Rationing Health Care

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The Basics

- Distributive Justice: How should goods be allocated
- Rationing is always necessary in the presence of scarcity
- Markets are rationing mechanisms
- So are lines, waiting rooms, busy telephones, formularies, too few physicians, etc.
- Rationing occurs at “macro” and “micro” levels
  - Health care system (insurance schemes)
  - Health care programs (organ allocation)

Screening Potential Recipients of Health Care

- By constituency (e.g., veterans, citizens, ability to pay)
- By potential for scientific progress (exclusion criteria in clinical investigation)
- By prospect of success (reasonable chance of benefit)

Selecting Recipients

- Medical utility
- Chance and queuing
- Social utility
- Triage

The Classic Case: Battlefield Triage

- Developed by French military surgeons during Napoleonic era
- Generally several categories, e.g.
  - Salvageable but not urgent
  - Urgent
  - Not salvageable

The Classic Case: Battlefield Triage

- All triage systems are utilitarian: aim to produce the greatest good for greatest number under scarcity
- Justice considerations:
  - Treat similar cases similarly (equity)
  - Treat equals equally (equality)
Crisis Triage Considerations
Pesik, Keim, and Iserson (2001)

- Should be considered
  - Likelihood of benefit
  - Effect on improving quality of life
  - Duration of benefit
  - Urgency of patient's condition
  - Direct multiplier effect among emergency caregivers
  - Amount of resources needed for successful treatment

- Should not be considered
  - Age, ethnicity, or gender
  - Talents, abilities, disabilities, or deformities
  - Socioeconomic status, social worth, political position
  - Co-existent conditions that do not affect short-term prognosis
  - Drug or alcohol abuse
  - Antisocial or aggressive behavior

Clinical Triage in the Emergency Department

- Burden of patient need defined by
  - Rate of patient appearance
  - Urgency of condition
  - Complexity of condition

When burden is excessive due to urgency and/or complexity the ED may go on "bypass" and thus regulate rate

America’s first experience with life or death rationing


The Scribner Tank at UW, 1960

- Early peritoneal dialysis at Swedish Hospital, Seattle
- Limited number of machines
- "God Committee"

A special exception

- End-Stage Renal Dialysis program is part of Medicare
- Guarantee of dialysis to all end-stage patients
- Included in Medicare Act by Congress after dialysis performed before House Ways and Means Committee, 1972

Is there a “Right to Health”?

- Health cannot be guaranteed
- Is there, then, a right to health care?
- The correlativity of rights and duties

As we’ll see, different theories have different conclusions
- If no right to health care, then what?
Theories of Justice in Health Care

- **Libertarianism**
  - “Taxation is theft”
  - Health care is a market commodity like any other
  - No societal duty to provide health care, therefore...
  - No right to health care
  - Charity should be encouraged, but is not a duty

- **Socialism**
  - Social inequalities are arbitrary
  - These inequalities should not compromise individual human dignity
  - Inequalities often aggravated by unfair socioeconomic arrangements
  - These arrangements impair fair access to goods, like health care
  - There is a right to health care, therefore...
  - Society has a duty to provide it

- **Social Contract**
  - Rationality requires fair socioeconomic arrangements
  - These arrangements help determine opportunity
  - Fairness can be achieved by creating conditions that favor the worst off
  - Access to health care is a factor in exploiting opportunity
  - Inequalities in health care system should favor the worst off (Rawlsian)

In Search of a “Decent Minimum”

- No agreement about a right to health care in the US (President's Commission, 1982)
- But consensus about a duty to provide a “decent minimum” of health care
- What counts as a decent minimum?
- Who is required to provide it?

An Escalating Crisis

- 1965-6% of GDP for defense and for health care
- 1972-Pres. Nixon begins HMO demonstration projects: cost and quality
- 1988-70% of Americans in fee-for-service
- Early 1990s, health care is 14% of GDP, defense still 6%
- 1993-70% of Americans in managed care

- Clinton “managed competition” proposal fails
- Late 1990s: 40 million uninsured, 40 million underinsured
- US morbidity and mortality lags behind other industrialized countries
- 1.4 trillion dollars spent on health care in 2001—world’s highest per capita – 14.1% of GDP
- 3.1 trillion estimated by 2012, 17.7% of GDP
Are HMOs as good as they get?

- Often focus on cost rather than quality
- Employ “rationing” procedures
- Risk of under-treatment (vs. over-treatment)
- Constrained by state laws (“drive-by deliveries”)

An Alternative: The Oregon Health Plan

- Goal: 100% coverage of those below poverty line
- Based on managed care/benefit limits
- Beginning in mid-1980s, Oregon began holding town meetings to discuss health care priorities
- Public rankings were combined with rankings by physicians
- Administered through state Medicaid program
- Also open to small businesses
- Implemented in early 1990s

The Oregon Health Plan

- Preference given to treatments that prevent death and reduce costs
- Adjustments based on perceived citizen values
- 745 items listed
- OHP pays for about 600 of them, depending on budget year
- Threshold generally does not permit organ transplants

Strict limits to benefits

- Excluded from coverage are treatments for liver cancer, cancers that have become widely spread, viral pneumonia, chronic bronchitis, acute viral hepatitis, slipped discs and other back disorders, aseptic meningitis, phlebitis, pleurisy, perinatal digestive disorders, kidney cysts, uncomplicated gallstones, traumatic brain injury, and progressive dementia.

- Also excluded are much, if not most of routine medical care such as treatment for non-fatal viral infections, upper respiratory infections, colds, minor burns, laryngitis, mononucleosis and others.

OHP from 1993-2003: A mixed record

- Unreimbursed hospital care down 30%
- Emergency room use down 10%
- Medicaid coverage expanded

But

- Expenditures up 112%
- Cost of drugs main driver, up 200%
A “Microallocation” Problem

- Human organs are genuinely scarce resources
- How should they be allocated?
  - Ability to pay
  - Social merit
  - Lottery (first come, first served)
  - Medical indications

2002 Data

- In 2002, there were nearly 25,000 organ transplants.
- In 2002, there were more than 12,700 organ donors.
- Every 14 minutes a name is added to the national transplant waiting list.
- More than 80,000 people currently await transplants.
- In 2002, more than 6,000 patients died waiting for organs.
- For each person who receives a transplant, two more are added to that list.

UNOS Process

- Following referral, evaluation for listing based on mental and physical health and social support
- Placed on waiting list
- When a deceased donor is identified, computer ranks based on tissue match, blood time, time on list, distance, urgency

Should there be an organ market?

- Organ markets are contrary to public policy
- Donor blood shown safer than sold blood
- Yet markets do exist ($1,000 on average in India)
- How many kidney donations in developed countries are truly altruistic?
2002 Survey in Southern India

- Average price a bit over $1,000
- Most sold due to debts but were still in debt 6 years later
- Most were more poor years later
- Most reported worse health

Modified proposals

- Modest payment toward funeral expenses proposed (Pennsylvania)
- Would respect for human beings diminish?
- Would poor be exploited?
- Would supply of organs be increased