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Rational Rationing: Impossible or Inevitable?

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Medical Service Corps
United States Navy

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Rational Rationing: Inevitable or Impossible?

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ABSTRACT

Health care spending in the United States is expected to exceed \$930 billion in 1993. Cost containment measures achieve one-time savings at the margins but fail to control the underlying causes of rising health care expenditures. These causes are new technology, an aging population, and high labor costs with low productivity growth. The national health care dilemma requires that we--as individuals and as a Nation--consciously and rationally decide what we expect from our future health care delivery system and how best to transform the current system. Rationing care in a rational manner is desirable contrasted to the current health care system that rations care irrationally based primarily upon one's ability to pay.

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ABSTRACT

Health care spending in the United States is expected to exceed \$930 billion in 1993. Cost containment measures achieve one-time savings at the margins but fail to control the underlying causes of rising health care expenditures. These causes are new technology, an aging population, and high labor costs with low productivity growth. The national health care dilemma requires that we--as individuals and as a Nation--consciously and rationally decide what we expect from our future health care delivery system and how best to transform the current system. Rationing care in a rational manner is desirable contrasted to the current health care system that rations care irrationally based primarily upon one's ability to pay.

Rational Rationing: Inevitable or Impossible?

"Perhaps society does not have to adjust to rising health-care costs, but health-care has to adjust to society's limited resources."

-Richard Lamm, Spring 1989

"With 28% of Medicare's budget going to patients in their last year, are Americans paying merely to extend life without making it more worth living? Will the U.S. ultimately have to ration health-care and deny it to the very old?"

-Lee Smith, *Fortune*, March 29, 1989

Total health-care spending more than doubled between 1980 and 1990, rising from \$230 billion to \$606 billion annually.¹ In 1992 this country's total health-care spending reached \$838.5 billion, an 11.5 percent increase over 1991.² In its 1993 *U.S. Industrial Outlook*, the Department of Commerce estimates the total this year will rise an additional 12.1 percent to \$939.9 billion. Just the change alone in national health-care spending from 1990 to 1993 exceeds the entire Department of Defense's annual appropriation.

Moreover, in 1965 health-care spending accounted for approximately six percent of this country's gross domestic product (GDP), and by 1989 it had reached 11.5 percent.³ In 1992 health-care accounted for 14 percent of GDP, ". . . that amounts to \$3,160 for every man, women, and child."⁴ In just four years, health-care spending as a total percentage of GDP increased by 2.5 percent. By the year 2000, some experts expect health-care spending to be 18 percent of GDP,⁵ and President Clinton predicts it will be at 20 percent.⁶

¹ Families USA Foundation, *Emergency! Rising Health Care Costs in America*, October 1990, p. 1. Families USA is a Washington-based nonprofit group concerned with the elderly and their families.

² Dave Skidmore, "Economy Trails Health-Care Cost," *The Virginia Pilot-Ledger Star*, January 8, 1993.

³ Patrick G. Marshall, "Setting Limits on Medical Care," *Congressional Quarterly Inc.*, Editorial Research Reports, November 23, 1990, p. 667.

⁴ Skidmore, *op. cit.*, p. 7.

⁵ Congressional Budget Office, *Economic Implications of Rising Health Care Costs*, A CBO Study, October 1992, p. 1.

Cost Containment Failures

Attempts during the last twenty years have failed to control health-care spending. Aaron and Schwartz describe these efforts, beginning with cost containment measures in 1974, when Congress began requiring Certificate of Needs (CONs) for building new facilities and purchasing major equipment. They indicate that President Nixon's price control program temporarily lowered the rate of spending, but it became too complicated to be maintained. In 1975 and 1976, after these controls were removed, real (adjusting for inflation) health-care spending increased by 6.9 percent; and in 1977, President Carter threatened to cap growth on revenues but Congress rejected his proposal.⁷

In 1984 the Health-care Financing Administration (HCFA) began using diagnosis related groups (DRGs) to prospectively reimburse hospitals for inpatient care provided to Medicare recipients. (See the Appendix for health care definitions.) Rather than receiving reimbursement for the cost of allowable services, hospitals received a fixed amount based upon patients' grouped by primary and secondary diagnoses, sex, and age.

While on initial analysis slower growth was realized in inpatient Medicare reimbursement, the costs were largely shifted to the outpatient setting where providers receive reimbursement on a fee-for-service basis. Incidentally, DRG reimbursement methodology covertly but effectively rationed some potentially beneficial services.⁸ As Patrick G. Marshall points out, "Medicare payments to hospitals may be significantly below the projections, but actual expenditures quadrupled between 1975 and 1988. Physician reimbursement fees rose even faster, increasing eightfold."⁹

⁷ Henry Aaron and William B. Schwartz, "Rationing Health Care," *Across the Board*, July/August 1990. p. 36.

⁸ *Ibid.*

⁹ Marshall, *op. cit.*, p. 672.

In 1989 Congress passed legislation to revamp the Medicare payment system to physicians. Called the Relative Value Resource Based System (RVRBS), this physician-payment system is being phased in between 1992 and 1996, establishing reimbursement predicated on the value of the service or procedure.¹⁰ Annually, the revised fee schedule is presented by the Secretary of Health and Human Services (HHS) to Congress for legislative approval.

Accordingly, in its early execution phase, RVRBS emphasizes primary care and de-emphasizes surgical care and diagnostic tests. Unfortunately, as with many other congressionally-mandated health-care programs, one can "game" this system by merely seeing additional patients. Of course, reimbursing physicians in this manner serves one primary purpose: to economically encourage physicians to provide more primary care and less specialty care, not to lower necessarily overall physician-payment spending.¹¹

From the CONs and price controls to DRGs and RVRBS, these cost containment efforts have failed to control the ever increasing real rate of health-care spending. The dilemma we face in health-care spending requires a solution that is a complete paradigm shift, a shift away from the incremental, politicized manner of years' past to one that reflects a rational, politically accountable, well-thought out scheme.

Managed Care and Health Maintenance Organizations Experience

From the "free-market" competition or "managed care" perspective, one sees several noteworthy examples of attempts to reduce health-care spending by using: preferred provider organizations (PPOs), health maintenance

¹⁰ *Ibid.*

¹¹ *Ibid.*

organizations (HMOs), and utilization-review panels. Most notable among these laudable attempts are HMOs. Abandoning the traditional fee-for-service, HMOs charge a flat fee per person. Their essential characteristics are:¹²

- (1) physicians receive salaries,
- (2) referrals to high-priced specialists are closely controlled, and
- (3) hospital admissions receive considerable scrutiny in an effort to minimize length of stays.

