S. HRG. 102-570

# WHO LIVES, WHO DIES, WHO DECIDES: THE ETHICS OF HEALTH CARE RATIONING

## HEARING

BEFORE THE

## SPECIAL COMMITTEE ON AGING
## UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

WASHINGTON, DC

JUNE 19, 1991

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# WHO LIVES, WHO DIES, WHO DECIDES: THE ETHICS OF HEALTH CARE RATIONING

WEDNESDAY, JUNE 19, 1991

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
*Washington, DC.*

The Committee met, pursuant to notice, at 9:04 a.m., in room 628, Dirksen Senate Office Building, Hon. Herb Kohl (acting chairman of the Committee) presiding.

Present: Senators Kohl, Reid, Cohen, Grassley, Simpson, Durenberger, and Burns.

Staff present: Portia Porter Mittelman, staff director; Christine V. Drayton, chief clerk; Kim Weaver, professional staff; and Sherry Hayes, legislative assistant to Senator Kohl.

## OPENING STATEMENT BY SENATOR HERB KOHL, ACTING CHAIRMAN

Senator KOHL. The hearing will come to order.

This morning we are going to be talking about the ethics of health care rationing in America. In discussing rationing and what it means in terms of our country and our budget, I think it is important to recognize that in virtually every part of government expenditures, we do have rationing.

There isn't a single dollar that we spend that doesn't have an element of rationing. Our educational expenditures are, finally, an expression of rationing in our country. Our defense expenditures—as vast as they are—represent a rationing of our financial resources. Entitlement programs—as vast as they are—are an expression of rationing. In none of these areas do we spend as much as many people think we ought to spend. I think health care is equally representative of that concept of rationing of financial resources in this country.

We are here to discuss that and perhaps to open up all of the different cans of worms that do exist when people talk about health care rationing and its morality, its reality, and its future, particularly in regards to the reform of our total health care system that is surely inevitable at some time in this decade—sooner, probably, rather than later.

This should be an interesting hearing. We are all looking forward to hearing from our witnesses.

[The prepared statement of Senator Kohl along with the prepared statements of Senators Sanford, Pressler, Grassley, Jeffords, and McCain follows:]

PREPARED STATEMENT OF SENATOR HERB KOHL

Everywhere we turn there is a discussion of health care reform. We have a system in crisis. We have millions of Americans uninsured. Millions of others are underinsured. The vast majority of senior citizens are denied access to long-term care unless they become impoverished. And poor children in this nation do not have access to the most fundamental health care services. The disparities between different populations are glaring.

If we truly believe in universal access to health care—and I do—then don't we have a fundamental obligation to define what benefits we are prepared to cover? Don't we have an obligation, as a government—and as the single largest payer in the system—to address the inequities that exist between one group and another?

In preparing for this hearing, several people have asked me if this is all about Oregon's waiver request. No, this is not about Oregon. And I don't think we should allow the Oregon proposal to define rationing for us.

When we say rationing, it conjures up all sorts of reactions. When U.S. citizens are told that health care in Canada is "rationed"—that folks wait for months for a certain technology—we are immediately appalled. When a state like Oregon struggles with an explicit rationing plan that will limit access to certain services for a certain population, constituency groups ranging from the Children's Defense Fund to Families USA arm themselves for battle. And when the Senate Special Committee on Aging convenes a hearing on rationing, a lot of people think we're jumping into an intergenerational debate. That is not why we are here today.

Rationing means different things to different people. It means Oregon, Canada, life-sustaining technology, organ transplants, triage and World War II, for those of us young enough to remember. People respond positively or negatively based on what rationing means to them. So today, we're going to try to define rationing.

I believe rationing exists in our current system. When someone says rationing, we don't immediately associate it with our own health care system. But it's real. We have price rationing. If you can pay for it, you get it; if you can't, you're out of luck. We have more explicit rationing too. Although it has since changed, we used to pay for liver transplants for kids under 18 but not for senior citizens. That was our policy—it was explicit.

In the emergency rooms across the country, there is nonprice rationing. When an ER gets to gunshot wounds, a slight fever and a broken arm, a system called "triage" is used to make decisions about who gets cared for first. If that ER gets five gunshot wounds in 30 minutes, but only has two ER teams, the decision can be a life and death matter. Rationing occurs as a consequence of limited resources. How are those decisions made?

The organ transplant system combines both price and nonprice rationing. Sometimes people wait for months. Sometimes people die while they are waiting. Yet that system seems to be relatively well accepted as long as no one is allowed to "take cuts" in line. As long as everyone shares the risks, it is somehow viewed as fair, even though rationing is involved.

In the current patchwork of health care, it is an absolute fact that we ration access to certain populations—the underinsured don't have access to preventive care, so they end up in emergency rooms. And as I stated earlier, some services aren't reimbursed. That might not bother most people if the service is a cosmetic one, say if we're talking about a face-lift. But it does bother us when someone we love can't get a life-saving treatment, because it's not reimbursed under their insurance coverage. When it comes to saving lives, we demand absolute access.

Are we prepared as a society to pay for absolute access?

What if we said tomorrow that we were prepared to spend 14 percent of our GNP on health care? Does anyone suggest we would then NOT have to still resort to rationing? What could we buy with that spending? How would we decide which services, which populations to cover?

It is clear to me that we have at least an implicit health care rationing system in the United States. I am not convinced that it is either rational or ethical.

Is explicit rationing more or less ethical?

Is it right to ration care by population as we must admit we currently do? And if we have a basic benefit for all Americans, how do we feel about allowing a small number of Americans—those who can afford it—to buy more or better health care?

Is rationing a viable cost-containment tool? Is there a place for rationing in any good health policy?

There are questions that academics, ethicists and health policy experts have been discussing in small circles. Today, we will raise them in the Senate. I think it will

be a useful addition to the debate on national health care, and I am very much looking forward to the discussion today.

PREPARED STATEMENT OF SENATOR TERRY SANFORD

I want to thank Senator Kohl for organizing this hearing that promises to be thought provoking and perhaps somewhat controversial.

We already have health care rationing in this country. Poor families do not have the same access as wealthy families do. And many of our working poor have the least amount of access to good health care in this country. Insurance companies do not cover the cost of organ transplants for all who are insured by them.

Many of our rural areas have no hospitals or clinics within easy reach. Even worse, a growing number of rural communities have no health care providers. There are rural communities in every state in this country without any primary care physicians because Medicare and Medicaid simply do not reimburse them enough to pay their costs. This is health care rationing that is on the rise in my state. We have health care rationing in this country. This rationing is just not based on a deliberate national rationing policy.

At issue here today is whether or not this country should have a deliberate rationing policy. I don't think deliberate health care rationing would be acceptable in this country, or should be. But I believe it is appropriate to discuss this very serious, often life and death, issue within the overall context of health care reform.

We need to ask questions and seriously consider all of our options. What are our alternatives? What kinds of cost controls can we utilize to avoid unnecessary rationing, to prevent the rationing we already have throughout the country because of our lack of a sound national health care policy? What will we ration? Who will we ration? Who will decide?

These are some of the questions that will be discussed here today, and I look forward to the debate on this subject.

PREPARED STATEMENT OF SENATOR LARRY PRESSLER

Mr. Chairman, I would like to commend you for holding this hearing on the ethics of rationing health care services. In my state of South Dakota, roughly eight percent, or 56,000 people, have no health insurance. There is no question that the U.S. spends considerably more than other countries on health care, yet the value of our health care dollar seems to be spreading thin. We need to take action now to improve the quality of health care and to provide coverage for uninsured individuals. However, it is extremely important that options to contain health care costs and expand access to health care services are thoroughly considered and discussed before changes are implemented. I am glad that we are discussing one of these options this morning and look forward to hearing from the witnesses, who have carefully studied the ethical questions related to health care rationing.

While there is a question as to whether or not health care services are rationed, I have no doubt that inexplicit rationing occurs in our current health care system.

In South Dakota, rationing of health care services goes beyond the individual's ability to pay. Shortages of health care providers, along with low reimbursement rates under Medicare and Medicaid, drastically reduce the number of individuals served by the system. The limited number of health care professionals and facilities in rural areas force providers to make ethical decisions by prioritizing emergency medical and trauma care services. If rationing were incorporated in the health care system as a method of expanding access to health services, I would advocate that careful attention be given to the effects that further rationing could have on rural areas, where services and manpower currently are limited.

There are both broad and narrow definitions of "rationing". Rationing plays an integral role in consumer demand for all types of goods and services. Without rationing, there would be no incentive to improve and perfect the efficiency of the product. However, the question we need to ask toady is how narrow a definition of "rationing" could or should be incorporated into our health care system to improve the efficiency of our current system without limiting freedom of choice for the individual health care provider or recipient.

I strongly believe that we need to preserve the element of choice that is such a fundamental part of the American way of life and the American health care system. Americans have prioritized medical technology and the U.S. has taken the lead in developing advanced medical equipment, drugs and services to meet these demands. Would it be ethical to limit access to these life-saving services in order to expand access to basic health care or long-term care services for a greater number of Americans? That is a difficult question to answer. Given the increasingly limited availabil-

ity of resources in our health care system, we need to consider the option of rationing before it becomes a reality, rather than a choice.

Reform of our health care system depends on all parties recognizing the serious weaknesses in our current system and bearing part of the burden of change. The problems facing us are complex, as are the most likely solutions.

I hope that through the hearing process, we can gain some insight into both the problems and the solutions to deficiencies in our health care system.

### Prepared Statement of Senator Charles E. Grassley

Thank you, Mr. Chairman.

I believe that it is useful to have a hearing on this topic as we focus in this Congress on the prospects for health care system reform.

"Rationing" is one of those words which carries more than its fair share of negative connotations. And when it is applied to health care, the negative connotations become even more pronounced.

I suppose that I respond like most other people when confronted with the word—I am not inclined to like it.

But I am responding to my own idea of the world. "Rationing" is also one of those words which means very different things to different people. Furthermore, even if we can arrive at a mutually satisfactory definition, when we try to apply it to health care it raises a cloud of difficult issues.

So far, we have not really at the national level confronted this question of rationing. We have flirted with it. There has been discussion about the Oregon program. Some talk of expenditure caps. We are reminded of the rationing we impose on the more than 31 million people without health insurance.

But, so far, in the Congress we have not discussed the subject systematically as far as I know.

There have been projects very indirectly connected to the subject. This committee produced a consultant's report several years ago on the subject of living wills and advance directives. The Office of Technology Assessment took up the topic of technology and the elderly and in their report on that subject discussed food and water as artificial interventions for the comatose terminally ill. But neither of these topics were taken up in a rationing framework.

So, therefore, I think it is useful for this committee to take up this subject to try and get some preliminary clarification of the topic and the issues that it includes.

I would like to make just one additional point. So far, I am not convinced that we have reached the point at which we must consider rationing, where that means substantial sacrifice of access to health care by those who currently have it, in order to provide health care to those who currently lack it.

To a considerable extent, it seems to me, whether we will have to consider rationing depends in large measure on the outcome of our current discussions about reform of the health care system.

Clearly, we can't go on much longer spending the way we are on health care, and tolerating a situation in which more than 31 million people are without health insurance.

### Prepared Statement of Senator James M. Jeffords

Mr. Chairman and members of the Committee, I wish to commend you roundly for organizing this hearing today to deal with a more fundamental issue: Who lives, who dies, who decides: the ethics of rationing healthcare. I am most impressed by the panel of experts you have assembled and I will study their testimony eagerly.

As you may know I have come out in favor of comprehensive health care system reform for the United States. As we contemplate what form that reform should take, however, I believe we must keep firmly in mind that some "rationing" is inevitable. In this country we currently ration essentially on the basis of ability to pay. Canada is often cited as a system the U.S. should emulate. While there are many fine features of the Canadian system, the fact is that health care rationing takes place there in the form of waiting lists, the lack of some high technology and the proximity of the U.S.

In reality, our choice is not, as some would suggest, between a system that can provide everything for everyone, and one that involves rationing. Our task, rather, is to evolve a system that makes, and does not avoid, the explicit judgments necessary for intelligent and compassionate rationing judgments in terms of health care policy and ethics.

Our current non-system fails to come to grips with these critical self-disciplinary judgments. One of the many heart rending cases in point was reported on the front

page of the Washington Post this past Sunday. 72-year-old Mr. Musolino had tried to chart his own medical destiny—in essence to discipline or "ration" the medical attention he would receive at the end of his life. In 1989 he'd written a "living will" stating that if he ever had a terminal condition, he didn't want to be kept alive artificially. He signed a "durable power of attorney" to this effect in favor of his wife.

Despite this, and despite his wife's very best efforts to have the hospital allow him to die in peace. Mr. Musolino was hooked to a kidney dialysis machine several times a week for months prior to his death. He was in constant pain and could not even recognize family members. The final bill for his hospital stay alone came to $385,000! The family says most will be covered by insurance—which may well reflect part of the problem here!

I do not wish to judge the particular facts of this case. However the process for making the necessary life or death judgment here was clearly flawed. Mrs. Musolino told the doctor when he finally agreed to stop the dialysis:

"You know, doctor, I was beginning not to know who to pray to anymore. Do I pray to you, or do I pray to God?"

These are issues we must face straight-on as a society which will require a new attitude toward health care from all of us. Providers, insurers and consumers will all have to give up some independence to ensure greater and more enlightened control over health and spending.

In my mind this new attitude toward health care should be centered around the premise that all Americans have a right to a core of basic health benefits. I have crossed the Rubicon on this point and am developing a proposal for the delivery of these basic benefits, a proposal I call MediCORE.

Let's face it, determining what those CORE benefits will be involves an excruciating process of explicit rationing. We must not avoid this duty. I applaud the Committee for its obvious willingness to contribute to that effort.

PREPARED STATEMENT OF SENATOR JOHN MCCAIN

Mr. Chairman, the subject of today's hearing—health rationing—is at the core of the debate over how to reform our nation's health care delivery system. And, it has profound ramifications principally for our nation's elderly. The hue and cry for the adoption of a national health insurance plan has grown to a feverish pitch over the past couple of years.

Proponents of such a plan focus on the desirability of universal coverage. They fail, however, to address what most would see as the major shortcoming of such a plan—the rationing of care. This particularly impacts the elderly, as these plans must often look to how resources can be meximized—using probability of the patient returning to a productive life as the guide for determining who receives services and when. At its most profound level, rationing involves the question of who lives, who dies, and who makes those decisions?

There isn't a week that goes by that I am not on a radio talk show in my state. Virtually every time, the issue of health care comes up. When it does, the phones lite up like a Christmas tree. Those calling want to extoll the virtues of the Canadian or British health systems. Callers can be heard to say, "my sister lives in Canada and only pays $5 for a doctor visit—why can't we have a system like that?

Comparing the health care delivery system of different nation's is a bit like comparing apples and oranges. In fact, these very callers take great pause when they learn that in London you cannot receive care for End Stage Renal Disease if you are over the age of 55, or that you have to wait for months for certain simple procedures in Canada, generally those used most frequently by the elderly, simply because they do not want to provide the necessary resources.

Without question, Americans are frustrated with their health care system, and for good reason.

Health care costs in this nation continue to be among the fastest rising in our entire economy—faster than energy, faster than food, faster than inflation. In fact, from 1981 to 1989, health care costs grew some 93.5%—while general inflaction for the same period rose 44.8%. This year, we will spend in excess of $750 billion on our health system—representing yet another double digit increase in health care inflation.

So difficult is this burden for our people and businesses to bear that this year has witnessed an unprecedented movement aimed at nationalizing at least some part of the health care system.

Daily, we hear and read of the Canadian System, of mandated health benefit plans, and of big business' support for some form of national health insurance.

But, before we dash, as a nation, headlong into the financial black hole that nationalization of health insurance would certainly create—and repeat the now repealed "Massachusetts Miracle", it's important that we understand what's good about our system, how it can be protected, and what alternatives exist in the marketplace to help deal with this crisis.

Most Americans enjoy state of the art health care. Nowhere in the world is the art and science of medicine so advanced, or advancing so quickly as in the United States. But that advancement has come, and will continue to come, at a price. With respect to costs, our challenge as policymakers and leaders, is to realize that our mission is to identify and contain those costs which do not contribute to quality of care, or advancement of medicine, and to find ways to provide care to more Americans.

The issue which is the subject of today's hearing is critical to the debate over how best to reform our nation's health care delivery system, and how to make it more responsive to the health needs of our people. For example, the outcome of the experiment being considered in Oregon is going to be key to exploring the issue of limiting health care to those services that have the best potential for improving the lives of the individual patient.

I look forward to the discussion this morning, and applaud you, Mr. Chairman, for bringing this important issue before us this morning.

Senator KOHL. Senator Cohen.

## STATEMENT OF SENATOR WILLIAM S. COHEN

Senator COHEN. Thank you, Mr. Chairman.

I want to commend you for holding the hearing and for your opening statement. It is going to be controversial. But, it is an issue, I think, that cannot be escaped.

Proponents of the explicit rationing plan, such as the one that has been proposed in Oregon, contend that some form of systematic health care rationing is essential if we are ever going to ensure universal access to health care. But for most Americans, the concept of rationing, as opposed to the reality of rationing, is systematic denial of medically necessary health care services is both morally and ethically unacceptable. We have not yet been willing to come to grips with the distinction between the concept and the reality.

The economist, Lester Thoreau, pointed out that ethically most Americans are simultaneously egalitarians and capitalists. None of us want to die because we can't afford to buy medical care. As egalitarians, few of us want to see others die because they cannot afford adequate medical care. But as capitalists, Americans believe that individuals should be allowed to spend their money on whatever they wish, including health care.

Unfortunately, health care rationing, I think to some extent, is a global reality. There is not a country in the world that provides completely unlimited health care services to all of its citizens—not one country, anywhere.

In the United States, health care is currently rationed on the basis of price and the ability to pay, so called de facto rationing or rationing by wallet. Care is rationed for the 37 million Americans without health insurance as it is for those who are unable to obtain medical coverage by virtue of a prior medical condition.

Health care services are rationed for Medicaid beneficiaries who are unable to find a physician who will treat them because of the low payment or the low reimbursement rates. De facto rationing is also a reality for the residents of rural and inner city neighborhoods plagued by chronic shortages of health care professionals.

In countries like Canada, access to health care is rationed by the government. While there may not be an official policy of denying access to care, funding for that care is limited. The system does, I think, a pretty good job of ensuring that everyone has access to basic primary care services, but it doesn't ensure that everyone has access to all of the care that they need.

In Canada, for example, access to new technology and diagnostic procedures that we take for granted, such as CAT Scans and MRIs, is quite limited. Expensive procedures that we routinely demand, such as organ transplants in this country, are rare in Canada.

Increasingly, hospitals are taking beds out of service, they are limiting the numbers of operations that they perform, and they are cutting back on other services as governments battle to hold down the costs of health care. The result has been a lengthening of waiting lists and a toll of deaths among patients who cannot survive long enough to get the surgery that they need.

The question before the Aging Committee today is not, Will we ration care, but rather, Must we ration further? Despite our cost containment efforts, health care costs are continuing to escalate, to soar. We spent roughly $671 billion on health care in 1990, approximately 12.2 percent of our GNP. As our first witness, Dr. Reinhardt, points out in one of his recent articles, "If the current trends continue, in about 82 years, all of our GNP will be going to health care."

Dr. Reinhardt, let me diverge here for a moment.

Norman Augustine wrote a book called "Augustine's Laws." I am fond of quoting one particular statistic that he used to show that if we continue to spend on the kind of high technology for our fighter aircraft, he said, "By the year 2050, it will take the entire budget to purchase one aircraft that will have to be shared between the Air Force and the Navy, except during leap year when one day during that year they will have to share it with the Marine Corps." [Laughter.]

I think you are citing a similar statistic here that within 82 years our entire GNP is going to be going to health care.

So what we have is a very curious paradox. Our system is capable of providing the finest, the most technologically superior health care in the world. Yet, for all of its sophistication and technological expertise, the system is critically flawed because it is not available to everybody. Not everyone can afford to have access to the basic services that they need, and this is an intolerable situation. The need for comprehensive reform in health care, so that all Americans can access to it, is very compelling. It is a moral imperative.

I have, obviously, some grave concerns about the moral and ethical implications of rationing, but I think it is an issue that has to be raised. The Chairman is right in raising it as we start to develop. There are a number of proposals now pending—or about to be pending—before the Congress, in terms of overhauling our health care system. This is going to be a critical element as far as the discussion and development of that comprehensive overhaul is concerned.

So, I commend you, Mr. Chairman. I regret that I can't stay for the hearing because I have two competing hearings. But, I do have

my staff here who will follow the testimony very closely and work with you in following up on it.

Senator KOHL. Thank you, Senator Cohen.

Senator Reid.

## STATEMENT OF SENATOR HARRY REID

Senator REID. Senator Kohl, thank you very much.

This hearing, as we've already heard from both you and Senator Cohen, addresses an issue of national concern. It is a topic that we don't discuss enough. The growing interest in this topic results from the growth in health care costs in recent years combined with the belief that efforts at cost containment have failed. Many conclude that we have no choice but to ration our health care resources.

In fact, the high cost of health care itself, as indicated by Senator Cohen, is a form of rationing. Health care in this country is rationed according to the ability to pay. Rather than issuing rationing coupons, like those issued in World War II, we rely on U.S. dollars or employment benefits as coupons. These health coupons are distributed unevenly in ways that might be considered illegal if it were a Government program. Some racial groups have more; children have the least; women get a smaller share; people at some companies get unlimited coupons, while other workers get nothing.

The bottom line is that we are rationing now under a certain definition of the term, only we are doing so in ways that we all can agree are unfair, that cannot pass the test of health ethics. I sincerely doubt that Congress would enact a program that left our wealthiest citizens with the finest health care available in the world, while many lower income and working Americans were left with little or no access to health care.

But that is precisely what we have today. To date, 35 million Americans remain uninsured. They receive no medical attention until they have a health crisis, when they end up in an emergency room or in some government hospital.

We must ask ourselves if the current patchwork system is an ethical way of rationing care. We must limit the resources we devote to health care, and make every effort to control costs; yet, we should not continue to allow those limits to fall randomly and disproportionately on our children and low-income citizens. We must engage in a national debate through the democratic processes to make fairer choices.

This hearing, Mr. Chairman, that you have arranged, gives us the opportunity to become more educated about rationing and how it occurs under our current system. This is a great starting point for finding a more enlightened way to distribute our life-preserving health resources.

Like Senator Cohen, I am not going to be able to stay for all of the hearing because I also have other places that I need to be. But I certainly think the panel is outstanding and for those witnesses that I will not be able to listen to and question, my staff will brief me.

Thank you very much, Mr. Chairman. Again, I regret that I will not be able to present for the entire hearing.

[The prepared statement of Senator Reid follows:]

PREPARED STATEMENT OF SENATOR HARRY REID

This hearing addresses an issue of great national concern, health care rationing. It is a topic we don't often talk about out in the open. The growing interest in this topic results from the mind-boggling growth in health care costs in recent years combined with the belief that efforts at cost containment have failed. Many conclude that we have no choice but to ration our health care resources.

In fact, the high cost of health care itself results in a form of rationing. Health care in this country is rationed according to the ability to pay for it or job status. Rather than issuing rationing coupons, like those issued in World War II, we rely on U.S. dollars or employment benefits as "coupons." These health "coupons" are distributed unevenly in ways that might be considered illegal if it were a government program. Some racial groups have more; children have the least; women get a smaller share; people at some companies get unlimited coupons, while other workers get few.

The bottom line is that we are rationing now under a certain definition of the term, only we are doing so in ways that we all can agree are unfair, that cannot pass the test of health "ethics." I sincerely doubt that Congress would enact a program that left our wealthiest citizens with the finest health care available in the world, while many lower income and working Americans were left with little or no access to health care. But that is precisely what we have today: 35 million Americans remain uninsured. They receive no medical attention until they have a health crisis, when they end up in an emergency room or a government hospital.

We must ask ourselves if the current patchwork system is an "ethical" way of rationing care. We must limit the resources we devote to health care. We must limit the resources we devote to health care, and make every effort to control costs; yet, we should not continue to allow those limits to fall randomly and disproportionately on our children and our low-income citizens. We must engage in a national debate through the democratic process to make fairer choices.

At this hearing, we have an opportunity to become more educated about rationing, and how it occurs under our current system. This is a good starting point for finding a more enlightened way to distribute our life-preserving health resources.

Senator KOHL. Thank you, Senator Reid.

Senator Burns.

## STATEMENT OF SENATOR CONRAD BURNS

Senator BURNS. Thank you, Mr. Chairman.

I will have staff here too. We have two other hearings going on. One of them is very important, I think. It is a hearing on the availability and what to do with research funds in the Commerce Committee. That all links up with this.

I have just a personal observation. Nobody likes to talk about rationing, who gets it and who doesn't, does everybody get a little, it is not effective, or do we work our way through this thing. I can't believe right now that we can talk about a lot of planning in rationing that will be very successful for this government.

But this is just an outsider looking in and I can tell you that every time that we have programs or spend money in this field, what do we add? We add a bureaucracy. The money doesn't get to the people that we are supposed to help. After all, if we could eliminate half of the paperwork and two-thirds of the work here in Washington and the offices around we would have more money available to take care of our people.

But what do we do? We add bureaucracy, we add more people in the field, and we think we are doing something and we look at the bottom line after all the expenses have been paid and all the money is gone. Then, we say how great that program is because we spent all that money.

Number two, Congress will not face the responsibility of any kind of tort reforms to keep doctors from practicing defensive medicine. One of the biggest costs in doctor's offices in providing medical care is liability insurance. Congress will not address a very basic factor that drives health costs up and limits the number of people that you can take care of. Congress will not address tort reforms that would limit that liability. So therefore a doctor has to practice defensive medicine because he doesn't want to get sued, or he may pass up something if he doesn't run all of these tests, some of which mean nothing.

I think we should start addressing what is driving up our cost of administering. All of these things have a cumulative effect. All of these items, a growing bureaucracy, defensive medicine, and no tort reform all add a great deal to the programs that we try to find as a government.

I don't like rationing either. I have a father that is 85. In 2 weeks we are going back home to celebrate my Mom and Dad's 60th wedding anniversary. They are still living in their own home. They are still plowing their own garden. But they have been very fortunate.

We have nutritionists running all over the country paid by the government that tells us how to eat to live longer. The nutritionist came up there and said you can't eat eggs, you are over 80 years old. Dad has never drawn a breath when he hasn't had two eggs and bacon every morning for breakfast. A terrible cholesterol problem.

Senator REID. Think how old he would be if he didn't eat those eggs.

Senator BURNS. He might live to be 160. Who knows? But with hard work and all of these things, I guess he is just an old farmer.

But we have all of these experts running around, we pay them gobs of money, and we still don't get the health care into the areas in which we need it. We don't take a commonsense approach.

There are also abuses in the program. We know some old people that go to the doctor everyday because they don't have anyone else to talk to, and we pay for that. The taxpayer pays for that. So it is a very difficult problem.

I don't know whether the decision has to be made here or not. But, some of those decisions that add to the cumulative cost of providing health care to Americans will have to made here. Right now Congress has not shown enough backbone to address some really tough questions that must be addressed before we can provide quality, affordable health care for all of our people.

Thank you, Mr. Chairman.

Senator KOHL. Thank you very much, Senator Burns.

Our first panelist is Dr. Uwe Reinhardt, the James Madison Professor of Political Economy at the Woodrow Wilson School at Princeton University. We very much appreciate the accommodations that Dr. Reinhardt has made to join us today. Dr. Reinhardt brings an economist's perspective to the rationing debate, and he also has a refreshing candor and considerable charm.

We look forward to our discourse with you, Dr. Reinhardt.

STATEMENT OF UWE REINHARDT, JAMES MADISON PROFESSOR OF POLITICAL ECONOMY, PRINCETON UNIVERSITY, PRINCETON, NJ

Mr. REINHARDT. Thank you, Senator Kohl, for these kind remarks.

One of the concerns I have in following the debate on national health insurance is that we Americans do not debate public policy sensibly. Instead, we discuss it in terms of cliches. In connection with health insurance, one of the more famous and most offensive cliches is: "If you like the Post Office, you will love national health insurance." Not a thought is given to the question whether the Post Office, for what we pay, might not be a good bargain. It is actually, by international standards, our mail services are fairly cheap and fairly good.

But if we must descend to cliches, I would offer the following: "If you liked Desert Storm, you will love national health insurance." After all, Desert Storm was brought to us courtesy of a Government-financed, single-payer, national-security insurance department, the DoD. Desert Storm was fought by Federal employees: soldiers. General Schwarzkopf is just another cabinet officer, so to speak, like Secretary Sullivan. So there, if cliches is what we want, let's chew on that one for a bit.

I mention Desert Storm in this connection just to show how mindless these cliches are. We are told that mandating health benefits upon employers is socialism, which means that you must call former President Nixon a socialist, because he was the first to propose the idea of mandating benefits upon business. In fact, the Democratic proposal is very much in the spirit of Richard Nixon's old Community Health Insurance Plan (CHIP). Is President Bush really calling CHIP the brainchild of a socialist, none other than Richard Nixon?

Finally, I saw in the Wall Street Journal, just the other day, the argument that the Democratic proposal will trigger the "rationing" in health care. This piece was by a John C. Goodman, President of the National Center for Health Policy Analysis. I was a little distressed that a distinguished paper like the Wall Street Journal would have published this piece without a little more editing, because there is very little in that piece on what an alternative approach (tax credits) might cost, nor is there any thought given to the fact that the private sector rations health care all the time now—as several of you have said—and quite brutally at that.

As a summary of my testimony, I might say this—and I say it in the paper: Those who oppose more government involvement in American health care by raising the specter of "rationing" have in mind an extremely elitist definition of "rationing." To these people, "rationing" means the withholding of desired care, whether needed or not, from someone who would be willing and able to pay for it. Period.

That is what troubles those people who raise "rationing" as a bugaboo, to stop us from even thinking of having more government involvement in health care. They worry only about the well to do possibly getting a little less. Usually they give no weight to the fact that the poor among us might get a lot more.

These people, ironically—or predictably—have very little concern with the other form of "rationing" which is very real: the "rationing" of health care by price and ability to pay. Very often, the people who will come before you and say that "if you have more government involvement in health care, you will get rationing," are also the very same people who caution you to go easy on bringing health insurance to working mothers and children who are now rationed out of the system by price, because that would increase public spending and thereby hurt the economy.

Rationing by price and income is fine for Gucci loafers. It is really the ethic of the marketplace. But the question Americans must ask themselves is this: Do we wish to impose the Gucci loafer ethic upon health care as well? That is the central core of the question before this Committee, and before the Congress at large.

I can show you from the Wall Street Journal the story of a comatose 3-year-old girl whose parents were uninsured and were not accepted by hospitals, and who had to travel 100 miles to find a hospital that would finally take them. I would be happy to submit that for the record. And yet, the people who now raise the specter of "rationing" seem not ever to have been terribly troubled by this form of rationing that other people—Americans and others—would consider quite brutal.

So when the issue of rationing arises before this Committee, I would plead with you to probe deeply the soul and mind of those who raise it. Are they equally concerned about our rationing out of the system working mothers, children, and the poor who now in fact don't get the basic health care that Canadians and Germans take for granted? Or are they merely concerned about their own welfare and that of the well-to-do? More often than not, it is strictly the well-to-do that triggers their concern.

In my testimony I explore initially the linkage between money and real health services. Very often before this Committee and in the press, there is the argument that if you contain health care costs, or if you reduce the flow of money into the system, you will ration health care.

This is a strange theory. Close your eyes and project the implied imagery. Do we take dirty dollar bills and put them on the wounds of people? Yet, that is the image the thesis projects. If you withhold dollar bills, somebody doesn't get care. But that need not at all be the case. The linkage between money and real health services is much looser, very much looser indeed.

In New York the going physician fee for a coronary bypass is $8,000–$10,000, in Atlanta it is $4,000, in Philadelphia it is $6,000, and a Canadian thoracic surgeon will do a coronary bypass for $1,200. These are all different dollar figures, yet the real resource going to patients is pretty much the same. So the notion that rationing money is rationing health care is one that I would urge you not to buy at face value. I do not blame the folks who proffer that notion before you; they have good reasons to do so and they are paid to do so. I merely counsel you not to buy that proposition at face value.

In my testimony I show money spent on the aged relative to money spent on everyone else. I am looking particularly at Figures 2 and 3. These figures are paginated following page 4. You will find

that spending on Medicare has out-paced GNP, and has out-paced overall national health spending. Spending on physicians by Medicare has out-paced even overall Medicare spending. If you look at Figure 3, you will find that in constant dollars between 1980 and 1990, we raised the real dollar allocation per aged by Medicare for physicians from $460 to $1,018.

That is a quite generous allocation by any standard. Yet all we ever heard through the 1980's was that Medicare's budgets have been brutally cut, that Congress has "carved Medicare to death" [1] and that the taxpayer and the politician are breaking a deal between society, on the one hand, and the aged and their physicians, on the other.

I would urge you, the members of this Committee, that when this kind of imagery is once again proposed to you, to ask those who make these statements the following two questions: (1) Look at Figure 3. You say that raising Medicare's budget allocation from $460 per aged in 1980 to $1,018 per aged in 1990 (in constant dollars) was not enough. Suppose I accepted this argument. What would have been enough? Tell me a number. Give me some number for 1990 that would have caused you, the medical profession, not to accuse me, the taxpayer, of having welshed on a deal with you and with the aged. Force physicians to come out in the open on this question. It is the least they owe you, the physicians, and me, the taxpayer. Don't you agree?

The volume performance standards legislated by this body is precisely the mechanism that will finally force the providers of health care to come to the table and tell you, if what you gave them wasn't enough, what would have been enough. If the VPS does only that, it will have achieved a lot.

You could also ask providers a second question, namely: If we don't give you all the dollars you want, precisely, concretely, in real terms, what is it that the aged will then not get? If you ask that question, members of this Committee, I guarantee you that you will not get an answer, because, as research has amply shown, no one really knows. In fact, you may be astounded to learn that; under a large experiment conducted by the Rand Corporation, the utilization of health services per capita was cut by up to 20–30 percent without any noticable effect on health status.

That brings me to the second linkage, and that is the linkage between real health services given to patients and medical outcome or the quality of life of patients. There is now abundant research that shows how tenuous that linkage really is. I have in my paper a diagram that follows page 9. Like in any other economic activity, as you apply more health care resources to a given population, you will eventually run into diminishing returns. Indeed, you can do too much and harm patients. If you put too much fertilizer on a field you will actually burn up the crop. If you do too many operations on patients, you can actually hurt them. Research abounds that shows that quite a few medical interventions in this country now given to patients are actually totally unnecessary and possibly even harmful. The medical profession would be the first to agree

[1] American Medical News, Jan. 8, 1988; p. 9.

on that point. In fairness I should add, however, that these unnecessary procedures probably are not applied willfully for the sake of profits. More likely, they are done in good faith, on a hunch that they will do good.

So the first observation that you should hurl back at people who say we are "rationing" care when we withhold dollars is that when we reduce thereby spending on unnecessary care, that is not "rationing", that is "rationalizing" care. Experts, such as Bob Brook at UCLA or Kathy Lohr at the Institute of Medicine, have written, that "Somewhere between 15 percent to 25 percent of most major medical procedures now applied to patients may indeed be unnecessary."

Before caving in to the image that constraining budgets "rations" health care, force the medical profession and other providers of care to demonstrate that everything they do is actually medically necessary. At the moment, they cannot demonstrate this, because no one really understands fully the linkage between the use of health services and the health of the patient.

