press.

- Davidson, T., Davidson, J. & Keigher, S. (1999). Managed care: Satisfaction guaranteed...not! *Health and Social Work, 24* (3), 163-168.
- Eastman, J. & Eastman, K. (1997). The ethics of managed care. *Marketing Health Services, 17* (3), 26-40.
- Friedman, E. (1997). Managed care, rationing, and quality: A tangled relationship. *Health Affairs 16* (3), 174-182.
- Galambos, C. (1999). Resolving ethical conflicts in a managed health care environment. *Health and Social Work, 24* (3), 191-198.
- Gibleman, M. & Whiting, L. (1999). Negotiating and contracting in a managed care environment. *Health & Social Work, 24* (3), 180-190.
- Havas, E. (1998). Managed care: Business as usual. In G.L. Schames & A. Lightburn (Eds.), *Humane managed care?* (pp. 75-84). Washington, D.C: NASW Press.
- Jameton, A. & Peirce, J. (2001). Sustainable health care and emerging ethical responsibilities. *Canadian Medical Association Journal, 164* (3), 365-369.
- Jonas, S. (2003). *An introduction to the U.S. health care system*, 5th edition. New York: Springer Publishing Company.
- Karger, H & Stoesz, D. (2002). *American social welfare policy: A pluralist approach*. Boston: Allyn and Bacon.
- Kapp, M. (2001). Economic influences on end-of-life care: empirical evidence and ethical speculation. *Death Studies, 25*, 251-263.
- Keigher, S. (1997). What role for social work in the new health care practice paradigm? *Health and Social Work, 22* (2), 149.
- Kohn, C., Hasty, S. & Henderson, C. (2002, 5 August). Recent poll of society of critical care medicine members reveals impact of 'bedside rationing'. *Managed Care Weekly Digest, 2-4*.
- Lown, B. (1999). *The lost art of healing: Practicing compassionate medicine*. New York: Ballantine Books.
- Mechanic, D. (2001). The managed care backlash: perceptions and rhetoric in health care policy and the potential for health care reform. *The Milbank Quarterly, 79* (1), 35-54.
- Mechanic, D. (1999). A balanced framework for change. *Journal of Health Politics, Policy and Law, 24* (5), 1108-1113.
- McBride, S. (1997). Costs/quality trade off pits physicians against managed care. *Physician's Management 37* (4), 72-77.
- Moniz, C. & Gorin, S. (2003). *Health and health care policy: A social work perspective*. Boston: Allyn Bacon.
- National Association of Pharmaceutical Companies. (2003). {Television advertisement.} Atlanta, Georgia: CNN.
- Pear, R. (2003, September 2). Emergency rooms get eased rules on patient care. *New York: The New York Times*.
- National Association of Social Workers. (1996). *NASW Code of Ethics*. Washington, D.C: Author.
- Reamer, F.G. (1998). *Ethical standards in social work*. Washington, DC: NASW Press.
- Reay, T. (1999). Allocating scarce resources in a publicly funded health system: Ethical considerations of a Canadian managed care proposal. *Nursing Ethics, 6* (3), 240-250.
- Rosenberg, G. (1998). Social work in a health and mental health managed care environment. In G.L. Schames & A. Lightburn (Eds.), *Humane managed care?* (pp.3-22). Washington, D.C: NASW Press.
- Rosenthal, M and Newhouse, J. (2002). Managed care and efficient rationing. *Journal of Health Care Finance, 28* (4), 1-10.
- Saltzman, A. & Furman, D. (1999). *Law in social work practice*, 2nd ed. Belmont, California: Wadsworth.
- Schneider, A. Hyer, K. & Luptak, M. (2001). Suggestions to social workers for surviving in managed care. *Health & Social Work, 25* (4), 276-279.
- Siskind, A. (1998). Agency mission, social work practice, and professional training in a managed care environment. In G.L. Schames & A. Lightburn (Eds.), *Humane managed care?* (pp.180-186). Washington, D.C: NASW Press.
- Specht, H. & Courtney, M. (1994). *Unfaithful angels: How social work has abandoned its mission*. New York: The Free Press.
- Tanenbaum, S. (1999). Technology assembly in managed care. *Journal of Health Politics, Policy and Law, 24* (4), 759-762.
- Vandivort-warren, R. (1998). How social workers can manage managed care. In G.L. Schames & A. Lightburn (Eds.), *Humane managed care?* (pp. 255-267). Washington, D.C: NASW Press.

World Health Organization. (1946). *Preamble to the Constitution of the World Health Organization as adopted by the International Conference*. New York: author.

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