HMOs have grown from practically zero enrollees in 1980 to over 39 million by the end of 1991 and have been successful in both reducing hospital admissions and reducing the average length of stays.¹³

Although at first these unique and innovative arrangements produced savings up to 25 percent and could offer rates as much as 40 percent below traditional fee-for-service insurers, HMOs have lost much of their competitive edge.¹⁴ There are several underlying reasons for HMOs losing this edge. First, those HMOs initially formed were comprised of relatively healthy individuals; therefore, the average demand for care was somewhat less resource intensive than the general population. Second, insurance companies failed to take full advantage of competitive market arrangements. Third, the rates charged for HMO care were artificially low and could not be maintained over the long run. Not too surprisingly, HMOs experienced financial problems from severe competition in 1986 and 1987.¹⁵

In fact, in the past few years rates charged for traditional insurance plans have gone up at a slower rate than those of HMOs--contrary to what

¹² Julie Kosterlitz, "A Sick System," *National Journal*, Feb. 15, 1992, p. 384.

¹³ Congressional Budget Office, *op. cit.*, p. 18.

¹⁴ Lynn Gruber, Michelle Porter and Patricia Ball, *The Bottom Line 2: HMO Premiums and Profitability, 1989-1990*, Interstudy Center for Managed Care Research, 1990, p.1.

¹⁵ Marshall, *op. cit.*, p. 669.

"managed competition" advocates desire.¹⁶ As Marshall reports, while the total number of enrollees in HMOs has increased [to 39 million], the number of HMOs has dropped from 650 in 1987 to 575 in 1990.¹⁷

The phenomenon one detects with many of these innovative approaches to health-care delivery, such as with HMOs, is that they achieve a one-time savings or reduction in health-care costs. It is not that these one-time savings cannot be significant--many are, including savings from HMOs. Incrementally, they trim some of the fat; however, one-time savings fail to make permanent reductions in the rate of spending. These rates of spending for total and per capita personal health-care expenditures have risen annually since 1950 at 5.5 and 4.1 percent, respectively.¹⁸ Therefore, for health-care reform to be effective and meaningful, it must address the underlying causes that remain elusive today.

Why Underlying Causes?

Although 60 percent of the increase in health-care costs are attributable to inflation and an increase in population, the other 40 percent--where real growth has occurred--spirals increasingly out of control.¹⁹ Perhaps the most important reason HMOs, other competitive or managed care arrangements, and, for that matter, governmental regulatory programs have failed to effectively control ever increasing health-care expenditures is that none of them addresses the underlying causes. Despite a multitude of well-intended governmental oversight and flawed competitive

¹⁶ *Ibid.*

¹⁷ *Ibid.*

¹⁸ Aaron and Schwartz, *op. cit.*, p. 34.

¹⁹ Kosterlitz, *op. cit.*, p. 378.

marketplace forces converging on the diverse and sophisticated health-care industry the results--individually and collectively--have not brought health-care spending within acceptable limits, limits that meet societal expectations: politically, economically, morally, and socially.

In order to better understand why various approaches to curtailing health-care expenditures have largely resulted in only one-time savings and not in reducing the total and per capita rate of spending, the discussion will detail the more prominent yet perennial root causes of growing health-care costs. It is important to understand these because any national health-care reform must comprehensively address and propose meaningful solutions to controlling these factors.

Root Causes of Spiraling Health-Care Spending

What are the underlying causes of spiraling health-care spending? Simply, they are: (1) new technology, (2) an aging population, and (3) high labor costs with low productivity growth. These three issues lie at the heart of runaway health-care expenditures. Within the context of the current health-care delivery system, its perverse economic incentives, and the U.S. public's expectations for unconstrained health-care, these underlying causes remain recalcitrant to meaningful control. The enormity of these issues and potential conflict with our values and principles require more than just a myopic incremental solution. The ramifications are staggering. In fact, our national security may well hinge upon our ability to develop answers and respond with solutions to an ever growing health-care system that is out of control.

New Technology

Aaron draws from Joseph Newhouse's forthcoming article, (entitled "Medical Care Costs: How Much Welfare Loss?"), and explains that health-care expenditures have risen principally because of the technological transformation in medical care.²⁰ In fact, Aaron and Schultze note that many of the technologies employed today did not exist when many practicing physicians started their medical training. Diagnostic technologies, such as computer-assisted tomography (CAT) and magnetic resonance imaging (MRI), have brought keen diagnostic capabilities within the easy grasp of physicians often with little-to-no additional physical discomfort or direct cost to patients.

Besides diagnostic technologies there are therapeutic technologies that abound throughout the practice of medicine, (e.g. organ transplants, such as heart/lung and liver transplants, and open heart surgery). Representative of the hundreds of emerging technologies is the automatic implantable cardiac defibrillator, a device used to regulate the heart when it develops life-threatening arrhythmias.²¹ Schwartz and Aaron discuss how this new therapy will cost approximately \$46,000 per patient with 20,000 patients demanding it annually. They claim this one therapy alone will drive up annual health-care expenditures by a billion dollars. Potentially, there are 100,000 patients annually that could benefit from this technology. And yet another example is azidothymidine (AZT), a drug used in delaying the onset of AIDs for those diagnosed with the human immunodeficiency virus (HIV). Annually, the estimated cost for the nation is \$5 billion.²² Again, these examples are typical of what occurs routinely in medicine today.

²⁰ Henry J. Aaron and Charles L. Schultze, *Setting Domestic Priorities: What Can Government Do?*, The Brookings Institution, Washington, D.C., 1992. p. 25.

²¹ William B. Schwartz and Henry J. Aaron, "Rationing Health Care: The Choice Before Us," *Science*, Jan, 26, 1990. p. 418.

²² Aaron and Schwartz, *op. cit.*, p. 39.

Because new technologies are continuously being introduced and quickly incorporated into the practice of medicine any one-time savings that can be achieved through innovative cost containment efforts eventually will be absorbed by increased spending on existing as well as emerging technologies. Without some sort of technological evaluation of emerging technologies that weighs potential benefits against expected cost, the marketplace will continue to employ technologies that are inherently not cost beneficial/effective.

One might possibly think that as a country we have pushed medicine's technological envelope to its limit, where there are few medical secrets remaining to be discovered. However, as alluded to earlier, there are literally hundreds, perhaps even thousands, of emerging technologies. These technologies run the gamut from extraordinarily expensive "bio-tech" pharmaceuticals to positron emission tomography (PET) equipment. "Bio-tech" drugs can cost over \$500,000 annually per patient.

Technological breakthroughs come from both ends of the technological scale. For example, on the lower end of the scale, recent [January 1993] improvements in using ultrasound techniques allow heart surgeons to repair heart valves rather than replacing them with pig or artificial heart valves. This example of low-end technology is used to demonstrate that not all technological advances result in greater resource consumption; however, not enough thought has been given to adapting existing technologies and developing emerging technologies that offer cost effective alternatives.

Balancing technological advancement/proliferation and cost effectiveness as it exists today is virtually impossible. In employing technology, physicians control not only the supply side but also the demand side of technology use. In many instances, physicians even own the technology, the equipment, they prescribe for their patients' use, (e.g. for radiological and laboratory services). Physicians and patients, alike, experience no real

incentive to make trade-off decisions, weighing the real price of the technology against potential benefits. Third party payers shield patients from making cost effective decisions that differentiate among alternative technologies and potential benefits and costs. Essentially, patients with insurance are insensitive to price.