For example, we cannot understand why Massachusetts spends 30 percent more per capita on health care than does the rest of the United States, on average. What do Massachusetts people get in the way of better health status that the rest of us don't get? If truth be told, no one knows. To test my proposition, just invite a dozen Massachusetts doctors before this Committee and have them argue, in the open, that they do better by their patients than do physicians in, say, Iowa City. It would be some spectacle to behold, especially if a dozen Iowa City doctors were in the hearing room as well. I do not want to believe our doctors or besmirch them. They certainly know as much about our bodies as economists know about the economy. But the sad fact is that both professions—doctors and economists—very often are forced to fly by the seat of their pants because they really do not know what works and what does not.

So be very careful on this linkage from real health services to quality of life. Not all real health services are actually necessary. Not all of them enhance the quality of life.

David Willis of the Milbank Memorial Fund who once told me, the economist, "If you really want to know what rationing is, why don't you do what comes naturally: look at Webster's." And so I did. There I found a startling "Rationing", says Webster's means "distributing equitably." That is Webster's definition!

As Senator Cohen said on that definition America cannot be accused of having ever rationed, not on Webster's definition, and I fear we never will, although I hope we would. That is what this "rationing of health aid" is all about. We want to reduce health care resources flowing to people who do not need them, or need them only marginally, and reallocate some of these resources to women and children and other sick and poor Americans who don't have health insurance, who don't have dollars, but who are demonstrably underserved by the health-care system.

We know the uninsured die at a higher rate in hospitals from given illnesses than do well insured Americans. To ration, a la Webster's, would be moving in the right direction—if you believe in the Judeo-Christian ethic—and be more pleasing to God. We would

take a little from the rich, probably without harming them, and give more to the poor, probably benefiting them.

Of course, well-to-do people who would be giving up some of their care—necessary or not—in order to help poor women and children call that "rationing." They are entitled to say that, and they are entitled to whine, of course. They are human and I might do it, too. This issue is, should you, the Congress, listen to that whining? My own advice would be, "No!" We Americans so often profess the egalitarian ethic. If we really mean it, that redistribution is in the right direction and you should close your ears and hearts to the whining of the well-to-do.

Finally, though, I say in my paper that we could, after all, possibly have the best of both worlds. Give up the phony notion that we run in this country a one-tier health care system, or that we are an egalitarian society. We are not and we never have been, not in jurisprudence, not in education, and not in health care. Let us come out of the closet and openly advocate a two-tier health system, one tailored to this nation's soul.

How about the following as an approach? Guarantee every American access to a health care system that is at least as good as Canada's, including all of the alleged "rationing" that they may do and some of queuing of health care. (In Houston now, in the public hospitals, Americans queue up much longer than the Canadians do for most of these procedures.) Then, if some rich people want better—want totally free immediate access, totally free choice of provider, and the right to buy unnecessary care, if that please them—let them buy that with their own money, but please don't make those premiums tax deductible. Let's force the rich to buy these extras with after-tax dollars.

I saw the other day, in the Wall Street Journal that people with an income of $1 million or more somehow manage to deduct something like $60,000 for medical expenses. I cannot imagine what this could be. It couldn't be insurance premiums, because most of them have company supplied health insurance. It must be jacuzzis and swimming pools. Yet, Congress allows this. I would draw a strict limit and say that no American may deduct more than, say, $3,000 per year for health care. Or if it is in addition, it would really have to be demonstrably health care and not cruises to Hawaii, jacuzzis or the like.

What kind of legislation might give us the two-tier or two-track system I have in mind. It would not have to be complex. We could legislate that everyone who is not privately insured is automatically in Medicare, or Americare, or some such Federal program that will limit the amount of resources available, will not underwrite absolutely every conceivable procedure, and may even limit some choice of providers. We will guarantee you that as an American. If you want something better, pay for it with your own private insurance.

It can be easily legislated. All of the pieces are already here. We have Medicare on the books and we have the reimbursements systems settled for the hospitals and doctors. It should be a relatively easy thing to legislate. If you would like to be as ethical as Canada in this country, you could very easily achieve that. And, to assuage the John C. Goodman's and Wall Street Journal readers of this

world, allows them to buy what they imagine is better care with their own after-tax dollars.

There was a headline in the New York Times that caught my eye the other day. On the very same page it showed the collapse of New York City's health care system and the associated said health statistics and it showed the superb health care statistics of Shanghai in Communist China, and underdeveloped country if there ever was one. I proposed to a very high officer of the current Administration, "If I were you, I would boldly announce that for the year 2000, we Americans have the goal that New York City's health statistics should be as good as those of Shanghai, China in 1990. How about that for a concrete policy goal whose achievement could easily be monitored." A bystander told me that I was too ambitious. I think we should be much more ambitious than that, would you not agree?

Thank you very much.

[The prepared statement of Mr. Reinhardt follows:]

# ON THE ECONOMICS AND ETHICS OF "RATIONING" HEALTH CARE

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Statement presented at the Hearing on

"Who Lives, Who Dies Who Decides: The Ethics of Rationing Care"

before the

**Special Committee on Aging**
**United States Senate**

Washington, D.C.
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My name is Uwe E. Reinhardt. I am Professor of Economics and Public Affairs in Woodrow Wilson School of Public and International Affairs and the Department of Economics of Princeton University, where I hold the chair of the James Madison Professor of Political Economy. Much of my research in the past two decades has centered on health economics and health policy.

I would like to thank you, Mr. Chairman, and the members of this Committee, for inviting me to submit testimony on the conceptual and practical issues surrounding the concept of rationing" in health care. I view that invitation as a privilege.

## A. HEALTH POLICY BY CLICHE

It is now widely taken for granted that our nation is moving toward a crossroad in health policy, just as it did during the 1960s when the Congress passed the twin Medicare and Medicaid programs. Two problems propel us toward this crossroad.

First, more and more American business executives have reached the conclusion that they cannot control the premiums for the health-insurance of their workers and that they cannot "afford" to absorb the continued sharp increases in these premiums.

Second, the private insurance industry is segmenting our population into ever finer risk classes and, through competitive underwriting techniques, prices more and more "high risk" [speak: chronically ill] Americans out of the private insurance market altogether. As a result, the ranks of the uninsured are growing not only among the very poor, but also among the nation's middle classes.

The question no longer seems to be whether or not the nation will veer off its current path. The question is only which of several possible branches of the crossroad will or should be taken. Whichever branch is chosen, however, it seems clear that government must take a strong hand in guiding the health sector along that path. As I have argued elsewhere in a recent paper[1], this nation's public sector has always acted, quite reluctantly, as "the private sector's shovel brigade, sweeping up the financial and ethical problems that the private sector leaves behind in its conquest of ever new economic frontiers[2]." As members of this Committee surely know, there is much left to shovel and there is much more to come.

The debate on the future path of American health policy deals with complex moral and technical trade-offs whose resolution will require both expertise and political courage. Alas, many of these issues are beyond the grasp of the uninitiated. That circumstance makes

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[1] See Uwe E. Reinhardt, "Research and Politics in Health Care," *Decisions in Imaging Economics*, Volume 4, Number 1, Spring, 1991; pp. 19-26.

[2] *Ibid.*, p. 21.

it easy for spin artists to replace serious dialogue on health policy with mindless sound bites and cliches. We shall be hearing many of these in the months to come.

One of the most well-worn and mindless cliches, for example, has been: *"If you like the Post Office, you will love National Health Insurance!"*, a refrain emitted without any thought to the question whether, for the relatively low postage[3] charged by the United States Postal Service, that Service might actually be a good bargain as it serves all of us, *rich and poor*. The only counter-cliche one can think of in this instance would be *"If you liked Desert Storm, you will love National Health Insurance"*, for Desert Storm was brought to us courtesy of a government-financed, single-payer National Security-Insurance Department and fought by the military analogue of federal bureaucrats. In fact, of course, this second cliche is just about as mindless as the first.

Another popular cliche these days is that health reforms based on government-mandated, employer-provided health insurance represents the type of communist yoke only now being lifted from the peoples of Eastern Europe. That cliche is downright amusing for, ironically, the idea of mandated benefits was first recommended by none other than former President Richard Nixon in his *Health Message to Congress* of February 18, 1971. It stretches one's mind to think of Richard Nixon as either a *Socialist* or a *Communist*.

Finally, there is the truly peculiar argument that the greater involvement of government in our health sector will lead to the "rationing" of health care, as if the rationing of health care were an entirely novel idea on these shores. In his assault on the health insurance proposal recently introduced by the Senators George Mitchell, Edward Kennedy and Donald Riegle, for example, John C. Goodman, President of the National Center of Policy Analysis, explicitly associates "rationing" with government programs, with the implied suggestion that we can avoid "rationing" by relying on private insurance[4].

Because the specter of "rationing" is likely to be raised repeatedly in this fashion during the coming months, it will be useful to explore more fully what the various users of that term actually mean by it. It turns out that those who now raise the specter of "rationing" typically have in mind very elitist definition of that term, namely:

> **"Rationing" of health care means the withholding of desired care, needed or not, from someone who would be willing and able to pay for it.**

It seems to be mainly this form of ***non-price rationing*** that is deplored by those who associate government with rationing, for it is the horror to which allusion is made whenever the topic of national health insurance is raised. Remarkably, commentators who use the term in this way usually show much less if any concern over another form of rationing that has always been an integral part of American health care: **the withholding of needed health care from someone unable to pay for that care.**

Presumably, rationing by price and income is deemed tolerable by these spokespersons, because it is effected by the Invisible Hand of the free, private market. Indeed, it is ironic how many of those who seek to frighten us with their particular idea of "rationing" also blanch at the idea for using government funds to bring even basic health care to the millions of low-income and uninsured Americans for whom rationing health care by prices has been the order of the day.

While we may not be able to have everyone in this country agree to a common usage of the term "rationing", it *is* important that participants in the health policy debate be forthright enough to make explicit their particular definition of the term. I would urge members of this Committee always forcefully to flush into the open, on this point, anyone resorting to the term "rationing" in testimony before the Committee. In particular, it is worth probing whether individuals who abhor "rationing" of health care for the well-heeled and well-insured abhor it with equal fervor for the poor and uninsured.

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[3] By international standards, U.S. postage is actually quite low.

[4] See John C. Goodman, "Wrong Prescription for the Uninsured," *The Wall Street Journal*, June 11, 1991, page A14.

In what follows, I propose to explore the term "rationing" at a conceptual level. In sections B and C, I shall first of all discuss a distinction that is fundamental to a clear understanding of resource-allocation in health care: the difference between the *financial* and *real* resource flows surrounding the process of health care. Although that discussion risks belaboring the obvious, these two quite distinct types of resource-flows are constantly being confused in our debate on health policy, sometimes quite innocently, and sometimes in the form of clever disinformation. The fact is that the rationing of *financial* resources and the rationing of *real health services* are not at all the same phenomenon. Thereafter, in sections C and D, I shall explore alternative definitions of "rationing" *real* health services proper. I shall end with the probably startling conclusion that, on Webster's classical definition of "rationing," the American health sector has never "rationed" health care and probably never will.

## B. HEALTH SPENDING AND MEDICAL OUTCOMES

Suppose for the moment there were at hand a practical and reliable method of measuring the value patients attach to enhancements in the quality of life achieved through medical interventions, and that we could convert such measures into a cardinal index called "value of medical outcome," or "medical outcome" for short. Suppose next that we tried to depict the relationship between *health spending* and *outcome* in a graph that had this quality-of-outcome index on the vertical axis and per-capita health expenditures on the horizontal axis.

Our interest would naturally center on the precise shape of the curve that links per-capita health spending to outcome, as measured by the quality index described above. Indeed, although phrased in so many other words, the shape of this *spending--outcome* curve really is the chief focus of the current, heated debate between those who pay for health care in this country and those who provide that care.

If one took seriously the arguments that have traditionally been hurled by the providers of health care against attempts by the payers to constrain the growth of health spending, and if one made graphic the hypothesized relationship between *health spending* and *outcome* implied by the providers' arguments, that hypothesis would trace out a linear graph such as that shown in Figure 1 below. The implicit assumption among providers seems to be that any reduction in the money flow into the health care sector will *ipso facto* impair the quantity and quality of American health care--that it will lead to the *rationing* of health care. By implication it is suggested also that any increase in that money flow would naturally bestow commensurately more benefits upon patients.

[Figure 1]

It can fairly be said that, during the 1970s and early 1980s, this linear hypothesis for the *spending--outcome* relationship tended to carry the day in debates over cost-containment--particularly before the Congress. Although that hypothesis no longer carries quite that much weight among private and public payers, it still seems firmly rooted in the minds of large segments of the provider community.

For example, between 1977 and 1988 Medicare reimbursement to physicians rose from $ 179 per Medicare enrollee to $ 741, or by 462 percent[5]. During the same period, total national health spending per capita (including Medicare reimbursement to physicians) rose from $ 753 to $ 2,124, or by only 182 percent[6]. By way of comparison, GNP per capita grew by only 120 percent during the same period.

Figures 2 and 3 depict the time path of Medicare spending in a broader perspective. Unbeknownst, apparently, to many providers of health care, Medicare spending has outpaced overall national health spending during the 1980s (see Figure 2). It has vastly outstripped the growth in GNP. Medicare spending on physician services has been particularly brisk. As is shown in Figure 3, average Medicare spending per Medicare beneficiary, *in constant 1990 dollars*, rose from $ 460 in 1980 to an estimated $ 1,018 in 1990.

[Figures 2 and 3]

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[5] Physician Payment Review Commission, *Medicare Volume Performance Standard Rate of Increase for Fiscal Year 1991*. Report to Congress, Washington, D.C., May 15, 1990; Table 2, p. 31.

[6] Health Care Financing Administration, April 1990.

FIGURE 1

## THE COST–OUTCOME RELATIONSHIP ACCORDING TO THE PROVIDERS' TRADITIONAL HYPOTHESIS

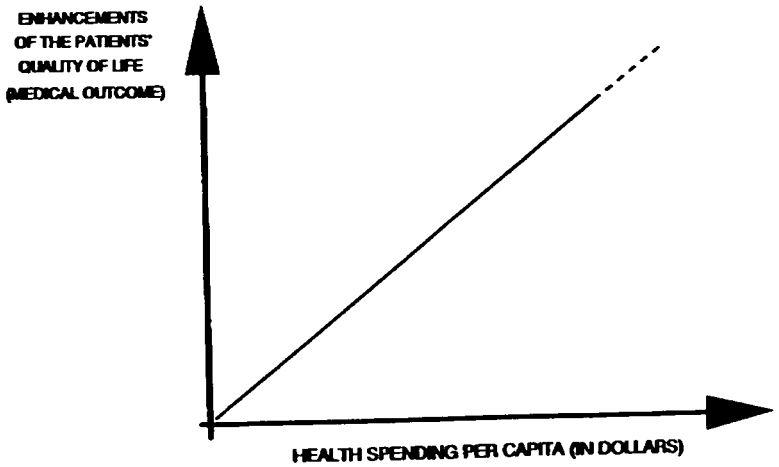
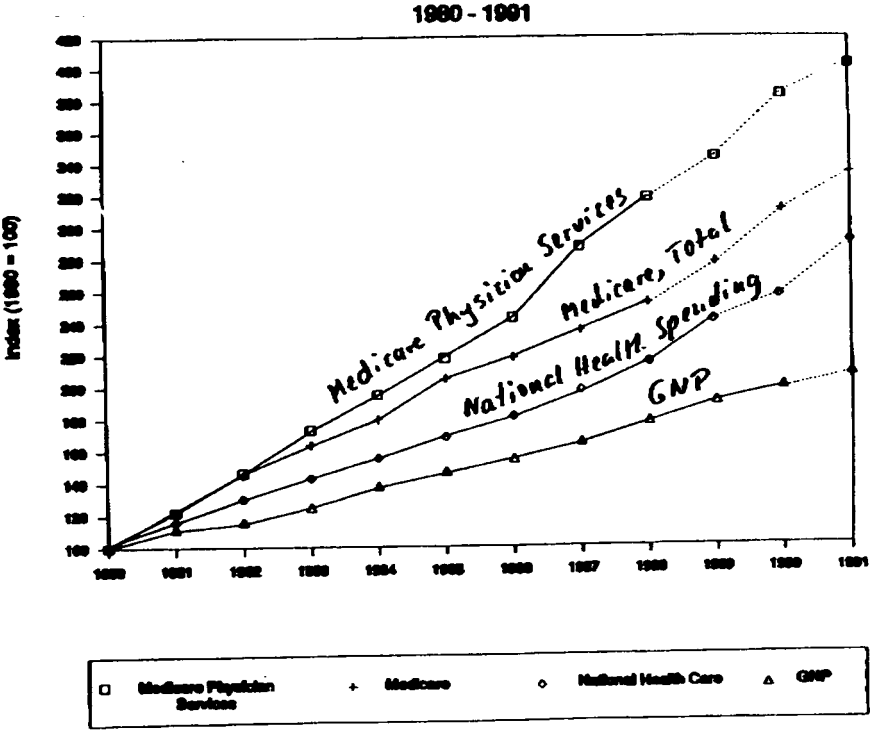


**Figure 2** Trends in Gross National Product and Expenditures for Medicare, Medicare Physician Services, and National Health Care

1980 - 1991



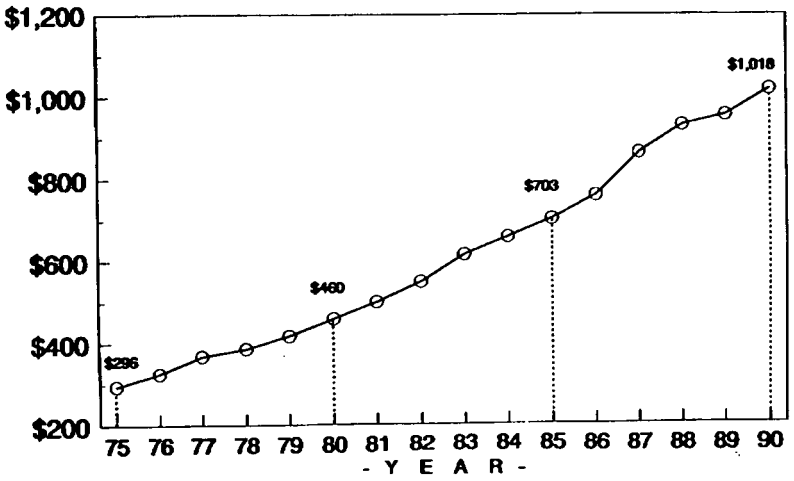

Sources: Health Care Financing Administration, Office of the Actuary; U.S. Department of Commerce

Note: ..... represents projections.

## FIGURE 3

## AVERAGE MEDICARE SPENDING PER BENEFICIARY

### ON DOCTORS' SERVICES AND LABORATORIES IN CONSTANT 1990 DOLLARS




SOURCE: DEPARTMENT OF HEALTH AND HUMAN SERVICES AND CONGRESSSIONAL BUDGET OFFICE
CITED IN ROBERT PEAR, "MEDICARE PROGNOSIS: UNWIELDY GROWTH," NEW YORK TIMES, MARCH 10, 1991, p. 4

On its face, the Medicare program's allocation of funds to physicians seems quite generous. By international standards, American taxpayers are known to be rather miserly[7] vis a vis their government, and they have consistently signaled that attitude to politicians in election after election. On the other hand, it is certainly not clear that American taxpayers have been equally miserly toward the aged and their physicians, and that they owe either of them an apology for inadequate budgetary allocations.

Virtually throughout the entire period of the 1980s, however, the trade literature published by organized medicine has sought to frighten the practicing American physicians with headlines announcing huge and brutal budget "cuts" that literally "have carved Medicare to death." That same literature now makes dire predictions about the quantity and quality of the health care likely to be available to America's aged if Medicare spending during the 1990s were to decline somewhat from the rather steep trend-line that was established in the 1980s. As I shall note further on, perhaps these headlines represent sound strategy in the political arena (although, of course, they do victimize the uninitiated, practicing physician in the field). It is fair, however, to confront the spokespersons for organized medicine with two questions, and Congress certainly should ask these.

First, precisely what it is in the way of *real* health services that America's aged missed as a result of the alleged "brutal budget cuts" of the 1980s? Second, if these cuts really were as brutal and intolerable as is being claimed, and if they led to the "rationing" of health care among America's aged, then what budget allocation would have been enough? More specifically, if an increase in the *constant-dollar* budget allocation from $ 460 per beneficiary in 1980 to $ 1,018 in 1990 was demonstrably inadequate, then what increase would have been enough to make the American taxpayer honor his or her implicit pledge to the aged? Sooner or later, American health policy must proceed on a forthright dialogue along these lines.

Two distinct sub-hypothesis slumber beneath the linear hypothesis that has traditionally been posited for the relationship between health *spending* and *medical outcomes*. First, there is the tacit assumption of a one-to-one relationship between *money* spent on health care and the *real* resources made available to patients. Second, there is the assumption that an increase in the use of *real* resources per patient will naturally enhance *medical outcome*. Both sub-hypotheses can and should be challenged. In Section C below, I shall explore the first sub-hypothesis--the relationship between money and real resources. In Section D further one, I shall explore the relationship between real resources and medical outcome.

## C. 'REAL' AND 'FINANCIAL' RESOURCES IN HEALTH CARE

Figure 4 below depicts health sector as a "market" in which those who provide *real* resources to health care swap favors with patients who hope to benefit from these *real* resources. The providers of these *real resources* include all those who directly or indirectly support the process of patient care. They include not only direct health workers such as doctors, nurses, hospital administrators, and so on, but also all indirect health workers, such as researchers in the laboratories of pharmaceutical manufacturers, insurance executives, government health officials and even full-time health policy analysts. For the most part, the real resources relinquished by these providers consist of hours of human labor; but they also include other real natural resources, such as land and energy[8].

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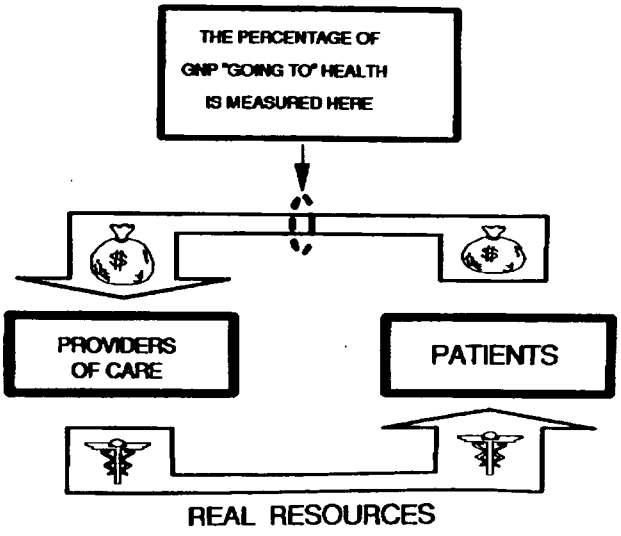
[7] Taxes at all levels of government have traditionally absorbed a much smaller proportion of GNP in the United States than in any other country of the industrialized world.

[8] Real resources such as structures and machines embody, for the most part, human labor and other natural resources applied further upstream.

# FIGURE 4
# THE BASIC STRUCTURE OF A HEALTH-CARE SECTOR




In return for relinquishing their real resources to health care, the providers are issued monetary vouchers (i.e., dollar bills) that are, in effect, generalized claims on all of the goods and services that are traded in the world market. In the United States, about 22 percent of these money vouchers are issued directly by patients, out of pocket, at point of service. The remainder are issued by private or public insurance programs who, however, ultimately replenish their coffers from actual or potential patients as well.

The total dollar denomination of the vouchers transferred to providers by the health-care sector represents the much discussed statistic *national health expenditures*. Obviously, that statistic measures only the benefits health care bestows upon the direct and indirect providers of care. The statistic is at best a very imprecise measure of the real benefits these providers have bestowed upon patients in return.

In principle, two nations of similar size, with a similar per-capita GNP and with similar demographic structures could bestow upon its patients identical sets of real resources--and incur identical *real-resource costs* of health care--but transfer rather different shares of their GNP to the providers of these real health-care resources, simply because one nation is more generous towards its health-care providers--or is made to be more generous by the latter--than is the other nation. After all, as Figure 4 illustrates, the process of resource allocation in health care addresses not only the ethically super-charged question *"Who Lives, Who Dies among Patients?"*, but also the more mundane question *"Who Eats and How Well among Providers?"* On the latter question, all available empirical evidence suggests that no other nation is now quite as generous to its direct and indirect providers of health care (including doctors, nurses, administrators, insurance brokers and executives and, yes, health economists) as are the people of the United States.

The relationship between *health spending* and *real health services* was recently illuminated in somewhat different form by economists Fuchs and Hahn[9] who found that, while the average American transfers to American physicians collectively about 72 percent more (U.S. dollar equivalent) money vouchers than does the average Canadian patient, this differential is explained entirely by higher American fees which were found to average about 2.4 times their Canadian equivalent (see Figure 5). In fact, the authors conclude that "the quantity of *[real]* physicians' services per capita is actually lower in the United States than in Canada" (p. 884). Although there are some analytic difficulties in comparing the per capita volume of services whose specialty mix differs somewhat between the two countries, the authors' general point nevertheless seems unassailable, namely, that differences in money transfers per unit of real physician service[10] account for the bulk of the observed differences in the per-capita spending on physician services in the United States and in Canada.

[Figure 5]

We need not rely solely on international comparisons, however, to make this important point. It is well known that the money transfers to the doctor and to the hospital for, say, as standard a procedure as a coronary bypass or a normal vaginal delivery can vary quite substantially from doctor to doctor and from hospital to hospital, not only among regions within the United States, but even within a single city and within the same medical arts building. According to statistics published by the Pennsylvania Blue Shield Plan, for example, in 1987 physicians in Philadelphia charged the Plan anywhere from $ 3,000 to $ 8,000 for a coronary bypass, with a median charge of about $ 6,000[11]. In New York City and in California these corresponding fees are much higher still; in Atlanta they are considerably lower. Differences in observable practice costs cannot account for the bulk of these differentials in fees, nor is there any evidence that these differentials in money transfers reflect underlying differences in real resource flows or in the quality of the care these real resources produced. Finally, it has never been established that the real-resource flows triggered by these varying money transfers could not have been had in equal magnitude had the payers bargained harder for lower money transfers (prices) per unit of health care.

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[9] Victor R. Fuchs and James S. Hahn, "HOW DOES CANADA DO IT? A Comparison of Expenditures for Physicians' Services in the United States and in Canada," *The New England Journal of Medicine*, Volume 323, No.13, September 27, 1990; pp. 884-90.

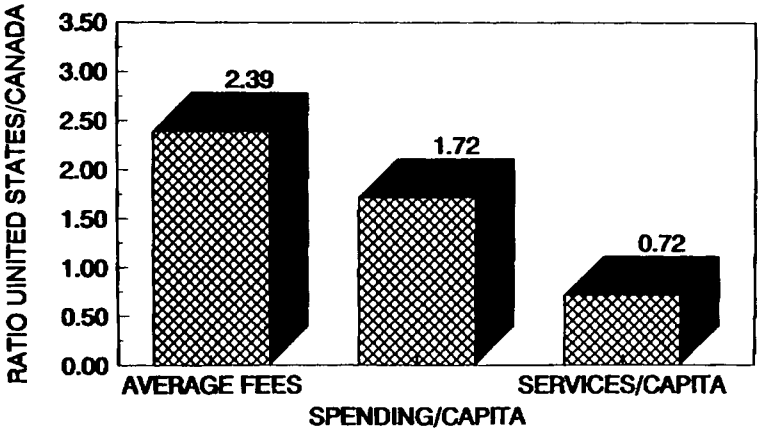
[10] Fuchs and Hahn do point out, however, that American physicians enlist a far higher amount of real resources in claims processing and other administrative chores than do Canadian physicians. In a sense, these added costs represent indirect real-resource transfers to patient care, although it is not clear what, if any, positive contributions such transfers actually make to the welfare of American patients. Quite possibly, these real-resource transfers *decrease* the overall quality of American health care.

[11] See Pennsylvania Blue Shield, *The Successful Experiment*. Annual Report 1988.

FIGURE 5

## SPENDING ON PHYSICIAN SERVICES IN THE UNITED STATES AND CANADA

RATIO OF UNITED STATES TO CANADIAN STATISTIC




SOURCE: VICTOR R. FUCHS AND JAMES S. HAHN, "HOW DOES CANADA DO IT?" NEW ENGLAND JOURNAL OF MEDICINE, SEPTEMBER 27, 1990.

8

If we think of our health sector as a giant national bazaar that pits payers against providers, then it becomes perfectly understandable that, *as a bargaining posture*, the direct and indirect providers of health care posit a very tight linkage between *money* paid to them and *real health services* going to patients. Thus, we should understand that surgeons and other procedural specialists who will see their fees cut substantially under the resource-based Medicare Fee Schedule legislated by Congress under OBRA '89 naturally will warn us that Medicare patients will lose access to these specialists' services. That riposte to the new payment policy is only human. Similarly, we should also understand that any attempt to place an overall cap on the amount of *financial* resources allocated to health care will be decried by the potential recipients of these funds as an automatic "rationing health care." Finally, we should expect the providers of health insurance to predict chaos if their administrative loadings on health-insurance premiums were squeezed, and we should expect health policy-analysts to predict chaos when funding for their research is squeezed. All of them are merely human.

To understand the nature and origin of such statements, however, does not compel one to take them at face value. For example, careful research and plain common sense suggests that the linkage between *health-care spending*, on the one hand, and the *quantity* and *quality* of health care, on the other, is far looser in practice than is commonly pretended in our debate on health policy. Granted, a reduction in *spending* may lower the flow of real resources if their owners were being paid the barest minimum needed to have these owners release their real resources to health care. That may well be the case, for example, for nurses and other health personnel who could earn as much or more than they are paid now in other sectors of the economy. But it need not be true and probably is not true for all direct and indirect health workers.

Similarly, added money flows into the health sector *may or may not* shake loose an additional real-resource flow to patients and, as will be noted in the next section of this paper, added real resource flows to patients *may or may not* bestow real benefits upon patients. Indeed, added money flows into health care may even be accompanied by a *decrease* in the flow of real resources, as is strongly suggested by data of the sort presented in Table 1. As that table shows, during 1983-85 the *financial* resources given a group of Colorado hospitals increased substantially while their patient-census dropped[12].

[Table 1]

The preceding observations on differential money flows to providers bear directly on the issue of *rationing* as it is commonly raised in the debate on health policy. The important point to note is this:

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[12] To be sure, the average intensity per remaining admission might well have increased if only the more serious cases remained. But the overall flow of real resources rendered by these hospitals per period (rather than per remaining case) is apt to have declined during the period.

TABLE 1

## Selected Hospital Characteristics 1983/85, North Region, Colorado

| Variable | 1983 | 1985 | Percentage change 1983–1985 |
|---|---|---|---|
| Number of admissions | 49,732 | 44,834 | −10% |
| Average length of stay (days) | 5.2 | 4.6 | −12 |
| Number of patient days | 256,733 | 208,359 | −19 |
| Inpatient charges ($ millions) | $130.4 | $143.4 | +10 |
| Inpatient charges per day | $510 | $680 | +33 |
| Inpatient charges per discharge | $2,617 | $3,199 | +22 |
| Net profit ($ thousands)* | $6,321 | $12,345 | +95 |
| Net profit margin*,** | 4.6% | 7.4% | +61 |

*Source:* Colorado Health Data Commission 1986, 31–34.

* Includes profits from outpatient services.

** Net profits as percentage of total net revenues (total inpatient and outpatient revenue minus total deductions from revenue).

CITED IN: Uwe E. Reinhardt, "Resource Allocation in Health Care: The Allocation of Lifestyles to Providers," The Milbank Quarterly, Volume 65, No.2, 1987; p.164.

*Constraining the flow of financial resources going into health care is not at all the same thing as "rationing" the flow of real health services going to patients. Typically, in the United States, payers ration only money; in response, the providers may or may not ration care.*

## D. THE PRODUCTION OF "MEDICAL OUTCOMES"

To explore the relationship between the use of real resources and medical outcomes (as defined earlier), let us assume that the prices of health services are fixed. On that simplifying assumption, changes in *spending* on health care (the horizontal axis in Figure 2 above) can be thought of as changes in the use of *real resources* in the production of health-care goods and services, or "health-care" for short.

It is widely appreciated that health care is only one of many determinants of a person's health status and, thus, of a nation's overall health-status statistics. It is also reasonable to suppose that, like any other production process, the production of health is subject to diminishing incremental returns and eventually to negative incremental returns, which implies that the relationship between real-resource use and medical outcome must be a curve such as that illustrated in Figure 6 below (rather than the straight line traditionally hypothesized by providers).

[Figure 6]

In one of the few formal empirical studies on the production of *health*, economist Jack Hadley had found that, other things being equal, health care does have a measurable, positive impact on the measurable health status of populations[13]. Not surprisingly, however, he also found that relationship to be subject to the expected diminishing incremental returns. Furthermore, a large and growing body emerging from epidemiological and clinical research[14] suggests that an alarmingly large part of American health care appears to be located on the *negatively-sloped* of the cost--outcome frontier, that is, that the overall quality of American health care could be improved if *fewer* real resources were applied to American patients. As Robert Brook and Kathleen Lohr have argued after extensive research on the issue: "We can speculate that perhaps one-third of the financial resources devoted to health care today are being spent on ineffective or unproductive care"[15]. To call the elimination of these types of *real health services* "rationing" would, of course, stretch the meaning of that term absurdly. One had best call it "rationalizing" intead of "rationing." The latter term should refer to withholding something of genuine value (see Figure 6).

To be sure, there is equally alarming evidence that many low-income and uninsured Americans are still located on the steeply upward-sloping part of the curve, that is, that the quality of American health care could be improved if more real resources were devoted to these target groups[16] to expectant mothers and to children in particular.

**This reallocation of real resources from dubious to more productive applications, and from currently over-served to currently under-served Americans, remains the central problem now confronting American health policy. In one form or another, all of the health-insurance proposals now before the Congress seek to achieve this redistribution of real resources and to achieve it with overall health budgets that grow less rapidly than did national health spending during the past two decades.**

It is only natural, of course, that those who might have to give up their currently easy access to needed and even unnecessary care will decry such attempts as "rationing," because that is precisely what the redistribution seeks to achieve as far as they are concerned. The question is, what weight such warnings should carry before our legislators whose members we have elected precisely to make such tough calls on our behalf.

Which brings us back to alternative definitions of "rationing."

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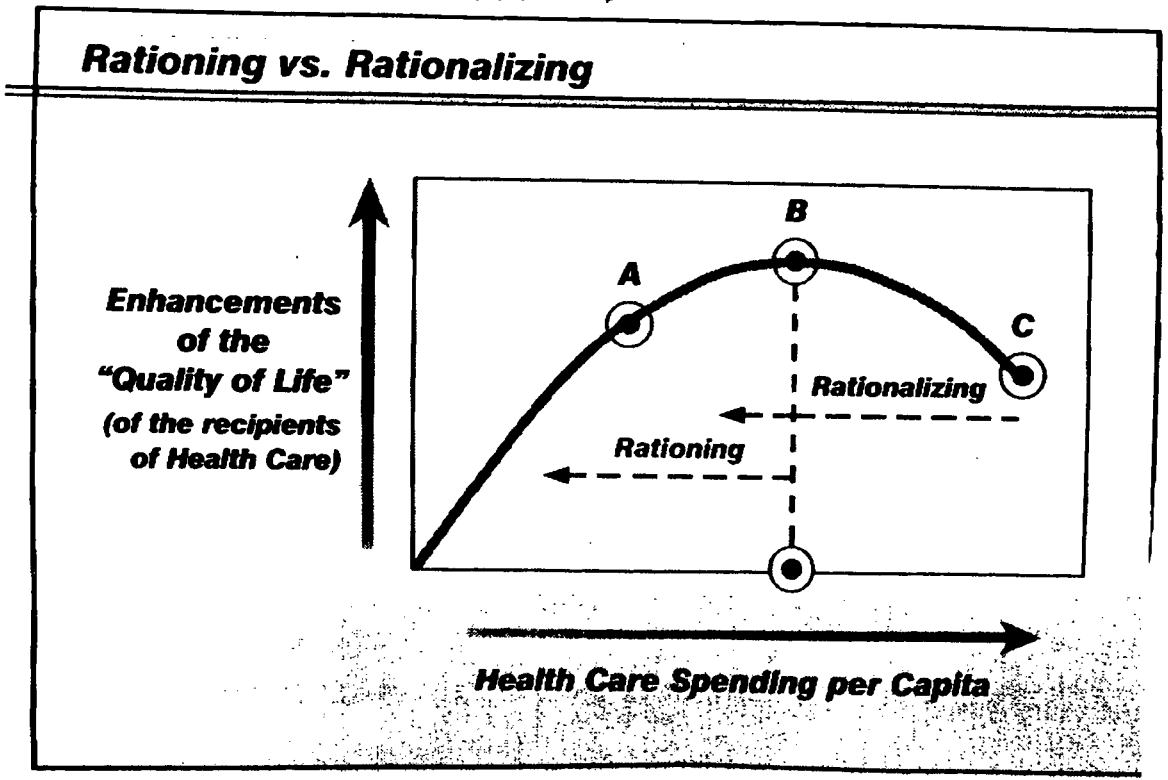
[13] Jack Hadley *More Medical Care, Better Health?*, Washington, D.C.: The Urban Institute Press, 1982.

