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Rationing as a Necessity

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In the current debate over healthcare reform, the mere mention of rationing has brought only fear and opposition. Some have argued vehemently that the American people will not tolerate proposals that would enable the government to limit the availability of effective treatment to them simply because of the cost.[1] Perhaps this stems from the belief that letting monetary considerations play a role in saving lives is immoral.[2] Perhaps this comes from a fear of the implications that a practice like this would have on the individual and his family. No matter which lens you look through, the fact remains that healthcare is indeed a scarce resource, and its rationing is unavoidable.[3]

While the United States does not have an explicit system of rationing in place as some nations do, the delivery of healthcare depends on an implicit form of rationing. There may not be waiting lists or lotteries impeding one's ability to access the care they seek, but the ability to receive needed services is dependant

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[1] *See* Sally C. Pipes, *Obama Will Ration Your Health Care*, WALL ST. J., Dec. 30, 2008, at A11.

[2] Peter Singer, *Why We Must Ration Health Care*, N. Y. TIMES, Jul. 19, 2009, at MM38.

[3] *Id*.

upon one's ability to pay or obtain insurance.[4] This applies even to those with insurance, as they experience rationing through the policies of their insurance provider (including physician discretion and evaluations of the medical necessity of a treatment, among other mechanisms).[5] Healthcare under Medicaid and Medicare is rationed both through the long waits and patient co-payments that discourage patients from seeking care, and low physician reimbursement, which discourages doctors from serving these types of patients.[6] A study of those injured in automobile accidents in Wisconsin found that those without health insurance received 20% less care that those with health insurance and had a 37% higher death rate.[7] While other countries have chosen to provide universal coverage and limit the range of healthcare services available, the United States has chosen a system that offers high-technology, comprehensive care that is not guaranteed to all.[8]

Healthcare costs are on the rise and will continue to increase as more high-technology treatments are made available.[9] This trend will only get worse in the coming years. The efforts to reduce healthcare costs by cutting waste and inefficiency from the system, leaving market competition and consumer driven care to drive down prices, and to eliminating futile treatments all will be unable to

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[4] RICHARD D. LAMM & ROBERT H. BLANK, CONDITION CRITICAL: A NEW MORAL VISION FOR HEALTH CARE 39 (2007).
[5] *Id*. at 40.
[6] Singer, *supra* note 2.
[7] Singer, *supra* note 2.
[8] LAMM & BLANK, *supra* note 4, at 42.
[9] *See* Ruud ter Meulen, *Is Rationing the Inevitable Consequence of Medical Advance?*, 27 MED. & L. 71, 76-77 (2008).

significantly affect the gross cost of healthcare.[10] It is time the United States implemented an explicit rationing of healthcare. Doing so will not only effectively curb the rising costs of healthcare, but will improve the health of the United States population.

I. RISING HEALTHCARE EXPENDITURES ARE UNAVOIDABLE

Current projections show that by 2040 total healthcare spending in the United States will claim over a third of the national GDP.[11] If this projection is correct, by 2040 Medicare and Medicaid spending as a share of GDP would equal the combined amount of all income and property taxes today.[12] Such figures are certainly worrisome, and there are a number of factors that have been identified as contributing to this effect.[13] While often leading to chronic conditions, changing health behaviors of the population, such as smoking, stress, over consumption of food, and lack of exercise, have also been identified as accounting for 40-50% of morbidity and mortality.[14] Changing treatment thresholds for many chronic diseases have resulted in more asymptomatic patients who are at risk for a number of diseases, like diabetes or hypertension, being treated both to prevent the onset of disease and as an effort to reduce the severity should the disease manifest

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[10] *See* LAMM & BLANK, *supra* note 4, at 68-79.
[11] Henry J. Aaron, *Health Care Rationing: What it Means*, POL'Y BRIEF, Dec. 2005, at 2.
[12] *Id.*
[13] *See* Kenneth E. Thorpe, *The Rise in Health Care Spending and What To Do About It*, 24 HEALTH AFF. 1436, 1437 (2005); Meulen, *supra* note 9, at 76-77.
[14] Thorpe, *supra* note 13, at 1437.

later.[15] This has contributed to a rise in treated disease prevalence in the United States population and consequently an increase in total spending on healthcare.[16]

Economic research has consistently shown that advances in medical technology are the single most influential factor in the rise of healthcare costs, causing more than half of the rise in costs in the past decade.[17] In addition to the obvious effect of making more procedures available, innovation also raises costs by enabling a greater array of patients to become eligible for treatments who in the past were not.[18] For example, the development of laparoscopic ***cholecystectomy*** as an alternative to open surgery to remove the gall bladder has decreased operation costs by 25%.[19] However, since the new procedure was less traumatic, more patients became eligible, and the number of operations increased by 60%, thus increasing total healthcare expenditures nationally.[20]