Aging Population

The second underlying cause of spiraling health-care costs is treatment of the elderly. According to the Census Bureau, the elderly, as an age group, have grown from approximately seven percent of the American population in 1940 to 12.7 percent in 1990.²³ By the year 2030, when the "baby-boomer" generation has passed into its golden years, the Census Bureau projects that the elderly could be as much as 25 percent of the population.²⁴

Generally speaking, as we get older we consume more health-care services. This is because of increased incidences of chronic diseases. In fact, more people die today of chronic diseases than they do from infectious illnesses. As a nation, we have done an amazing job at developing preventive medicine measures, establishing public health programs, and educating our public. Through these efforts, great strides have been made in decreasing morbidity as well as mortality associated with infectious diseases. As a result, our life spans are longer.

Today, people in industrial societies live 20 to 30 years longer than they did just 100 years ago. For example, living in the U.S. today there are

²³ Marshall, *op. cit.*, pp. 673-674.

²⁴ *Ibid.*, p. 674.

21 times more Americans that are over the age of 85 than in 1900.²⁵ Other nations that have established good preventive health programs experience a similar increase in their population longevity. As an example of a developing nation, the People's Republic of China has an average human life span that approaches 70 years; in 1940, it was less than 35 years. The point is that our longer life span and China's is not a function of sophisticated and complex medical intervention. Rather it is largely a byproduct of the strides made in the fields of public health and preventive medicine against the ravages of infectious diseases.

There is a problem with longer life spans, though. Before dying from an acute or chronic illness or disease, many of the elderly manifest chronic conditions spanning one to two, perhaps even three decades. In fact, chronic conditions eventually cause 87 percent of all deaths.²⁶ Everything being equal, the more people that a country has comprising its elderly population, the greater the demands for health-care services. The greater the demands for health-care services, the greater the total cost.

When one discusses rising health-care costs in the context of the elderly, it often evokes considerable emotion. By some accounts there is a gaining sentiment ". . . that society must intervene in the allocation decisions of the medical marketplace."²⁷ Some experts believe the only real way to deal with the changing demographics is to overtly ration care.²⁸ This is based on the notion that the elderly consume disproportionate amounts of

²⁵ Nancy S. Jecker and Lawrence J. Schneiderman, "Futility and Rationing," *The American Journal of Medicine*, Vol. 92, Feb. 1992, p. 191.

²⁶ Richard Lamm, "Health Care and Public Policy: The Need to Develop an Ethic of Restraint," *Compensation & Benefits Management*, Spring 1989, p. 183.

²⁷ Robert L. Barry and Gerard V. Bradley (Editors), *Set No Limits: A Rebuttal to Daniel Callahan's Proposal to Limit Health Care for the Elderly*, (Urbana and Chicago: University of Illinois Press, 1991), p. 94.

²⁸ Marshall, *op. cit.*, pp. 674-675.

health-care services that are of marginal value or benefit. The elderly certainly use health-care services more than any other age group, accounting for one third of the nation's total personal health-care expenditures, exclusive of research costs.²⁹

Some experts say benefits for the elderly should be based on anticipated medical benefits versus cost. Individuals, like Daniel Callahan, a bioethicist, believe that there should be an age-based criteria used for employing life-extending measures when public funds are involved.³⁰ At the vanguard for "limits-to-medicine" philosophy, he says that the health-care system of the future ". . . must acknowledge limits to life and to society's interest and ability in prolonging it. And . . . emphasize quality of life over length and society's health over the individual's."³¹ As it relates to the elderly, Callahan writes:

"in the face of scarcity and to advance other societal goods, no society is required to devote an unreasonable or harmful share of its resources to the struggle against disease."³²

This paper will touch again on the philosophy of the limits-to-medicine approach in the section that discusses rationing. What is important to remember is that some proponents of the limits-to-medicine approach espouse the idea that life-extending medical benefits should be cut off for the elderly without regard to medical outcome. The premise is: ". . . life-extending care in old age is futile. . . death in old age is inevitable and an acceptance of limits is therefore fitting."³³

²⁹ Jecker and Schneiderman, *op. cit.*, p. 191.

³⁰ Julie Kosterlitz, "Rationing Health Care," *National Journal*, June 30, 1990, p. 1593.

³¹ Kosterlitz, *op. cit.*, p. 1593.

³² *Ibid.*, p. 1594. Quote comes from Daniel Callahan's book, *What Kind of Life: The Limits of Medical Progress* (Simon and Schuster, 1990).

³³ Jecker and Schneiderman, *op. cit.*, p. 191.

High Labor Costs With Low Productivity Growth

Much of the productivity gains in other industries have been realized through the employment of automation and supportive technologies. However, in the health-care industry, measurable productivity gains have been low, and health-care labor costs have been high--despite an explosion of medical technology.

Aaron and Schwartz posit that health-care expenditures are driven upwards by the ". . . tendency for the price of services characterized by low growth in productivity to rise relative to the price of commodities."³⁴ They acknowledge that hospitals today are in many ways different from those of 1960, but they foresee little change in the hotel services: feeding, berthing, and nursing services, and other para-professional support services. There have been efficiencies or productivity gains made but the rate of growth has been slow, particularly considering the health-care industry's technological sophistication and abundance.

When technology is introduced into hospitals, it often does not result in improving hospital service efficiency but rather the state-of-the-art diagnostic and therapeutic care. For example, many secondary and tertiary hospitals acquired MRIs during the last few years at a unit cost of over one million dollars. In order to operate MRIs, hospitals usually have had to hire for each shift two skilled radiology technicians and a receptionist, at an annual cost of \$80,000 to \$120,000 per eight-hour shift.

Rather than requiring fewer personnel and less human interaction between man and machine, the health-care arena has steadily required more personnel with a greater percentage of them possessing high-level skills and training,

³⁴ Aaron and Schwartz, *op. cit.*, p. 35.

(e.g. nuclear medicine technicians, intensive care nurses, laboratory technicians, pulmonary technicians).³⁵ In part, this explains why salaries are high, but salaries are high also because of qualified personnel shortages (actual and perceived).

Clearly, the technological impetus focuses on improving effectiveness--quality of care--not efficiency. While one can clearly make this assertion, one must qualify it by saying: a "unit of output" today is different than one 20 years ago. When measuring efficiency or productivity in health-care services one cannot readily ascertain qualitative differences among seemingly like units of outputs.³⁶ In particular, upon closer assessment one finds that rather than merely producing a "Volkswagen" unit of output, one sees today that the health-care industry produces a "Mercedes-Benz" unit of output, and, if left unchecked, strives to produce a "Ferrari" unit of output.