[14] See, for example, John H. Wennberg and Alan Gittelsohn, "Small Area Variations in health Care Delivery," *Scientific American*, Volume 246, No. 4, April, 1982 and Robert H. brook and Kathleen N. Lohr, "Will We Need To Ration Effective Health Care? *Issues in Science and Technology*, Volume III, No. 1, Fall, 1986; pp.-68-77. An illuminating summary of many of such studies as provided in Robert H. Brook and Mary E. Vaiana, *Appropriateness of Care*, Washington, D.C.: The National Health Policy Forum of George Washington University, June, 1989.

[15] See Robert H. Brook and Kathleen N. Lohr, *op. cit.*, pp. 73-74.

[16] See, for example, The U.S. Bipartisan Commission on Comprehensive Care (The Pepper Commission), *A Call for Action*. Final Report of the Commission (S. PRT. 101-114). Washington, D.C.: U.S. Government Printing Office, September 1990; Chapter 1.

FIGURE 6


Rationing vs. Rationalizing
Enhancements of the "Quality of Life" (of the recipients of Health Care)
A
B
C
Rationalizing
Rationing
Health Care Spending per Capita

## E. ALTERNATIVE DEFINITIONS OF "RATIONING."

It is remarkable what awesome sway in the political realm is held by a word that is as commonly misunderstood as is the word "rationing."

To economists, who can claim to have used the term ever since mankind's Fall from Grace[17], the term "rationing" connotes the withholding of anything valuable from someone for whatever reason and by whatever means. To quote at some length a standard textbook in freshman economics on this point:

> *When a good (or resource) is scarce, some criterion must be set up for deciding who will receive it and who will do without it. Scarcity makes rationing a necessity.... Various criteria, including price, can be utilized to allocate a limited supply.*[18]

Economists make a distinction between *price-rationing* and *non-price rationing*. Rationing a scarce thing by price allocates the thing to those willing *and able* to give up the most of other good things in order to gain access to the desired, scarce thing. More so than any other industrialized nation, the United States has long relied upon *price rationing* as a means to allocate scarce health-care resources among Americans. It is well known by now that financial barriers stand between needed health care and millions of Americans who are poor and uninsured. It is also known by now that the uninsured die at a much higher rate from given illnesses than do comparably situated insured Americans. In the face of this evidence, the argument that national health insurance would *introduce rationing* into American health care is either absurd, or it must be based upon a very distinct definition of that term.

*Non-price rationing* may take the form of allocation by perceived need, by the perceived political or social power of potential recipients, or even by their perceived relative beauty[19]. Yet other forms of non-price rationing may be based on lotteries or on the first-come-first-served criterion. Which form of rationing a person judges "best" depends in large part on how he or she would fare under alternative methods of rationing or, at the least, upon the beholder's judgement of the context in which rationing takes place. As I regularly point out to my students (see Appendix A, attached hereto), ultimately that judgement must be based on one's social ethic.

As already noted in the introduction to this paper, the current hysteria in this country over the specter of "health-care rationing" is a reaction to the replacement of *price-rationing* with sundry forms of *non-price rationing*. One suspects that those who deplore and fear *non-price rationing* in health care--economists prominent among them--tend to be members of the upper-middle- and upper-income classes for whom non-price rationing has always been a bugaboo, for obvious reasons. They tend to be made worse off by *non-price rationing* than they would otherwise be.

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[17] See Genesis, Book III. Until the fateful apple incident, Adam and Eve were permitted to consume all commodities, save apples, without limit. After the Fall from Grace, apples could be consumed as well, but limits were placed on the availability of all other commodities--all commodities became scarce. Henceforth, by the sweat of their brows Adam and Eve and their descendants have been forced to make painful trade-offs among commodities. Because these trade-offs constitute the heart of economic science, that profession can rightly date its origin to the Fall from Grace.

[18] James D. Gwartney and Richard L. Stroup, *ECONOMICS: Private and public Choice*, 4th Edition, New York: Harcourt, Brace, Jovanovich, 1987; p. 52.

[19] *Ibid.*

This brings us to yet another definition of rationing, namely, the classic definition found in Webster's dictionary, according to which

> ***To ration*** **means** ***to distribute equitably***[20].

Webster's definition suggests that *rationing* is a non-price mechanism expressly engaged to avoid the inequities of *price-rationing* in a free market. On that definition of *rationing*, it might be judged eminently sensible to move along the *cost--outcome* frontier from point B of Figure 6 towards point A, if scarce real resources thereby could be shared more equitably among members of society. Would that form of *rationing* implicitly put a price on human life--or, more correctly, on human life days or years? It would. In fact, we routinely do just that when, say, we decide not to put seat belts into school buses, or when we decide not to make our cars, roads and airports quite as safe as they might technically be.

## F. CONCLUDING OBSERVATIONS

Whether or not this nation now does *"ration"* health care and whether or not it should or will in the future depends largely on one's own preferred definition of the incredibly confusing term *"rationing"*. It also depends, of course, upon one's own social ethic.

*The fundamental question on social ethics is this: Is it better (A) to withhold some procedures from all of the people so that all of them may have easy access to most medical procedures, or (B) to withhold most or all medical procedures from only some (low-income) individuals, so that the rest of society can enjoy completely unfettered access to any imaginable type of medical procedure?*

Most industrialized nations have chosen the second option and subjected their health sector to various forms of non-price rationing, in a more or less successful pursuit of the goal of social equity. To achieve their objective, these nations typically limit the physical availability of some high-cost facilities or procedures. Next, virtually all of them impose ceilings on the money-prices paid the providers of care for particular procedures. Finally, where price ceilings lead to an undesired expansion of the volume of services rendered to patients, these countries typically constrain overall spending through formally negotiated budget caps on particular segments of the health sector (for example, on each hospitals, or on all physicians in a region) or on the entire health sector as a whole. Figure 7 illustrates these approaches.

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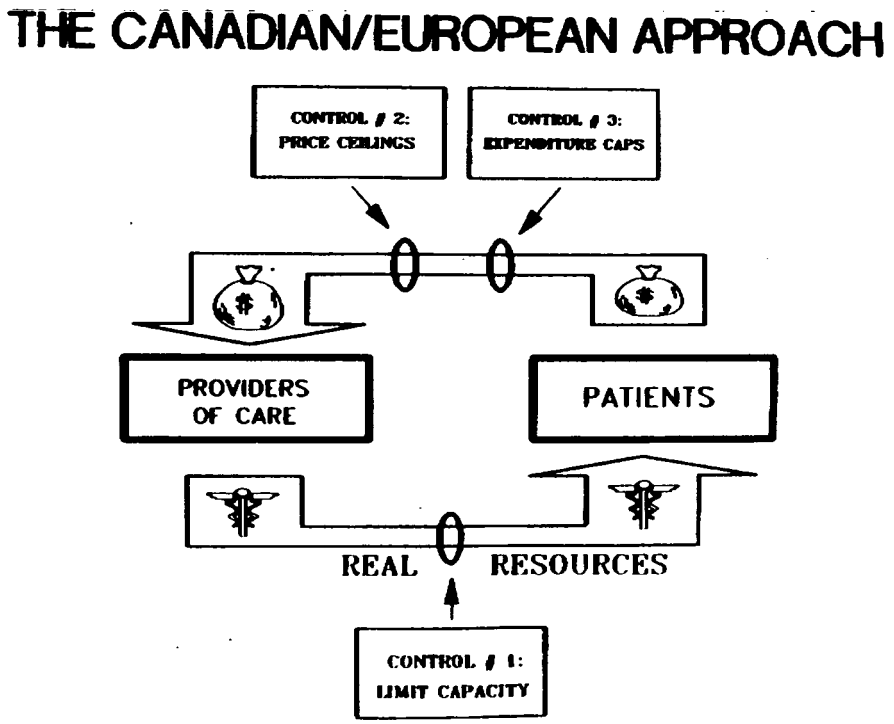
[20] See, for example, *Webster's Ninth New Collegiate Dictionary*, Springfield, Massachusetts: Merriam-Webster Inc., 1989; p. 977.

[Figure 7]

Americans may legitimately reject, as ~~it has~~ they do, the approach chosen elsewhere in the industrialized world and adopt, instead, the first style of rationing described above (Option A); but they are not in a moral position to naysay the rationing strategies pursued by other nations, as has been this nation's wont, particularly because Option A (the approach we have chosen) is so starkly at variance with our own professed social ethic.

There is, of course, a middle course that recommends itself to this nation's fiercely individualistic culture. Under that option, American society would guarantee every American access to a health system that rations health care in the manner adopted elsewhere in the industrialized world; but the system would allow persons with a taste for a richer package to procure it with their own *after-tax* income. In fact, most other industrialized nations offer that option to their citizens as well, and roughly 5 to 10 percent of these nations' citizens to take advantage of that option. In terms of Figure 6 above, one might guarantee everyone access to point A on the curve, but permit the well-to-do to procure with their own *after-tax* funds a higher level of quality (e.g., level B in Figure 6 or, if they fervently wish it, level C).

FIGURE 7



Econ 102 APPENDIX A Reinhardt

PROBLEM FOR THE LUNCH TABLE

NON-PRICE RATIONING: EQUITY VS. EFFICIENCY

Professor and Mrs. Reinhardt are the proud owners of a Sylvan Swimming pool, visible symbol of bourgeois accomplishment. Every fall and winter the pool collects dead leaves, dead branches and dead mice. Every spring the pool is drained, scrubbed, and refilled with the fresh, sparkling tap water provided, at a remarkably low price, by the Elizabethtown Water Company. Thereafter, the Reinhardt family spends leisurely summer months around their pool and their Cuisinart, imitating the genteel rituals that constitute prep culture.

Into this genteel frolick strikes Governor Brendan Byrne's brutal system of non-price rationing for water. It appears that, at the prevailing, low price for tap water, there may not be enough water in New Jersey to meet the quantity demanded. The Governor, therefore, proposes to limit every household in Mercer County (and elsewhere in New Jersey) to a daily usage of 50 gallons per person, a scheme he proposes to apply even to Princeton! What truly strikes terror into the heart of Princetonians, however, is that the Governor also proposes to prohibit altogether the use of tap water for the washing of cars, the filling of swimming pools and the watering of the priceless shrubs and lawns of which Princetonians are so proud. It can be anticipated that the Governor's harsh system will drive many Princetonians to the shores of Maine or Bermuda, there to offer their offspring the well-deserved diversions the Governor would deny them at home.

In one of his lectures in Econ 102, Professor Reinhardt bitterly denounces the Governor's proposal. Waxing stern and eloquent, the Professor warns that, "once again the government embarks upon a policy that is woefully inefficient, as economic science defines that term! Elementary economic theory demonstrates that, if only the Governor allowed the price of water to rise sufficiently, the water shortage would disappear. Persistent shortages are always a signal that someone is preventing free market prices from doing the work God had intended for them!"

The very importance of this particular issue has raised Professor Reinhardt's lecture to unprecedented heights of scientific fervor. Indeed, he is certain to receive from his colleague Professor Baumol, President of the American Economic Association, that Association's coveted Croix de Kal d'or, a gold medal economists bestow upon one another for scientific valor in the face of unreasonable politics.

a. Enrolled in Econ 102 are several high-ranking officers of PEP, the Proletarian Elite of Princeton University. PEP is a student organization dedicated to fight the evils of capitalism wherever it rears its ugly head. As the students in the course file out of the lecture hall, one of the PEP officers is overheard to remark: "Reinhardt is one of those capitalist pigs who know the price of everything but the value of nothing. Has he ever thought about equity?" Assess the PEP officer's sentiment. Might (s)he possibly have a point?

b. A common fallacy among certain social commentators is that the so-called "free market solution" to society's problem of distributing economic privilege is an alternative to "rationing." We hear this often in connection with health care and energy. We shall hear it in connection with water as well. The distinction is misleading.

Actually, almost all good things must be rationed somehow among members of society. The so-called "free market solution" is but one particular form of rationing. Proponents of free markets often overlook this fundamental point, or they delicately suppress it from memory, should they ever have realized it.

The distinction, then, is not between "free market solutions" and "rationing," but between "rationing via household budgets and money prices" and various forms of "non-price rationing," including the administrative scheme proposed by Governor Byrne. To make the case for the free market solution one must demonstrate the economic and ethical superiority of the first type of rationing. Is that easily done? Try it! Fight it out over lunch with persons not of your persuasion.

Further on this point, can you think of a rationing scheme that could, in the present example, satisfy both PEP's yearning for "equity" and the economic profession's yearning for "efficiency," as economic "science" defines that term? There are such schemes.

## APPENDIX B

**Princeton University**
**Economics 102**

**Prof. Reinhardt**

### ON THE ETHICS OF RATIONING AND MARKETS

Great advances are being made in the technology of organ transplants in humans. Alas, there is a perennial shortage of transplantable organs. Many patients linger and ultimately wither during the wait in the queue for transplantable organs.

Suppose our government decided to allocate the available organ *among patients likely to benefit from transplant* on the basis of a lottery, a mechanism that might be viewed ethically acceptable, because it has been so judged in other life-or-death situations, for example, the military draft during the Vietnam War.

Suppose next, however, that the lucky winners in such a lottery were issued a coupon for the requisite organ and that these coupons were made tradeable for money in a well organized market. Low-income persons might well choose death in return for leaving their loved ones a large bequest. Rich persons might have enough money to jump the queue. Because, in the absence of coercion and in a well-organized market, each such trade must be deemed mutually beneficial (or it would not be done), many economists might favor such an arrangement.

What do you think of the proposal? Discuss it among yourselves at your leisure.

By the way, suppose we had a military draft based on a lottery. Should we allow those picked by the lottery and unwilling or too scared to serve to swap their draw with someone who was not picked by the lottery, but who would be willing to serve, for a sufficiently large payment from the unlucky and unwilling (and, possibly, well-to-do) draftee?

Senator KOHL. Thank you very much, Dr. Reinhardt.

Is it your opinion, Dr. Reinhardt, today that, in fact, in America—whether or not we like to use the word—we do have clearly a system of health rationing, and further that it is rationing on a very uneven level in terms of to whom it applies and how it affects Americans all across our country?

Mr. REINHARDT. Yes, Senator. Every freshman textbook—and indeed I cite one—says that all good things in life are rationed. It actually had to do, as I mentioned, with the Fall from Grace. Since that time all good things in life have been rationed, even in America, and even in American health care (at least for some Americans).

There are only two ways we can ration. One is by income and price. It is a convenient way to do it, although ethically troublesome. The other is through various forms of non-price rationing. It could be by need, it could be by lottery, or it could be any numerous administrative devices. On Webster's definition of rationing as "distributing equitably" one replaces price rationing with some non-price rationing, as we did in World War II, for the sake of social equity.

The people that complain that national health insurance, any Government program, will ration care are really complaining that price rationing is replaced by non-price rationing. They prefer to ration by money and price, presumably because they have money (or insurance). That is, these people have very little compunction telling a poor mother, an American working mother with children, who is not now insured, "Well, this is a market, you don't have any money, you don't have any vouchers, you just can't get care, but life just isn't fair, and it's a free market." They have very little trouble with that.

How can I say they have very little trouble? Because they haven't done anything about it for 20 years. So I know. I am entitled to say that they have very little trouble with this because it goes on this very moment and yet these people typically counsel against expanding public programs to embrace these unfortunate Americans, who are being shunned by the private insurance system. There is, at this moment, a mother in America with a sick child who doesn't get access to care because she doesn't have the money. It is happening right now, as I speak. We allow this, we always have, and probably will for some time.

National health insurance doesn't have to be government financed, but it needs some government orchestration. It could be mandated benefits, it could be the democratic proposal, it could have been President Nixon's CHIP proposal. All such proposals seek to replace rationing by price with non-price rationing.

Senator KOHL. Dr. Reinhardt, what are the obstacles to setting an overall spending limit in this country and then deciding what it is and for whom it will be spent?

Mr. REINHARDT. There are two obstacles to that. One is intellectual. It is extremely difficult to set that budget cap correctly. The second major obstacle is—obviously I often quote Alfred E. Newman's cosmic law of health care which is, "Every dollar of health spending is someone's health care income."

Cost containment is really just health care income containment. So if you set a global budget, you are setting a budget for health care incomes. Those who call health care expenditures income don't like it. They are politically powerful, as you well know. They are super-organized, and should you propose a budget cap you will get many little Desert Storms coming into this chamber bombarding you with all kinds of images of how health care will be rationed, how Americans will have low quality life, and so on. That is really the major obstacle to budget caps.

As for the former, if you set a budget—and supposing you do set it too low—then after all the system should be able to tell you what it is that you are not funding. We hear, for example, that Canada now has queues for coronary bypasses, and that Canada does not have the CAT Scanning ability and MRI machines that we have in this country. They could easily fix that problem by targeting additional funds that way.

But what is good about the Canadian approach is that they know what it is that they are not getting. They actually know it. They do send patients to Cleveland Clinic to get MRI scans or to get coronary bypasses. So they know what they are missing and they could easily appropriate, if they wished, the additional funds to buy those things, if the democratic process allows them to do it.

We have a different system, one that runs by Conway Twitty's famous ditty, "More, Anything Less Wouldn't Do." When he croons that to a lady, it makes perfect sense (I think). But as a budgeting premise for health care, it makes a little less sense. Every testimony you have ever heard from the providers of care basically has that Conway Twitty motto as a philosophical basis. What I'm saying is that that is inadequate, nay, that it is ridiculous. There has to be some better notion of some kind of budget constraint.

I think the Volume Performance Standard that was legislated by this Congress is a step in the right direction. For the first time, the medical community actually has to come before Congress and say, "We believe that we need an increase of at least 12 percent in Medicare spending for physicians to do the job right for the aged." At least you have a number you can discuss. I would, of course, immediately ask, "If I gave you only 10 percent, what is it the aged wouldn't be getting?" It seems to me to be a fair question to ask. But at least we have here, for the first time an American health policy, the basis for a sensible discussion.

Some notion of a national budget, at least as a starting point for a debate, I think will be necessary and unavoidable in the future. By the year 2000 we will have it one way or the other.

Senator KOHL. Thank you very much.

Senator Simpson.

## STATEMENT OF SENATOR ALAN K. SIMPSON

Senator SIMPSON. Mr. Chairman, I thank you for convening the hearing and assembling this fine group of witnesses. I admire what you're doing in presenting this little topic where people sometimes flee for the exits when they're in public life because they don't want to deal with this. The only thing we do deal with is new groups wanting to get covered under Medicare. They come in and

we are unable to say no. That is what we do a good part of the day with regard to the issue that is consuming, as we all know, this 12 percent of the gross national product.

So I am very personally pleased that you have done this and have these fine witnesses. It is an opportunity for us to step away from the nuts and bolts of program functioning, regional politics, and raw budgeting to indulge in a discourse of ethics with the most informed and provocative thinkers in the field. I thank you for coming.

If I recall correctly, my friend, Dick Lamm, raised some of these issues several years ago and got clobbered in the process. I have great regard for Dick. Dick and I have worked together on a lot of issues. He was simply presenting a provocative proposal and it was certainly taken as something more than that, and yet critically serious issues—heart transplants, liver transplants—and this budget sucking it up. We are unable really to grapple with it.

No one that comes to me in the health care field wants to give up a nickel. Many are thriving on the chaos, and $670 billion a year is chaos. The durable goods—people are thriving on it and the doctors and the providers, the hospitals. They know that they can't continue. They know in their hearts, as American citizens, that somebody is going to have to give up something, but nobody is willing to do that.

So now we have this system of ours where somebody else is paying and people like that as long as they have the care they want at the moment they want. When somebody else is paying for it, you can't beat a system like that. So we see this.

I notice ads for cosmetic surgery now in every possible upscale publication, male and female, anatomy reductions and additions of all sorts of curious attitude. And yet, we have an immunization problem. We have children who are not immunized against polio and measles. And while millions of Americans go through unnecessary—sometimes—bypass operations, millions more lack access and many aren't even educated to know what it is they are seeking or how to take care of themselves. So what we have to do is unravel it.

There are a lot of proposals of reform out there, but we are in a political system here. You don't see many of us--and I include myself—saying no to anybody that wants to get into the system. I say that if you are going to come into the system, you are going to be limited and restricted and HCFA is going to drive you crazy. They say, "That's all right, we want in," so we take them in. Psychologists and dieticians have been working to get in now, and Lord knows who else will be seeking to get in, but it will be our job to take them in and we are not good at telling them to stay out. We don't know what we are ready to trade away, but when some have more others are going to have less. We can't even stick it to the wealthy for additional funds on Part B premiums on Medicare when the mail room breaks down.

We lost catastrophic health care because the people in the top 5 percent of society wouldn't put up another $20 per month. So it is easy to talk and do the white papers, but this is where is gets tough right here. It will be so.

I admire you, Mr. Chairman, as politically daring and courageous. I congratulate you for it. I think this is long overdue. I appreciate what you're saying. Tell us what we ought to do. Was the German plan good? How about the Japanese plan? The Canadian plan? People tell us these things, and then we go to a town meeting, and they say, "We want the Canadian plan." Do you really? "You bet." Then you start talking to them about it and they don't want the Canadian plan.

What has worked, in your view, anywhere in the world?

Mr. REINHARDT. First of all, I am quite well aware of all these other countries. In fact, I studied them so well that I lived there. I was born in Germany and lived in Canada so I know these systems. But I would urge you not to even think of importing any system, lock stock and barrel, from abroad. These systems grow in their own cultural soil and have idiosyncracies we couldn't take. Canadians apparently have a different attitude to government: believe it or not, by and large they respect their government. They cherish peace, order, and good government. That is their slogan. We cherish liberty and the pursuit of happiness, we are much more individualist, and as a people, we almost price ourselves on our disrespect for government. Just read the editorial page of Wall Street Journal to see what I mean.

I wouldn't advocate importing another plan from another country. You might go there and look to see how certain things are implemented. For example, Germans are very skilled at negotiating between private insurance carriers and physicians. One could learn from them the dos and don'ts of negotiation. Canadians are fairly good at this budgeting that I mentioned. We could learn a trick or two from them.

But I believe, as I mentioned, that we ought to go with what we have. We have a Medicare program in place. It could be better, but it is working. In fact, it's working so well that if you ever dared to suggest eliminating it, you would really have umbrellas rain down on your car.

So here is a program the aged obviously like. Why couldn't we build on this and follow the proposal, for example, that would mandate the individual to be insured, not business, but the individual? Then, tell people that if your company gives you insurance, or if you are rich enough to buy it with your own money, God bless you. But if you're not, you will be in Medicare and we'll charge you for it.

We would fold Medicaid into Medicare, abolish Medicaid, which is a terrible program, and then the cost to the individual would be X percent of his or her Adjusted Gross Income. If you're poor, X is zero. If you're near poor, it may be 1 percent or 2 percent. If you earn $30,000 or more it could be 12 percent. You will have to pay that. Why? Because we, the people, give you this insurance product, and it is a great one at that, and you have no insight to run around uninsured, relying on our mercy when you are in trouble.

That would raise most of the money that you need. Then I would put onto the 1040—I often kid about this—I would say: "Do you or do you not subscribe to the Judeo-Christian ethic?" That is, do you or do you not want to be your brother's and sister's keeper. If yes, we will ask 1 percent of your income for an earmarked indigent-

care tax. If no, you will be excused from the tax, but we will publish your name in the Federal Register, something like that. [Laughter.]

Mr. REINHARDT. Something like that. That scheme is very simple to legislate. All of the pieces for it are there. You have done all the hard work. You have legislated Medicare, you have legislated how the hospitals should be paid, and you have legislated how doctors should be paid. There is an enormous storehouse of research in HCFA and in the new Agency for Health Care Policy Research on running these programs. The pieces are there. It really wouldn't take that much to expand the program to all Americans who need it. It would, of course, mean spending more Federal money, but you would collect it on the 1040. It would be an earmarked tax.

I think it is an approach worth accomplishing and pursuing. This is not importing any other system. It's building on what we have.

Senator SIMPSON. Thank you very much.

Thank you, Mr. Chairman.

Thank you, Doctor.

Mr. REINHARDT. Incidentally, I do also want to thank Senator Kohl for the courage to put on this hearing. As the Senator knows, I was actually supposed to be at a board meeting in New York. But of all the testimony that I could have given in the last 10 years, this is the one that I really wanted to give. I hope it is only the start of an honest debate on these issues. I agree with you that Governor Lamm and Dr. Callahan, who is sitting behind me, have been much maligned, and unjustly so, by people who probably never read what they wrote. What they are really arguing about is moving in the direction of greater social equity. They are not fascists who want to somehow limit health care so that we can have more Hula Hoops. That's not at all what they're about, and you will hear that from Mr. Callahan later.

Senator KOHL. Thank you.

Senator SIMPSON. Mr. Chairman, I have a personal dimension here, too. My father is 93, my mother is 90, and my wife's mother is 90. It is fascinating to see the discussion of their care in a small community and the cost of that care to the family, which we feel should not be in the Federal programs.

There are 39-year-old doctors who say, "Well, I hope you and your brother will consider the issue of perhaps ending the care for your dear one." I say, "Yes, go tell my mother, will you? You do that for me, and then let's see how it works." So it's great on paper, but when you're in it, that's not the first human response, to figure out how to pull the plug.

Senator REID. Do they eat eggs every morning?

Senator SIMPSON. They eat eggs and the old man used to drink a little scotch now and then, too. [Laughter.]

He's still going.

Senator REID. We just had a discussion before you got here. Conrad Burns' father is 86 and eats two eggs every morning. Maybe we are missing something here.

Senator BURNS. I tell you that we could do without a lot of nutritionists. [Laughter.]

Mr. REINHARDT. Senator, on this point, I don't think for many, many decades to come this Nation will be in a position of having to

pull the plug on any senior citizen who wishes to live. I could see myself in this. I happen to be a news junkie. I would hate to have to have the plug pulled on me just before a Presidential election. I want to at least know how it came out ahead before I go to the Pearly Gates. [Laughter.]

Mr. REINHARDT. We will not soon have to do this in this country. Maybe never. No other country does this. No other country pulls plugs on people who demonstrably want to live. But we have a case in Minnesota where there is a lady, a senior citizen, comatose, that doctors say is hopeless whose 87-year-old husband wants to fight on and hope for a miracle.

Now, here is an issue where one could tell the 87-year-old husband, "We've been good to you, and you've been good to us. However, that $200,000"—I don't know if that's the number but it might well cost that per year, that goes into this hopeless case—"does deprive—with fixed budgets—American children of measles vaccination, polio vaccination. Is that really what you have in mind? Are you happy with that allocation of funds."

Now maybe this gentleman should be spared that, but as a political issue it needs to be raised. After all this country didn't have enough measles vaccine this and last year. If you go to Europe and try to explain that to a European, you are hard put to sell the idea that the richest country in the world, I can't find the money or enough measles vaccine for all American children. But it is a fact.

Senator SIMPSON. I admire the Chairman. I am going to try to help and participate. I thank you.

Senator KOHL. Thank you.

I believe in term limitation, so this is an easy hearing for me to have. [Laughter.]

Senator KOHL. Senator Reid.

Senator REID. Thank you very much, Senator Kohl.

Dr. Reinhardt, tell me about the fact that we hear so much about defensive medicine and the only reason doctors order all these tests is because they are afraid they will get sued. What is your feeling about that?

Mr. REINHARDT. I think the American tort system is harsh on doctors. In fact, being an American doctor is a very hard thing these days. American doctors now practice in a fishbowl. They have utilization review people chasing them on the one hand, and they have malpractice lawyers chasing them on the other. I certainly would like to add that I don't think doctor-bashing is in fact what is required on this rationing, nor is cutting doctors' income really what I am talking about. I think, first, we should ask doctors to join us in a debate and ask, for once, please never use slogans like "rationing" to stop a debate. Let us discuss what's really on the table.

Senator REID. But answer my question.

Mr. REINHARDT. Number two, on the issue of malpractice, I am not so sure that that one hasn't actually been a blessing for doctors. Why? Because all this defensive medicine—the extra tests and so on—which is said to be $15 billion or more a year, represent after all income for doctors. The real question I would ask myself is: "If you could wave a magic wand and get rid of malpractice, do you think the medical profession would give up cheerfully some

$15 billion—or now $20 billion—of gross revenue year?" I am not sure that malpractice per se is in fact the cost driver it is said to be. I'm just not convinced of that.

Senator REID. I have heard you speak once before. It is my understanding that you indicated that if you could wave a magic wand and do away with all those defensive tests that the medical profession would figure out some other way to make that money.

Mr. REINHARDT. I am not the only one who says that. Almost everyone—HCFA now believes that physicians will have a 50 percent volume offset in response to the lower fees implied by the new fee schedule. That is what Dr. Wilensky and her staff believe.

Jack Wennberg had a piece in the New England Journal of Medicine not long ago arguing that outcomes research by itself will not do the trick of cost-control because physicians can think of every new thing to do—and not in a venal way, I might add. You don't have to be a venal physician to say an additional CAT scan may be a desirable thing, if it's insured and someone else will pay for it. I think this process is far more subtle—far less venal—in fact far more honorable than we might think. But I am totally convinced that if malpractice went away as an issue in this country, you would not see physician's gross billing decrease by very much, certainly not by $15 to $20 billion out of the $110 billion or so now spent on physicians. That I am totally convinced of.

Senator REID. Tell me why you are convinced of that.

Mr. REINHARDT. Simply because the physician population ratio is increasing. Physicians, as highly trained professionals, have high income aspirations just as do lawyers, economists, and even politicians. They have at their hands an extremely imprecise science going by the motto: The more information, the better. Therefore, the search for income and the search for perfection in medical practice coincide. There is absolutely nothing that would stop physicians from going the direction of added spending, especially if the patient is well insured. As I said before, they can do this—and usually do do this—in the most honorable way. It's not that they say that they're going to do another useless test because they want to go on a vacation. I can't imagine it works that way. It is much more subtle—our billings are a little slow, and here's the insurance, since I have fewer patients I can spend more time with them and be a little more thorough, and so on and so forth. It can all be mentally and in prose explained in very honorable terms. Professionals work that way—lawyers are famous for it, and health-services researchers are not far behind.

Senator REID. We have a figure that we use around here that there are 35 million people that are uninsured. In addition to that figure of people that are uninsured, it is my understanding that there are a lot of people who are underinsured. That is, they may have insurance that doesn't cover things that they need to take care of them, or in fact they may be covered, or family members covered.

What has your research indicated in that regard, relative to the underinsured, not the uninsured?

Mr. REINHARDT. I, personally, have not done this research. If the committee wants information, I think Kathy Swartz at the Urban Institute may have good information, or Deborah Chollet, formerly

of the Employee Benefit Research Institute and now at Emory University. They have these numbers.

Underinsured means that there is a lot of fine print in your policy that doesn't cover X, Y, and Z. To my mind, underinsured also means having a policy and then when you get sick they jack up the premiums. That happens in quite a few instances.

Basically, you read about someone who has AIDS and the premium went up from $180 per month to $900 per month within 3 months. If you have that kind of policy that allows an insurer to do that to you, you are underinsured, even if the fine print really doesn't show it. To tell an AIDS patient that the insurance is now $1,000 per month is basically to say that you are not insured.

Senator REID. In your paper, you say,

> First, more and more American business executives have reached the conclusion that they cannot control the premiums for the health insurance of their workers and that they cannot afford to absorb the continued sharp increases in these premiums.
>
> Second, the private insurance industry is segmenting our population into ever finer risk classes and, through competitive underwriting techniques, prices more and more high risk Americans out of the private insurance market altogether. As a result, the ranks of the uninsured are growing not only among the very poor, but also among the Nation's middle classes.

But also, aren't we missing another category, just sick people? I was stricken—somebody that I know from Nevada has a large business based here in this area. He is finding it more and more difficult to maintain group health insurance for the reason that if he has one sick person among his employees, it so skews his premium for everybody that the people who aren't sick—he can't afford to insure them.

So what I'm saying is that in addition to the poor and middle class, we are also developing a group of people who are sick and can't get insurance. Would you agree with that?

Mr. REINHARDT. Yes, I think we, in this country, have allowed the insurance industry to superimpose on health care an ethic that we never openly debated. They had an ad in the paper 2 years ago—every major magazine carried it—where they said that if you didn't charge premiums by health status then low risk people—which is healthy people—would end up subsidizing high risk people—which is sick people—and the insurance industry said that that wouldn't be fair.

That is an ethical statement that I think should blow the mind of every American. What the insurance industry was saying was that for healthy young people to subsidize sick people would be unfair. They obviously price their product in the competitive market that way.

Of course, to my mind, the industry is committing suicide in the process, as an industry. At this time the industry's claims to have two-thirds of Americans as privately insured, but it accounts for only one-third of the dollars going into health care. If it continues to exclude sick people from insurance coverage, by the year 2000, maybe the insurance industry will cover perhaps 40 percent of the American people, but control only 10 percent of the health care dollars. They are literally on the march to suicide as an industry.

So I feel—and I tell members of this industry—that if it wishes to survive this decade it must do the following for America: It must

develop a portable insurance product that doesn't lock people into a job just for the sake of insurance. It must have a community rated product that makes it possible for small business people to get health care insurance on the same terms as Alcoa's employees have. And it must have an all payers system.

That is, small business firms shouldn't pay more for a normal delivery at St. Joseph's Hospital than a big business for its employees. Those three things are required, and also the coverage should also be administratively simple because for a small business now 30 percent of the insurance premium is just the administrative cost of the insurance carrier, let alone the claims to be borne by doctors, hospitals and patients.

If the insurance industry cannot produce those four design parameters—portability, community rating, same payment rates to providers, and simplicity—then, as an industry, as a cornerstone of American health care, it will crumble and disappear. I believe this Congress should help that industry survive by regulating it towards those ends.

Senator REID. Thank you.

Senator KOHL. Thank you very much, Senator.

Senator Burns.

Senator BURNS. I had a whole host of questions and they flew by.

We live in a border State in Montana. We look at the Canadian plan. Our doctors in Great Falls, MT, and even the little towns of Showtow, MT, and Havre, MT, and Glasgow, MT, continually pick up more and more patients from Canada. They are not just the upper echelon of the income scale, but they are people that fear walking into a hospital and being told to take a number because when you're sick, you're sick. Then they look at their income taxes and they shudder again. Whether that be right or wrong, I don't know. I don't know how that all shapes out in the bottom line.