Medical advances have saved many lives, but the increase in life expectancy has resulted in higher healthcare costs.[21] For instance, those whose lives were saved by medical advances may require high cost medical treatments for the rest of their lives if they suffer permanent injuries.[22] Additionally, as all people increase in age they will continuously suffer more of the effects of any chronic illnesses they may have.[23] That is not to say that innovation ought to be

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[15] *Id*. at 1438-39.
[16] *Id*. at 1437.
[17] Meulen, *supra* note 9, at 76-77.
[18] *Id*. at 75.
[19] *Id*.
[20] *Id*. at 75-76.
[21] *Id*. at 77.
[22] Meulen, *supra* note 9, at 77.
[23] *Id*.

suppressed, however, as the benefit of the advancement of medical technologies cannot be denied. Yet the resulting increases in healthcare costs remain an inevitable consequence.[24] Rationing of healthcare provides the only effective way to curb these rising costs.

II. ALTERNATIVES TO RATIONING FALL SHORT

Alternatives to rationing have been proposed to cut health care costs, but none will be unable to sufficiently curb the increasing costs resulting from changing human behaviors and the advancement of medical technologies. First, much of the American public stresses a need to cut wasteful spending and inefficiency from the healthcare system.[25] While such measures would result in some cost savings, it is unlikely to impact the increasing costs of developing new technologies.[26] For instance, personal care, such as washing and feeding, is required for many chronic and debilitating conditions, and is unlikely to be made more efficient.[27] Even if inefficient procedures can be identified and eliminated, certain symptoms will then require alternative treatments, which will cost money to develop.[28] Moreover, researching the effectiveness of any treatment will be costly and will not always clearly determine whether a particular drug or treatment is ineffective.[29] Once a treatment has been determined to be effective,

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[24] *See*, *Id*. at 75-78.
[25] LAMM & BLANK, *supra* note 4, at 69.
[26] *See* Meulen, *supra* note 9, at 73.
[27] *Id.* at 78.
[28] *See* LAMM & BLANK, *supra* note 4, at 71-72.
[29] *Id.* at 72.

the pressures to make it available to patients will be great, leaving the treatment to remain a burden to healthcare budgets.[30]

Alternatively, many economists assert that competition and market forces will be able to contain healthcare costs, but neither will have much of an impact due to the very unique nature of healthcare as a commodity.[31] For a market-based health system to work, three things are required: (1) the consumer must make all of the decisions; (2) the consumer must know the actual value and costs of the goods available; and (3) the consumer must receive the full value and pay the full costs of the goods purchased.[32] This can never be satisfied in healthcare because patients are forced to rely upon the medical knowledge of their doctors in determining treatment.[33] Further, an insured patient usually only pays for monthly premiums, deductibles, and copayments and never has to worry about the full value or cost of the treatment received, which is bargained by the insurance company and healthcare providers.[34] Efforts to make healthcare more consumer-driven through cost sharing will also fall short for these same reasons. Additionally, studies have shown that cost sharing reduced the likelihood that individuals would receive effective care because many did not want to spend money and as a result did not receive timely treatment.[35]

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[30] Meulen, *supra* note 9, at 74.
[31] LAMM & BLANK, *supra* note 4, at 73.
[32] *Id.*
[33] *Id.*
[34] *See Id.*
[35] *Id.* at 76.

Moreover, there is a market phenomenon unique to healthcare in which supply creates demand known as Roemer's law.[36] Many studies that have been conducted to understand this occurrence reveal that, when the resources are available, doctors will increase the number of treatments or procedures performed without necessarily targeting those patients who need them most.[37] This does not mean prescribing such treatments is an abuse of physician discretion, but rather that when more resources are available physicians exercise their discretion in an overly cautious or in an unreasonably hopeful way.[38] Those patients for whom it is uncertain whether the treatment is necessary or even beneficial will not be given the treatment when resources are more limited, but will be given the treatment when the resources are available. [39] For example, one study examined catheterizations throughout the United States.[40] The regions that had many more catheterization labs per person were those with the highest rates of catheterization and invasive cardiology procedures; and those with the fewest had the lowest rates.[41] This study also found that there was no difference in mortality rates among the different regions.[42]

Finally, reducing costs of end of life care by cutting futile treatment has also been proposed as a way to curb the rising healthcare costs, following from

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[36] SHANNON BROWNLEE, OVERTREATED: WHY TOO MUCH MEDICINE IS MAKING US SICKER & POORER, 111 (Bloomsbury) (2007).

[37] *Id*. at 109.

[38] *Id*. at 113.

[39] *Id*.

[40] *Id.* at 108 (*referring to* Therese A. Strukel, F. Lee Lucas & David E. Wennberg, *Long Term Outcomes of Regional Variations in Intensity of Invasive vs Medical Management of Medicare Patients With Acute Myocardial Infarction*, 293 JAMA 1329-37 (2005)).

[41] *Id*.