To illustrate this point of qualitative differences, the author had major surgery to repair a ruptured cervical disc. In years past, the surgeon would have made an incision at the back of my neck, cutting into and around many muscles and nerves. Today, however, the standard approach is to make an incision from the front of the neck, where there is little chance of muscle or nerve damage. Even though the unit of output is the same as 20 years ago--taking the disc out and fusing the spine--the qualitative improvements allowed me to be discharged two days after major surgery and to workout the following day. I missed one week of work and never experienced any pain from surgery.

³⁵ Marshall, *op. cit.*, p. 674.

³⁶ It is often difficult to determine from the Consumer Price Index (CPI) exactly what cost increases are attributable to price inflation rather than quality improvements. Official measures cite quantity of care but do not adequately adjust for technological improvements. See Henry J. Aaron, *Serious and Unstable Condition: Financing America's Health Care* (Brookings, 1991), pp. 103-107. See Congressional Budget Office, *Economic Implications of Rising Health Care Costs*, A CBO Study, October 1992, p. 22. See Joseph P. Newhouse, "Measuring Medical Prices and Understanding Their Effects," *Journal of Health Administration Education*, vol 7, no.1 (Winter 1989), pp. 19-26.

The above example illustrates that qualitative improvements are not factored into the productivity calculus. Therefore, productivity growth from a purely quantitative perspective is low; however, one should at a minimum caveat or mitigate this with the knowledge that qualitative improvements are vast and have markedly improved the product, albeit, a product many cannot afford.

As a service sector industry, health-care literally requires "hands-on" the consumer, which severely limits the health-care industry's ability to increase productivity. Without productivity growth sufficient enough to offset salary increases, spending for services has had to rise.³⁷ Basically, unless technological advancements sufficiently supplant human labor, thereby increasing productivity, real labor spending will continue to grow.

One-Time Savings

While these three broad categories--new technology, an aging population, and high labor cost--must be at the focal point in developing a long-term meaningful health-care reform package, there are corollary issues that warrant individual attention. These range from eliminating unnecessary care to changing federal tax laws. In crafting a plan that is comprehensive and responsive to this country's health-care crisis, our policy makers must envisage a balanced, cost-effective system. Regardless of the ultimate solutions that will result from a redesigned health care system, they must "cure" the underlying causes, as well as many of the current symptoms of a sick system. In many instances, correction of these symptoms will bring significant one-time savings.

³⁷ Schwartz and Aaron, *op. cit.*, p 39.

Cost of malpractice insurance has driven health-care clinicians' cost upward, especially for certain surgical specialties, such as neurosurgeons and obstetricians. In most cases, the cost of malpractice is passed on to patients in the form of higher charges. In other cases, physicians may actually change the location of their practices, avoid taking high risk patients or performing high risk procedures, or, in some cases, terminate their practices altogether. While malpractice premiums cost physicians approximately \$4.5 billion in 1990, the largest cost associated with malpractice comes from the practice of defensive medicine.³⁸

The practice of defensive medicine cost this country as much as \$100 billion annually.³⁹ The American Medical Association (AMA) studies suggest, however, the practice of defensive medicine only costs \$21 billion annually.⁴⁰

Defensive medicine combined with over treatment--unnecessary care--accounts for \$132 billion each year or 20 percent of all medical procedures and treatment, according to Dr. Robert Brook, director of health sciences for Rand Corporation.⁴¹ It would seem that the Congressional Budget Office study entitled, *Projections of National Health Expenditures*, supports the AMA position, suggesting ". . . that changing the medical liability system would have little effect on total health spending."⁴² However, Aetna believes discretionary care, of which defensive medicine is a part, accounts for as much as 30 percent or \$198 billion.⁴³ The difference, I believe, lies in the fact that defensive medicine is a subset of unnecessary care, and, even if one

³⁸ Marshall, *op cit.*, p. 674.

³⁹ Janice Castro, "Paging Dr. Clinton," *Time*, Jan. 18, 1993, p. 25.

⁴⁰ Janice Castro, "Condition Critical," *Time*, Nov. 25, 1991, p. 40.

⁴¹ *Ibid.*, p. 40.

⁴² Congressional Budget Office, *Projections of National Health Expenditures*, A CBO Study, October 1992, p. 12.

⁴³ Janice Castro, *op. cit.*, p. 40.

were to limit malpractice tort awards, physicians would continue (many maintain) ordering superfluous tests and performing unnecessary procedures. Perhaps the "maximal" approach to medicine that many physicians demonstrate is now an indelible part of their psyche.

Physicians control both supply and demand. The fee-for-service physician payment mechanism provides a perverse economic incentive for physicians to prescribe more rather than less health-care service.⁴⁴ Contributing to this "unique" economic arrangement, third-party payment systems artificially shield most patients from the immediate economic realities of their health-care consumption. Additionally, when patients need care the most, they are least able to make informed decisions. From the patients' perspective, individual health-care decisionmaking is fraught with imperfect information. Information rests with physicians, as does power.

There are more physicians than actually needed. Marshall believes that this is the principle reason labor costs have risen. In 1950s and '60s physicians per capita in the U.S. remained fairly consistent--141 for each 100,000 Americans.⁴⁵ However, by 1980 the number had reached 200 and was expected to reach 260 by 1990.⁴⁶ Unlike other industries, the health-care industry experiences the opposite effect of supply and demand: the more physicians (suppliers), the greater the demand (by patients); ergo, as supply increases total consumption increases. Ultimately, physicians control the supply function, as well as the demand. The natural marketplace force that would make the standard rules of supply and demand prevail is competition. Physicians do not compete based on price or quality per se. Health-care labor spending and total expenditures reflect this glut of physicians. As Davies

⁴⁴ Kosterlitz, *op. cit.*, p. 378.

⁴⁵ Marshall, *op. cit.*, p. 672.

⁴⁶ Nicholas E. Davies and Louis H. Felder, "Applying Brakes to the Runaway American Health Care System," *Journal of the American Medical Association*, Jan. 5, 1990, p. 75.

and Felder write,

"It is well accepted that each new physician added to the health-care system adds millions of dollars to the cost of the system during his or her lifetime by increasing the volume of services given to the American public."⁴⁷

There is an imbalance in physician mix. Even though there are more physicians than actually needed, there are too few general and family practitioners. Physicians make more money as surgeons and medical specialists than they do as generalists. More generalists would provide the advantage of better use of available resources and act as "gatekeepers" who, when needed, would guide patients through the complicated health-care system.

Cost shifting occurs throughout the health-care industry. Insurance companies have had to inflate premiums to cover charges passed onto them by physicians and hospitals. Employers, who pay their employees' premiums, and those with private policies feel cost shifting is unfair. As mentioned, DRGs reduced Medicare inpatient spending but raised outpatient spending, where physicians received reimbursement on a fee-for-service basis.