Let's take, for instance, in my town of Billings, in which we are a medical center for a large area. We have a very, very good medical corridor, two hospitals, a lot of research going on there. We are very proud of our medical facility there. I am told that they deny no one access to those hospitals even though they know that some of the people that apply that come there under emergency conditions—they are very sick—that they cannot pay the bill. They have no insurance and they cannot pay the bill.

We are told that 25 cents of every dollar spent—whether it's from personal funds or from insurance premiums—goes to satisfy the bills of people who cannot pay, or did not pay—let's put it that way—and they have no way to pay it. That's 25 percent. So in essence, don't we have a subsidized plan now in that those who have the ability to pay are subsidizing for those people? Hospitals are telling me that they are not denying anyone access to health care. Is that a good assumption?

Mr. REINHARDT. It may be valid for Billings. It is not valid for the United States. Let me address the two issues you raised.

One is that Canadians coming South for health care. That is true, particularly for high tech intervention and often for psychiatric care. On the other hand I was just in Toronto 2 days ago, and I was told that in the Province of Quebec, some 7 percent of their outlays goes for Americans who come across the border to get free

care. Recently I was at my alma mater, the University of Saskatchewan, and they also told me that Canadian hospitals have many Americans come across the border to get free health care.

So what we really have is an exchange of health care. Some high tech care is exported by the United States to Canada, and routine health care that is not accessible to Americans is actually exported from Canada to the United States. That is apparently what is really happening.

To answer your second question, aren't we subsidizing health care for the poor, the answer is yes. This country has traditionally used cost shifting as a device to cover the uninsured. In 1978, I would have said we almost had a one-tier health system because we had retrospective reimbursement and every hospital could take every patient—insured or not—treat them, and just pass the cost on to government or commercial insurance.

The United States is really three or four different parts. You have the somewhat socialist northeast. For instance, in my State of New Jersey, no patient is ever denied access to a hospital. We have explicitly socialized this through a surcharge on the hospital bill. Every patient who is sick and goes to the hospital will get taken care of and the hospital is paid through this fund.

But in the Sunbelt, 25 percent of the population is uninsured. So you find in Southern California hospitals closing the emergency room and the neonatal unit because those are the two portals through which the uninsured come through.

They say, "We don't deny anyone, we just don't have the emergency room open." But that is rationing of a totally unacceptable form, particularly as these emergency rooms stand idle.

Then in parts of the Sunbelt you find brutally denied care with open emergency rooms. There was a famous case with Vanderbilt University who refused to accept a burn victim because he was not insured and they had to fly the poor fellow all the way to Texas. You find those instances in the Sunbelt.

So the agony varies very much by region within the United States. If you go to Wisconsin, you will have very little denied care, I would imagine, if it is critically needed—maybe even routine care. So you can't infer from one town, like Billings, MT, for the entire United States—it's a problem far more severe in Louisiana, Florida, or in southern California.

Senator BURNS. When we take a look at figures—we are always batting around this 30 million that are uninsured. If you would break those down to those who did not have insurance for at least 9 months out of the year, that curve drops drastically.

Mr. REINHARDT. Yes.

Senator BURNS. Or for 6 months, it drops even more drastically. For some reason or other, they are between jobs, and all those figures. So I think sometimes our figures are distorted a little bit. It's nice to use the 33 million because if this Government is going to have to do something, they are going to have to look at the outside and what it is going to cost to build. We have been wonderful at underestimating the cost of everything.

I appreciate your testimony. I will read all this. I have to go now. I thank you very much for coming. I appreciate your remarks here

today. I learned much more from you than you learned from me, and that is the purpose of this hearing.

Thank you very much.

Mr. REINHARDT. Don't take that for granted. [Laughter.]

Senator KOHL. Thank you, Senator Burns.

Thank you, Dr. Reinhardt. You have been very informative and helpful. We appreciate your comments.

Mr. REINHARDT. Thank you very much for having me.

Senator KOHL. We are going to call our second panel right now, but there is a vote scheduled in 5 minutes at 10:15. I am going to make the suggestion that before we commence and then have to stop a minute or two into our panel, why don't we call a temporary recess and I will attempt to get back just as soon as I can. I am sorry, but there is a vote at 10:15.

[Recess.]

Senator KOHL. I am sorry and would like to reconvene promptly. I apologize for the delay.

We have here with us now our second panel. It is truly a distinguished panel of bioethics.

First, we will have Dr. John La Puma, Director of the Center on Clinical Ethics at Lutheran General Hospital in Park Ridge, IL. Next to him, we have Charles Dougherty, who is the Director of the Center on Health Policy and Ethics at Creighton University. Welcome. Next to Dr. Dougherty, we have Dr. Daniel Callahan, who is the Director of the Hastings Center in Briarcliff, NY. Welcome, sir. And finally, we have Dr. Edmund Pellegrino, the Director of the Center for Advanced Study of Ethics at Georgetown University. Welcome to you, sir.

Dr. La Puma.

## STATEMENT OF DR. JOHN LA PUMA, M.D., DIRECTOR, CENTER FOR CLINICAL ETHICS, LUTHERAN GENERAL HOSPITAL, PARK RIDGE, IL

Dr. LA PUMA. Thank you, Senator. It is a privilege and honor to sit before you this morning, sir, and I want to thank you for inviting me and for encouraging the contributions of practicing physicians to the debate on ethics and health care rationing.

My position at Lutheran General Hospital is that of a practicing internist and of a clinical ethicist. You may not have heard someone introduce themselves as a clinical ethicist before. A clinical ethicist is ordinarily a practicing physician, in any medical field, who has taken post graduate training in identifying, analyzing, and helping to resolve moral problems in a particular patient's care. The first post graduate fellowship in clinical ethics was at the University of Chicago in 1985. I was the first fellow in that program.

Presently, I see patients as an ethics consultant in the hospital,[1] I train other community physicians in clinical ethics, and I practice general internal medicine in a medical office and in the community teaching hospital.

Typically, doctors ask me to help them to decide how to think and construct the pros and cons in cases in which life support may

[1] See appendix, p. 119.

be limited, in cases where there are questions about whether to keep information confidential, and in cases where there are questions about how to use quality of life assessments in making clinical decisions for patients. Rationing health care, as we have talked about it this morning, assumes that quality of life can be measured well enough to make policy judgments about it. Some patients with what is thought of as a "poor quality of life," however, are unable to make these decisions and have no one to speak reliably for them. Other patients would rather live no matter what others think of their quality of life.

One of my patients, a woman named Mrs. G., was a 69-year-old woman with severe liver failure. She had begun to throw up blood once every 3 to 6 weeks as a result of her liver failure. She then lapsed into a coma from the metabolism of the blood causing encephalopathy, and collapsed at the nursing home. She was on Medicaid and lived in the nursing home and was widowed. She had two kids who lived in another State and called her regularly to keep up.

Each time this happened—that is, that she bled and went into coma—she was so sick that it seemed as if she would die. She was always taken to the hospital directly.

The second time this happened, the resident and intern asked if they should continue to treat her. After she received fluids, medication, and transfusions, she told us on the third hospital day, "It is like a dream when I pass out. I wake up in the hospital and I feel better. I don't even remember throwing up and then you treat me and I go home."

She lived 8 more months in this throw up-coma-back and forth-hospital-to-nursing home cycle, to her own satisfaction. She wanted to live.

What does this story mean? Why do I tell it? It is because of the lives of patients like Mrs. G.—the indigent, the critically ill, and the elderly—rationing judges to be of inadequate worth. For groups of patients like her who are not asked about their own quality of life, quality of life assessments simply cannot be made accurately.[2] If rationing means excluding patients like Mrs. G. because someone else might need those resources some time in the future, then for physicians, the choice between being a patient advocate and a public resource agent becomes untenable.

I want to mention that I think at least six alternatives to rationing exist. These are: close attention to disease prevention, health promotion, as featured in the Washington Post this morning; elimination of administrative waste, something we have mentioned frequently; elimination of financial incentives for medical entrepreneurs, particularly those collecting extremely high incomes; a role for primary care physicians in deciding specialist referrals; a willingness to critically evaluate what we do every day; and finally a concern for teaching the practice of clinical ethics.

I want to close by saying that I don't think that available resources should be used for rationing services that have already been shown to be effective and beneficial, but for different, more

[2] See appendix, p. 125.

fundamental changes in the health care system. Patients go to doctors for help. Doctors should not be forced to refuse medically necessary, appropriate services to patients who he would have helped before rationing and who need us now.

[The prepared statement of Dr. La Puma follows:]

# Medical Ethics from a Practical, Patient Care Perspective:

# Is Rationing Ethical?

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Presented at "Who Lives, Who Dies, Who Decides: The Ethics of Rationing Health Care" at the invitation of Senator Herbert Kohl of Wisconsin, before the United States Senate Special Committee on Aging, in Washington, D.C., on June 19, 1991.

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## Introduction

Thank you, sir. It is a privilege and honor to sit before you this morning. I'm John La Puma of Lutheran General Hospital in Park Ridge, Illinois, and I'm a practicing internist and clinical ethicist. A clinical ethicist is ordinarily a practicing physician in any medical field, who has taken postgraduate training in identifying, analyzing and resolving moral problems in patient care. The first postgraduate fellowship in clinical ethics began in 1985 at the University of Chicago Hospitals; I was the first fellow there. Presently, I see patients as an ethics consultant, train other practicing physicians in clinical ethics, and practice general internal medicine in a medical office, and in our community teaching hospital.

Typically, doctors ask me to help them decide in particular cases whether to limit life-sustaining treatment, or whether to keep information confidential, and whether to use quality of life to make clinical decisions for patients. Rationing assumes that quality of life can be measured well enough to make policy judgments about it. Some patients with "poor quality of life", however, are unable to make decisions, and have no one to speak reliably for them; other patients would rather live, no matter what others think.

One of my patients, Mrs. G, was a 69 year old woman with severe liver failure. She had begun to throw up blood once every three-to-six weeks, and then lapsed into a coma, from hepatic encephalopathy. She was on Medicaid, lived in a nursing home, was widowed, and had two children who lived in another state, who called her regularly to keep up. She was so sick, that every time she threw up blood it seemed as if she would die, and she was always taken to the hospital directly. The second time this happened, the resident and intern asked, "Should we continue to treat her?" After she received fluids, medication, and transfusions, she told us on the third hospital day, "It's like a dream when I pass out. I wake up in the hospital, and I feel better. I don't even remember throwing up, and then you treat me, and I go back home." She lived eight more months in this cycle, to her own satisfaction.

What does this story mean? The lives of patients like Mrs. G- the indigent, the critically ill and the elderly -- rationing judges to be of inadequate worth; for groups of patients like her, who are <u>not</u> asked about their own quality of life, quality of life assessments cannot be made accurately. If rationing means excluding groups of patients like Mrs. G because someone else might need those resources sometime in the future, then for physicians, the choice between being a patient advocate and a public resource agent is an untenable one, and might have been lethal for Mrs. G.

Finally, alternatives to rationing exist. They include close attention to disease prevention and health promotion, elimination of administrative waste, and of financial incentives for medical entrepreneurs, particularly those collecting extremely high incomes, a role for primary care physicians in deciding specialist referrals, a willingness to evaluate critically the process and outcome of what we do every day, and a concern for teaching the practice of medical ethics.

Available resources should not be used for rationing services that have been shown to be effective and beneficial, but for different, more fundamental changes in the health care system. Patients go to doctors for help; doctors should not be forced to refuse medically necessary, appropriate services to patients who we would have helped before rationing, and who need us now.

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Senator KOHL. Thank you, Dr. La Puma.
Dr. LA PUMA. Thank you, Senator.
Senator KOHL. Dr. Dougherty.

**STATEMENT OF CHARLES J. DOUGHERTY, DIRECTOR, CENTER ON HEALTH POLICY AND ETHICS, CREIGHTON UNIVERSITY, OMAHA, NE**

Mr. DOUGHERTY. Thank you, Senator.

The United States is facing a combination of runaway health care spending and continued problems with access. Any genuine reform of the health care system, therefore, must assure universal access to basic, comprehensive health care in a system with serious cost containment measures. In other words, any reform must address the difficult issue of health care rationing.

Obviously, people differ on the meaning of health care rationing. Some see it as inherently negative because it denies people care, and others see it as inherently positive because the word suggests a sense of equity or equitable distribution of a burden.

I prefer to use a neutral definition because it invites further ethical analysis. I propose this: health care rationing is the withholding of potentially beneficial health care services because policies and practices establish limits on the resources available for health care. Understood this way, it is plain that we have rationing throughout our health care system, but it is not explicit nor systemic and it is very hard to justify the de facto pattern of rationing that we have.

I believe that rationing is inevitable and that it ought to follow from conscious public decisions. I offer the following criteria for evaluating specific proposals to ration health care in an explicit and systemic fashion.

First, the need for any specific program of health care rationing should be demonstrable because rationing denies care to people and therefore may permit otherwise preventable deaths and suffering. Specific programs of rationing need to be justified. This means ensuring that spending amounts and priorities are adequate and waste in the system is controlled.

Second, the common good must be an explicit goal in any health care rationing program. We must use statistical reasoning to maximize the number of citizens who live long and happy lives. We cannot do everything for everybody. Our principle must be doing the best possible for the most.

Third, every American must be guaranteed a right to a basic, comprehensive level of health care. This level of care should not be rationed.

Fourth, rationing schemes should be universal. They should apply to all. Rationing schemes, in my opinion, are ethically flawed when some Americans ration others' health care. Rationing schemes are especially unacceptable if they are rationed only for the poor.

Fifth, the process for determining how the limits on care are to be set and maintained should be public. Citizens should know why their health care is rationing and how appeals can be made for special treatment in special cases.

Sixth, the unmet needs of America's worst off have an ethical priority. African Americans, American Indians, and some Hispanic American groups have special health care deficits that must be addressed before their care is limited.

Seventh, there should be no wrongful discrimination in any health care rationing scheme. No one should be denied access to potentially beneficial health care because of gender, race, sexual orientation, age, or because of the association between their lifestyles and their need for health care.

Finally, the social and human effects of health care rationing must be monitored closely. The ability of professionals to care for their patients must be protected and trust in the doctor/patient relationship must not be undermined by health care rationing.

I am confident that with guidelines such as these, an explicit, systemic, and ethically defensible program of health care rationing within a reformed health care system for all Americans will meet the approval of the vast majority of citizens.

[The prepared statement of Mr. Dougherty follows:]

CREIGHTON UNIVERSITY

Center for Health Policy and Ethics

**TESTIMONY TO THE SENATE SPECIAL COMMITTEE ON AGING CHAIRED BY SENATOR HERBERT KOHL**

June 19, 1991

**"Health Care Rationing"**

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My name is Charles J. Dougherty. I have a doctorate in philosophy from the University of Notre Dame and direct the Center for Health Policy and Ethics at Creighton University. I am the author or co-author of five books in the area of ethics and health policy including American Health Care: Realities, Rights and Reforms (Oxford University Press, 1988). I was a member of the Hastings Center's Oregon Medicaid Initiative Project (1990-91) and authored the project report that will appear in the next issue of the Hastings Center Report. I served on the Catholic Health Association's Working Group on Health Care Rationing and was one of the main authors of their June 1991 report, "With Justice for All? The Ethics of Health Care Rationing." I offer the following testimony as an individual. I am not speaking on behalf of any organization.

**Costs and Access**

The 1980s was a period of conscious cost-cutting in American health care. An array of innovative techniques were developed to contain spiraling health care costs: pre-admission certification for hospitalization, utilization review, PROs, prospective payment for hospitals, new managed care arrangements, increasing deductibles and co-payments, mandatory second opinions before surgery. In spite of these and other efforts, health care costs continues to increase at an unsustainable rate. Health care now consumes 12.2% of the U.S. gross national product, the highest percentage of spending on health care for any economy in the world.

Although the U.S. is spending more and more on health care, individual Americans still have no guarantee of access to even the most basic care. Approximately 35 million Americans have no public or private health insurance coverage and must rely on the charity of providers for their care--or they simply go without. Millions more--perhaps as many as 60 million--are seriously underinsured. The U.S. still lacks a primary health care network and a long-term care system for those with custodial needs.

The combination of runaway spending and continued problems with access argues for fundamental reform in American health care. The general formula for any genuine reform must be: **universal access to basic, comprehensive health care in a system with serious cost containment measures.** But the twin goals of extending access and limiting expenditures can be achieved only if some medical care that might be beneficial to some people is withheld. In other words, the necessary reform of American health care means confronting the ethical challenges of explicit and systemic health care rationing.

## The Definition of Rationing

Debates about the ethical and policy implications of health care rationing in general and about specific proposals to ration care explicitly have been marred by acrimony and deep conceptual disagreements about the meaning of rationing.

For some, the notion of withholding a potentially beneficial health care measure is unacceptable because of the harms entailed for patients and potential patients. Under rationing, some will

die who otherwise might have been saved. Some will experience diminished quality of life that might have been prevented. Some will experience pains that might have been avoided or ended. And many may face the indignity of having to queue up for needed health care services.

Those who stress these negative consequences also point out the skewed spending priorities in our nation, the massive amounts spent annually on luxury items, for example. There are also many costly and unnecessary health care interventions, wide-spread waste in the system, rapidly increasing administrative costs, and high levels of profits taken out of the health care arena. How can the U.S. consider rationing health care for those with bona fide needs, they ask, when so much money is wasted both outside and within the health care sphere?

Critics of rationing are also quick to note the potential for undermining trust in the doctor-patient relationship should doctors become agents of explicit rationing systems. Patients are vulnerable before their doctors. They must rely on physicians to put their interests as individual patients first. But when a doctor becomes a rationing agent, when he or she makes judgments prejudicial to the interests of some individual patients for the benefit of others, the ethical core of the doctor-patient relationship is undermined.

For proponents, however, rationing has a positive connotation. Dictionary definitions typically associate the concept of rationing with that of equity so that on these

accounts rationing means the equitable distribution of a scare commodity or service. The rationing of scarce commodities in the U.S. during WWII is a good example of this positive interpretation. Supplies of sugar and gasoline were short. Wartime planners might have simply allowed the price system to ration. They might have let prices rise on these commodities to the point where only the wealthiest of Americans would have had access to them. Instead they adopted an explicit rationing system, distributing coupons that assured some access for all Americans. Thus a certain equity was introduced into the distribution of scarce commodities, an equity that would not have been present had the marketplace operated on its own.

Those who favor explicit rationing see a parallel in today's health care situation. Money and insurance status operate to create forms of implicit rationing. Those with money or insurance have ready access to care; those without them often do not. Since this form of implicit rationing seems to function without any notion of equity, an explicit rationing system would be an improvement. Then the equity question would be raised consciously and publicly.

But in spite of dictionary associations and some positive historical experiences, not every system of rationing can be considered equitable. Coupons for sugar could have been distributed in a way that was simply unfair: on the basis of race, gender, or party affiliation, for example. It is possible to ration and not achieve the equity that many dictionary

definitions associate with the term. Therefore, it is important to anchor a discussion of health care rationing with a neutral definition of the term, one that points out the essential features of rationing but leaves open for inspection the question of whether or not a specific system of rationing is or is not equitable.

For these reasons, the CHA Working Group on Rationing found it necessary to stipulate a neutral definition of rationing. Here was the definition put forward. **"Health care rationing is the withholding of potentially beneficial health care services because policies and practices establish limits on the resources available for health care."** This definition does not prejudge the issue of whether a given program or proposal for rationing is good or bad. The definition is alert to the central concern that potentially beneficial care is being withheld, but it allows for the possibility that withholding may be justified because of limits on resources. The definition provokes a self-conscious analysis of ethical questions without attempting to resolve them by definition.

## Ethical Concerns

Four ethical concerns are raised directly by this understanding of health care rationing. Most ethicists believe that each one of us has an ethical obligation to come to the aid of others in need. This duty does not extend to sacrificing oneself to save another or even to placing oneself at high risk for a small benefit for another. But when another can be helped

in a significant way without great sacrifice to oneself, most ethicists agree that there is an obligation to come to the other's aid. This is sometimes called the ethical obligation of "easy rescue". Health care rationing, depending on how it is organized, may violate this ethical obligation.

Secondly, as indicated above, health care rationing means deaths, loss of quality of life, and pains that might have been avoided without health care rationing. In this sense, health care rationing is not like issuing coupons for sugar. The ethical stakes are much higher.

Thirdly, depending again on how health care rationing is arranged, it can cause indignities to persons. For example, a rationing system might embodied wrongful discrimination. It might isolate some people from the care of the community because of their diseases or because of their socioeconomic status. Such a rationing system would offend the notion of human dignity. Even when there are no direct inflictions of physical harm, offenses against dignity raise serious moral concerns.

Finally, health care rationing might simply be unfair. Access to health care can profoundly shapes individuals' opportunities in life. Limitations in access to health care can therefore affect the equity of life opportunities. A rationing system that created disproportional burdens for some part of the population but shielded others would be unfair. It would add to the inequities of life.

**Present Forms of Rationing**

The neutral definition of rationing proposed here promotes the recognition that there is rationing in the present health care delivery system. Potential health care benefits are withheld from many Americans because of deliberate choices made at various levels of government. The choice to cover wealthy sixty-five year olds in the Medicare program, but not poor sixty-four year olds has significant rationing effects. When state legislatures meet to reset the eligibility criteria for their Medicaid programs, rationing takes place. When counties deliberately create administrative and paperwork barriers to assistance for health care needs, rationing occurs. When compensation to providers of Medicaid services is set so low as to discourage doctors and hospitals from accepting Medicaid patients, potentially beneficial health care services are withheld by policies and practices that establish limits on the resources available for health care.

Health insurers also pursue deliberate health care rationing policies. Significant rationing occurs throughout our nation because thirty-five million Americans have no health insurance. Many uninsured Americans with genuine health care needs stay away from the health care system knowing they cannot pay. Others arrive too late for effective care and at inappropriate and costly points of service. Potentially beneficial services become unavailable to them.



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Over the last several decades, health insurers have pursued aggressive policies of market segmentation, abandoning community rating in favor of experience rating. As a result, Americans at high risk for serious illnesses find it increasingly difficult to get health insurance coverage. Companies and whole industries with high risk jobs or with large populations of individuals thought to be heavy utilizers of health care find it more and more difficult to get health insurance. Deliberate rationing choices by third-party payers have created a new class of health insurance pariah: the victim of a serious health crisis who has thereby become an "uninsurable". Rising deductibles and co-payments have rationing effects for all but the wealthiest Americans.

Other choices, though not consciously intended to withhold access, nevertheless have important rationing consequences. Decisions by hospitals to follow their paying population's flight from the inner-city to suburban areas have closed urban hospitals. Doctors' choices of residence have, in effect, rationed health care in rural America and in inner cities. The disproportionate emphasis by providers of nearly every kind on highly technological rescue medicine has withheld important preventive care.

In summary, health care is rationed in the United States today. It is rationed on the basis of ability to pay in the open market and on the basis of age in the Medicare program. It is rationed on the basis of income, marital status, and the having

of dependent children in the Medicaid program. Access to private health insurance is rationed on the basis of employment and by history of illness. Health care is rationed on the basis of race and location by the Indian Health Service and on the basis of military service by the V.A. It is rationed on the basis of insurance status and on the basis of provider charity for those who are medically indigent. Health care is rationed on the basis of geography for those in rural America and inner cities. And it is rationed on the basis of luck--bad luck--for the millions of American children born into uninsured families, the majority of which are headed by an adult working full-time.

Moreover, current forms of health care rationing raise serious ethical questions in terms of the four considerations set forth above. When so many millions of Americans have no health insurance and no routine access to basic health care the obligation to perform easy rescue is violated by each of us as individuals and by all of us as a society. Given our resources as a nation, we could make much better efforts to aid those with serious health care needs without great sacrifice to ourselves. And serious harms are created. The U.S. infant mortality rate is among the worst of industrialized nations; Americans do not lead the world in longevity. While there are many factors that account for these poor results, the barriers created to routine access to health care by the de facto rationing built into our system undoubtedly accounts for a good deal of it.

There are also indignities created for those who must go without health care in the midst of health care affluence. Whether or not they literally suffer premature death, unnecessary loss of function or pain, those excluded from routine access to health care are isolated from the community of care. They suffer indignities when they are forced to present themselves and their families as objects of charity. Finally, the present system of rationing is simply unfair. Many peoples' life opportunities are shaped significantly and beyond their control by virtue of being born into families that have no health insurance and no public support for access. Health care is rationed for them with no sense of equity.

Recent calls for explicit and systemic health care rationing in the state of Oregon's Medicaid program, in the use of expenditure targets and global budgeting for Medicare, or in the several proposals for systemic health care reform put forward by political leaders and health care organizations around the country--all of these proposals have fostered a new level of awareness of health care rationing. They have forced us to see that health care rationing is a part of the present American system. Though often invisible, health care rationing occurs right now, and in ways hard to defend from an ethical point of view.

**The Values at Stake**

As Americans consider calls for explicit and systemic health care rationing against a background of the de facto rationing of

the present system, certain key values must be kept in mind. These values should help shape the environment within which difficult public and private choices about health care must be made.

First and foremost, the challenges of health care rationing returns us to the value of community. Health care is not simply a private commodity. Contemporary health care is based on centuries of scientific progress and clinical experimentation to which no individual can make a rightful claim of private ownership. The health care infrastructure has been built with significant public investment. Aid to health care research and education over the last several generations has fostered the development of professional care and professionalism. The contemporary structure of private employer-based health insurance would be inconceivable without close government regulation and massive support from the federal tax code. Modern health care is very much a collective achievement.

Continued social investment in health care in an age of limits must be shaped by a commitment to what is good not simply for individuals, but for the national community as a whole. In clinical contexts, doctors, nurses and others who care for individuals must put individual patients first. But in social policy, the common good must be the value that takes precedence.

Secondly, the achievements of human dignity and human rights, values that Americans pioneered and brought to much of the world, are incomplete expressions in our own national

experience without an explicit guarantee of a right to a basic level of health care. Before explicit rationing systems are adopted, every American must be assured access to the basics--and to a package of benefits sufficiently comprehensive to be equitable and to assure that national public health goals are achieved.

Third, citizens have an obligation to use natural and social resources wisely. When health care makes imperious claims on budgets, there are significant opportunity costs. Money that might go to education or to transportation or to redeveloping cities is lost. These and other priorities must be balanced politically against the need for health care. Internal to the health care arena, hard choices must be made about which services are truly cost effective and produce the medical outcomes patients seek. No system can do everything for everybody; health care rationing is a call to the value of prudent decision making.

Finally, as the inevitability of health care rationing becomes more plain, it must be recalled that not all Americans are equally situated. Over the last several generations, significant deficits in health status have been amassed in the African-American community, among American Indians and some Hispanic-American groups, and among individuals in certain rural areas. Before costs are cut by rationing health care, the unmet needs of these highly vulnerable populations must be addressed. The disadvantaged should be brought up to a reasonably equitable

standard of care before they are asked to share the burdens of rationing.

**Ethical Criteria for Acceptable Health Care Rationing**

Health care rationing is neither good nor bad in itself. What makes health care rationing good or bad are the details of the program or proposal put forward. Difficult contextual judgments about rationing will have to be made. New reform proposals that contain explicit or implicit rationing must be judged against the unacceptable forms of rationing presently in place, as well as against alternative proposals for reforms. To help focus the ethical issues at hand, I offer the following eight criteria for justifying health care rationing. They are drawn from the Catholic Health Association's "With Justice for All?"

1) The need for any specific form of health care rationing proposed must be demonstrable. The general case for health care rationing is easily made at the global level. Americans simply cannot continue to spend money indefinitely at the same rate on health care as they have over the last decade. Yet more Americans need to be brought into the system. The only way these two goals can be realized together is by restriction on the amount of health care available to any individual.

But while the general point is easily made, the specifics of any given health care rationing system need

justification. Many states, for example, spend comparatively little money on their Medicaid programs and thus set exceptionally restrictive criteria for coverage. These states are simply not spending enough money on health care even though total U.S. spending is lavish by world standards. Some states in this situation may have a genuine problem raising more tax money for their Medicaid program. But others have simply elected, for political expedience, to maximize some of their citizens' disposable incomes irrespective of the unmet health care needs among their poorer citizens. This is irresponsible. Health care rationing in this context is unfair.

Citizens and corporations must pay a responsible level of taxation to allow for a reasonably comprehensive package of health care benefits for all. Inefficiencies and waste should be removed from the health care system. Administrative costs and high profits should be reduced. Every effort should be made to use the dollars available for health care as wisely as possible before health care rationing can be justified.

2) Service to the common good must be an explicit goal in any health care rationing program. Moral psychology is such that people are often prepared to devote virtually unlimited resources to the rescue of an identifiable individual, especially if that individual is a loved one. But social policy must set different standards. Here appeal must be

made to what is good for the community as a whole. This requires use of statistical reasoning that seeks to maximize the number of persons who can experience a long life lived well. In practical terms, emphasis on the common good means a restriction on expensive technologies that serve only a few so that more rudimentary, less expensive technologies can be distributed more widely to the many.

This criterion does not express a preference for the value of the general public over the value of each individual. The value of each individual is incalculably great. But resources for health care are not. The only reasonable criterion for the distribution of the limited resources at hand must make explicit reference to the well being of the community as a whole.

3) Every American must be guaranteed access to a basic, comprehensive level of health care. Access to a basic, comprehensive package of health care benefits is recognized in industrial societies around the world as a right of citizens and a duty of government. The United States is the lone exception. How ironic that one of the main birthplaces of human rights should be among the last to recognize the application of that value to the field of health care, a field in which Americans have also pioneered.

Health care is a human right. By its nature it is a limited right because resources are necessary to guarantee it. No one has the right to make unlimited demands on the

community's resource. No one can have a right to every possible medical service that might prove marginally useful. But there must be a right to a basic and comprehensive minimum of care, a minimum that can never be rationed in an affluent society. A right to health care must be recognized and guaranteed in order to secure the promise of our Founders to "life, liberty, and the pursuit of happiness."

4) Rationing schemes should be universal; they should apply to all. The "Golden Rule" captures in the Judeo-Christian tradition a fundamental moral intuition that is found worldwide, namely, the principle of reciprocity. The hallmark of immorality is to use lower standards in the treatment of other people than those reserved for oneself. By contrast, the mark of morality is to treat others as one's self. The relevant implication here is that arrangements in which some individuals ration health care for others without facing similar rationing themselves are ethically wrong.

Plainly, this criterion anticipates a large change in American health care, a systemic reform that creates a health care insurance arrangement unified enough to allow for common sharing of the burdens of limitation. Would some Americans always be able to "buy out" of any such common arrangement? This is probably inevitable. American commitment to the value of personal freedom is such that we

are willing to accept inequalities even in something as fundamental as health care in order to insure the liberty of persons to use their own disposable wealth. Thus, any politically conceivable rationing arrangement in the U.S. will allow some to purchase more care on an open market, to buy additional insurance coverage, or to travel to other nations that allows access to the health service rationed in the U.S.

The key political consideration that makes this ethical criterion practical is that the vast majority of Americans must face the same rationing constraints together. If ten or fifteen percent of the wealthiest Americans were able to buy additional health care outside of a rationed system, equity would certainly suffer, but the system would not be crippled. If forty or fifty percent of Americans left the rationed system for other alternatives, however, the common system would increasingly become a welfare program. It would enter a political death spiral, the middle class leaving and taking its political support and tax base with it.

One important implication of this criterion in the present political context is that Americans should not begin explicit and systemic rationing of health care for the poor while the middle class and the wealthy continue to use and overuse health care with few restraints. Two tiers of health care are ethically tolerable if the first tier is

broad-based, basic and comprehensive level of care with a second, smaller luxury level beyond that. But two tiers of health care are ethically intolerable if one is a comprehensive luxury model and the other is a rationed welfare program for the poor. The first case is a reasonable political compromise with equity, a compromise based on the important value of personal freedom. The second case is an injustice to the poor and an assault on their human dignity as members of one national community.

5) However we organize a health care rationing system there ought to be periodic opportunities for open participation in the process of determining how the limits on care are set and maintained. It is especially important that those who have been disenfranchised in the past--the poor, the sick, the handicapped--participate actively in this process or have strong advocates who speak on their behalf. Health care is not simply a matter of science nor a field for economic choices. It also represents a profound set of commitments to individual and community values. There should be methods for individuals and local communities to shape rationing schemes with their values.

An open process also must have clear foci of accountability so that the public can know who has made choices to restrict access to health care and why the choices were made. There should also be an explicit appeals

process that allows individuals to make claims for special consideration in special cases.

6) The unmet needs of America's worst off have an ethical priority as we approach health care rationing. Instead of beginning explicit health care rationing with public programs that serve the poor, these programs should be protected and enhanced simply to bring their beneficiaries up to the health status enjoyed by other Americans. The health care needs of African-Americans, Hispanic-Americans, and American Indians make an urgent claim on all of us. In the future, health care rationing should seek equal treatment for equal health care needs. In the present environment of highly unequal pockets of need, affirmative action in health care should be the rule.

7) There should be no wrongful discrimination in any program of rationing health care. No one should be denied access to potentially beneficial health care because of their gender, race, or sexual orientation. Age is an especially sensitive issue here. When age has a direct bearing on likely health outcomes in individual cases, age is relevant to decisions to withhold medical services. But when this is so, rationing is not based on age itself. It is based on the fact that age can make what might otherwise be a potentially beneficial health care service into one that is not. In other words, likely medical outcome as a

function of age is a legitimate rationing consideration; age alone is not.

Also important is a prohibition against health care rationing based on lifestyle choices. It is appropriate, even imperative, for policy makers to develop incentives for Americans to adopt healthy lifestyles and to use preventive health care resources. Some limited financial disincentives may be appropriate, too--say, higher insurance premiums or deductibles for cigarette smokers. These measures will likely become more important as the cost of health care becomes more burdensome. But health care should never be denied to individuals simply because of their lifestyles and habits. Too little is known about human genetics and about the psychologies of choice and of addictions to be sure that such policies would be fair to all involved. Furthermore, refusal in the clinical setting to provide available services to those with harmful lifestyles would coarsen health care providers' sensitivities and sap the sympathy on which health care delivery must be premised.

8) The social and human effects of health care rationing must be monitored closely. Many of the foreseeable consequences of health care rationing will be harmful. Some persons will die who might have lived without rationing; others will face disfunction and pain that might have been avoided. But considering the impossibility of providing everything for everyone, such hard choices must be made.

Nevertheless, these consequences are of such ethical significance that their nature and distribution must be constantly monitored to insure that a program of rationing remains as compassionate and fair as possible.

Two other features of explicit and systemic health care rationing must be monitored particularly closely. First, trust in the doctor-patient relationship must be protected from erosion. It is important that health care rationing decisions be made at the level of social and institutional policy. They should not be clinical decisions made about individual patients at the bedside by their doctors. Nothing would more rapidly undermine trust in the doctor-patient relationship than requiring doctors to ration health care among their patients--to the benefit of some and the detriment of others. Instead, doctors should remain patient advocates, fighting against social and institutional policies on behalf of his or her individual patients.

The other significant intangible value that must be protected as we move towards health care rationing is the caring function in health care. From the beginnings of Western medicine until WWI, health care could offer little more than humane caring in the context of suffering, disability, and death. With the assistance of science, twentieth century medicine has developed unprecedented power for cure. But at the same time, some of the traditional human energy of caring has been overwhelmed by the

impersonal technological and bureaucratic dimensions of curative medicine.

This situation may worsen under explicit and systemic rationing. Under rationing, frank calculations of economics will be added to the impersonal dimensions of curative medicine. Caring must be protected in this environment. Ways must be devised to shelter human relationships and to create opportunities for personal exchanges between providers and patients. Explicit and systemic rationing programs must protect the ability and willingness of health care professionals and institutions to remain concerned about their individual patients even as tough collective decisions are made about the resources available to health care.