[42] *Id*. at 109.

the fact that, on average, care received during the last year of life accounts for 18% of one's lifetime healthcare expenses.[43] Inherent to this argument is the understanding that futile treatments are not worth the cost because they are bound to fail.[44] With this belief, it may be easier for some people to embrace restrictions on the availability of such treatments as they would perceive no obligation to make them available.[45] This can prove to be very difficult; however, as the concept of futility itself is difficult to understand.[46] First of all, it is very difficult to predict when any individual medical treatment will not prove beneficial to a particular patient.[47] For example, advancing age is often one of many medical criteria used by physicians to predict a successful clinical outcome, but it is difficult to determine the extent to which the predictive validity of any single medical criteria has been demonstrated empirically.[48] Older people are very different from one another both psychologically and physiologically.[49] As such, any efforts to set an arbitrary age-based delineation of when a particular treatment is futile or beneficial would not only be unfair in failing to take into consideration other medical criteria, but could actually hasten death of patients for whom the treatments could help.[50]

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[43] LAMM & BLANK, *supra* note 4, at 76.
[44] *Id.* at 78.
[45] *Id.*
[46] *Id.*
[47] *Id.*
[48] Douglas J. Besharov & Jessica Dunsay Silver, *Rationing Access to Advanced Medical Techniques*, 8 J. LEGAL MED. 507, 522 (1987).
[49] George P. Smith, *The Elderly & Health Care Rationing*, 7 PIERCE L. REV. 171, 176 (Apr. 2009).
[50] *Id.*

In addition, as the implementation of advance directives has shown, there is little evidence that cutting intensive and expensive treatments at the end of life will really save much money.[51] Only a relatively small amount of costly advanced treatments are expended on unquestionably terminal patients.[52] In contrast, critically ill patients, those for whom death is possible but not probable, receive most of this costly care.[53] While these patients may die even with the most aggressive and expensive treatments available, the treatments may still be beneficial because the patient may survive. [54]

III. LESS CARE (AND LESS EXPENSIVE CARE) WILL MEAN BETTER HEALTH

The idea of explicit rationing of healthcare is frightening to many people who worry that poor health outcomes will result. However, studies have shown that paying more for healthcare does not result in longer life expectancy, a result commonly used as a measure of better health outcomes.[55] In the United Kingdom, a country recognized for healthcare rationing, spent only 8.6% of its GDP on healthcare in 2004.[56] In contrast, the United States devoted 16 % of its GDP to healthcare that year.[57] One study showed that although United States spending on healthcare was almost double that of the United Kingdom, the average life expectancy was significantly lower. The average life expectancy in

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[51] LAMM & BLANK, *supra* note 4, at 77.
[52] *Id.*
[53] *Id.*
[54] *Id.*
[55] Meulen, *supra* note 9, at 78.
[56] *Id.*
[57] *Id.*

the United States was 69.5 years for men and 76.3 years for women, as compared to 76.5 years and 81.3 years, respectively, in the United Kingdom.[58] Even when comparing different spending rates within the United States, one study found that patients who went to the highest spending hospitals were 2-6% more likely to die than patients at the lowest spending hospitals.[59] Research also suggests that hospitals with more specialists order more consultations, which results in additional tests and procedures, and consequently more days in the hospital.[60] This also increases the chance for complications and latent errors that may accumulate into disastrous adverse events.[61]

One study compared amenable mortality rates[62] of the United States with fourteen European countries, Canada, New Zealand, Australia, and Japan over a six year period from 1997 to 2003.[63] The United States spent the most GDP on healthcare, but by 2003 the United States also had the highest amenable mortality rate in the study.[64] Amenable mortality rates declined in all countries an average of 17% over the study period, while the United States had a decline of only 4%.[65]

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[58] *Id.*
[59] BROWNLEE, *supra* note 36, at 50.
[60] *Id*, at 63.
[61] *Id.*
[62] Ellen Nolte & C. Martin McKee, *Measuring the Health of Nations: Updating an Earlier Analysis*, 27 HEALTH AFF. 58, 59 (Jan./Feb. 2008) (explaining that amenable mortality refers to deaths resulting from causes that should not occur with the administration of timely and effective healthcare).
[63] *Id.*
[64] *Id.* at 62.
[65] *Id.* at 59.

IV. EXPLICIT IMPLEMENTATION

No matter which way you look at it, it is apparent that Americans need an explicit rationing of healthcare. Advances in medical technologies result in more treatments available to patients, and a widening of the eligibility criteria for such procedures and treatments.[66] Romer's law has shown how the motivations of physicians, both the admirable goals of doing everything in their power to try to improve the health of their parents, and the less commendable interest in increasing revenue, will only further increase the number of services and treatments rendered to patients.[67] Additionally, as patients do not have the expert medical knowledge or full awareness of the cost and value of treatments required to make a truly informed decision, market forces will be unable to bring costs down. Explicit rationing is essential in providing Americans an equal right to healthcare, and is much more just than the forms of implicit rationing at play today.

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[66] Meulen, *supra* note 9, at 75.
[67] BROWNLEE, *supra* note 36, at 113.