Fraud, waste, and abuse appear rampant in the U. S. health-care industry. According to the National Health-Care Anti-Fraud Association, fraud alone may account for as much as \$75 billion of annual health-care expenditures.⁴⁸ In her *Time* article, Castro gives several examples of nefarious activities committed ". . . daily in laboratories, hospitals, and doctors' offices to inflate the costs of care, often under the guise of doing patients a favor by circumventing cumbersome insurance regulations."⁴⁹ A survey done by Aetna Life & Casualty indicates that 4 out of 10 customers said

⁴⁷ Marshall, *op. cit.*, p. 75. Marshall's article "Setting Limits on Medical Care," actually contains this quote.

⁴⁸ Castro, *op. cit.*, p. 38.

⁴⁹ *Ibid.*

their doctors had cheated insurance companies.⁵⁰ In 1989, the Congressional Budget Office estimated that as much as \$58 billion annually could be reduced from administrative costs for insurers, doctors, and hospitals by utilizing a single plan such as Medicare,⁵¹ or, as Dr. Stewart Wesbury proposes, a plan that is based on a medical individual retirement account (IRA).⁵²

Governmental tax policy rewards middle and upper-class Americans and provides a tax break of approximately \$84 billion to companies that can write off employer-provided insurance.⁵³ Castro and others argue that this is one reason corporate America failed to take initiatives earlier to curtail health-care costs. Employer-provided insurance provides disproportionate benefits to the affluent by subsidizing those most able to pay.⁵⁴ Again, this tax incentive shields those patients most capable of paying the true cost.

The items discussed in this section are not all inclusive but rather representative of the types of savings that could accrue to our health-care system, if appropriately overhauled. This overhaul by its nature must be catastrophic and pervasive, eliminating the major inequities, inequalities, and inefficiencies found in today's system. It must incorporate solutions to the root causes underlying runaway health-care expenditures, as well as capture substantial one-time savings. Not only must the private sector be transformed but also governmental programs such as Medicare and Medicaid. Four major features need to be incorporated: effective cost control, universal access, acceptable quality, and predictable availability (security).

⁵⁰ *Ibid.*

⁵¹ Kosterlitz, *op. cit.*, p. 379.

⁵² Dr. Stewart Wesbury spoke to the Industrial College of the Armed Forces, National Defense University, Washington, D.C. on Feb. 17, 1993 and proposed the Medical Individual Retirement Account (IRA) as a solution to the national health care reform.

⁵³ Castro, *op. cit.*, p. 42.

⁵⁴ Kosterlitz, *op. cit.*, p. 378.

The Oregon Experience

The state of Oregon stands out among state governments in its attempt to develop a viable Medicaid program that provides "basic" care for all eligible beneficiaries. According to Oregon's Democratic State Representative Rick Kotulski, the goal of the plan ". . . is to let the entire population have access to medical treatment and let everyone get basic treatment before we go beyond that for any of them."⁵⁵ Oregon has been commended for publicly-- through elected officials, community leaders, and health professionals-- defining adequate minimum health-care standards for its Medicaid population.⁵⁶ As Fox and Leichter describe, Oregon has done this in a politically accountable manner for a population rather than an individual based on a broad coalition of citizens.

The mantlepiece of the Oregon's program is a priority ranking system for medical conditions and treatments. In establishing a priority ranking system, the Oregon Health Services Commission used a four-step process by:⁵⁷

- (1) folding more than 10,000 diagnoses and treatments into 709 condition/treatment pairs;
- (2) developing 17 general categories of conditions and treatments and ranking them in order of social importance;
- (3) placing each of the 709 conditions/treatments into one of the 17 categories and then developing an algorithm for rank ordering them within categories by their effect on quality of life and clinical effectiveness; and
- (4) moving conditions/treatments pairs up and down the rank order by commissioners' subjective determination.

Not all conditions and treatments are part of the minimum benefits

⁵⁵ Kosterlitz, *op. cit.*, p. 1594.

⁵⁶ Daniel M. Fox and Howard M. Leichter, "Rationing Care In Oregon: The New Accountability." *Health Affairs*, Summer 1991, p. 8.

⁵⁷ Joshua M. Wiener, "Oregon's Plan for Health Care Rationing," *The Brookings Review*, Winter 1992, pp. 26-28.

package. For instance, in July 1991 Oregon approved state funds for condition/treatment pairs through 587; therefore, conditions/treatments from 588 through 709 were not part of the initially covered basic services proposed under the Medicaid program.⁵⁸ But what was proposed is expanded access to an additional 160,000 Oregonians who have no insurance.⁵⁹ Oregon promises to provide coverage to all Oregonians with incomes below the federal poverty line. Currently, Oregon's poor are only eligible to receive Medicaid if their income is ". . . lower than 50 percent of the poverty line (except for pregnant women and young children), and childless families and individuals are generally excluded."⁶⁰

Oregon explicitly confronts two of the most pressing issues on the national agenda for health-care reform: cost-effective care with nearly universal access. John Kitzhaber, state senate president, physician, and chief architect of the Oregon proposal, clearly states that the main issue is:

"what was the equity in giving sophisticated and costly services to a few Oregonians covered under Medicaid before providing basic health-care services to other needy citizens, including the working poor, who lacked any public or private coverage?"⁶¹

Kitzhaber vehemently denies and bristles when his critics accuse him of introducing rationing into the system. His aide, Mark Gibson, retorts saying that "Oregon and every other state rations [sic] already. . . . in a dumb way. . . . and many people die, silently."⁶²

As the Medicaid monster eats up state budgets, insidious forces are

⁵⁸ Fox and Leichter, *op cit.*, p. 9.

⁵⁹ *Ibid.*, pp. 9-10.

⁶⁰ Weiner, *op. cit.*, p. 26.

⁶¹ *Ibid.*, p. 26.

⁶² *Ibid.*, p. 28.

employed in an effort to control the rate of spending. Wiener points out that some states cut reimbursement rates so low to physicians that they refuse to accept Medicaid patients. In other cases, states change the financial threshold for Medicaid eligibility, set arbitrary limits on covered hospital days, physician visits, and prescriptions.⁶³ The difference in Kitzhaber's proposal and the way many other states ration care--and they all undoubtedly ration care--is that the Oregon proposal is open, explicit, and rational. Oregon proposes to ration using a conscious, explicit, public-determined plan while other states use ". . . subconscious, hidden rationing through mechanisms that prohibit access to the health-care system (lack of insurance, gaps in coverage, and burdens that make access so unattractive that getting care is not worth it)."⁶⁴

There are numerous critics of Oregon's rationing approach, ranging from special interest groups, some of whom purport women's rights, to such people as Vice-President Gore. Many object to the Oregon plan based upon moral grounds. Some moralists feel that rationing can never be justified, only rationalized. Others object to Oregon's plan because the plan emphasizes ". . . quality of life in the ranking process . . . violates the principle of sanctity of life."⁶⁵ Weiner explains that some moralists object to the Oregon's limit-to-care approach because the state has failed to eliminate savings that could be achieved through better cost containment efforts.