## Conclusion

I hope these considerations shed some light on the difficult ethical problems raised by of health care rationing. Every proposal that rations health care, whether explicitly or implicitly, must be analyzed on its own terms, compared to the status quo, and compared to other reasonable alternatives for achieving the same or similar goals. These ethical considerations can make the analysis of health care reform proposals more complete. It is my hope that they can also contribute to the kind of health care reform that will make the ethical dimensions of American health care the envy of the world.

Senator KOHL. Thank you, Dr. Dougherty.
Dr. Callahan.

## STATEMENT OF DANIEL CALLAHAN, DIRECTOR, THE HASTINGS CENTER, BRIARCLIFF MANOR, NY

Mr. CALLAHAN. Thank you, Senator.

I would like to focus on three points.

First of all, it is a false assumption that rationing would necessarily hurt the poor, that it would demean a great country that is not used to rationing much of anything, and that it would be to abandon the search for a reduction of waste.

It is my belief that if we are to have national health insurance—which I believe we ought to have—it will have to be accompanied by some rationing scheme. The Government is not going to be able to give everybody everything they need, nor can I, as an employer—I run an organization—give my employees everything they need in the way of health care. So the very fact that one has to provide health care forces rationing if you are trying to do it in a fair and just way.

It is a great mistake to think that we should not ration health care until we have found a way to cut out all of the waste in the system, until we have assessed all of our technologies, and until we have gotten rid of the bureaucracy. We have somehow looked at rationing as an alternative to cost containment. I believe serious cost containment, itself, would be a form of rationing. It means saying no to people and it means putting in very rigorous standards.

I don't see any serious difference between rationing and cost containment. I don't believe we are going to wring the waste out of the system until we understand that we have to live within limits; until we understand that we have to set priorities; and until we understand that we have to set some just form of allocating resources.

Would rationing affect the poor? It seems to me that inevitably it would. The dilemma for me is this: we know that rich people—even rich Americans—can fly to Switzerland for drugs not available here and we know that rich people can shop around the country to find the very best surgeon to get what they need. I don't think any Government program—nor for that matter, any private employer program—can provide everybody with what we allow the richest among us.

Moreover, I believe it would take a totalitarian state to try to impose a system which would say that the poorest people have to get exactly what the rich get. That seems to me not feasible.

What we could ask is: What is a decent level of care for the poor? There would continue to be some gap between the richest people and the poorest people, but it need not be an outrageous gap. It would be a reasonably tolerable, accepted gap. To me, that is only possible if we understand the need for limits and, understanding that, understand the need also to set priorities.

Oregon, I believe, has charted a very important course for us nationally. They started with the reality that, for one reason or another, the voters would not put up more money. That is a political limitation. Then, they set about establishing priorities. That seemed to me a sensible response. They will now throw that issue

back to voters who will understand that if they are unwilling to put up all the money necessary to cover the entire list of items on the priority list, some people are going to be denied. At least the moral burden will be put back directly on the taxpayer.

Finally, I would suggest that the entire debate about rationing and the need for rationing have another dimension. We are not, in our lifetime, or any human lifetime, going to conquer mortality. We are not going to overcome all illness, disease, aging, or death. In the very nature of the case, we have got to set limits on health care. We can't possibly have everything that medicine might scientifically achieve some day. Moreover, it seems to me dangerous to try.

Right now, we spend twice as much of our gross national product on health as we do on education. I don't think that necessarily makes any sense whatsoever. We have an enormous need for investment in industrial development, housing, and a whole variety of things. We can't turn the country into one big hospital. We have to balance health off against other things.

So for that very reason, we need to understand that rationing has to be an inherent part of the health care system. Indeed, by taking it seriously, making it explicit, we are going to be in a position to have a fair and sensible system.

Thank you.

[The prepared statement of Mr. Callahan follows:]

Rationing Health Care:
The Way to National Health Insurance
Testimony of
Daniel Callahan
before the
U.S Senate Special Committee on Aging
June 19, 1991

My name is Daniel Callahan, and I am the Director of The Hastings Center, Briarcliff Manor, N.Y.

I want to argue that one of the most important domestic tasks before the United States is to put in place a fair, humane, and universal health care plan.

I also want to argue that such a plan is neither feasible nor plausible without accepting the need for health care rationing.

It has often been taken for granted that health care rationing would harm the poor, that it would demean a country as rich and powerful as the United States, and that it would represent a precipitate abandonment of efforts to control costs and eliminate waste. My contention is that it need not do any of those things. On the contrary, rationing is the only likely way we can improve care for the poor and manage our health care system in a more efficient manner. It would also bespeak a nation no longer so immature that its only standard of greatness is that of setting boundaries to nothing whatever. That is an increasingly unrealistic notion of greatness.

Let me try to make my case, but before doing so provide a brief definition of "rationing." I will mean by that term a recognition that resources are limited and that, when faced with scarcity, an open, democratic method must be devised to fairly and reasonably allocate those resources. A natural outgrowth of a rational allocation plan is the setting of priorities.

"Rationing" may be understood in a hard and a soft sense. The hard sense is that of the lifeboat at sea, where a limited amount of fresh water must be shared. In that case a method of distribution must be devised that accepts the fact that there will be no more water: the limits are absolute.

The soft sense of rationing is the kind we confront in the United States with health care. The limits to resources are not absolute. We could, if we chose to do so, spend far more on health care. We could, for that matter, declare it the main goal and industry of American society.

That is not likely to happen, and a good thing that is. First, there are practical political constraints on how much money can be

spent on health care. Those limits are imposed by an unwillingness to pay higher taxes, or to increase the burden on employers to provide health care, or to personally pay more out of our own pockets.

Second, there are limits imposed by common sense. We ought not to spend excessively on health care. We can do so only at the cost of depriving other important areas of required resources. We need a good educational system, good parks and roads, good welfare and poverty programs, good industrial research and development policies. Health is, in short, not the only human good.

For the most part, American citizens already have a high and adequate level of general health. The greatest problem is not to see how much higher we can raise average life expectancy or whether we can cure every human disease. The most immediate, pressing problem is whether we can bring to the poor and deprived the same benefits now available to the majority of Americans, and whether we can maintain a system that will not see a deterioration of available benefits.

My ideal for the American health care system is this. Every American should be guaranteed a minimally adequate, affordable level of health care. The poor, in particular, would be provided with such care. The goal would be universal access to decent care. I believe such a goal will require significant government expenditures. Government should provide the base guarantee. Beyond that, a combination of employer and personal contributions would provide the remainder of the needed money for the health care system as a whole. I will not address here the details of such a system.

Such a system would make no economic sense without some form of rationing, at least in its public government programs and its private employer programs. Why rationing? Because the government would be foolish to promise an open-ended unlimited system of health care, one devised independently of the costs of that system. No country on earth, even those with the most generous systems have done that. Of course no employer can promise unlimited benefits either.

The government can not say, in effect, that we will pay whatever it costs to give you the most advanced health care.
It can not promise to pay for every technological advance, however expensive. It can not promise to help all of us live as long as we choose, regardless of the burden this imposes upon others. It can not promise to jeopardize other important societal needs in the pursuit of improved health. It can not promise to conduct an unending, financially limitless struggle against mortality.

It has often been said that, if we could simply wring the waste, inefficiency, and excess bureaucratic costs out of the system, we would not even have to think about rationing. I have been hearing that siren song for at least a decade. During that time, and despite a variety of cost-containment programs, nothing has worked to any serious degree. We have tried DRGs., managed care, HMOs, and competition. None have

had any striking success. The most we can say is that costs might have been higher without them. Health care costs continue to increase at about twice the rate of inflation in general, and even more sharply over the past three years. The surest prescription to maintain the unfair and costly status quo is to continue talking about all the money that we can save simply be eliminating waste. Why should we expect to happen in the future what we have manifestly failed to achieve in the past? Why should we count on it?

We do not know how, in practice, to eliminate waste. In fact, we make things all the harder by posing the elimination of waste as an alternative to rationing. I believe, on the contrary, that we will eliminate waste only by rationing. Only if we understand that we must live within limits, and take the steps consistent with that recognition, can we contain costs.

To be seriously undertaken, cost containment must be understood as another form of rationing. Responsible cost containment means saying "no" to some things people want, both physicians and patients. Serious cost containment will mean establishing practice guidelines, and making them stick. Serious cost-containment will mean the setting of priorities.

The issue before us is not a matter of cost containment or rationing. Both are necessary. They should be thought of as two sides of the same coin, not as alternatives.

The main concern about rationing is that the burden will fall upon the poor. That is a serious problem. How can it be avoided? The first step is to have national health insurance and, with it, an adequate baseline of care. Inevitably, this baseline will have to be set at a lower level than the richest people can set their baseline.

Rich people can hire helicopters to get to their medical treatment. Rich Americans can fly to Switzerland to use experimental treatments not available here. Rich people can seek out the very best specialists in the country and use them rather than their local doctors. No conceivable government program could offer benefits of that kind to everyone. No conceivable private employer program could offer such benefits.

The crucial issue is whether the baseline of care for the poor is set high enough to eliminate the most serious disparities. It could not eliminate all of them. But if the poor could receive most of the benefits available to the affluent, that would represent a great triumph. It would take a totalitarian state to keep the rich and powerful from the health care they want. A democratic society would not even attempt to do so. But it will try to make certain that the poor have decent health care.

A fair system of rationing will have to set some priorities. If not everything can be made available to everyone, what is comparatively

more or less important? The Oregon initiative is of great national importance. Using a combination of technical and economic considerations, and tempering them with expressed public values, that state has set up a system of priorities. It is now up to the legislature to decide how much money it is willing to spend on its Medicaid program, and thus how far down the list the range of offered services will be.

Is that a system of rationing? Yes, but then so is every other government entitlement program, federal or state. None of them give everyone everything they might want. Is it a fair and reasonable form of rationing? Yes. It has worked to be just, to set sensible priorities, and it is part of a long-range plan to provide universal health care for everyone in Oregon.

The common horror expressed at the idea of rationing is misplaced. What we do now is capriciously and thoughtlessly deny millions of people adequate health care. By refusing to ration--by refusing, that is, to face up to our limitations, political or otherwise--we simply evade the truth of what we are now doing. Open and thoughtful rationing would force us to set limits in a fair and democratic way. It would allow us to plan. It would lead us to set priorities.

Most importantly for the long run, an acceptance of the need for rationing would help us to focus on just what it is we should be aiming for in our health care system. We can not achieve immortality. We can not overcome the biological fact that we age. We can not conquer the finiteness of our bodies.

We seem unwilling to recognize those truths. We seem to believe that more money, more research, more political will can change them. Up to a point we can, and we have. But the cost--both economic and social--for trying to do so is going up. Particularly with the aging we are now struggling against some powerful biological barriers. They can not ultimately be overcome. Or, perhaps more to the point, it is not a worthy expenditure of our money and energy trying to do so.

We need to create a rounded, modest, prudent set of health care goals. The acceptance of health care rationing will help us see that the conquest of human mortality ought not to be among them.

Senator KOHL. Thank you, Dr. Callahan.
Dr. Pellegrino.

## STATEMENT OF DR. EDMUND D. PELLEGRINO, M.D., DIRECTOR, CENTER FOR ADVANCED STUDY OF ETHICS, GEORGETOWN UNIVERSITY, WASHINGTON, DC

Dr. PELLEGRINO. Thank you very much, Senator, for the opportunity to be here as well. I want to applaud the committee for examining the ethical issues behind the rationing question.

With that in mind, therefore, I would like to provide what I think are some of the criteria that might make a rationing system ethically sustainable. I am going to reverse the approach we have been taking. Rather than move from economics to rationing, I would like to move from ethics to rationing.

I apologize for not having a prepared statement. I was travelling when the invitation came. I will submit something later.

The criteria that I think ought to be looked at are these. There are five.

First are the factual presuppositions on which the thesis that rationing is inevitable is based. I don't have time to go into it. You heard this morning, however, a statement, here and there about some of the presuppositions on which we go. They need to be fully reexamined. More care is not better care. More information does not lead to better diagnosis. All of what we are talking about is not necessarily cure. There is also the matter of caring for patients. This doesn't come up. It is not a technical matter. So look at those factual presuppositions very, very critically. I think they are not well substantiated.

Second, I do think we have not exhausted all of the other possibilities. We are not practicing effective medicine. That is, medicine that demonstrably can be shown to change the natural history of a particular disease. We have heard—and I would agree—that we spend between $15 billion and $25 billion on unnecessary medical care. Good medicine is economic medicine. We are not doing good medicine, in my opinion.

We have not exhausted the other means of reducing the costs. The cost of administration is enormous. The New England Journal of Medicine had an article recently estimating the figure to be between $90 billion to $120 billion. Even if that figure is 100 percent inflated, that is a tremendous amount of money going without producing anything in the way of health care. (The Deteriorating Administrative Efficiency of the U.S. Health Care System—Steffie Woolhandler and David U. Himmelstein (N. Eng. J. Med. 324, May 2, 1991, p. 1253).)

We are paying for industrializing health care and for competition. We are paying for advertising. We are paying for added levels of executives and officials who pre- and post-audit as everyone tries to get their part of the market. Those things cost money. There are many more examples, but I will go on to item three because of the lack of time.

Whatever you do, the doctor ought not be the rationer. This creates a conflict between the interest of the patient, the interest of the physician, and the interest of the larger group. A physician is

no better judge of human values and other human beings than anyone else. In my view, it is a very dangerous road to go down. As a physician myself, I don't think I should be the judge on a case-by-case basis of who should get the kind of care that we can provide in this country. If rationing is strictly justifiable. And I think it is not, it should be by public policy, by category and not by patient.

The fourth point I would make is that whatever is done—and you're doing it here, of course—it ought to be a matter of public debate. We need a better notion of what the American people want out of this health care system. I think they feel they are not getting a return for their money, for one thing. But on the other hand, we are not sure how they want to use this vast array of resources that we have for them.

I would like to compliment the committee that this is quite properly an ethical issue. Aristotle, developed ethics in its formal sense—his book of ethics was followed by his book on politics. He saw ethics and politics as indisputably connected. So it is important, therefore that somehow we get a notion of what it is that people want out of that system. If all of those conditions could be satisfied—and I would submit that they would not be satisfied in this country today—then we might be strictly justified in rationing.

Under rationing we ought to at least have the following. There ought to be some clear principle of distribution. I would suggest that in this country it should be equity and not ability to pay, not age, or any other criterion. I want to make a statement here that I'm sure will be provocative. There are many things that should not be provided even if one can pay for them. I would be glad to develop that later if that is a matter of interest to you.

Finally, I would suggest that we might take a look at our other discretionary expenditures in the United States today. I agree very much with Dr. Callahan that we have to have a change in our values. I think we have to have a look at what kind of a society we want to be.

If you look at our discretionary expenditures—and I will mention only one or two just to titillate your fancy, I have a larger list—we spent $3.8 billion on potato chips in the United States last year, it cost us $3.5 billion to provide renal dialysis for 100,000 people, keeping them alive, the only alternative being death, and I could go on and on. We spent the same amount on pet food. I am not against pets, but et cetera, et cetera.

I see the red light is on. I had better stop.

What I try to suggest, therefore, that there are a set of criteria that would provide the ethical substratum for the kinds of decisions that you must make in the practical realm. This is a very practical matter, not an abstract matter. You become what you think you are. When you finally decide what kind of a Nation you want to be, then I think we can go back and see what we want to do about rationing.

My final conclusion is that we could not in this country today ethically defend rationing of the kind that is being proposed. By that, I mean systematic, organized, deprivation of needed health care to the citizens of this country. I don't think we could justify it. I think there are other ways to do it.

Thank you, sir.

Senator KOHL. Thank you.

I would like to try out this thesis—because I think we have heard it now from the four of you, as well as, Dr. Reinhardt—that what we have today in our system is rationing. If there is any element of cost containment in any system, particularly health care, then there is—by almost definition—the rationing of health care. We have it in our country today. It certainly does apply in particular to children and poor people.

If you agree with the first premise, would you also agree that the system—because it has never been clearly thought through and has been done in a patchwork way—is chaotic and that it doesn't represent the best that this country can do? What we urgently need is the reevaluation of this system in light of the fact that what we have is rationing today, but it is not well done. It needs to be looked at, redone, and improved. To what extent would you dispute that statement?

Dr. LA PUMA. I don't think that I would dispute it at all. I think it is exactly right.

I would also like to make the point, in contradistinction to Dr. Reinhardt this morning, that I am not sure that we need to spend more money on health care. We already spend $2,300 per capita, our nearest competitor in that race, if you will, is West Germany, which spends $1,500 or $1,600 per capita. I think we have plenty of money for health care. I think the problem is that it is not being used well and it is not being distributed well.

If we focus not on limiting services that we know already to be beneficial and effective, but instead on promoting health, preventing disease, eliminating administrative inefficiencies, and putting caps on medical professionals' incomes—I think it's outrageous that some doctors earn $1 million or $2 million a year—then I think we can think more constructively about the system as a whole and reorganizing it as a whole instead of the kind of patchwork form that is presently being proposed.

Mr. DOUGHERTY. Senator, I would agree with both of your assertions, that there is rationing presently in the system and that the system is chaotic. The problem, I think, both from a political and ethical point of view, is that the rationing does not apply equally to all Americans and the chaos is not equally shared as a burden by all Americans.

We know that 35 million Americans, have no health insurance and therefore have a systematic barrier to health care. But the other way of putting that point is that 85 percent of Americans have some coverage. Most of them think, some erroneously, that they are well covered. Therefore, even though there are some elements of the system that the majority finds chaotic to some extent and distasteful to some extent, they find themselves reluctant to accept a large change in the health care system because they don't experience the daily rationing that a smaller percentage of Americans experience. That is the political problem.

The ethical dimension of that problem is that when we consider the justice of a system, we have to struggle to get out of our own particular points of view. That is, justice requires that we be nonbiased when we describe a system as fair. It strikes me, therefore, that we should evaluate the present health care system as if you or

I could be anyone in the system, especially if you or I could be among those who don't have health insurance, among those who face the routine inequities of present rationing patterns. I think that is the kind of ethical appeal to begin with when we restructure the health care system politically.

Mr. CALLAHAN. I think a poor person in our system would find it strange to hear that there are some people opposing rationing out of concern for protecting the poor when in fact they are already the victims of it. To me the question is: Do we do rationing in a casual ad hoc back-of-the-hand, capricious way, or do we say that we really have a problem here? There are constraints. We have to live within them. We thus need to try to make our limits rational.

I am resistant to the notion that we should attend to get rid of all waste and bureaucracy before considering rationing. After 20 years of trying to do that, after 20 years of seeing health care costs continue to rise, I have come to think that the appeal to get rid of waste is just a subtle way to maintain the status quo. Cost containment has patently not worked.

We don't know how to get rid of bureaucracy. We can't get rid of bureaucracy because we have a very complex system. Short of having an all-payer, single system, we are going to have bureaucracy. Bureaucracy comes about in great part because we have overlapping systems in this country, a suspicion of government, and a demand for public accountability. We have to live with the fact that we are going to have some waste and a fair amount of bureaucracy; that is part of our social reality.

But we can be more rational and reasonable about it. I believe rationing will help as much with the bureaucracy as it will our other long-term needs.

Dr. PELLEGRINO. I agree with the two propositions, that we have de facto rationing and that the system is chaotic. The de facto rationing, however, is often used as a justification for more rationing. I think that de facto rationing is, itself, not sustainable. It is not morally justifiable. Instead we should be looking at doing away with de facto rationing because health care, as far as I'm concerned, is an obligation of a good society to its citizens. Therefore, de facto rationing, though it exists, is an argument that doesn't have any weight. It is one that simply says that we have an injustice, so we must correct it.

The second point I want to make is that we have not—in response to Dr. Callahan—we have not attended to getting rid of the excess fat, or whatever you want to call it. We haven't done it with a will, we haven't done it with any real attempt. I will just speak for the medical profession. As far as I am concerned, as a teacher of medicine, we do not practice effective medicine in the United States today. I think that would make a very significant difference.

So de facto rationing is not an argument that weighs, as far as I am concerned. De facto rationing ought to be eliminated. Second, we really have not put our minds to doing away with the other inefficiencies and waste I outlined. I did not deny, however, the possibility of rationing if we could satisfy those five ethical criteria. I think that's an orderly way of going about the discussion.

Senator KOHL. Gentlemen, there is another vote. I have to leave.

Senator Durenberger is on his way back. He would like to ask you a few questions.

I will be back presently. We will recess for a few minutes.

[Recess.]

## STATEMENT OF SENATOR DAVE DURENBERGER

Senator DURENBERGER [assuming chair].

Thank you very much.

The Chairman said I might go ahead and ask some questions. I regret not being here earlier. Dr. Callahan will be back here in a few minutes. I just saw him in the hallway. I wanted to use him for starters here because he's the one that thinks you can't change the system in any way and that you have to accept it the way it is and start rationing as quickly as you can. What I would like to do is challenge you at some point to respond to that.

But let me start with a slightly different part of that question. Earlier last week, in the Labor Committee, we had former Secretaries of HEW, Califano and Richardson, there. They both seemed to agree on one thing: that health care is the right of all Americans and that universal access to health care is our goal, but they didn't spend any time defining it. My experience in politics over the last 13 years is that no one spends time defining that particular issue.

Americans have a fetish, as we know in this debate on rationing, for medical wizardry. As we do in every other field, we are all caught up in finding a better way of doing things, a more appealing way to do things, a more attractive way to do things, a more economical way to do things, a more creative way to do things—whatever it is, we have encouraged innovation from the beginning of time.

We have made innovation into an art form and we take great pride in that. Deliberately, I think, our public policies from World War II have been built around more innovation, more creation, more invention, and all that sort of thing. So we tend to think about universal access, to some degree, without defining what it is we have access to.

One of the things that bothers me—of which I would be curious as to your response on—is before we begin to talk about rationing it, how in the world do we as a society begin the process of defining it? In many countries that I have visited, the so-called "developed" countries, they have a broader definition of health care than we seem to have in my experiences on this committee and the Labor and Human Resources Committee, where we are largely preoccupied with access to doctors and hospitals. Those countries have a much larger definition of health—one that deals with genetics, the environment, water, air—the whole big picture—with accident prevention as well as disease cures, and on and on and on.

One of the problems confronting those of us who are responsible for reforming this system to provide universal access, then, is defining what we mean. When we say that the poor don't have access to something, what do we mean? Over at NIH, they are finding cures for diseases that will benefit everybody, rich and poor. And in the medical alleys of Minnesota and Massachusetts, they are in-

venting all kinds of new things that will be accessible to the accident victim, rich or poor. We don't have income barriers at hospitals. You can find a few in this country, I would guess, but it is largely anecdotal.

Generally, when you are all mashed up, whether you wore a helmet on your cycle or not, they don't ask you whether or not you are insured, whether you were wearing a helmet or not. They take you to the hospital and fix you up. It's only later that they ask for your Blue Cross number. But if you don't have it, they still let you into the emergency room.

The reality is that in most places in America, the hospital is not where the barriers seem to get drawn. So the notion that the poor are becoming increasingly disenfranchised may be true of some parts of the health care system, and many of us would say the most important part. What is health? It is staying healthy. Now that you're pregnant, let me tell you some of the realities of life—those kinds of issues.

As ethicists and values experts in this field, I wonder if in some way or other each of you would try to be helpful to us by defining the word health care for us? Then, try to define, in an ethical sense, if you will, what the national responsibility or—put another way—the individual citizen's right is to this vast panoply of health services. Where in all of that are the rights? Where are they not characterized as rights, but just the benefits? And, where are the responsibilities? That's a hell of a question. [Laughter.]

Senator DURENBERGER. That's kind of where we ought to start. If we're getting down to ethics and we're getting to national values, and we're getting down to limiting the water in the lifeboat, isn't this where we should start?

Mr. CALLAHAN. Go ahead.

Dr. LA PUMA. Senator, thank you.

I would agree that under most circumstances for the Nation's poor, the barriers are not to high-tech care. It is relatively easy to get an intensive care unit stay paid for, or an angioplasty paid for, for a Medicare patient, for example. It is impossible to get a second pair of eyeglasses paid for if you are a Medicare patient. Medicare only covers one pair of eyeglasses annually. But it only takes a call to the hospital billing department to get angioplasty and intensive care unit stays paid for.

In my office, about 3 weeks ago, a 47-year-old Hispanic man was brought by his companion to see me because he was having shivers down his left side. He had been to see a neurologist in private practice about 3 years before because he was a bartender and he could not pick up a glass; it kept slipping. She knew—his companion knew—that this could be a nerve problem.

So she brought him to the neurologist. He said, "You're 43, you don't have any other symptoms, but it's not normal not to pick up a glass, you probably need a CAT scan or an MRI." He said, "I don't have $800 and I don't have any money." I don't know if he was a legal alien or not, but he needed care. This was an obvious medical need. So he went home and didn't work. He actually had——

Senator DURENBERGER. Pardon me for interrupting. What would she have done before there was an MRI? If she could have accessed

him to some other neurological exam, would she not have done that at a lower price?

Dr. LA PUMA. I don't think another neurological exam would have given the diagnosis. The differential diagnosis there is between brain cancer and multiple sclerosis. You may be able to do something about brain cancer. We are not sure what we can do about multiple sclerosis.

That's a good question because it shows that details matter in medical cases. It matters here. Sometimes a neuro exam is enough. Frankly, sometimes we rely on CAT scans and MRIs too much. But in this particular case, which is what medicine is all about, it mattered. He needed the scan, and he didn't get it, and got worse. He actually went into a clinical depression and that was 6 weeks as an inpatient in a psychiatric unit. So his clinical depression got treated before his neurologic disorder got treated. In the hospital, they said, "Oh, you have this nerve problem? We'll do the CAT scan in the hospital." He is now an inpatient for a new disease that he likely got because he didn't have access to the previous care.

Senator DURENBERGER. So, at the diagnosis level, there is a lot more rationing going on than there is at the repair level.

Dr. LA PUMA. By price.

Senator DURENBERGER. In Canada and places like that, where they don't even have MRIs, you are not going to get diagnosed and you're going to get just as sick, right?

Dr. LA PUMA. Fair enough.

Mr. CALLAHAN. Could I take a crack at that? I have the feeling that, when we discuss health care in this country, since World War II we have equated health care essentially with high technology advances. That is where the glory has come. That is where the money has gone. Of course, one of the major consequences of that is a neglected public health and a neglected primary care arena. One thing striking about the other countries in the developed world is that over 50 percent of their physicians are usually primary care physicians; it is significantly lower in this country.

Also, one of the unforseen consequences of the great success with high technology in extending life is that we have increased the number of sick and disabled people. To me, the great most important statistic in all of medicine is that death rates are going down across all age groups, whereas disability and chronic illness rates are going up.

We are getting more and more sick people as the price of the great success of medicine, but we don't have a health care system that is oriented toward dealing with those sick people, people that the system cannot cure but who are going to be part of the system one way or the other.

I suppose this is best symbolized in Medicare—wonderful care for high tech medicine but you have to go into Medicaid to get the long-term care, and that is much more poorly supported. I am very struck that a country like Great Britain has a much better balance between caring and curing. We are, as you said initially—we like this kind of stuff even though it is not giving us a good rate of return, it is leading us to skew our priorities, and it is going to get worse and worse.

Every new invention that is going to save a life is also going to create a further burden of illness in the long-run; eventually we all die, and we die of some particular disease. We may cure disease A, but if so, then we're going to get sick and die from disease B; but we never look ahead to disease B to see what that will mean.

Senator DURENBERGER. Are there any other comments?

Mr. DOUGHERTY. Yes, Senator.

First, I would like to thank you for your longstanding interest in access to health care. You may recall that you were one of the first speakers at Creighton University's Center for Health Policy and Ethics when we opened in 1988.

Senator DURENBERGER. I remember that one because it was right in the middle of the Iran Contra and we were doing the investigating.

Mr. DOUGHERTY. Let me begin by picking up something that Dr. La Puma mentioned, that medicine is about particular cases. The difficulty of health care policy is that it is not about particular cases. Health care policy has to make judgments on a larger level. It must consider what is the best for the most of us, understanding at the same time that this will not always mean the best for everybody in every particular case. I think that's where rationing becomes a difficult ethical problem.

To the question you raise about how to define a right to health care, I think the simplest answer is that it is almost a conceptually empty notion unless it is placed in a context. That context has to make reference to what is technically feasible for us. It would make no sense to say there is a right to a heart transplant in an age when that was impossible to do. It must refer to what is economically plausible for us. We can't reproduce every organ in the body for everybody. This would be far too expensive. And it has to make some reference in a substantive way to our values as a national community.

If you asked, for example, why Thomas Jefferson didn't claim a right to health care, it was because in the 18th century it made no sense to talk about a right to health care. It wasn't worth getting. The chances of getting hurt by a doctor were higher than being helped by a doctor in the 18th century.

But now the facts have changed. So what we have here essentially is a moving target that is partly ethical, partly political, partly technological, and partly economic. My own view is that the content of a right to health care cannot be defined in advance of a process that creates equity for all of us but that inevitably involves rationing. It will have to be defined within that kind of public process.

The key issue is to get everybody in the process so that we all have an equal stake in how a right to health care is defined. It is one thing to think of making rationing schemes for somebody else's health care when we know that our care is covered. But when we have to make rationing decisions about health care where it has an impact on us, our political views, over ethical concerns, will be a lot different and focused in a much fairer way.

I think that who is in the system and who is not is one of the most important questions because this sets the stage for how we define the right to health care and how we ration health care.

Dr. PELLEGRINO. I would like to take a crack at one of your questions, Senator.

I think I construed it to mean access to what? What are we talking about. I would like to offer this as a possible answer, or at least look at it. I would like to give you a list that I have gotten on at least a dozen occasions in talking with nonmedical people and nonproviders.

I asked ordinary people what they were most concerned about, what they really were worried about in their own lives about their health and so on. I would like to give you the list just to give you some idea. This is very rough. A sociologist would find this totally unacceptable, but I did a lot of listening. As I go through the list, I would ask you to reflect yourself what you are most concerned about in your own life as far as health goes.

Here is the list they gave me, and that I get repeatedly. Primary care—the availability when I become ill or somebody in my family becomes ill, 24 hours a day—the capacity of this health care system that we're paying for, for some representative of that system to take the anxiety and tell me what to do next. Emergency care is the second thing. If I need emergency care, wherever I'm run down, whether in the State of Wyoming, the State of Montana, wherever, that I will be able to get a high standard of quality in emergency care.

Third, was prevention, the immunization that we've been talking about, the prenatal care. They put this in this order. Fourth, was catastrophic illness, unfortunately we reversed that. I think that was a very bad move on the part of the public. And the last one was nursing home care.

Notice that you do not have in there high tech care. I will mention two things about high tech care, and then I will stop. First, I think it is overrated as part of the increased costs of care. It is there, yes, but it is not that big a figure. And the second point about is clearly that it there are certain kinds of high tech care that save us more extended expenditures because the large expenditure is in personnel required in chronic and nursing care.

Senator DURENBERGER. Mr. Chairman, may I continue?

Senator KOHL [resuming chair]. Sure.

Senator DURENBERGER. Since you weren't here, I didn't begin by taking the opportunity to thank you for calling this hearing and calling these particular witnesses. I regret not having heard Uwe on this subject. I haven't had this pleasure before. For me, this is a wonderful opportunity. I hope it is only the beginning of exploring this issue.

Dan, while you were out, I said I wanted to lift the thesis out of your printed remarks and explore it a little bit in the light of the conversation we have just had. At the bottom of page 2, I quote, "It has often been said that, if we could simply wring the waste, inefficiency, and excess bureaucratic costs out of the system, we would not even have to think about rationing. I have been hearing that siren song for at least a decade. During that time, and despite a variety of cost containment programs, nothing has worked to any serious degree."

Then you go on at the top of page 3 to say, "We do not know how, in practice, to eliminate waste. In fact, we make things all the

harder by posing the elimination of waste as an alternative to rationing. I believe, on the contrary, that we will eliminate waste only by rationing."

I am one of the people who has been singing that siren song for a long time. I believe it and you would never change my mind in the 10 minutes or whatever that we have available. I could sit here and for 10 minutes tell you why I believe you are wrong. But I am assuming that what you are saying is that the will to do it probably isn't there.

Even if you could identify all these elements—whatever it is in the intermediary system and the inefficiencies of not distinguishing between insurance and payments—all this stuff that we know so much about. But you're probably talking about the will.

Mr. CALLAHAN. I suppose I have gotten uncomfortable with that because I have heard it so much, and yet nothing seems to change. Every year there is a new scheme. Technology assessment seems to have been the favorite for the last couple of years. That is going to be the new magic bullet. If people can't give up smoking for 10 years, and then they say that the reason is that they went to the wrong course or took the wrong class, you can say that that is not the issue, that somehow it is a lack of will. We don't seem to realize how resistant our system is to these schemes.

There is something in our health care system that will defeat these cost containment schemes. You'd better try to understand where the deep disease is here. It is not the lack of gimmicks and schemes. Everybody has them.

Senator DURENBERGER. Let me tell you about DRGs. If you listen to one of Uwe's public presentations, he will tell you that in the 10 years from the early 1980's to the early 1990's, the Part A increases in Medicare have been only a total of 34 percent. That is DRGs. That is getting efficiency into the system. Nobody calls their institutions hospitals anymore. They are medical centers. They're saving a lot of money.

Mr. CALLAHAN. Every analyst would also point out that a lot of those moneys have been transferred to out-patient care and to long-term care.

Senator DURENBERGER. Of course, but at least it is a sign that when you know something about something and you put some kind of an incentive in that system, you can change a part of the system. What we didn't do was do anything about Part B.

Mr. CALLAHAN. You have to change the entire system. You can't just do one thing unless you are prepared for the results of that. We don't quite know how to manage the entire system, so you put a finger in the dike here with the understanding that the pressures are going to put new holes somewhere else.

Senator DURENBERGER. But my ethics will not permit me to deny access to health care to anybody—the water bottle in the lifeboat—as long as I know there is one person underneath that boat that is sucking that water away and I can see the water level going down. Why should I say to the people in the boat that they can't have any. Why don't I deal with that guy?

So, as long as I see physicians increasing their specialties, seeing more people than they need to see, prescribing more procedures than they need to prescribe, charging somebody three or four times

as much in Los Angeles as they charge in Milwaukee or Minneapolis, watching the Mayo Clinic do things for a third of the price that other people do, I'm going to go find that guy underneath that boat that is sucking down the water bottle. That's what my ethics say to me.

We're doing this ethically, or values-wise. That's why I really struggle with buying into your notion that access to certain procedures to the poor is so important that we should deny life to a certain part of our society.

Mr. CALLAHAN. Over this same decade where we have failed to adequately manage our course well, we know that certain parts of the system have in fact deteriorated. So the de facto rationing has gotten worse. I would want to say that maybe this may not be a total accident. By your holding out for the ideal world where we're going to have better management—which somehow never comes—and in the meantime our system keeps getting worse and worse.

Senator DURENBERGER. Is it worse, or is it more costly, using John's example?

It is clearly more costly. But when he finally breaks down, he gets his care. That's not always the case, but it is usually the case in America. You can use the womb as an ICU very easily by just spending a few bucks ahead of time. We don't do that, but we do spend it in the neonatal intensive care unit. It's stupid, really, but we do it. I don't want to beat on you on this because I really want to get to my other question.

Let's leave aside the waste and inefficiency argument. We have a difference on that which I would love to explore sometime, but how about another approach which is the slow down of certain invention. Does anybody have any ideas how we might slow down certain invention in America? What we were talking about earlier, where the costs go up and life goes on—are we really saving?

Mr. CALLAHAN. I think we need to make the distinction between slowing down progress in general and slowing particular applications. I'm very much in favor of investing a lot of money in basic biomedical research. The way you slow things down is to control what gets introduced into the system as a result of that research. For instance, if you want to slow things down in a hurry, you say that Medicare will accept no new technologies into the system until they have been proved in advance to be efficacious and have a good cost benefit ratio. You, Mr. Manufacturer, show us that before we introduce your product. What we do now is to let it into the system and then try to do catch-up.