Veatch argues that Oregon's rationing model treats care as basic in the context of being cost effective.⁶⁶ To him and others the utilitarian ethical theory is at odds with our Judeo-Christian traditions and culture. Using a

⁶³ *Ibid.*, p. 28.

⁶⁴ Robert M. Veatch, "Should Basic Care Get Priority? Doubts About Rationing the Oregon Way," *Kennedy Institute of Ethics Journal*, Sep. 1991, p. 189.

⁶⁵ Weiner, *op. cit.*, p. 29.

⁶⁶ Veatch, *op. cit.*, p. 197.

different frame or lens than the cost effective rational lens, one could redefine basic care--the centerpiece of the Oregon proposal--by incorporating the principles of *respect for autonomy* and *equity or justice*.⁶⁷ The idea of basic care incorporating a different lens than the cost effective one changes the approach. For instance, *respect for personal autonomy* places the responsibility for voluntary risky lifestyle behavior on the individual. If through risky behavior an individual develops a disease, the person receives a lower relative priority for treatment.⁶⁸

The second aspect challenging the cost-effective approach is equity or justice. The premise is that the algorithm used in Oregon's plan fails to consider how the health benefits are distributed in the affected population.⁶⁹ Proponents of greater equity or justice are adverse to those worse-off receiving less even when those somewhat better-off receive more. Greater equity provides benefits to those in greatest need, regardless of the net benefit/cost ratio.

The state of Oregon has made commendable headway in developing a scheme that realistically, honestly, and openly provides basic care for its Medicaid beneficiaries. One can argue philosophically about the definition of basic care, the rank ordering priority system mechanics, and the ethical and moral validity of Oregon's approach, but the bottom line is that the state has made a noteworthy effort to provide an acceptable level of care to its poor in a resource constrained milieu. It is a model the nation can evaluate not just in the context of reallocating resources but also in building coalitions and accepting political accountability for its actions.

⁶⁷ *Ibid.*, p. 197.

⁶⁸ *Ibid.*, p. 198.

⁶⁹ *Ibid.*, pp. 198-199.

The British and Canadian Models: Good or Bad?

Frequently, Canada's and Great Britain's health-care systems are compared and contrasted to our own. Both Canada and Britain have national health-care systems, which, though similar in some features, have many dissimilar characteristics. What these countries provide for us are models that we can use to assess the feasibility of developing our own national health-care program and the degree to which "rationing" is designed into their systems and its effects on quality, cost, access, and availability (security).

The following discussion will briefly examine the similarities of these two systems, their dissimilarities, and then some of the pros and cons, including the physician's role in rationing health care. And, finally, the discussion will compare the British National Health Service physician with those working in this country's HMOs.

For the period 1987 through 1990, Canada and Britain experienced (after adjusting for inflation) a 2.45 and 2.46 percent "average annual growth in per capita health care spending," respectively, and, the U.S. averaged a 5.49 percent growth.⁷⁰ During the 1980s, Canada was able to keep its health-care spending at eight percent of GNP and Britain around six percent; the U.S. finished the 1980s with spending for health care near 11.5 percent of GNP.⁷¹

Both Britain and Canada offer each citizen free health care. Therefore, there is universal availability or security. Both countries require queuing by its citizens to receive certain services. Queues effectively serve as a form of rationing. The governments control the delivery of health care and the process for financing this delivery.

⁷⁰ Kosterlitz, *op. cit.*, 387.

⁷¹ Marshall, *op. cit.*, p. 678.

While both countries have a national health care system the differences in their two systems are many. Britain's central government is more involved than Canada's. In Britain, resource allocation decisionmaking largely occurs at the national and regional levels with a national budget set, limiting sharply the supply of some services.^{72 73} In Britain, the government owns most of the hospitals and physicians receive a salary through the National Health Service (NHS). Similar to Britain, Canada minimizes its costs by setting spending "targets" but differs in that it negotiates binding fees for physicians services.⁷⁴ Receiving an annual budget from the national government, Canada's provincial governments actually set fees for physicians and allocate funding within the provinces. Clearly, the incentive remains to minimize health care expenditures and to make cost-effective, systemic decisions. The Canadians do this using a mix of public and private facilities, as well as by allowing its citizens to choose private physicians.⁷⁵ As Kosterlitz explains,

"Canada saves a bundle by eliminating most of the marketing and administrative costs that come from having a welter of private insurance plans: It spends roughly \$15 per person on such costs; the United States spends \$95."⁷⁶

Unlike Britain, Canada prohibits its citizens from acquiring private insurance for those services provided through the national health care system. By restricting its people in this manner Canada has avoided creating a two-tiered health care system, but, in turn, has created at least a modicum of frustration from within. For instance, in Newfoundland, the wait for hip replacement takes six to ten months, for routine pap smears it takes five

⁷² *Ibid.*, p. 678.

⁷³ Kosterlitz, *op. cit.*, p. 387.

⁷⁴ *Ibid.*, p. 387.

⁷⁵ *Ibid.*, p. 387.

⁷⁶ *Ibid.*, p. 387.

months, and for cataract surgery and non-emergent bypass heart surgery it takes two months.^{77 78} On the other hand, Britain does allow its people to purchase private insurance, which ten percent now have.⁷⁹ Because the queues are much longer in Britain than in Canada, it is probably imperative for Britain to have a safety valve that accommodates those who demand "more timely" health care services. Yet, despite what Americans would consider inordinately long waits for certain services, Canadians, survey-after-survey, rate their satisfaction as "very high."⁸⁰ Britons, too, are ". . . fiercely protective of their access to government-provided health care."⁸¹ Each country supports its national health care system, despite the inherent flaws.

Undoubtedly, care is rationed in a non-price fashion in both countries. A look at the British NHS reveals that they spend about two-fifths as much as we spend per person.⁸² Schwartz and Aaron note, though, that the most striking feature of the British system is that it fails to allocate resources in an efficient manner, giving several examples of nonmedical factors affecting clinical decisionmaking.⁸³ Also, one could compare the NHS physicians' role to that of our HMO physicians' and surmise that there are amazing similarities. The difference is probably only in degree in that both of these delivery systems require their "gatekeepers" to make trade-off decisions--decisions between the "fundamental physician ethic" and the

⁷⁷ *Ibid.*, p. 387.

⁷⁸ Marshall, *op. cit.*, p. 676.

⁷⁹ Marshall, *op. cit.*, p. 676.

⁸⁰ *Ibid.*, p. 678.

⁸¹ Kosterlitz, *op. cit.*, p. 387.

⁸² William B. Schwartz and Henry J. Aaron, "Must We Ration Health Care?" *Best's Review*, Jan. 1991. p. 40.