Switch the standards. Make it an entrance exam standard and you will slow things up in a big hurry.

Senator DURENBERGER. Any other thoughts on that?

Dr. PELLEGRINO. You said slow down invention. That is a little different.

Mr. CALLAHAN. This will slow down invention because they will have to be much more careful about the invention and much less——

Dr. PELLEGRINO. That is a little different. I think you are talking about R&D and they are two different facets.

I want to warn again against technology bashing. That is the popular game today. But if we were able to do something about

Alzheimer's Disease, or Parkinson's Disease, for example, we would certainly have a tremendous economic impact. We mustn't underrate the economic impact of a scientific breakthrough.

I agree with you that new technology ought not to be introduced until proven effective. That was one of my criteria for ethical rationing. You had to have effective medicine. We don't have that. But I think we have to be very, very careful of limiting research at the fringes or diseases that are now incurable but perhaps could be curable. So it must be taken with great care. Technology is not the great problem we think it is. When you look at the costs, they are not all in technology.

Mr. DOUGHERTY. I agree that the heart of the matter is the reimbursement system.

Senator DURENBERGER. That sends signals back to the inventors, too, doesn't it?

Mr. DOUGHERTY. It goes back from the manufacturer to the point of research and development. But it seems to me that the question of reimbursement is a global one. What do we want to pay as a society? How do we want to pay it? Under what circumstance do we want to pay it?

I think it has been demonstrated pretty well that a one-payer system, for example, could squeeze out such administrative costs and profit from the present system, the way Canadians do, to pick up the anticipated costs of all of those who don't have any health insurance right now.

Senator DURENBERGER. You would also slow down invention and all that.

Mr. DOUGHERTY. I think with a single lever, we might very well be able to slow it down.

Senator DURENBERGER. They don't have MRIs in very many places in Canada and they aren't inventing any of them up there, right? So if you want to go to Canada, that's a great way to slow down invention, right?

Dr. LA PUMA. That would be one way to slow down invention. You could move to Canada. But I don't think that is really the point. The point is that inventions, like mammograms and PAP smears and treadmill testing, I think can probably prove to be cost effective and can certainly improve both quality and longevity of life. If anything, our appetite for invention, as a society, I think will only increase, everything from the 280-gram baby that was reported to survive in the New England Journal a month ago to the gene project and its tremendous implications for preventing disease before birth.

So I think the question might be reshaped to read something like, How do we use medical invention so that effective care is delivered that is also beneficial? Effective would be the technical part of it and beneficial would be the personal and social values oriented part of it.

Senator DURENBERGER. Thank you, Mr. Chairman.

Senator KOHL. Thank you very much, Senator Durenberger.

I just have a single question.

To go back to what we were talking about earlier concerning that we do have cost containment that equals rationing. The

system is not working well and needs to be redone. I just want to investigate with you all a little bit about how that might be done.

You, Dr. Pellegrino, made what I regarded as the opening comment to keep the doctors out of that process because they are self-involved. I would postulate that one of the reasons why the system is the way it is today is because it has been designed by self-involved people, organizations, and entities like the insurance industry and so on and so on.

First of all, is there any disagreement with that theory? Then I would like each of you to comment on who are the people, generally, who should redesign the system—if we are going to redesign the system? Is it the politicians, the educators? And who should not be involved in that process?

Dr. Dougherty.

Mr. DOUGHERTY. I would also stress the importance of removing doctors from the rationing loop. This is not because doctors are self-interested but because their professional role is one of patient advocates. This is an issue not only for doctors, but also for the public—for patients, and for potential patients.

Do you want doctors making decisions to ration health care? I think not. It undermines his or her role as patient advocate. I would prefer to think that my doctor is restricted by a hospital, a State, or a Federal policy that says that I cannot get X in this condition because that is the rationing policy. I would prefer to think that my doctor is fighting that policy on my behalf, doing the best he or she can to get me in spite of the rule. I think that is the role we want doctors to play: to try to get the best they can for their individual patients.

This means to me that doctors operating as clinicians ought to be out of the rationing process. Doctors, of course, with their experience of what works, clinically and what doesn't work ought to be partners in helping to decide what rationing policies should be adopted.

But I think this is essentially a political issue, a public issue. There is a role for experts in health care policy but a limited one. The issue of rationing is ultimately about our public values. Average citizens should have a lot to say about it. The debate needs to be framed in a way that allows for public discourse on values.

Dr. PELLEGRINO. I would agree with that general outline. Just quickly, what I think the physicians role in this might be—I fully agree that he ought not to be the rationer making the one-to-one decision because at that point he is really bound in a covenant with the patient to act in that patient's interest. He ought not to have that obfuscated by other considerations. He should not be an instrument of social public policy but an advocate for his patient.

Physicians, however, have a very, very important role, which I don't think we're playing well either. That is, to provide expert testimony on which a rational decision can be made by others on the policy level. That is, to talk about effectiveness. We don't have the data that we need on that. It's more a matter of effectiveness, Dan, than the question of technology curtailment. Is this going to change the natural history of the disease in some demonstrable way? What is the evidence? I think that is a level at which we can function. But that's not when we are tied into our patient.

The third level is that we are citizens and we ought to participate as citizens in developing what is, in my view, the characteristic of a good society that would be concerned for the most vulnerable members among it. I think it was stated a long time ago that you can judge a society by the way it responds to the sick, the poor, and those at fringes and at the margin. I think, as citizens, we physicians ought to be participating. But we have no special mandate as physicians on the value questions.

So to answer your question of who should make the decisions, it has to be in the public policy realm, preserving for us the right, at some point to say that what you're asking us to do is not morally acceptable and we might have to disobey. You want that, too, because that is part of the covenant with the patient. For example, if we were in a system that says, as the Soviet system said, "Mr. Psychiatrist, this person is obviously psychotic, he disagrees with the political set-up here," I would have to say no and maybe go to jail.

Mr. CALLAHAN. It seems to me that the only fair way to make decisions is to involve everyone in those decisions who is going to be affected by the decisions. I take that to be a fairly fundamental democratic principle. So it seems to me that if we're putting together groups or commissions, anyone who is going to establish policy, it should have a representation of those groups likely to be most affected, which is certainly going to be the industrial side, the citizens, the potential patient side, and the physicians and health care administrators. All of those have to have a role.

I was struck by the process used in Oregon in setting up their priority list. I think they did a pretty good job there of getting a mixture of people on that commission. They came up with a list of priorities that seems to have been accepted as a pretty good job. That was a mixed lay, professional commission drawing upon economic and technical expertise, as needed. They did a pretty good job.

Dr. LA PUMA. I would like to agree that a mixture of public and professionals should be involved. I think that is sensible. As to the particular role of physicians in that process,[1] I think that physicians owe their patients at least three things in this debate. The first is compassion, the second is loyalty, and the third is competency. Increasingly, under competency—I think not only of medical knowledge of the natural history of disease and how patients cope with it, but also two new duties.

Haavi Morreim talks about these duties in an Archives of Internal Medicine article that I would be glad to submit if there is interest.[2] They are economic advising and economic advocacy, spoken of a moment ago as the need to go to the wall for patients to protest unfair economic constraints on their care.

I think doctors have a duty to do that because their patient is the one in front of them, not the one in the waiting room, and not the one who might be in the waiting room, but the one in the office who needs help there. So I think physicians should play a role in the public policy debate that can and should, in my view, produce

[1] See appendix, p. 119.
[2] See appendix, p. 133.

fundamental change in our system so that it becomes more fair, but always with individual patients in mind.

Senator KOHL. Any other comments, gentlemen?

[No response.]

Senator KOHL. I want to thank you very much for coming. You have made a real contribution to the discussion.

Thank you, and the hearing is closed.

[Whereupon, at 12:07 p.m., the committee adjourned, to reconvene at the call of the Chair.]

# APPENDIX I

## QUESTIONS FOR SPECIAL COMMITTEE ON AGING HEARING ON RATIONING HEALTH CARE SUBMITTED BY SENATOR GRASSLEY

### FOR PROFESSOR REINHARDT

In your statement, you stressed that American health care providers are highly compensated compared to health care providers in other countries, and suggested that it would not necessarily seriously harm the health care available to people were American providers to be compensated less.

It is often noted that the Federal Government subsidizes employer-provided health insurance to the tune of some $40 billion a year, perhaps more. You allude to this question of the role of tax subsidies in the concluding paragraph of your written statement where you say that those who want more than basic health care could buy it with their own after-tax income. As an economist, approaching this question from your perspective, how would you think about reallocation of this Federal subsidy?

### RESPONSE TO SENATOR GRASSLEY'S FIRST QUESTION

Most people who directly or indirectly support the process of health care in the United States are well compensated relative to their peers in other countries. That includes health economists.

The question, of course, is whether being "relatively well paid" means one is necessarily "overpaid." Indeed, the question is, what does "being overpaid" actually mean in this context? If we take the pay executives in the financial or industrial sectors as a standard, then is there any American physician who is "overpaid" relative to them, or even appropriately paid?

Economists do not usually engage in these musings on "comparable worth." They define being "overpaid" as "earning a 'rent' or 'profit' ", where by "rent" or "profit" is meant the amount of money one earns over and above the minimum one would have to be paid to stay in one's job. On that definition, for example, most unionized auto workers are "overpaid", because most of them earn wages in excess of the amount they would have to be paid to stay in the job, were they free to contract with the company on their own. As I always tell my students at Princeton, probably the largest amount of "profits" at General Motors is taken home not by the capitalist shareholders, but by the firm's unionized workers.

Not everyone in health care is earning "rents" of this sort. The fact that there is a nursing shortage, or a shortage of many highly skilled medical technologies, suggests that there are not many "rents" that could be squeezed out of these professions before one

drives this type of labor out of the health care market. Depressing their wages would ultimately harm American patients.

On the other hand, most physicians (and many health economists) probably do earn a "rent" in the sense that they would stay in the health-care sector (or enter it anew) even if their earnings from health care were reduced from current levels. As is well known, even at the currently high levels of tuition and debt borne by medical students, every year many more well qualified American youngsters apply to medical school than can be accepted by those schools. This implies that an overall average decline in physician income would be unlikely to trigger in this nation a physician shortage. There are probably other suppliers of labor or goods and services to health care that are in a similar position.

In fact, in every country that controls physicians fees and keeps physician incomes much lower relative to average employee compensation than we do in the United States, there is still a physician surplus. It is so in Canada, and it is certainly so in Europe which suffers from a veritable physician glut, in spite of tight controls on physician fees.

Now, one can understand why physicians do enjoy hearing this kind of talk, especially as they observe corporate executives whose high incomes do not seem very well correlated with either their education or their performance on the job.

## RESPONSE TO SENATOR GRASSLEY'S SECOND QUESTION

The fact that the health-insurance premiums paid by business firms for their employees (including corporate executives) are not treated as taxable income to the employee helps the latter evade about $40 billion in Federal income taxes and another $26 billion in Social Security taxes. Some people view this tax exclusion as a kind and gentle gesture. Most economists view it not only as inefficient, but ethically indefensible.

This tax exclusion allows a corporate executive, who faces a combined marginal tax of, say, 40 percent for income-related taxes of all sorts, to purchase $100 dollars worth of dental care for only $60 after-tax dollars. In contrast, an uninsured gas-station attendant pays $100 of after-tax dollars for $100 worth of dental work, and similarly for all other types of medical care. It has been shown that, in absolute dollars, our tax system now bestows many more health-related tax benefits on the rich than it does on the poor. Only a very small percentage (about 6 percent) of this tax preference of some $67 billion goes to households with incomes below $20,000; 26 percent goes to households with incomes above $75,000.[1]

Permit me, Senator Grassley, to introduce into the record some data on medical-related tax benefits regularly published by the Wall Street Journal (attached). You will notice that taxpayers with an annual income of $1 million or more deducted an average of $66,478 for "medical expenses" in 1989. Given that most of these folks probably have employer-provided health insurance (even in retirement), one must wonder just what kind of "medical care" these high expenses might represent? Perhaps every Jacuzzi and

[1] Estimates prepared for the Heritage Foundations by Lewin/ICF.

work-out room they own, and many more wondrous things. I believe these figures warrant some scrutiny.

It is astounding that this highly regressive tax preference is so widely supported by many distinguished American legislators. It is, if I may say so, a truly troublesome comment on this nation's social ethic. Alone in the industrialized world, we have not so far seen fit to grant every low-income, harried American working mother of American children the benefit of adequate health insurance, and yet we have no problem bestowing such enormous tax benefits upon millionaires. How is one to explain this policy to still idealistic Princeton undergraduates?

Like most economists, I recommend that ultimately all fringe benefits be fully included in taxable income and that the huge additional tax revenues yielded in this way be recycled toward health-care for the poor. A good start could be made by capping the amount of fringe benefits that may be excluded from income, and by placing an upper limit (perhaps, $50,000) on households that may exclude any fringe benefits from taxable. Although this may seem like raising taxes—because it is—it would also be putting our ethics on a more defensible keel.

THE WALL STREET JOURNAL.



WEDNESDAY, JULY 24, 1991

**HERE ARE THE AVERAGES for itemized deductions on 1989 personal returns.**

They were figured unofficially by Research Institute of America from preliminary IRS data on filers claiming deductions and are no guarantee of what the IRS may allow. Few law changes affected the averages: The deductible share of personal interest fell to 20% from 40% in 1988 (it's zero for 1991); standard deductions for nonitemizers were raised a bit. The number of returns with itemized deductions rose slightly after sharp drops in 1987 and 1988, yet total 1989 itemized deductions climbed 7.5%.

The 1989 averages by adjusted-gross-income group for medical, tax, charitable-gift, and interest deductions follow:

| Income (-000) | Med. | Tax | Gift | Int. |
|---|---|---|---|---|
| $ 25-30 | *3,128* | 1,975 | *1,109* | 4,314 |
| $ 30-40 | *2,849* | 2,342 | *1,184* | 4,887 |
| $ 40-50 | *3,546* | 2,947 | *1,318* | 5,400 |
| $ 50-75 | *4,713* | 3,943 | *1,607* | 6,271 |
| $ 75-100 | *6,448* | 5,713 | *2,108* | 8,531 |
| $ 100-200 | *10,090* | 9,020 | *3,532* | 12,150 |
| $ 200-500 | *24,134* | 19,645 | *7,213* | 19,853 |
| $ 500-1000 | *40,556* | 43,499 | *18,374* | 29,788 |
| $ 1,000+ | *66,478* | 148,529 | *83,929* | 68,303 |

FOR DANIEL CALLAHAN

After listening to your statement, your concept of rationing seems more benign than I had anticipated. In fact, I am not sure I see the difference between your perspective on how we allocate our health care resources and Professor Reinhardt's—you both seem to be saying that some reallocation of the resources we are willing to put into health care could result in a better distribution of it across our population. Put this generally, it doesn't seem like a particularly fearsome prospect.

Do you see yourself in substantial agreement with Professor Reinhardt at this general level?

Answer: In response to Senator Grassley's inquiry: Yes, I am in essential agreement with Professor Uwe Reinhardt. There should be nothing "fearsome" about the rationing and reallocation we both espouse. It should in fact improve health care delivery in this country by creating a more rational system. We now ration casually, randomly, chaotically, and unjustly, refusing all the while to even admit we are "rationing." With Uwe Reinhardt, I believe we can have a better and fairer system, and that some thoughtful rationing is a necessary step in that direction.

FOR PROFESSOR DOUGHERTY

Perhaps the same question can be put to Professor Dougherty using an idea presented in his testimony, the idea of "easy rescue"—the ability to help another in a major way without great sacrifice to oneself.

Can we have an "easy rescue" in providing health care to all? Call on the many to make minimal sacrifices in order that the smaller number without health insurance may gain protection?

Answer: The duty of easy rescue is the obligation to assist others when assistance can make a significant positive difference in the lives of those who are in need without making a significant negative difference in the lives of those who provide the assistance. Making large sacrifices for those in need is praiseworthy but is not an ethical obligation. However, when people in need can be helped without large sacrifices, those who can help are ethically obliged to help.

Does the duty of easy rescue oblige us as citizens to create a system of health care that covers all Americans? Yes. First, the positive difference such a systemic rescue can make to those who are presently uncovered is significant. The uninsured have high rates of premature death and preventable disease. Assured financial access to care can save lives and enhance the quality of lives. Second, coverage for the uninsured can be accomplished without significant negative consequences. The experiences of our major trading partners—Canada, Japan, Germany, United Kingdom, Italy, France, South Korea—demonstrate that there are many ways to structure a health care system so that it covers all residents, maintains high quality, and controls costs. Citizens in these comparable nations suffer no significant negative effects from universal coverage. On the contrary, universal coverage enhances their national solidarity and contributes to their international competitiveness.

The relevance of this issue to the rationing question is profound. Until the United States creates a system in which all are covered for basic and comprehensive care, health care rationing—implicitly or explicitly—unfairly affects the least well-off and is therefore ethically unacceptable.

# APPENDIX II

## MATERIAL RELATED TO HEARING

ITEM 1

Princeton University **Woodrow Wilson School**
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### SPENDING ON HEALTH CARE IN THE UNITED STATES:

### The Long-Run Perspective

Figure 1 overleaf illustrates the two resources flows that surround the process of health care: the flow of *real* resources (mainly human labort) to patients and the flow of *financial* resources back to those who have devoted their *real* resourcesto the process of health care, either directly (e.g., doctors and nurses) or indirectly (e.g., insurers, administrators, researchers, etc). As is noted in the sketch, the percentage of the GNP "going to health care" measures the financial reward paid these direct and indirect providers of health-care. By itself, that statistic tells one relatively little about the flow of *real* resources going to patients.

During the past two decades or so, share of the United States Gross National Produce (GNP) "going to health care" has grown substantially. In fact, the average annual compound growth rate of total health spending in the United States has been close to 3 percentage points higher than the comparable growth rate in the non-health components of the GNP. During the past five years, that differential has actually widened. At this time, it exceeds 3 percentage points in part, of course, because GNP is not growing very rapidly.

Figures 2 and 3 project the past experience into the future. Because these projections are based on the average long-run experience during the past two decades, they sit a bit lower than do the projections that have been offered more recently. If the projection were based strictly on the period since 1985, then it would appear that as much as 17% of the GNP might be spent on health care in the year 2000, versus about 9% in 1980 and about 12.2 - 12.5% in 1991.

Finally, Figure 4 provides a cross-national perspective on health spending. It is seen that the United States allocates by far the largest share of its GNP to health care among the countries listed in Figure 4 and, indeed, in the world. It can be expected that, by the year 2000, the spending gap between the United States and the rest of the world will have widened, because most other industrialized nations now try to tie the growth of their health spending to the growth in their GNP. The United States has never attempted to do so. In the short run--the next decade or so--the United States probably could not do so even if it tried.

# FIGURE 1

# THE BASIC STRUCTURE OF A HEALTH-CARE SECTOR

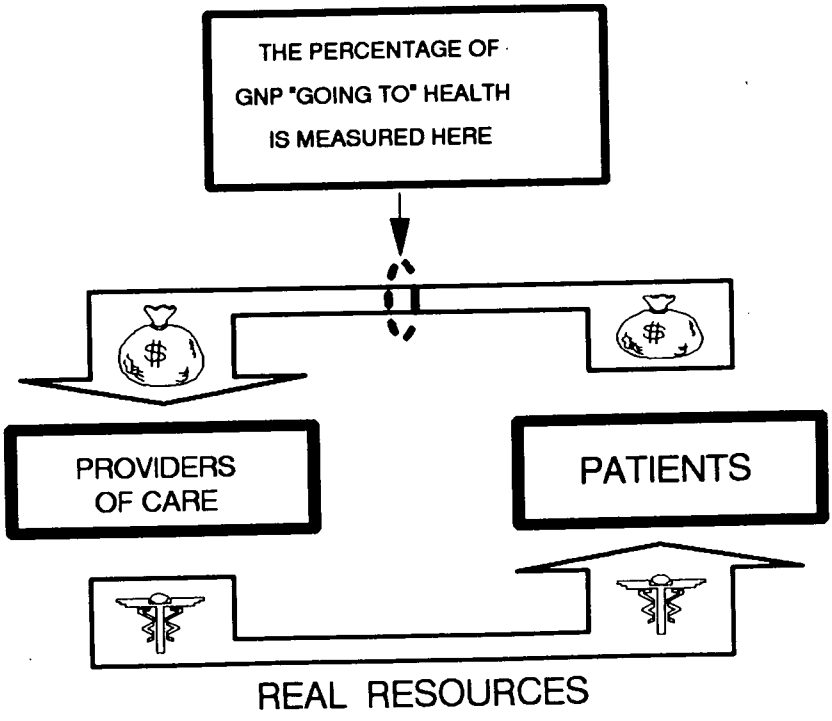


FIGURE 2

## HEALTH CARE AS PERCENT OF THE GNP

### UNDER DIFFERENT ASSUMPTIONS

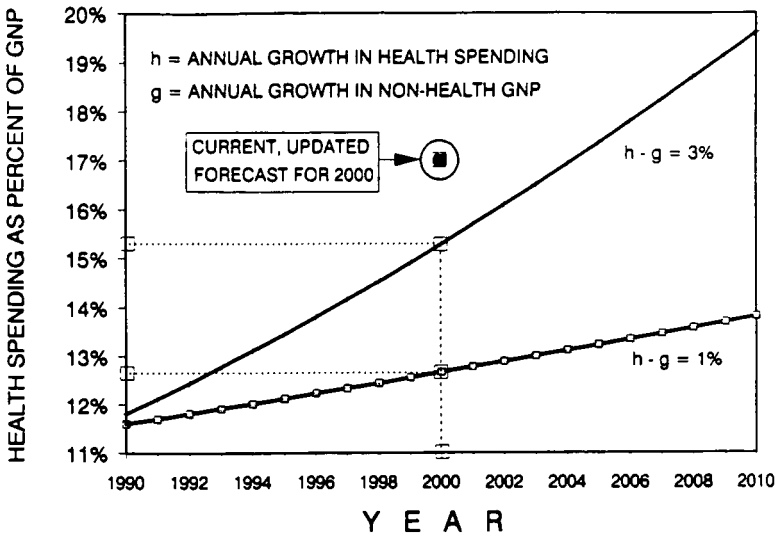



FIGURE 3

## HEALTH CARE AS A PERCENTAGE OF THE GNP

### UNDER DIFFERENT ASSUMPTIONS

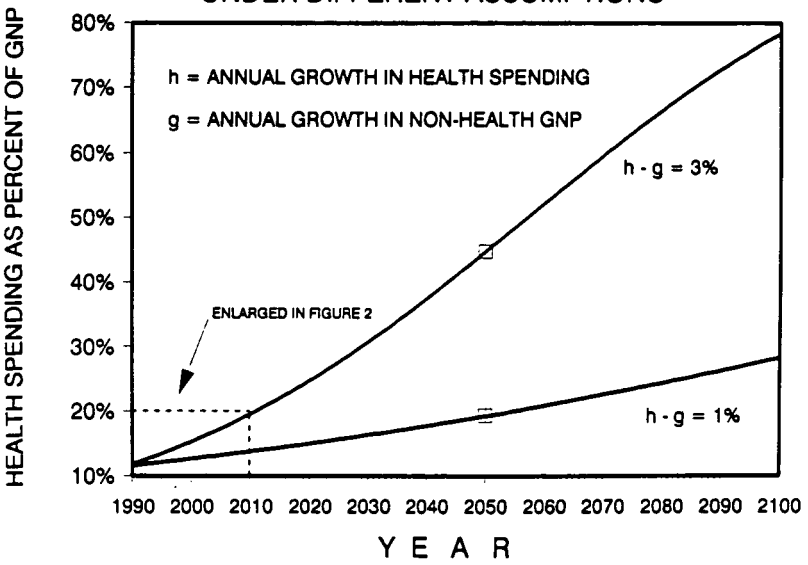
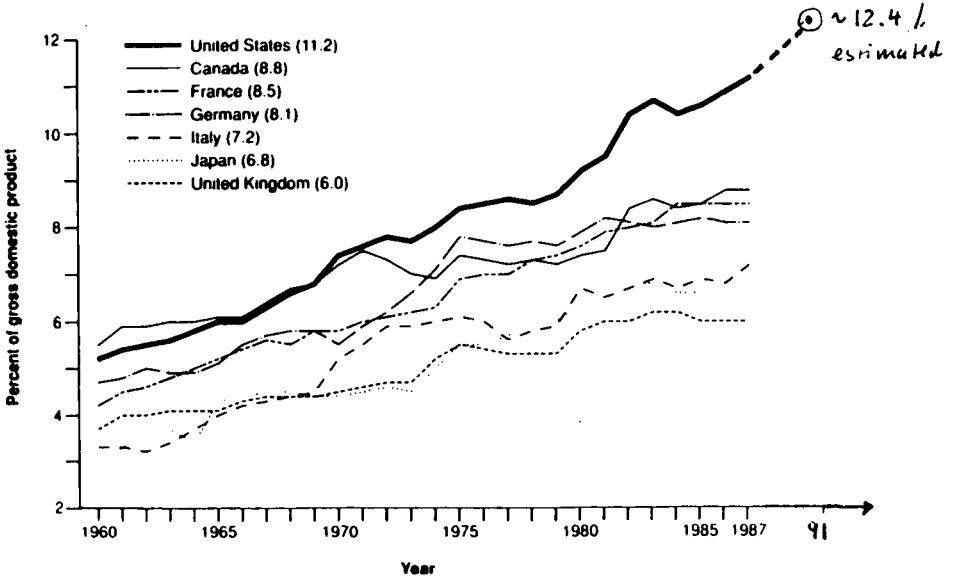


**Figure 1**

**Total health expenditures as a percent of gross domestic product: Selected countries, 1960-87**




NOTE Countries are listed in descending order based on the share of gross domestic product devoted to health for 1987 (in parentheses)

SOURCE Organization for Economic Cooperation and Development Health care expenditure and other data An international compendium *Health Care Financing Review* 1989 Annual Supplement HCFA Pub No 03291 Office of Research and Demonstrations Health Care Financing Administration Washington U S Government Printing Office Dec 1989

Source: George J. Schieber, "Health Expenditures in Major Industrialized Nations," Health Care Financing Review, Summer 1990; Figure 1.

Submitted by Uwe Reinhardt

S. Hrg. 101-900

# RISING HEALTH CARE COSTS: ARE THEY REALLY MAKING IT HARDER FOR U.S. FIRMS TO COMPETE?

## HEARING

BEFORE THE

## JOINT ECONOMIC COMMITTEE
## CONGRESS OF THE UNITED STATES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

MAY 23, 1990

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54-004 - 92 - 5

Chrysler Corp.; Paul H. O'Neill, chairman and chief executive officer of ALCOA.

To assure adequate time for questions and discussion, I would appreciate it if you would limit your opening comments to about 10 minutes. Your prepared statements, of course, will be entered into the record in full.

Mr. Reinhardt, you may begin, sir.

### STATEMENT OF UWE E. REINHARDT, JAMES MADISON PROFESSOR OF POLITICAL ECONOMY, PRINCETON UNIVERSITY

Mr. REINHARDT. Thank you, Mr. Chairman. It is a privilege and a pleasure to appear before this committee to explore an issue that has been discussed in the press and in health policy and has confused many people, including, I am sure, myself.

The first question I would like to address is this: Does spending by American business on health care for employees impair these firms' competitiveness in their product markets? In order to get at that problem, we can decompose that question into four subquestions, the first one being: Is the American health care system wasteful in the sense that some of the productive resources it uses would create greater well-being if we shifted them to other sectors of the economy?

I raise that question because business executives who complain about health care costs usually allude to the waste in the American health care system. Now, the answer to that question does appear to be: "Yes, there is waste." There is mounting evidence of unnecessary surgery in this country. For example, I think no other country in the OECD wastes as much on paper to process health care as we do. I think if we had a more efficient insurance system, we could probably save 8 to 10 percent of health expenditures, just on the paperwork.

There is, we can all agree, no question the answer to this first question is: "Yes, there is waste in American health care." But then comes question No. 2: Is that then the problem American business executives are complaining about? In other words, if we eliminated that waste, would their problem then be solved? The answer to that question seems to me to be no.

Put the case that we could eliminate all waste in American health care. With enormous efforts, suppose that we could get health spending down to only 9.5 percent of the GNP from the 11.1 percent now. Do we then believe that Chrysler, for example, would produce for us a Miata? Do we believe that Kodak would again produce cameras of the quality of a Minolta? Do we believe that the RCA Corp. would design and produce a video camera actually made in the U.S.A. rather than merely importing them from Japan and just sticking their RCA label on Japanese-made VCR's?

My answer would be: "No." The problem that U.S. business cannot compete with foreign products has to do with many other factors, among them product design and, among them, production costs in general; including the opulent life style of American managers.

The third question I would like to raise is this: Supposing waste were really not the chief culprit, but that the chief culprit is our



habit of financing health care through the payroll expense line of business rather than through taxes. Does the fact that health care goes through payroll expense make American business noncompetitive?

Intuitively, one would have the feeling, "Yes, that must be so." But as one thinks about it more, it becomes hard to believe how this could be so. The price of labor in the labor market is total compensation including fringe benefits. That is the price that equilibrates the demand for and supply of labor.

Now, as long as fringe benefits are voluntarily offered by business, they are really part of the bargain between labor and management. Management and labor can decide to put some of that total compensation into fringes, but that means that there will be then less to put into cash wages. In a well-functioning labor market fringe benefits and cash wages are substitutes for one another.

Suppose again we got health care costs down from 11.1 percent of the GNP to 9.5 percent. I would project that most of those savings would just go in added cash wages for workers or for executives, or for other expenses. It's hard to believe that product prices would fall, for example, that Chrysler would cut the price of its cars if its health expenditures would go down.

So the answer to the third question, in my view is: "No, there is no reason why health care costs per se should price American business out of the international markets—unless American business executives choose to price themselves out of those markets come hell or high water.

My fourth and final question is this: If it really is true that their outlays on health care does not make American business noncompetitive, if I could make that argument stick, doesn't that then really make the case for mandatory employer-paid health insurance? Here I would argue "No." There is a crucial difference between offering health insurance voluntarily—where it's a voluntary deal between labor and management—and the Government to mandate health insurance, in which case we are really talking about a tax, and in particular we are talking about a head tax that is independent of the income of the worker.

If you mandate health insurance upon small business firms who have low-income employees, these small business firms might try to pass these costs forward through higher prices. But if they could not do that, they would then shift the costs backward to their employees by paying lower cash wages, in which case you actually have put a head tax on the very people whom you wanted to protect.

So I do not believe it is mutually inconsistent to argue, one, that health spending per se does not make business noncompetitive in the product market, and two, there are sound arguments against mandating business of all sizes to offer health insurance to their employees. I have actually in the literature held both positions, and I am willing to defend both propositions at once.

Now, having said all this, one must then ask: Does the Congress owe business any form of relief with health care costs? I would argue "No." I would argue that most of the financial problems besetting American health care today are really the making of the

rigid ideology of American business executives and of the inconsistent decisions they have based on that ideology.

It was business who, in World War II, decided to evade Government strictures on wages by offering fringe benefits. It was business who has, to this day, insisted on shielding these fringe benefits, which is a form of income, from taxation, biasing the worker's choice to that health insurance. It is business that, to this day, has literally surrendered the key to its treasury to the providers of health care. And it is business that to this day insists that the "market" can best regulate the American health sector.

For instance, in New York, I will bet you ALCOA still pays surgeons $8,000 to $10,000 for a coronary bypass. The Physician Payment Review Commission, Harvard, and the AMA jointly, in the resource-based relative values scale, has concluded that something between $3,000 on average would be more appropriate. And perhaps somewhat more in high-cost New York. But not $8,000 to $10,000. Any yet, I would predict that when Medicare introduces this fee schedule, ALCOA will continue to pay the $8,000 and $10,000 it probably now pays in New York. That is what puzzles me. Why do American business firms pay these higher fees? Why will they be doing that, as I predict, and yet come before the Congress complaining that they cannot compete because health care costs are too high?

If American business really wants relief in health care costs, my preferred strategy would be to let business for some time wrestle with the problem it created. After all, if the Government jumped in too soon to help business, Government would then bear all the blame for anything that might go wrong, as is usually the case.

The proper strategy is to make business, first of all, confront in a very painful way, for some 5 years or so, the agony that it unleashed in health care. Maybe then the ideological basis of business will cease to dominate their thinking on health care and they will be able and willing to come forth with something more practical.

Let me close with the following hypothetical: Suppose President Bush invited a random sample of 100 business executives from the Business Roundtable to spend a week in the Willard Hotel. Let's be generous and grant each of these executives two support staff. Suppose next that President Bush asked this group of executives, "I would like you to emerge at the end of this week with a viable strategy for health care for America, a strategy that you would either support, or at least not sabotage."

I would predict that these executives would emerge, after a week, without any concrete plan, without any coherent strategy. Instead, they would emerge with the following three platitudes: First, everyone in America should have access to health care, regardless of ability to pay. Second, health care costs in America are too high. Third, we do not like Government regulation in health care or anywhere else.

That's what these executives would be likely to come out with. And therein lies the main problem of American health care. It is the intellectual bankruptcy of the business community—and I say that with all due respect to the colleagues on my left—it is the intellectual bankruptcy of the American business community in regard to health policy that has plagued this country's health



policy for some 20 years and, I predict, that will plague it for at least another half decade.

But in the latter part of the 1990's, I do believe forces will ultimately push straight thinking on that side of the health care sector as well. By that time America's business leaders may find themselves so frustrated by their inability to control their health spending that they will ditch their rigid ideology in favor of a pragmatic compromise. Let us all hope that day will come sooner rather than later.

Thank you very much.

[The prepared statement of Mr. Reinhardt, together with the attachments referred to for the record, follows:]

## SPECIAL ARTICLE

# HOW DOES CANADA DO IT?

## A Comparison of Expenditures for Physicians' Services in the United States and Canada

VICTOR R. FUCHS, PH.D., AND JAMES S. HAHN, A.B.

**Abstract** As a percentage of the gross national product, expenditures for health care in the United States are considerably larger than in Canada, even though one in seven Americans is uninsured whereas all Canadians have comprehensive health insurance. Among the sectors of health care, the difference in spending is especially large for physicians' services. In 1985, per capita expenditure was $347 in the United States and only $202 (in U.S. dollars) in Canada, a ratio of 1.72. We undertook a quantitative analysis of this ratio.

We found that the higher expenditures per capita in the United States are explained entirely by higher fees; the quantity of physicians' services per capita is actually lower in the United States than in Canada. U.S. fees for procedures are more than three times as high as Canadian fees; the difference in fees for evaluation and management services is about 80 percent. Despite the large difference in fees, physicians' net incomes in the United States are only about one-third higher than in Canada. A parallel analysis of Iowa and Manitoba yielded results similar to those for the United States and Canada, except that physicians' net incomes in Iowa are about 60 percent higher than in Manitoba. Updating the analysis to 1987 on the basis of changes in each country between 1985 and 1987 yielded results similar to those obtained for 1985.

We suggest that increased use of physicians' services in Canada may result from universal insurance coverage and from encouragement of use by the larger number of physicians who are paid lower fees per service. U.S. physicians' net income is not increased as much as the higher U.S. fees would predict, probably because of greater overhead expenses and the lower workloads of America's procedure-oriented physicians. (N Engl J Med 1990; 323: 884-90.)

AMERICAN interest in the Canadian health care system is growing rapidly for two principal reasons.[1-3] First, costs have escalated in the United States to such an extent that health care now accounts for approximately 11.5 percent of the gross national product, whereas in Canada the comparable figure is about 9 percent. Second, one in seven Americans has no health insurance, and tens of millions of others have incomplete coverage; in contrast, Canada provides comprehensive, first-dollar health insurance to all its citizens. If U.S. spending could be held to the Canadian percentage, the savings would amount to more than $100 billion a year.