⁸³ For example, as Aaron and Schwartz describe: CAT scanners were not widely used for 10 years at major teaching hospitals while concomitantly the NHS authorized expensive forms of IV nutrition, which is of marginal benefit. Also, Schwartz and Aaron note that social values in some cases overrode medical benefits with age-based criterion being a decisive factor. The young receive aggressive care, irrespective of cost versus medical benefit. Certain diseases are favored for aggressive treatment over others, regardless of the expected medical outcome.

economic realities of resource constraints.⁸⁴ Though physicians do not like being placed in this role, they are truly the best ones, some experts believe, to make these medical-based decisions. In so doing, the process of rational rationing allows physicians on an individual basis to strike a balance between standards of care and scarce resources.⁸⁵

Rationing As An Option Or Inevitability?

During 1993 the nation will spend approximately \$2.5 billion daily for health care--three times more than that allocated for defending this country. Each day more of our national wealth is used to pay for escalating health-care services. Indeed, we have first-rate care, if one can gain access! But health care has become too expensive for many individuals who have other personal and family necessities, (e.g. housing, clothing, education, and transportation) and for employers who must compete in the international arena. Nationally, our industries are moving offshore, our inner cities disintegrating, our standard of living stagnating, and our way of life uncertain. Individually and collectively, as Americans, we have sub-optimized precious scarce resources, pursuing ever increasing diminishing marginal returns on our health-care investment.

Dietrich Bonhoeffer, a theologian, who died in a Nazi concentration camp, said that, "The ultimate test for a moral person is how the coming generations will live."⁸⁶ Our great nation is saddled with the dubious distinction of having the highest rates among industrial nations for such things as: homicide, teenage pregnancies, illiteracy, suicide, and the list

⁸⁴ Schwartz and Aaron, *op. cit.*, p. 40.

⁸⁵ *Ibid.*, p. 40.

⁸⁶ Lamm, *op. cit.*, p. 179.

goes on. However, the U.S. is not recognized for having the healthiest population--despite the enormous amounts it expends for health care. Yes! we produce the highest quality product; it is on the other fronts that our peoples' quality of life and health suffer: our homeless, neglected children, jobless, disintegrating families, and our own lack of personal responsibility and individual values.

Our inability to deal with the health-care crisis is symptomatic of our greater inability to deal with a number of politically sensitive, potentially explosive national issues. Is this the price we must pay for a pluralistic society? Our recent past indicates that our great country has only dealt with this dilemma incrementally--a little tinkering here and there--in its effort to compromise with various professional organizations, special interest groups, and lobbyists. The product--today's U.S. health care delivery system--perpetuates a process that for many is unresponsive, inefficient, irrational, inequitable, and unethical:

- Unresponsive. 37 million Americans are without health care coverage and an equal number are underinsured.
- Inefficient. We are spending too much on unnecessary care/tests;
- Irrational. Physicians employ extraordinary measures that have little-to-no marginal value at significant costs based largely upon one's ability to pay;
- Inequitable. Many below the federal poverty line are not eligible for Medicaid, cannot afford insurance, and, thus, cannot afford health care;
- Unethical. Many elderly patients who are terminally ill are overtreated through use of heroic efforts.

Essentially, the U.S. health care system is out of balance. The four cornerstones--access, quality, costs, and availability (security)--are not properly functioning. Americans, who can gain access to the system, usually receive exceptionally good care, especially those with comprehensive third-party coverage. However, we irrationally ration access and care to the extent of one's ability to pay. In fact, within this country a multiple-tier system

of rationing exists based upon one's ability to pay. Yet, as reflected in the employment of new technologies and high-cost treatments--such as with MRIs, CT scans, high-cost drugs, and \$150,000 Autologous Bone Marrow Rescues--many Americans often receive care that would have been only a year before considered experimental.

While quality of care is exceptional and access somewhat limited and inequitable, the two other cornerstones--costs and security--are far more disproportionately out of balance. Many employers have dropped employer-provided insurance coverage, and individual policy holders, too, have found that insurance premiums are unaffordable or exclude preexisting conditions. There is no safety net unless one is completely destitute, and, even then, Medicaid rations care based upon arbitrary thresholds. Increasingly, the average citizen and employer just cannot afford the health care system that has evolved. It is a system that encourages over consumption of care, fraud, abuse, waste, and inefficiency.

We must completely rethink what it is we want from our health care system and how we can best restructure it to achieve our broader and more comprehensive national goals. We cannot have 254,000 millionaires receiving Medicare when 600,000 pregnant American women are going without prenatal care in their first trimester.⁸⁷ We can ill afford to let large segments of our population go without health care coverage. We are at a juncture that requires us to make conscious and rational choices. As Lamm discusses, we cannot let our "ethical individualism" interfere with acting responsibly for social connectivity and interdependence. For those that believe the newest cost containment proposal--"managed competition"--will actually control the underlying causes of escalating spending they are in psychological denial, perhaps even are delusional, or, at the very least, yearn for the days of

⁸⁷ *Ibid.*, p. 184.

ole'. Managed competition is merely a new spin on controlling at the margins, the fringes without making truly tough and politically accountable decisions. Laissez-faire health care and marketplace forces have not worked and cannot work when it comes to ordering our national health care priorities. Our desires are open-ended and our hopes boundless. We must realize that trade-off choices are before us. The inevitable choice between rational rationing or continued irrational rationing is at hand. The question we must ask ourselves is not, "How do we avoid rationing?", but "How do we allocate finite resources to meet indefinite demand, and do it compassionately and justly?"⁸⁸

How exactly do we achieve allocation of finite health care resources to meet indefinite demand and do it compassionately and justly? Do we use the Oregon model, do we use Callahan's limit-to-medicine approach, do we use a strict age-base criterion, do we use some type of mathematical function weighing costs against longevity and quality of life, do we allow a multiple-tier system of access and care, do we guarantee a specify level of access and services to everyone or to only those that meet a certain income level? These are somewhat rhetorical questions to illustrate the point that there is no easy and simple, single solution.

In transforming our current health care system to one that enables us to achieve our broader national goals and is not an elusive end in-and-of itself, we must acknowledge and accept that some individual health care desires, even needs, will go unmet for the greater needs of the community as a whole. As discussed, we must incorporate solutions to the underlying causes--root causes--of escalating health care spending. We must control the use of technology, develop acceptable protocols for treating the chronically ill, especially the elderly, and regulate labor costs and encourage greater productivity advancements. Restructuring the system, we must streamline the

⁸⁸ *Ibid.*, p. 181.

health care processes and allow for only those features that sufficiently add value to the end product.

We can and should achieve one-time savings with a restructured health care system. Specifically, though not all inclusive, we need to eliminate approximately 1,500 hospitals, encourage less physician-based care and more individual responsibility, go to a "single payer," eliminate the tax write off for employer-provided insurance, increase the number of general clinicians, including para-professionals, but reduce total physicians in the U.S. by 125,000, prohibit physicians from referring patients to their own diagnostic facilities, limit malpractice tort awards, regulate the salaries of all health care workers, eliminate fee-for-service reimbursement, develop standards of care practical guidelines/protocols, measure clinician performance against these protocols, control the use of technology, and provide a "basic" health care package for all Americans. These are just some of the many features that need incorporation into a coherent health care restructuring plan. Again, the U.S. cannot afford for changes to be at the margins; the underlying causes must be at the heart of the restructuring.