There have been numerous descriptions of the evolution of national health insurance in Canada and of the current federal-provincial system.[4-6] A detailed statistical analysis of trends in Canada and the United States has identified prospective global budgets for hospitals and negotiated fee schedules for physicians' services as major reasons for lower spending in Canada.[7] Other studies have focused on hospital costs,[8,9] drug prices,[10-12] the use of surgical services,[13,14] and administrative costs.[15]

This study concentrates on per capita expenditures for physicians' services because in this important sector the ratio between U.S. and Canadian spending is particularly large (1.72 in 1985). In other words, after adjustment for population size and the overall purchasing power of the Canadian dollar, Americans spend 72 percent more than Canadians for physicians' services. The comparable ratio for hospital expenditures is 1.34, and for all other health expenditures combined it is 1.30.

How does Canada do it? Do Canadians receive fewer physicians' services? Are the higher U.S. expenditures attributable entirely to higher fees? Do higher fees result from the use of more resources to produce a given quantity of services (more physicians, nurses, equipment, and the like), or do they reflect higher prices for those resources (higher physicians' net incomes, nurses' salaries, and the like)?

Our principal objective was to provide quantitative answers to these questions. Our analysis of the ratio between the United States and Canada was supplemented by a parallel comparison of Iowa and Manitoba. The state and the province have small, relatively homogeneous populations, and we had special access to data for the two regions. Our analysis of the ratio between Iowa and Manitoba in per capita expenditures for physicians' services (1.51) served as a check on the comparison between the United States and Canada and helped to sharpen our understanding of the reasons for the differences between countries in spending, fees, and use. The effect of physicians' services on the health of Americans and Canadians is not addressed in this paper.

### METHODS

Data on health care expenditures, the number of physicians who care for patients, vital statistics, and socioeconomic variables for the United States, Canada, Iowa, and Manitoba for 1985 were gathered from published sources,[16-34] and the appropriate ratios were calculated. All data in Canadian dollars were converted to U.S. dollars according to the purchasing-power-parity exchange rate of $1 U.S. equals $1.22 Canadian. This rate, calculated each year by the Organization for Economic Cooperation and Development, is based on

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the relative prices of the same comprehensive basket of goods and services in the two countries. All dollar amounts mentioned in this paper are in U.S. dollars. Total expenditures for physicians' services were allocated to procedures or to evaluation and management according to a formula based on the distribution of specialists in each country (or region). Details of the allocation are available elsewhere.*

### Fees

The necessary data on physicians' fees were not available — except from Manitoba — in published form. We therefore relied on data made available to us on a confidential basis by the Health Insurance Association of America, California Blue Shield, Iowa Blue Cross and Blue Shield, and Health and Welfare Canada. Fees in the United States for surgery (33 procedures) and evaluation and management (22 kinds of visits that we combined in five broad categories to achieve comparability with the Canadian data) are based on billed charges reported to the Health Insurance Association of America by its members. The association did not have data for ancillary services; charges for radiology (eight procedures) and anesthesiology (eight procedures) were therefore obtained from California Blue Cross and adjusted to the levels of the association by comparing surgery fees from both sources. Billed charges for Iowa for the same procedures and visits were provided by Iowa Blue Cross and Blue Shield. A list of the procedures and types of visits according to CPT-4 code (Current Procedural Terminology, fourth revision), as well as the precise methods we used to calculate the fee ratios, is available elsewhere.*

All U.S. and Iowa charges were reduced by 20 percent to measure the fees actually received by American physicians more accurately. There are services that are provided but never paid for; there are differences between what is billed and what insurance companies will allow; preferred-provider and health maintenance organizations extract explicit or implicit discounts from billed charges; physicians who accept Medicare assignment may receive less than their usual fee; and Medicaid is frequently the lowest payer of all. A survey of the Medical Group Management Association for 1985 reported that fee-for-service cash collections were 15 percent less than gross fee-for-service billed charges.[35] It is widely believed that the collection ratio for such groups is higher than the ratio for physicians in solo practice or small partnerships. A sample of Medicare-approved charges for 30 major services and procedures showed a median difference from Health Insurance Association of America billed charges of −23 percent.[36] Reducing U.S. billed charges by 20 percent therefore appeared appropriate. No such adjustment was necessary for Canada because bills are paid fully and promptly by the provincial governments according to predetermined, annually negotiated rates.

Fees in Manitoba were taken from the physicians' manual of the Manitoba Health Services Commission and included an adjustment for services provided in rural areas. Because overall Canadian fees were unavailable, Manitoba fees were adjusted to an all-Canada level according to a ratio of benefit rates between Canada and Manitoba that we calculated using provincial data assembled by Health and Welfare Canada. Because there is considerable interest in the United States in reimbursement for procedures as compared with reimbursement for evaluation and management, we calculated separate fee ratios for the two categories of services.

### Quantity of Services per Capita

In principle, the quantity of services per capita is the sum of all the visits, tests, operations, and other services provided by physicians. Because comprehensive data to measure these services directly were not available, we estimated the ratios between the United States and Canada and between Iowa and Manitoba by dividing the ratio of expenditures per capita by the appropriate fee ratio. Because expenditures equal the product of fees and the quantity of services, this method provided an indirect measure of the relative quantity of services provided.

### Price of Resources

Physicians' services are produced through the use of resources such as physicians, nurses, equipment, and office supplies. We estimated the ratio of the prices of these resources for the United States and Canada (and for Iowa and Manitoba) from physicians' net incomes, nurses' salaries, and other relevant data. The overall ratio was a weighted average (weighted according to expenditures) of the price ratios for four categories of resources: physicians, other personnel, office, and equipment and supplies. This average was then adjusted to take liability-insurance premiums into account.

### Quantity of Resources

Of the four categories of resources listed above, we only had data on quantity for the number of physicians. We therefore estimated the ratio of the quantity of resources per capita for the United States and Canada (and for Iowa and Manitoba) by dividing the ratio of expenditure per capita by the ratio of the price of resources. Because expenditures equal the product of the price of resources and the quantity of resources, this method provided an indirect measure of the quantity of resources.

## Results

Table 1 presents selected background statistics for each country and for Iowa and Manitoba in order to put the data on expenditures in context. Most of the populations of the United States, Canada, and Manitoba are urban, whereas more than half of Iowa's population is rural, which helps to explain the low number of physicians per capita in that state. Despite its huge territory, 90 percent of Canada's population lives in a narrow band of land just north of the border with the United States. Manitoba, like Canada in general, has a large area, most of which is thinly populated. More than half of Manitoba's population and more than three quarters of its physicians live in one city, Winnipeg. The elderly are relatively more numerous in the United States and in Iowa; were all other things equal, this would lead to a slightly higher use of medical services. The higher per capita gross national product in the United States would tend to increase health care expenditures per capita, mostly through higher incomes for physicians, nurses, and other personnel.

The differences in the number of physicians per capita, both in the aggregate and according to the type of physician, are worthy of special note. On a per capita basis there are more physicians who care for patients in Canada than in the United States, and many more in Manitoba than in Iowa. The disparity with respect to general practitioners and family physicians is very large. In most specialties and subspecialties, however, the ratio between the United States and Canada is much greater than 1. Rates of hospital admission are similar in the two countries; the average length of stay is considerably longer in Canada, partly because some of Canada's short-term general hospitals include rehabilitation units.

Canada does better than the United States with

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respect to life expectancy and infant mortality, but Iowa does slightly better than Manitoba. There is no reason to believe that access to or the quality of medical care in Iowa is superior to the U.S. average or that care in Manitoba suffers in comparison with care in the rest of Canada. The reversal in ratios therefore suggests that these differences in gross measures of health are determined largely by nonmedical factors, such as personal behavior, the environment, and genetic endowment.

Table 2. Health Expenditures per Capita, According to Type of Expenditure, 1985.*

| Expenditure | United States | Canada | Ratio of United States to Canada | Iowa | Manitoba | Ratio of Iowa to Manitoba |
|---|---|---|---|---|---|---|
| | *dollars* | | | *dollars* | | |
| Total | 1,780 | 1,286 | 1.38 | 1,432 | 1,326 | 1.08 |
| Physicians | 347 | 202 | 1.72 | 240 | 159 | 1.51 |
| Procedures | 193 | 69 | 2.78 | 130 | 51 | 2.54 |
| Evaluation and management | 154 | 133 | 1.16 | 110 | 107 | 1.02 |
| Hospitals | 698 | 520 | 1.34 | 541 | 519 | 1.04 |
| All other† | 735 | 564 | 1.30 | 651 | 648 | 1.01 |

*Values are in 1985 U.S. dollars. Data were collected from references 20 and 30 through 34.

†Includes expenditures for nursing homes and other institutions, drugs, dentists' services, other professional services, public health, appliances, prepayment administration, construction, research, home care, ambulance services, other personal health care, and miscellaneous expenses.

The data on per capita health expenditures (Table 2) show that the ratios between the United States and Canada and between Iowa and Manitoba are much greater for physicians' services than for hospital services or other expenditures. They also show that within the category of physicians' services, procedures account for nearly all the higher spending in the United States. To understand the difference between the ratios for procedures and for evaluation and management, it is necessary to examine the ratios for fees and for the quantity of services separately.

### Fees

Physicians' fees for procedures are approximately 234 percent higher in the United States than in Canada (Table 3); the difference between Iowa and Manitoba is about 199 percent. By U.S. standards, fees for procedures are exceedingly low in Canada. For example, in Manitoba in 1985 total obstetrical care was reimbursed at $245; the fee for a hernia repair was $186 and for a cholecystectomy $311. Canadian surgical fees are much lower across the board than U.S. fees: for the United States and Canada, 27 of the 33 ratios for surgical procedures are between 2.0 and 4.5; and for Iowa and Manitoba, 29 of the 33 ratios are between 1.75 and 4.25.

Fees for evaluation and management are also higher in the United States than in Canada, but the ratios are much smaller: 1.82 for the United States and Canada, and 1.72 for Iowa and Manitoba. Canadian fees for hospital visits are particularly low; in Manitoba physicians received only $7.20 for a "moderate" hospital visit in 1985 (a visit limited in scope and duration).

The overall fee ratio was moderately sensitive to our allocation of expenditures between procedures and evaluation and management. For instance, if the true share of procedures were five percentage points larger than our estimate, the overall fee ratio between the United States and Canada would increase from 2.39 to 2.47. If the share were five percentage points smaller, the ratio would be 2.32. The exchange rate also affected the fee ratio. If we had used the market rate ($1.00 U.S. equals $1.36 Canadian), which reflects capital movements and speculation as well as the relative purchasing power of the two currencies, the overall fee ratio would be 2.68. Finally, the relation between the fee ratio and our assumption of a 20 percent discount from billed charges for U.S. fees should be noted. If we had assumed a 25 percent discount, the overall ratio would be 2.24; a 15 percent discount would yield a ratio of 2.54.

Table 1. Selected Background Statistics, 1985.*

| Variable | United States | Canada | Iowa | Manitoba | Ratio of United States to Canada | Ratio of Iowa to Manitoba |
|---|---|---|---|---|---|---|
| Population (000s) | 283,739 | 25,358 | 2,905 | 1,070 | — | — |
| Percent rural | 26.3 | 24.3 | 52.3 | 28.8 | — | — |
| Percent in cities of ≥100,000 | 25.4 | 34.5 | 10.5 | 55.5 | — | — |
| Percent over 65 years old | 12.0 | 10.4 | 14.2 | 12.5 | — | — |
| Births (per 1000) | 15.8 | 15.1 | 14.3 | 16.0 | — | — |
| Gross national (domestic) product per capita† | 16,703 | 14,801 | 14,490 | 13,791 | 1.13 | 1.05 |
| Patient-care physicians (per 1000)‡ | 1.81 | 2.05 | 1.21 | 2.02 | 0.88 | 0.60 |
| Private-practice general practitioners and family physicians | 0.24 | 0.90 | 0.29 | 0.88 | 0.26 | 0.33 |
| Other‡ | 1.57 | 1.15 | 0.92 | 1.14 | 1.37 | 0.81 |
| Short-term general hospitals (per 1000)§ | | | | | | |
| Beds | 4.20 | 4.43 | 5.22 | 4.89 | 0.95 | 1.07 |
| Admissions | 140 | 136 | 142 | 153 | 1.03 | 0.93 |
| Days | 994 | 1,293 | 1,084 | 1,317 | 0.77 | 0.82 |
| Life expectancy at birth (yr) | | | | | | |
| Men | 71.2 | 72.9 | 73.1 | 72.9 | 0.98 | 1.00 |
| Women | 78.2 | 79.7 | 80.2 | 79.7 | 0.98 | 1.01 |
| Infant mortality (per 1000) | 10.6 | 8.0 | 9.5 | 9.9 | 1.33 | 0.96 |

*Data were collected from references 16 through 29. Calculations in this and the subsequent tables were performed with unrounded numbers.

†Values are in 1985 U.S. dollars. Canadian figures were adjusted according to the purchasing-power-parity exchange rate. $1.00 U.S. equals $1.22 Canadian.

‡Values include interns and residents.

§Canadian data include rehabilitation units.

### Quantity of Services per Capita

Table 4 provides striking refutation of the hypothesis that lower spending in Canada is achieved by providing fewer services. On the

Table 3. Physicians' Fees, 1985.*

| Service† | Ratio of United States to Canada | Ratio of Iowa to Manitoba |
|---|---|---|
| Surgery | 3.21 | 2.76 |
| Anesthesiology | 3.73 | 2.86 |
| Radiology | 3.59 | 4.19 |
| Procedures (weighted average) | 3.34 | 2.99 |
| Moderate office visit | 1.56 | 1.44 |
| Extensive office visit | 1.55 | 1.50 |
| Moderate hospital visit | 4.77 | 3.56 |
| Extensive hospital visit | 2.57 | 2.70 |
| Consultation | 1.60 | 1.64 |
| Evaluation and management (weighted average) | 1.82 | 1.72 |
| All services‡ | 2.39 | 2.18 |

*Values are in 1985 U.S. dollars.

†"Moderate" visits were limited in scope and duration. "Extensive" visits were longer and broader in scope.

‡Values are weighted averages of the procedures and evaluation-and-management ratios.

contrary, the ratio between the United States and Canada for all services is 0.72, and between Iowa and Manitoba the ratio is 0.69. The disparity in use is much greater for evaluation and management than for procedures. These results are sensitive to possible biases in the fee ratios, but the conclusion that the rate of use is greater in Canada than in the United States appears robust. For instance, if the overall fee ratio between the United States and Canada were 2.0 instead of 2.39, the ratio of the quantity of services per capita would be 0.86, still well under 1.0. These results are not sensitive to assumptions about the exchange rate because using a different rate would change the expenditures and fee ratios in equal proportion; the ratio of the quantity of services per capita would not be affected.

### Prices of Resources

As a share of total expenditures, the most important resource in both countries is the physician; the physician's net income is 52 percent of gross income in the United States and 66 percent in Canada. In 1985 net income per office-based physician was $112,199 in the United States and $73,607 in Canada.[37,38] After adjustment for differences in the mix of specialties, U.S. incomes were 35 percent higher than those in Canada, and 61 percent higher in Iowa than in Manitoba (Table 5). The price ratio for other personnel was based on the full-time compensation of a registered nurse.[16,39-41] The price of occupying and maintaining an office varies greatly depending on geographic location, and direct estimates were unobtainable. We assumed that the price increases as the relative wealth of an area increases; our calculations were therefore based on regional and state per capita income weighted according to the number of physicians in the area. We assumed that the real prices of equipment and supplies used by physicians are roughly the same in both countries; the ratio was therefore assumed to be 1.0.

We calculated the price ratio for all resources as an expenditure-weighted average of the ratios for the four categories, using the average of U.S. and Canadian weights. Liability insurance is an important item of expenditure for U.S. physicians, but their Canadian counterparts do not incur a similar expense: estimates of liability expenses for Canadian physicians are less than 1 percent of gross receipts. We did not consider expenditures on liability insurance to reflect any real resource used in the practice of medicine; thus, liability insurance was treated as a tax on the prices of all resources. The ratios of resource prices were therefore increased by the share of all expenditures attributable to liability-insurance premiums. We concluded that the prices of resources are moderately higher in the United States than in Canada (Table 5), but the ratio is small as compared with the fee ratio of 2.39. Most of the excess of U.S. over Canadian fees must be attributable to the fact that Americans use more resources to produce a given quantity of services.

### Ratio of Quantity of Resources to Quantity of Services

The results of our estimation of the ratios of resources to services (Table 6) were extraordinary. It appears that the United States uses 84 percent more real resources than does Canada to produce a given quantity of physicians' services. The difference between Iowa and Manitoba is somewhat smaller, with a ratio of 1.53.

### Summary and Update

The study's most important results are summarized in Table 7. First, higher expenditures on physicians' services per capita in the United States were entirely explained by higher fees; in fact, the quantity of services per capita is actually lower in the United States than in Canada. Second, the higher fees were attributable primarily to the fact that Americans use more resources to produce a given quantity of services. Third, a small portion of the higher U.S. fees was reflected in higher prices of resources, especially physicians' net incomes. Fourth, the results of the comparison between Iowa and Manitoba were similar to those of the comparison between the United States and Canada, except that a larger proportion of the

Table 4. Estimation of the Ratios of Quantity of Physicians' Services per Capita, 1985.

| Service | Ratio of United States to Canada | Ratio of Iowa to Manitoba |
|---|---|---|
| Procedures | | |
| Expenditures per capita (Table 2) | 2.78 | 2.54 |
| Fees (Table 3) | 3.34 | 2.99 |
| Quantity of services per capita* | 0.83 | 0.85 |
| Evaluation and management | | |
| Expenditures per capita (Table 2) | 1.16 | 1.02 |
| Fees (Table 3) | 1.82 | 1.72 |
| Quantity of services per capita* | 0.64 | 0.60 |
| All services | | |
| Expenditures per capita (Table 2) | 1.72 | 1.51 |
| Fees (Table 3) | 2.39 | 2.18 |
| Quantity of services per capita* | 0.72 | 0.69 |

*Values are expenditures per capita divided by fees.

Table 5. Estimation of the Prices of Resources, 1985.

| Resource | Ratio of United States to Canada | Ratio of Iowa to Manitoba |
|---|---|---|
| Net income per physician* | 1.35 | 1.61 |
| Other resources | | |
| Compensation rate of other personnel | 1.09 | 0.98 |
| Office | 1.15 | 1.05 |
| Medical supplies, equipment, and other | 1.00 | 1.00 |
| All resources† | 1.24 | 1.37 |
| All resources, as adjusted for liability insurance | 1.30 | 1.43 |

*Adjusted for mix of specialties
†Weighted average of all ratios

higher fees in Iowa reflected higher physicians' net incomes. Finally, updating the analysis to 1987 with data on changes in each country from 1985 to 1987 yielded results similar to those obtained for the 1985 comparisons between countries.

## Discussion

Two striking conclusions emerged from our statistical analysis of the difference between the United States and Canada in spending for physicians' services. First, the data firmly reject the view that Canadians save money by delivering fewer services. On the contrary, the quantity of services per capita is much higher in Canada than in the United States. Second, as compared with Canada, the United States uses appreciably more real resources to produce a given quantity of services. We will discuss eight possible explanations for these findings: the effects of insurance on demand, the effects of physicians on demand, billing costs, amenities, other administrative costs, overhead accounting, the workloads of procedure-oriented physicians, and the quality or intensity of care.

### Effects of Insurance on Demand

Canadians have universal coverage and face no out-of-pocket expenses, whereas U.S. patients pay coinsurance rates ranging from 0 (full insurance) to 100 percent (for the uninsured). Thus, lower rates of use in the United States must reflect in part the price sensitivity of the demand for physicians' services.

Table 6. Estimation of the Quantity of Resources Relative to the Quantity of Services, 1985.

| Variable | Ratio of United States to Canada | Ratio of Iowa to Manitoba |
|---|---|---|
| Expenditures per capita (Table 2) | 1.72 | 1.51 |
| Prices of resources (Table 5) | 1.30 | 1.43 |
| Quantity of resources per capita* | 1.32 | 1.06 |
| Quantity of services per capita (Table 4) | 0.72 | 0.69 |
| Ratio of quantity of resources to quantity of services | 1.84 | 1.53 |

*Values are expenditures per capita divided by the prices of resources.

If, on average, Americans face the equivalent of 25 percent coinsurance, the results of the Rand Health Insurance Experiment predict that there will be 27 percent fewer visits and 33 percent less outpatient expenditure per capita than if they had full coverage.[42] We found that the use of evaluation and management services in the United States was 36 percent less than in Canada, and the difference between Iowa and Manitoba was 40 percent. Another source has estimated per capita contacts with a physician at 7.1 in Canada in 1985 and at 5.4 in the United States in 1986.[43]

### Effects of Physicians on Demand

To the extent that higher rates of use in Canada are not fully explained by more complete insurance coverage, they may be explained by demand induced by Canadian physicians.[44] The number of general practitioners and family physicians is very high in Canada, and their fee per visit is low. They may thus be more inclined to recommend additional evaluation and management services.

### Billing Costs

In each Canadian province there is only one source of payment for physicians' services. Physicians typically submit one bill, and payment is usually punctual and complete. In contrast, American physicians must bill a myriad of private and public third-party payers, and often must also bill patients directly. Numerous complex forms must be filled out, there are frequently delays in payment as well as disagreements concerning the amount to be paid, and collection efforts impose additional costs. The differences in billing undoubtedly account for some of the additional resources reflected in the U.S. data, but we do not know exactly how much. The order of magnitude can be inferred from the fact that approximately 16 percent of the gross receipts of physicians are devoted to personnel who are not medical doctors. If one fourth of those personnel are needed for billing tasks that are not required in the Canadian system, then 4 percent of U.S. expenditures can be explained by this factor. There are also additional billing costs for physicians' time, computers, stationery, and postage.

### Amenities

Fragmentary data from one Canadian province and the American Medical Association suggest that U.S. physicians spend considerably more than their Canadian counterparts for rent and related office expenses, possibly twice as much. It is unlikely that this large difference is primarily the result of higher prices for identical offices. Some portion, probably a considerable portion, reflects a higher level of amenities in the average U.S. office. This may take the form of a more desirable location, more space per patient, newer furnishings, or more elaborate decor. Why would this occur? One reason is that real per capita income in the

Table 7. Summary and Update of Estimates.

| Variable | 1985 Ratio of United States to Canada | 1985 Ratio of Iowa to Manitoba | 1987 Ratio of United States to Canada |
|---|---|---|---|
| Expenditures per capita | 1 72 | 1 51 | 1 75 |
| Fees | 2 39 | 2 18 | 2 61 |
| Quantity of services per capita | 0 72 | 0 69 | 0 67 |
| Prices of resources | 1 30 | 1 43 | 1 32 |
| Ratio of quantity of resources to quantity of services | 1 84 | 1 53 | 1 98 |

United States is 10 to 15 percent higher than in Canada: Americans are therefore accustomed to a somewhat higher level of amenities in most aspects of life. But the income difference would probably explain only about a 10 to 15 percent difference in amenities. More important may be the fact that competition for well-insured patients is more intense in the United States, especially among procedure-oriented physicians, many of whom have lower workloads than they desire. Physicians usually do not compete for insured patients by lowering fees, but they can try to attract such patients by offering a higher level of amenities.

#### Other Administrative Costs

There are numerous other costs incurred by many U.S. physicians that are lower or nonexistent for their Canadian counterparts. For instance, concern over possible malpractice suits (much rarer in Canada) may cause U.S. physicians to keep additional notes and records, or to undertake other activities that require their time and other resources but that are not reflected in the measures of quantity of services. (If concern over possible malpractice suits leads U.S. physicians to order additional visits and tests, the ratio between resources and services is not affected, because both the additional services and resources required to produce them are accounted for.) Other administrative costs that are more likely to be incurred by American than Canadian physicians involve maintaining contractual relations with preferred-provider organizations, dealing with third-party use reviews, and marketing.

#### Overhead Accounting

Overhead makes up 48 percent of expenditures in the United States, but only 34 percent in Canada.[37,38] Some of this difference undoubtedly reflects the greater use of resources in the United States, as discussed above. Some, however, may reflect more stringent scrutiny of overhead accounting by the Canadian government, because the overhead percentage is part of the background for negotiations between the provincial governments and physicians' organizations over fees. This constraint is not present in the United States. If identical accounting practices were applied in both countries, the overhead percentages might be slightly closer to each other and the difference in net income might be slightly larger. Such an adjustment would increase the ratio of the price of resources in the two countries by a few percentage points and decrease the ratio of resources to services by an equivalent amount.

#### Workloads of Procedure-Oriented Physicians

There can be little doubt that the average Canadian physician who specializes in procedures does more of them during a year than his or her counterpart in the United States. We estimated that there are about 40 percent more procedure-oriented physicians in the United States than in Canada (relative to the population), but the number of procedures performed appears to be about 20 percent higher in Canada. For some specialties the difference in workloads may be of the order of magnitude of two to one. This explanation is not as relevant for the comparison between Iowa and Manitoba, because the per capita supply of procedure-oriented physicians is about the same in both places. The difference in the supply of physicians may help explain why the ratio of resources to services is much higher between the United States and Canada than between Iowa and Manitoba.

#### Quality or Intensity of Care

The most uncertain and potentially controversial explanation concerns possible differences in quality or intensity of care. This question required that evaluation and management and procedures be considered separately. We estimated that approximately two thirds of the evaluation and management services in Canada are delivered by general practitioners and family physicians, and one third is delivered by internists, pediatricians, psychiatrists, and other specialists. In the United States the proportions are reversed. Should this be interpreted as a difference in quality of care? Some would argue that care provided by physicians with specialty training should be considered as "more" care. But there are others who believe that in most cases the quality of care provided by general practitioners or family physicians is as high, and may even be superior because of their greater familiarity with the patient and his or her circumstances. The question of intensity of care arises because of the possibility that some of the additional evaluation and management services provided in Canada are for patients with minor problems such as colds or upset stomachs. Some visits of this type may be deterred in the United States because insurance coverage is not as complete and because patients have been urged by employers and insurance companies not to visit physicians for minor problems. If the category of moderate office visits included fewer patients with minor problems in the United States, an adjustment for intensity would result in a slight increase in the ratio of the quantity of services per capita and a slight decrease in the ratio of resources to services.

With respect to procedures, the question of possible differences in the quality of care arises for other reasons. The technical competence of the specialists performing the procedures in the two countries is probably not an issue. A comparison of surgical mortality in Manitoba and New England concluded that the differences were small.[45] Timeliness and convenience, however, may differ. Because on a per capita basis there are so many more procedure-oriented specialists in the United States than in Canada, it is likely that Americans with insurance find it easier to have procedures performed when and where they want. From the patient's perspective, this may offer an additional source of satisfaction with the service provided. Whether such differences exist, how large they are, and how they are valued by patients are subjects for further research. These issues are much more muted in the comparison between Iowa and Manitoba than in that between the United States and Canada, because there are so few physicians per capita in Iowa as compared with Manitoba.

This discussion points up the need for additional studies to determine the magnitude of the many factors affecting fees, use of services, and use of resources to produce those services. Further refinements in the ratios of physicians' fees and the prices of resources would be particularly valuable, given the central role of these ratios in the statistical analysis. Such studies and refinements, however, are not likely to alter the principal lesson of this paper: U.S. fees are more than double those of Canada, but physicians' net incomes are only about a third higher. The disparity is explained in part by much greater overhead expenses in the United States and in part by the lower workloads of American procedure-oriented physicians as compared with their Canadian counterparts.

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PERSPECTIVE ITEM 2 INSERT A

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# Ethics Consultation: Skills, Roles, and Training

John La Puma, MD and David L. Schiedermayer, MD

**A clinical ethics consultant gathers information firsthand at the patient's bedside. The consultant's special clinical skills include the ability to identify and analyze ethical problems; use reasonable clinical judgment; communicate effectively; negotiate and facilitate negotiations; and teach others how to construct their own ethical frameworks for medical decision making. Appropriate roles for the consultant include those of professional colleague, negotiator, patient and physician advocate, case manager, and educator. The training necessary for an ethics consultant includes substantial patient care experience, instruction in health care law and moral reasoning, and preparation in medical humanism. We favor a clinical model for ethics consultation. When urgent care is needed, other consultants promptly see the patient; the clinical ethics consultant can be expected to do the same.**

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Ethics consultants have expertise in the bedside identification, analysis, and resolution of ethical problems in patient care. Since Purtilo (1) addressed the role of the hospital ethics consultant 6 years ago, ethics consultation has become increasingly accepted in health care institutions. Several methods of ethics consultation have been described (2-6), and a society for bioethics consultation recently held its fourth national meeting. The foundation of the developing body of medical ethical knowledge has recently been described (7-11). The field of biomedical ethics, now has a clinical discipline (ethics consultation) and an academic foundation (in medicine, philosophy, law, sociology, literature, and theology) (12, 13).

Despite the growing literature on hospital ethics committees and ethics consultants (14-25), little has been written about the necessary skills, appropriate roles, or required training for consultants. Our purpose here is to suggest the skills, roles, and training needed to practice in this emerging clinical field.

## Historical Development

Although its genesis is debated, it is generally agreed that ethics consultation is a recent phenomenon. Tentative exploration of hospital ethics consultation began in the late 1960s and early 1970s at Pennsylvania State University (Vastyan and Clouser), the New Jersey College of Medicine (McIntyre), and the University of Wisconsin (Fost). In the late 1970s, Fletcher (26) at the National Institutes of Health (NIH) gained experience with clinical ethical dilemmas in a research hospital. In 1978 and 1979, Siegler and Pellegrino (27-30) wrote a series of papers that outlined a role for "clinical ethics" as a special field of expertise in medicine. Jonsen (31) asked "Can an ethicist be a consultant?" in 1980, and in 1982, the handbook *Clinical Ethics* was published (32). A joint conference of the NIH and the University of California, San Francisco, on ethics consultation was held in 1985 (33), and, in 1987, an empiric study of ethics consultation was first reported in the peer-reviewed medical literature (34). In 1988, Pellegrino (35) noted that with the practice of clinical ethics came the opportunity to study empirically values, assumptions, and patient preferences. The first issue of a journal devoted to clinical medical ethics was published in 1990 (36).

## What Legitimates Ethics Consultation?

Moral authority for ethics consultation arises from several sources. The primary justification for ethics consultation derives from the mandate to protect and foster shared decision making in the clinical setting (37). Physicians should share health care decisions with well-informed patients who can understand their diagnoses, prognoses, and the various alternatives of proposed treatment and of nontreatment, and who can make decisions (38). When an ethical problem arises, ethics consultation should be used to assure that issues are clarified so that decision making can be shared.

Ethics consultants' demonstrated ability to help resolve ethical dilemmas in patient care legitimates the use of ethics consultation. Ethics consultants have practical expertise in the clinical arena and are increasingly recognized as members of the health care team. The physician's need for analysis and advice in individual cases, the institution's need for counsel in patient-related policy issues, and the patient's need for an advocate further legitimate the use of ethics consultation. Courts and presidential commissions have recommended that clinicians seek appropriate assistance in making moral decisions (39, 40). The American College of Physicians and the American Medical Association have recognized that protecting and enhancing shared doctor-patient decision making is an ethical responsibility (41, 42). Physicians' concerns about liability and payers' concerns about the costs of care have fueled the search for special expertise.

Ethics consultants should be accountable for the process and outcome of their work. Having an institutional locus of accountability is reasonable, although the specific lines of authority and reporting relationship will differ according to each institution's structure and mission (43). Vision and commitment are necessary to sup-

 

**Table 1.** *Institutional Credibility, Sponsorship, and Relationships for Ethics Consultants*

| |
|---|
| Institutional credibility |
| Clinical, practical, and ethical expertise |
| Fellowship training in medical ethics |
| Demonstrated patient advocacy |
| Legal and professional acceptance |
| Mastery of medical ethical information and patient-related policy issues |
| Institutional sponsorship |
| Medical staff executive committee |
| Department chairperson |
| Chief executive officer |
| Dean |
| Board of trustees |
| Institutional relationships |
| Chairperson of ethics committee |
| Chairperson of consulting subcommittee |
| Consultant on hospital policy |
| Liaison with hospital legal office |
| Educator of and advisor to various hospital committees, such as ethics, quality assurance, utilization review, and institutional review |

port the consultant in synergistic ventures with health care professionals specializing in other clinical areas (44). A consultant may wish to report to or be sponsored by the medical staff executive committee, the department chairperson, the chief executive officer, the dean, or the board of trustees. Accountability keeps the consultant honest and humble and permits the consultant to work effectively within an institution. Finally, in the clinical model of ethics consultation, the consultant is accountable to his or her patients and their physicians.

Consultants should inform institutional ethics committees of relevant clinical activities. Ethics committees can use the consultant's knowledge of individual cases to reflect on larger trends and, when needed, suggest institutional policy; in addition, the committee may be able to provide the consultant with a multidisciplinary critique of his or her work.

### Ethics Consultants and Ethics Committees

Ethics consultants are professionals with specialized training and experience that equip them to identify, analyze, and help resolve moral problems that arise in the care of individual patients. Consultants have the specific task of collecting disparate, but essential, aspects of a patient's medical course and personal history. The professional charge of gathering the relevant data, identifying opposing arguments and values, and restoring a central ethical focus to a case makes the consultant's role "ethical" in nature (18). Assisting physicians in developing structured, coherent, and humane strategies for identifying, analyzing, and resolving ethical dilemmas is the clinical ethics consultant's special responsibility (18).

Ethics consultants may choose to work with ethics committees (Table 1). The consultant is often the chairperson or co-chairperson of the committee and may go to the bedside, do the consultation, and report back to the committee at its regularly scheduled meeting. The consultant-chairperson may form a consulting subcommittee of several members, or the entire committee may meet to consider cases, either at the bedside or in a committee room.

Although practical constraints sometimes hinder the efforts of ethics committees (20, 45, 46) and reported empiric evaluations of ethics committees are few (47), many ethics committees presently consult in cases. In our experience, the most effective consulting committees—those that offer helpful assistance in the clinical setting—have one or several members who possess the skills and may perform the roles of ethics consultants (48).

### The Ethics Consultant's Clinical Skills

The consultant should be able to identify and analyze moral problems in a patient's care; use reasonable clinical ethical judgment in solving these problems; communicate effectively with health care professionals, patients, and families; negotiate and facilitate negotiations; and teach medical students, housestaff, and attending physicians how to identify, analyze, and resolve similar problems in similar cases (Table 2).

The ability to analyze and separate the ethical questions in a complex case is among the most important of the ethics consultant's skills (49). Data gathering usually begins with an interview with and examination of the patient, followed by a review of the medical record and hospital course and interviews with physicians, nurses, family members, and others of importance to the patient. Through consultation, ethical issues are often identified and clarified: In one series, the consultant identified a mean of 3.0 issues per case and was "very important" or "somewhat important" in clarifying ethical issues in 94% of cases (4). Considerable change in case management has been reported in 18 of 44 cases at county and Veterans Affairs hospitals (5), 20 of 51 cases at university hospitals (4), and 53 of 104 cases at community hospitals.

Clinical judgment, based on both long experience with many patients and familiarity with the natural histories of many diseases (50, 51), is difficult to acquire. Skill in clinical judgment underlies effective consultation, enabling the consultant to make the medical distinctions that are technically and morally relevant in each case. The consultant considers the care of a particular patient in a particular circumstance with a particular illness, as particularity is the hallmark of good medical practice.