We must accept the fact that as a country, and as individuals, we simply cannot afford today's health care system. We should achieve one-time savings where possible, but from a national/community perspective upper bounds must be placed upon our incessant quest for more technology, immediate gratification, and health care services of marginal value. As Lamm notes, this will require us to develop an "ethic of restraint" and to answer the perennial question, "What kind of world are we going to leave for our children and grandchildren?" We cannot let laissez-faire and marketplace forces dictate our ordering of national/community priorities. As citizens, we have an ethical and moral responsibility to consciously and rationally choose the upper and lower boundaries this nation will accept for its peoples' health care. Resources are finite. Rationing is inevitable, not impossible.

Appendix

Health Care Terms

Managed Competition. Not to be confused with managed care, this refers to the type of reform Clinton advocated during the campaign to overhaul the country's health care system. It requires the government to regulate insurers so that no individual can be denied coverage and everyone buying the same plan in the same region would pay nearly the same for it.

Most employers and individuals would purchase insurance from a nonprofit agency (a Health Insurance Purchasing Cooperative or HIPC) that would negotiate the best price and service from competing health plans. Health plans would likely be organized by insurers or managed care companies (such as health maintenance organizations, or HMOs) that would own or contract with hospitals, doctors, clinics, etc., to provide care for the people who choose their plan. Experts agree most plans would likely evolve into "super-HMOs."

All health plans would have to offer a standard benefit package, the contents to be established by a government board. The government would collect information from health plan on their medical effectiveness and on customer satisfaction, which consumers could use during open enrollment periods to choose a plan.

Managed Care. Refers to health care organizations--such as Health Maintenance Organizations or Preferred Provider Organizations--that "manage" or control the cost of health care by closely monitoring how doctors treat specific illnesses, by limiting referrals to costly specialists and requiring preauthorization for hospital care, among other measures.

Single Payer. A system that has a single payer--the government--for all health care. The government would impose a health tax of some sort to pay for it. Doctors, hospitals, and other medical services would remain in private hands, although the government would impose various forms of price controls on them. This is also often referred to as the "Canadian model" or national health insurance," although many politicians have used the latter phrase simply to mean that all people should be able to buy health insurance.

Medicare. Federal program that pays for medical care of those over 65 and others, such as the disabled.

Medicaid. Joint federal-state program that pays for medical care of low-income citizens.

Prospective Payment System (PPS). The system introduced by the Reagan administration in 1983 to reimburse hospitals for Medicare patients "prospectively"--on the basis of rates established ahead of time--rather than on the basis of the hospital's charges. The system was intended to hold down the federal government's Medicare costs.

Diagnostic Related Groups. A list of more than 475 medical conditions specified under the PPS system, together with the rates at which the federal government will reimburse hospitals.

Utilization Review. Describes several methods used by insurance companies and corporations to reduce the cost of covered employees' medical claims, usually for elective surgery. These include reviewing a doctor's recommended hospital stay for a patient upon admission to a hospital and reviewing the doctor's recommended treatment plan once the patient is in the hospital.

Fee-for-service. The traditional system of paying doctors in America, through a separate fee for each medical service, such as a doctor's visit, medical test, or operation.

Health Maintenance Organization (HMO). An organization of physicians, frequently salaried, that charges each patient a fixed annual fee for all medical care.

Preferred Provider Organization (PPO). A list of doctors who agree to treat the members of a group health plan. In return for the expected increase in patients, the doctors frequently agree to offer their services at a discount.

Outcome Studies. Studies that track groups of patients after they have received a specific treatment in order to determine the procedure's effectiveness.

Practice Guide/Protocols. Practice guidelines are recommended treatments for specific ailments. The guidelines take into account outcome studies, the patient's condition and the likelihood that the patient will benefit from a particular treatment. The American Medical Association is developing its own practice guidelines.

Selected Bibliography

- Aaron, Henry J. and Schultze. *Setting Domestic Priorities: What Can Government Do?* The Brookings Institution. Washington, D.C. 1992.
- Aaron, Henry J. and Schwartz, William B. "Rationing Health Care." *Across the Board*. July/August 1990.
- Barry, Robert L. and Bradley, Gerard V., ed. *Set No Limits: A Rebuttal to Daniel Callahan's Proposal to Limit Health Care for the Elderly*. Urbana and Chicago: University of Illinois Press. 1991.
- Castro, Janice. "Paging Dr. Clinton." *Time*. January 18, 1993.
- Castro, Janice. "Condition Critical." *Time*. November 25, 1991.
- Congressional Budget Office. *Economic Implications of Rising Health Care Costs*. A CBO Study. October 1992.
- Congressional Budget Office. *Projections of National Health Expenditures*. A CBO Study. October 1992.
- Davies, Nicholas. and Felder, Louis H. "Applying Brakes to the Runaway American Health Care System." *Journal of the American Medical Association*. January 5, 1990.
- Families USA Foundation. *Emergency! Rising Health Care Costs in America*. October 1990.
- Fox, Daniel M. and Leichter, Howard M. "Rationing Care in Oregon: The New Accountability." *Health Affairs*. Summer 1991.
- Gruber, Lynn and Porter, Michelle and Ball, Patricia. *The Bottom Line 2: HMO Premiums and Profitability, 1889-1990*. Interstudy Center for Managed Care Research. 1990.
- Jecker, Nancy S. and Schneiderman, Lawrence J. "Futility and Rationing." *The America Journal of Medicine*. February 1992.
- Kosterlitz, Julie. "A Sick System." *National Journal*. February 15, 1992.
- Kosterlitz, Julie. "Rationing Health Care." *National Journal*. June 30, 1990.
- Lamm, Richard. "Health Care and Public Policy: The Need to Develop an Ethic of Restraint." *Compensation & Benefits Management*. Spring 1989.
- Marshall, Patrick G. "Setting Limits on Medical Care." *Congressional Quarterly Incorporated*. *Editorial Research Reports*. November 23, 1990.
- Schwartz, William B. and Aaron, Henry J. "Must We Ration Health Care?" *Best Review*. January 1991.
- Schwartz, William B. and Aaron, Henry J. "Rationing Health Care: The Choice Before Us." *Science*. January 26, 1990.
- Skidmore, Dave. "Economy Trails Health-Care Cost." *The Virginia Pilot and Ledger Star*. January 8, 1993.
- Veatch, Robert M. "Should Basic Care Get Priority? Doubts About Rationing the Oregon Way." *Kennedy Institute of Ethics Journal*. September 1991.
- Wiener, Joshua M. "Oregon's Plan for Health Care Rationing." *The Brookings Review*. Winter 1992.