**Table 2.** *Skills and Roles for Ethics Consultants*

| |
|---|
| Fundamental skills |
| Identify and analyze clinical ethical problems |
| Use and model reasonable clinical judgment |
| Communicate with and educate team, patient, and family |
| Negotiate and facilitate negotiations |
| Teach and assist in problem resolution |
| Appropriate roles |
| Professional colleague |
| Patient advocate |
| Case manager |
| Negotiator |
| Educator |

Excellent interpersonal and communication skills are necessary for ethics consultants. Consultants can teach and model effective communication (listening, reflecting, encouraging discussion) and appropriate attitudes (respect, compassion, and courteousness). Ethics consultants use both verbal and nonverbal communication as diagnostic and therapeutic tools (52).

The ethics consultant must be especially competent in helping to resolve interpersonal conflicts in patient care. Emotionally charged situations may be identified as "ethical dilemmas," but are more usually the result of miscommunication (53). The consultant must be able to negotiate—at the bedside, in hospital conference rooms, and with administrators and third party payers. The consultant's expertise includes the ability to facilitate understanding, emphasize common interests instead of opposing positions, and remain tactful while suggesting a course of action. The consultant must consider the interests of patients, doctors, nurses, and administrators, because the clinical setting is a place of compromise. The consultant's ability to resolve cases in conflict hinges largely on mediation skills (54).

Finally, the ethics consultant teaches medical students, housestaff, and attending physicians how to identify, analyze, and resolve ethical problems in similar cases (55, 56). Case process and case synthesis are inextricably integrated in ethics consultation: Both illustrate how ethical issues change over time. In addition, the consultant's written report may provide a detailed case analysis. Appended references of didactic and practical value allow requesting physicians to consider several views as they construct their own frameworks for decision making.

### The Ethics Consultant's Roles

The consultant's roles may properly include those of professional colleague, educator, negotiator, advocate, and case manager (Table 2). The ethics consultant is a professional colleague. Rudd describes a professional colleague as "someone with whom to share the case's complexity and from whom discernible help will emerge" (57). The consultant's clinical judgment and ability to analyze ethical issues in individual cases identify the consultant as a professional colleague. The consultant should tailor the information, perspective, critique, or reassurance that he or she provides to help the requesting physician (58). As Goldman and colleagues (59) note, the effective consultant communicates directly and nonthreateningly with the requesting physician.

Teaching ethical decision making to physicians is a central goal of ethics consultation (60). The ethics consultant recognizes the requesting physician's ability and experience in analyzing and managing ethical dilemmas and provides effective, individualized instruction. The consultant then emphasizes principles that may apply to similar future cases.

The role of negotiator requires effective interpersonal and communication skills. The consultant can try to be a consensus-builder, but reasonable persons may disagree about the decisions made in a particular case (61). The consultant acts as a rational, clear-headed participant who seeks to help disagreeing parties come to morally permissible conclusions. More often than not, disagreeing parties can agree on a practical solution, although their reasons for agreeing will be different (62). The role of negotiator may properly include using persuasion, because ethics consultants have a professional obligation to effect morally permissible outcomes.

When a patient's situation mandates it, the consultant must be a patient advocate. The ethics consultant's primary duty is to the patient, but he or she also has duties to the requesting physician to be timely, clear, and specific (55). Dual loyalty can be risky for the consultant, especially if he or she opposes the wishes or actions of family members, legal proxies, or physicians. When a patient's interests seem threatened by planned treatment, financial constraints, legal proceedings, or an unreliable proxy, the consultant's obligation may extend to confronting the family or physician, appealing economic constraints, and pursuing legal appeals (63-65). Such actions may be difficult and time-consuming, but when harm to a patient seems imminent, consultants should try to prevent it.

The ethics consultant will seldom be required to manage a patient's case, even when a patient, family, or physician requests it. The attending physician should retain decision-making responsibility and authority, using the consultant's ongoing involvement as needed (66). Ethics consultants should be prepared to help manage difficult cases when a patient's medical interests are threatened or when a patient, family, or professional colleague requires the consultant's skills in case management.

Ethics consultants can anticipate some pressure to assume other roles in the clinical setting. These roles properly belong to others, however, and should be referred to persons with the needed expertise. Ethics consultants may be asked to act as a case conscience (this role belongs to all physicians managing the case); case counsel (this role belongs to the legal office or the patient's attorney); case quality reviewer (this role belongs to hospital quality assurance); case psychoanalyst (this role belongs to a psychiatrist or psychologist); or case clergy (this role belongs to the hospital chaplain).

### Difficulties for Ethics Consultants

Several general objections to ethics consultants have been raised (67). Whether "objective" advice can be given by ethics "experts" and, if so, how this expertise is acquired are debated (68, 69). The long-term effects of ethics consultation in the hospital are unknown (70). Trained in moral philosophy, not in decision making, philosopher-ethicists may lack clinical judgment. They may be aloof, unavailable, or uncomfortable in the clinical setting. Alternatively, a physician-ethicist may focus on problem solving and neglect important social, philosophical, or theologic aspects of a case.

A second objection is financial: Ethics consultants presently generate little or no revenue. Although consultants' revenue-generating potential may increase with use of the resource-based relative value scale (a weighting scale that increases compensation for cognitive work), whether ethics consultants ought to be paid as

well as at what rate and by whom are unresolved questions of practical, political, and moral import (1). As an institution-based service, like radiology or anesthesiology, consultants require costly malpractice coverage. If cost-savings criteria are used to evaluate ethics consultation, morality may become a charade for cost-cutting, to the patient's disadvantage.

Third, ethics consultants' risk for legal liability is unknown. We have previously suggested a standard of care for ethics consultants (18). To our knowledge, however, an ethics consultant has not yet been sued. In 1986, charges were brought against an ethics committee in southern California; the suit was dismissed in 1990, but reportedly has dissuaded the committee from reconvening (Ross JW. Personal communication).

Fourth, questions remain about intrusion into the doctor-patient relationship. Who has the authority to request a consult? For whom does the consultant work? These questions are controversial. In our view, physicians may ask ethics consultants to speak with families, third party payers, or patients; patients may speak with consultants directly.

The consultant should be able to answer requests from many quarters, but the primary physician engages and dismisses the consultant. In a clinical model of ethics consultation, the consultant works for both the physician and the patient. If a team member wants an ethics consultation, suggesting it first to the primary physician may promote an open dialogue and help to resolve the problem. If the suggestion is not taken, the team member can appeal the refusal to his or her supervisor. Uninvited consultants should not intercede in cases: Ethics consultants should not be moral policemen.

Finally, whether ethics consultants must be physicians or may also be nonphysicians is controversial. Nonphysicians may have the years of clinical experience necessary for the development of clinical judgment; if this is not the case, the clinical expertise of a physician colleague is required. More important than a medical degree is a consultant's ability to acquire and use the necessary skills and fulfill the appropriate roles of the ethics consultant. A professional who wishes to do ethics consultation should be trained in those skills and roles.

### Training and Certification in Ethics Consultation

Training program curricula should provide the necessary skills for consultation practice. Ethics consultants need substantial patient care and hospital experience (71), instruction in case law and legal processes (72), practice in casuistic moral reasoning and ethical decision making (73), and knowledge of medical humanism and humanistic behavior (74-76). The experience of consulting with a skilled, well-trained mentor, reading carefully about the patient's medical and ethical presentation, and following the patient's case to its conclusion, constitutes a practical, established process of medical learning.

Who should train as an ethics consultant? Ideal candidates are clinicians who are expert in their own medical discipline and who have or wish to gain the skills and play the roles of the consultant (77, 78). Such candidates include physicians who are completing a primary care residency or who are the ethics committee chairperson or co-chairpersons.

To acquire the clinical skills of an ethics consultant, nonphysicians require several years of clinical experience and routine participation with medical teams in clinics, hospital rooms, and special care units. Training in different medical settings provides the necessary foundation for understanding the diversity and details of many medical illnesses and for developing clinical judgment. The complexity of the doctor-patient relationship; the individuality of patients' and families' preferences, goals, and interests; and the exigencies of hospitals, health care professionals, and third-party payers are best appreciated when observed firsthand.

To become ethics consultants, most nonphysicians and many physicians would require training in medical humanism, clinical psychology, medical sociology, and health law. Essential topics in medical humanism include integration of the qualities of integrity, respect, and compassion with bedside behavior; in clinical psychology, differentiation between organic and functional illnesses, recognition of differing doctor-patient relationships in different medical specialties, and determination of patient decision-making capacity; in medical sociology, comprehension of the special language, interrelationships, and hierarchies of hospital medicine, nursing, and medical social work; and, in health law, case and statutory law relevant to life-sustaining treatment, advance directives, and surrogate decision making.

Physicians who wish to become ethics consultants require training in moral reasoning and ethical decision making. Training must provide opportunities to reflect on and critique clinical ethical dilemmas, discover and discuss multidisciplinary perspectives, and learn and apply techniques of facilitation and negotiation. Continuing to hold primary clinical responsibilities during training is a direct, vital way of appreciating ethical dilemmas in patient care.

Whether clinical ethicists can or must have certification in a new medical field is controversial. Certification requires a defined body of useful clinical knowledge and an evaluation process that determines whether the candidate has mastered the knowledge and possesses a specified level of clinical competency. The American Board of Internal Medicine criteria for a new discipline include a significant scientific base and clearcut relation to internal medicine or its subspecialties; a recognition of the discipline in the medical, academic, and scientific communities; the potential for a significant number of practitioners in a well-defined practice; a requirement for formal training with prescribed standards; and improved patient care (79). Ethics consultants, particularly those who are physicians, have begun to meet several of these criteria (for example, an identifiable base of scientific knowledge and improved clinical practice). Practical, political, and professional questions remain, however, about the incorporation of nonphysician ethics consultants (currently, the majority of ethics consultants) into a field of expertise in medicine.

## Conclusion

The ethics consultant's role will continue to evolve. We favor a clinical model of ethics consultation, the process and outcome of which require continued study. Empiric data and critical review are necessary to evaluate the utility and limitations of consultation. An important question is whether patients, families, and physicians find ethics consultation to be beneficial. The issue of specialty certification in ethics consultation also requires further consideration and debate.

The consultant teaches the analytic, interpersonal, and communication skills that physicians need to solve ethical problems. The consultant assists in the decision-making process as a negotiator or advocate when the physician, the patient, or the family requires such assistance. Finally, the consultant is a clinical colleague with specialized training and experience who is available for consultation. Consultants who are competent in clinical ethics and who can use their skills and knowledge to assist patients and physicians at the bedside should be trained and available to assist patients, families, and physicians.

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INSERT B

Special Communication

# Quality-Adjusted Life-Years

## Ethical Implications for Physicians and Policymakers

John La Puma, MD, Edward F. Lawlor, PhD

Quality-adjusted life-years have been used in economic analyses as a measure of health outcomes, one that reflects both lives saved and patients' valuations of quality of life in alternative health states. The concept of "cost per quality-adjusted life year" as a guideline for resource allocation is founded on six ethical assumptions: quality of life can be accurately measured and used, utilitarianism is acceptable, equity and efficiency are compatible, projections of community preferences can substitute for individual preferences, the old have less "capacity to benefit" than the young, and physicians will not use quality-adjusted life-years as clinical maxims. Quality-adjusted life-years signal two shifts in the locus of control and the nature of the clinical encounter: first, formal expressions of community preferences and societal usefulness would counterbalance patient autonomy, and second, formal tools of resource allocation and applied decision analysis would counterbalance the use of clinical judgment. These shifts reflect and reinforce a new financial ethos in medical decision making. Presently using quality-adjusted life-years for health policy decisions is problematic and speculative; using quality-adjusted life-years at the bedside is dangerous.

(*JAMA*. 1990;263:2917-2921)

A QUALITY-ADJUSTED life-year (QALY) is a numerical description of the value that a medical procedure or service can provide to groups of patients with similar medical conditions. Quality-adjusted life-years attempt to combine expected survival with expected quality of life in a single metric: if an additional year of healthy life is worth a value of 1 (year), then a year of less healthy life is worth less than 1 (year).[1]

Quality-adjusted life-years represent a progression in the cost-effectiveness analysis of health care, as concepts of health, quality of life, and utility are inherently amorphous and elusive. Albert Mulley, MD, calls this "the stuff of poets and philosophers," but in QALY assessment they are also the stuff of economists and psychometricians. Health economists have struggled for decades to estimate the value of life and many have been uncomfortable with life-years gained as an outcome, but have had little more to offer.[2]

Serious clinical ethical questions, however, have been raised about QALYs.[3-9] We review herein QALY methods and historical development and attempt to identify the ethical issues they present.

### QALY METHODS

Calculations of QALYs are based on measurements of the value that individuals place on expected years of life. Measurements can be made in several ways: by simulating gambles about preferences for alternative states of health, by inferring willingness to pay for alternative states of health, or through "trading off" some or all likely survival time that a medical intervention might provide to gain less survival time of higher quality.

A reference gamble reveals preference by asking the respondent to choose the consequences of a hypothetical game (such as choosing balls out of an urn) with known probabilities. Willingness-to-pay estimates rely either on statements of the sacrifice an individual is willing to make to obtain alternative outcomes or on the analysis of actual observed behavior. Estimates of QALYs can also be derived by asking respondents to explicitly trade years of life for different presentations of quality of life.

In theory, these techniques could be employed to elicit QALYs for an individual patient who faces a choice between alternative therapies that yield different probabilities for pain reduction, abilities to engage in activities of daily living, and life expectancies. A patient with severe angina and triple-vessel disease will likely generate different QALYs with bypass surgery, without surgery, and with medications; a patient with severe angina and single-vessel disease would generate still different QALYs than the former patient.

How much survival time groups of patients would trade off for what degree of quality may change as more is learned about disease. New data may be folded into the analysis as they become available, eg, cyclosporine has improved survival after organ transplantation, requiring QALY recalculations to higher, more accurate values. In effect, QALYs "discount" years of life saved by a health care intervention by how much patients' subjective well-being is diminished by discomfort or distress.

The methods used to calculate QALYs are still under development.[10] Quality-adjusted life-year assessments have been shown to vary by how health states are described, how outcomes are reported, how scales are generated, and how surveys are administered.[11] We will not belabor the technical issues involved in utility measurement[12] and quality-of-life assessment,[13] but they are controversial and variable.

### COST-EFFECTIVENESS ANALYSIS IN HEALTH POLICY

Cost-effectiveness analyses attempt to assess how efficiently interventions are being used, given how much they cost. When divided by cost, QALYs can yield a measure of cost-effectiveness[14] and help establish priorities for funding. Interventions of highest priority (yielding the most QALYs per unit of cost) would receive the most resources: the more QALYs per dollar, the more resources and the greater development of that intervention. In theory, QALYs can help provide for an efficient use of those resources that already exist and for the allocation of new resources.

Quality-adjusted life-years are also a potential result of community medical ethics: the public identification, prioritization, and implementation of an equitable, virtuous distribution of health care resources. Accurate, detailed knowl-

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edge of community preferences is essential to allocate resources fairly. At least 10 state programs in community clinical ethics now exist.[15] Oregon Health Decisions, for example, helped persuade the state legislature not to fund organ transplantation because it received a lower community priority than preventive programs.[16] Although coverage for transplantation was reinstated after a public outcry,[17] the concept of small town meetings to allocate resources has broad appeal.

### QALYs AS A RATIONING TOOL

Most QALY proponents expect QALYs to inform resource allocation decisions, especially large-scale decisions that deploy resources across disease states and population groups. In theory, a QALY analysis compares the merits of devoting resources to an intervention likely to extend the lives of a population for a specific period, but with high levels of disability and distress, with another intervention, which may not yield as many years of life saved, but generates higher levels of subjective well-being.

Cost-per-QALY analyses are motivated by scarcity: if resources were unlimited, rationing would be unnecessary. In the United Kingdom, there is explicit rationing of some health care services, requiring physicians to be both caretakers and resource agents. In the United States, rationing is accomplished through patients' differential ability to pay: 37 million uninsured people do not have equal access to health care.[18] Aaron and Schwartz[19] found that British physicians most often find medical reasons to deny a needed treatment (eg, dialysis) to a patient. Such patients are said to be too old, too sick, or too unlikely to benefit; physicians generally do not say that the resource is relatively scarce and unavailable.

Explicit health care rationing, with selected priorities for funding, has been proposed in Oregon[20] and by scholars.[21] Oregon state officials hope to ration Medicaid services by July 1, 1990, using the "Quality of Well-Being Scale" and "Well-Years" very similar to QALYs.[22] These plans call on physicians to ration care at the bedside and could benefit from a clear explication of how QALYs have developed.

## HISTORICAL DEVELOPMENT

### Technical Development

Derived from operations research in engineering and mathematics, QALYs were first introduced by decision analysts and researchers in the United States.[23,24] Weinstein and Stason[25] described QALYs as a way of elucidating the trade-offs between quality of life and additional survival, representing "the net health effectiveness of the program or practice in question."

In 1978 in Britain, Rosser and Kind[26] reported the results of psychometric testing of 70 selected patients, volunteers, physicians, and nurses. The authors devised a scale that assigned a numerical value to 29 hypothetical states of disability and distress. The resulting Rosser index has been the foundation of most British work on QALYs, pioneered by health economist Alan Williams.

### Clinical Decision Making

Quantitative analytic techniques such as those of economic analysis can make the components of clinical decision making more clear; these techniques are most effective when their underlying value assumptions are made explicit. The algorithms and decision trees of health status assessment are not readily accepted as clinical tools,[27] however, as they miss the complexity and subtlety necessary for many clinical decisions. Still, Jennett and Buxton[28] have suggested that QALYs can and should be part of clinical considerations about quality of life and should be used at the bedside.

The process of clinical decision making, itself an outcome, is not taken into account by measures such as QALYs. The significance of this criticism is undervalued. Many interactions between physician and patient do not result in a tangible intervention or easily measurable data. Patients often seek physicians for attention, information, reassurance, encouragement, and permission, not just prescriptions and procedures. In QALYs, there is no attempt to integrate the therapeutic value and outcome of talking with patients[29] or their families: patient care is evidenced by the boxes checked on the office encounter sheet.

### Health Policy Proposals

Calculations for numerous interventions have been reported. Weinstein and Stason[25] applied QALYs to the resources allocated to manage hypertension and proposed a threshold value of blood pressure below which it would not be cost-effective to treat patients. It costs less than £200 ($350) to gain 1 year of quality-adjusted life for general practitioners to counsel patients not to smoke, £1000 ($1500) for coronary artery bypass grafting for left main disease with severe angina, more than £2000 ($3000) for coronary artery bypass grafting for left main disease with mild angina, and £15 000 ($22 500) for hospital hemodialysis.[30] Policy implications of these findings are that treatments with costs-per-day QALY above £5000 ($7500) "should be taken off the . . . budget completely and financed only as research and development activities."[30] More recently in America, QALYs and quality-adjusted life-months have been calculated for estrogen use in postmenopausal women,[31] neonatal intensive care,[32] dialysis,[33] coronary artery bypass grafting,[34] and prostatectomy.[35]

In 1985, Williams[36] compared the QALY costs and benefits of coronary artery bypass grafting with renal transplantation, concluding that bypass grafting for left main disease with severe or moderate angina and for triple-vessel disease should be funded before renal transplantation.

In 1986, Gudex[37,38] reported the results of the preliminary use of QALYs in the North Western Regional Health Authority in Britain, which, like other health authorities, receives monies from the National Health Service to fund its health care activities. Gudex compared the QALY efficiency of several unrelated interventions, using life-expectancy data from current literature and a revised Rosser index.[39] Surgery for a "neuromuscular" patient had the lowest cost per QALY (£194 [$291]), corrective surgery for an adolescent scoliotic patient had a higher cost per QALY (£2619 [$3929]), and chronic ambulatory peritoneal dialysis lasting 4 years had the highest cost per QALY (£13 434 [$20 151]). The North Western Regional Health Authority has not continued the studies and the Department of Health and Social Services has not made a formal statement about QALYs, although it continues to fund the work of Williams, Rosser, and Gudex.

The need for outcome management in American and British health care is increasingly newsworthy; the brief, efficient, accurate measurement of quality of life is an important part of that management. Ellwood[40] has encouraged the Health Care Financing Administration to define the quality-of-life data set, and more than 100 scales can be used to measure quality of life. Despite continuing uncertainty about how to deploy these measurements in health policy,[41,42] we can identify the ethical assumptions that underlie QALYs.

## QALYs AND MEDICAL ETHICS

The debate about QALYs occurs on at least four levels. First, there are methodological problems of theory, measurement, and interpretation. Second, practical questions of implementation arise, assuming the technical properties of

QALY-based policy guidance are clarified and agreed on. Third, QALYs present moral and professional challenges to the fundamental values and assumed prerogatives of physicians. Fourth, QALYs hold an uneasy, conspicuous, critical place in the recent evolution of health policy, an evolution preoccupied with the agenda of cost containment.

### QALYs' Ethical Assumptions

The formal use of QALYs and QALY-like scales makes six ethical assumptions. First, quality of life can be accurately measured and should have "standing" in determining resource allocation. Second, utilitarianism ("the greatest good for the greatest number") is the appropriate ethical theory for resolving resource allocation dilemmas. Third, equity and efficiency are compatible and should be balanced in QALY construction. Fourth, projections of community preferences for interventions can ethically substitute for the preferences of individual patients when allocating and rationing resources. Fifth, older and sicker patients have less "capacity to benefit" from interventions than those who are younger and healthier. Sixth, physicians will be able to differentiate between a patient's medical need and a resource's availability and between being a patient advocate and a public agent, will favor the measurable outcome of clinical decision making over its process, and will not use QALYs as clinical maxims.

### Quality of Life

The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research noted that "quality of life [is] an ethically essential concept that focuses on the good of the individual, what kind of life is possible given the person's condition, and whether that condition will allow the individual to have *a life that he or she views as worth living* [italics added]." One prominent philosopher has recently suggested that quality-based societal limits are needed and are morally correct.[43] In a recent national survey, nearly three fourths of Americans felt that an unconscious, terminally ill patient should be removed from life-support systems because of his or her quality of life and that of his or her family.[44]

Quality-adjusted life-years assume that quality of life can be measured well enough to make policy judgments about it. They also assume that at some point—the same point for all persons—life becomes so miserable that it is worse than death.[45] Incalculables such as freedom from the fear of dependency on a ventilator or the value of time spent awake, alert, and participatory are part of quality of life.

We do not say that such incalculables render impossible the useful measurement of quality of life. Some patients, though, would rather live no matter what their disability/distress score. Other patients cannot or will not decide and have no one to speak for them. The lives of these patients—the demented, the mentally ill, and the "old-old"—QALYs judge to be of inadequate worth; for these patients, quality-of-life assessments cannot be made accurately.

### The Greatest Good for the Greatest Number

Consider the estimation of QALYs generated by a zidovudinelike therapy for patients infected with the human immunodeficiency virus. Whose utility assessments count? Should a representative sample of the public be interviewed? Or should potential candidates for the therapy be interviewed? Should some form of weighing be developed for respondents with knowledge of or experience with the relevant health states? How should the valuation of outcomes in the distant future be treated?[46] How should individual preferences and attitudes about risk taking be accommodated?[47] How should resources for individuals with impaired decision making be handled? How should these assessments be summed or interpreted, particularly if there are major differences in assessments among respondents?

These questions are not new or unfamiliar to health planners and analysts, but the answers may be contained within the ideology of cost containment and the moral perspective of utilitarianism. As Caplan[48] has said, "The quantification of value . . . often is ideology masquerading as a moral point of view."

### Equity and Efficiency

Legitimate concerns arise about how QALYs may influence the conduct and direction of health policy. Our society continues to evolve toward a utilitarian ethic, one that appreciates medicine for what it can measurably produce, rather than for humanistic care. Quality-adjusted life-years are controversial not only for what they are, but also for the new financial ethos they represent. They symbolize a movement to make health a commodity and to shift the balance of power in and philosophy of clinical practice from highly discretionary physician-patient encounters to more standardized, quantified, and regulated protocols.[49] Thus, many critics of QALYs are fundamentally concerned with the problems of integrating explicit economic guidance and formulas with clinical decision making, fearing that policymakers will conflate efficiency and equity[50] and that physicians will be forced to choose between being a patient advocate or a public agent,[51] to the disadvantaged patient's disadvantage.[44]

### Whose Autonomy? Whose Justice?

Quality-adjusted life-years risk projecting community preferences over those of individual patients. The ethical principle of autonomy or self-determination, generally most important for individual patients, would be trumped by that of justice or fairness, generally most important for a community. The preferences of a selected population sample or the preferences of a representative sample of patients in hypothetical medical situations would be used as if they were individual patient preferences. For example, Williams, Rosser, and Gudex use an assessment of community values in QALY calculations. Their assessment for an individual patient would come from the preferences of the average member of the public, not the average patient and not the patient himself.

This departure from codes of medical ethics and from clinical ethics reflects underlying QALY assumptions—that the projections of healthy others can be generalized to any patient with a particular medical condition. If all members of the public were reliably asked how many years of life they would trade off for different conditions and their verified responses were analyzed, a sound public policy statement on health care resources could be made. Using such a policy to allocate resources at a high level could be tenable, but does not obviate the physician's professional responsibility to work at the bedside for a patient's medical interests. In the current era of cost containment, the physician should not be in the position of defending public policy: patient advocate or public agent should be an easy choice.

Finally, individual patient preferences cannot always be accurately assessed by others. One study has suggested that chronically ill elderly outpatients believe their quality of life is better than their physicians believe it is.[52] Another study found that quality of life is a poor predictor of individual patient preferences for intensive care.[53] Although the preferences of family members and others can be included in technology evaluation, even family preferences may not represent those of the patient. Spouses may overestimate patient preferences for many intensive therapies, including cardiopulmonary

resuscitation, and physicians both underestimate and overestimate patients' preferences.[54,55] Given the variability and difficulty of assessing individual preferences[53] and the potential for misuse when grouped, implementation of QALY-like standards in clinical practice would present significant risks to patients.

### What Is 'Capacity to Benefit'?

Several studies of QALYs assume that patients' "capacity to benefit" from an intervention is a relevant measure of QALYs. Researchers define "capacity to benefit" as the ability of an intervention to provide more life-years of adjusted quality. This definition would likely direct care away from patients who have a poor quality of life and little or no "capacity to benefit" (eg, terminally ill, locked-in, and comatose patients),[56,57] because their care would yield few QALYs at a relatively high cost. While the care of the terminally ill and the neurologically impaired may not be QALY efficient, it is part of the traditional role of health professionals. Attending to time-consuming patients and their families is part of this compassionate, although QALY-inefficient ethos of medicine.

Although straight counting of life-years undervalues the lives of the elderly,[5] they have less "capacity to benefit" than the young. If QALYs are calculated with patients' families in mind, reducing the disability or distress of patients with dependents will be preferable to reducing the disability or distress of patients without dependents. Patients who are more critically ill or whose quality of life is poorer would probably receive treatments *after* those who were less critically ill or whose quality of life was better.

### QALYs as Clinical Maxims: The New Diagnosis Related Groups?

Much of the concern about QALY implementation appears to have less to do with their technical properties than with how they might be abused. Clinician reaction to a 1977 *Hastings Center Report* article, for example, is instructive.[58] A simple didactic quality-of-life equation (not a QALY) was presented; the equation was intended to aid decision making for incompetent individuals. It was misinterpreted by many as a decision-making rule—an algorithm to be interpreted strictly and applied uncritically to individual cases. Neither the author nor critics envisioned any such use for this formulation.

Diagnosis related groups were similarly conceived to provide guidance about use for relatively large numbers of cases,[59] but instead of simply guiding prospective payment they have been employed directly in clinical decision making about individual cases.[60,61] The overall effect of diagnosis related groups has been to force hospitals to economize, accepting fewer uninsured patients, reducing patients' length of stay, and increasing the acuity of illness at discharge. While there is nothing wrong with encouraging physicians to be efficient, the point is that both QALYs and diagnosis related groups try to combine efficiency with equity to yield a blunt, economically driven tool. Whether QALYs will be used as clinical maxims remains to be seen.

### QALYs and Clinical Practice

Quality-adjusted life-years attempt to clarify judgments about quality of life. Clinicians make quality, cost, and survival judgments implicitly and individually, based on their experience with different patients and on the particular needs of an individual patient. These judgments are often subjective and always difficult to quantify. By identifying specific quality states, survival estimates, and societal preferences, QALYs may improve the efficiency and objectivity of medical decision making, reducing the subjectivity of judgments about quality of life.[62]

Quality-adjusted life-years are intended to be a "macro" tool. Quality-adjusted life-years use aggregate community preferences and trade-offs to determine what is best for an individual patient, regardless of whether societal preferences and an individual's preferences are the same. Using QALYs as a "micro" clinical decision-making tool has health system–wide implications that may promote decision making not by the numbers from physical examination and laboratory measurement, but by single metrics, eg, QALYs, diagnosis related groups, and age. Such decision making impoverishes medicine as a science of numbers and robs it of the richness of clinical detail.

Quality-adjusted life-years assume that the duration and quality of an individual patient's life are not different from most other commodities that can be purchased. While utilitarianism may be an acceptable ethical theory with which to make health policy at the macro level, at present, clinical practice is not primarily conducted to benefit society as a whole, the public interest, or the common good. The physician's primary duty is to meet the patient's medical needs as they together find them, the physician with technical knowledge and expertise and the patient with his or her personal history and values. Conserving society's resources is secondary or tertiary; if such conservation is brought about by considering some patients expendable or by serving opposing masters of patient and society,[63-66] the seemingly imminent role of public agent must be acknowledged, appealed, and refuted.

Using resources in response to patient need, however, as assessed by health professionals and as differentiated from patient or physician want, and in proportion to the expected benefit, should be the objective of clinical encounters. If rational, reasonable health policies are constructed and physicians are constrained from offering expensive technologies of marginal benefit,[67] then can we keep straight the difference between what is medically needed and medically available? Civil suits, licensure actions, courts of public opinion,[68,69] ethics consultants,[70] and the media have already appealed these constraints, but the real question is whether the physician's role must be redefined to include "negotiator" and "advocate" at the policy level. Understanding QALYs will help physicians influence policy in a way that preserves a level of choice within the reality of increasing fiscal constraints on patient care.

## CONCLUSION

Quality-adjusted life-years are a new health measurement tool that many health care economists and decision analysts believe has promise to provide health care to those who have the greatest capacity to benefit. Despite interest in the deployment of QALYs, there are significant computational problems of utility theory, instrumentation, measurement, and interpretation and ethical dilemmas of equity, justice, autonomy, beneficence, and discrimination.

Policymakers who wish to use QALYs to allocate resources must fully identify and disclose QALYs' ethical assumptions, so that they can be debated. How to reconcile variability in individual medical values and preferences with cost-per-QALY calculations is still uncertain. What is certain is that QALY analyses have bedside implications for patients and physicians.

If physicians use community-derived QALYs to determine which of their patients will receive treatment, full disclosure to patients will not help. Medical treatments are not like other commodities that can be proffered and purchased. Patients' preferences and needs for health care may be replaced by an economic analysis that relies on selected community opinions, giving insufficient weight to the patient's preferences or the clinician's judgment. Physicians' so-

cial responsibility to use resources carefully may supplant our professional responsibility to care for our patients medically.

It is unclear whether resources available for research should be directed toward cost-effectiveness analyses such as QALYs or toward superior outcome measures. The improper or overzealous deployment of QALYs may mask a simpler and more arbitrary cost-containment agenda. Policymakers should consider quality-of-life factors in decision making, but must do so with better data and great compassion. Excluding needy patients must be an anathema to both policy-makers and physicians. The tension between selected societal and individual interests will continue and heighten; guarding against economic analyses' imposition of selected societal interests on individual patients will increasingly become the physician's duty and charge, one that physicians must seize and defend.

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# Ethics, Economics, and Endocarditis

## The Physician's Role in Resource Allocation

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**• Medical decisions are increasingly shaped by financial considerations. Biomedical ethicists have encouraged the practicing physician to remain the agent of the individual patient, sometimes pitting physicians against health care institutions. The limitation of medical resources has given rise to the need for a clear conceptual basis for allocating scarce resources. The role of resource gatekeeper may be used to the indigent patient's disadvantage when the principles of triage are used incorrectly in situations of *relative* scarcity. To allocate limited resources fairly under changing policy and economic conditions, health care institutions should ensure that systematic processes, such as those of ethics consultants and committees, are readily available to help resolve problematic cases and policies. Physicians with clinical judgment and a primary commitment to patient care must assume active roles in these processes in order to build an ethically sound framework for clinical decision making in times of relatively scarce resources.**

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In today's competitive marketplace of medical practice, some patients have become economically undesirable. As these patients have become more prevalent, physicians are increasingly responsible for the allocation of their medical resources.[1] Indeed, general internists have been encouraged to assume a "gatekeeper" role and control all of the medical resources that a patient receives.[2] The medical responsibility of caring for the patient is becoming the fiscal responsibility for the use of the patient's money, the institution's money, and society's money.

What exactly are we doing when we "allocate scarce resources"? In this article, we will use clinical ethics and the principles of resource allocation to define and illustrate this phrase. We will suggest how clinicians might use these principles in clinical situations and how clinicians can participate in the institutional allocation of scarce resources.

### REPORT OF A CASE

A 37-year-old man (AB) with a history of intravenous drug use and alcoholism was admitted to hospital A with one week of temperatures as high as 40°C, right upper quadrant abdominal pain, jaundice, and weight loss. Seven of ten blood cultures were positive for *Pseudomonas aeruginosa*, and the diagnosis of endocarditis was made. An echocardiogram showed large mitral valve vegetations involving the anterior and posterior leaflets. One of AB's physicians suggested that AB be transferred to a public hospital because of his likely prolonged treatment course.

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On the second hospital day, AB's condition severely worsened. In spite of appropriate antibiotic treatment, high temperatures persisted and his neurologic status deteriorated. Results of a lumbar puncture were consistent with meningitis. Computed tomography of the brain showed a right temporal lobe infarct with edema and possible early uncal herniation. AB was treated with intravenous mannitol therapy, with dramatic improvement in his neurologic function and mental status, and he was able to carry on meaningful conversations with his physicians by the third hospital day.

On the eighth hospital day, AB suffered acute pulmonary edema. He required endotracheal intubation and hemodynamic support with dopamine hydrochloride and dobutamine hydrochloride. Swan-Ganz pressure readings and a repeated echocardiogram were consistent with mitral valve incompetence and regurgitation.

The cardiac surgery consultation team was asked to consider valve replacement. The team noted that AB's only insurance was Medicaid, which was unlikely to adequately compensate the hospital for operative care. Even if AB were treated, he might continue drug use and infect an artificial valve. They asserted that AB needed to be transferred and that surgery was not an option, recording these three reasons: (1) surgical risk was very high ("Class V" New York Heart Association status); (2) operative and postoperative care would be "costly"; and (3) the likelihood of "recidivism" would be high.

AB's deteriorating condition was discussed with cardiac surgeons at hospital B across town. They were willing to attempt valve replacement as long as AB's family understood the significant surgical risks.

AB was transferred to hospital B. A No. 25 Carpentier valve was placed in the mitral position the day after transfer. Control of postoperative bleeding required a second thoracotomy on the first postoperative day. Thereafter, AB's recovery was uneventful. He received six additional weeks of postoperative intravenous antibiotic therapy, with six of six blood cultures negative for organisms, and returned home eight weeks after the day of transfer.

### COMMENT

AB was an "undesirable" patient for a number of reasons: (1) he was poor and inadequately insured; (2) he had a serious illness that would require prolonged hospitalization and intensive use of services; (3) he suffered from illicit drug dependency, for which only relatively ineffective treatment is available; and (4) his drug dependency might infect a prosthetic valve. Undesirable or "hateful" patients have been described in the past,[3,4] most commonly with attributes of personality disorder, self-destructive behavior, or chronic disease. AB had these same attributes, but an additional one seemed to take precedence: medical indigence, or being uninsured.

Authority in medicine is established by the physician's skill in assessing the patient's degree of illness and likelihood of recovery. Clinical knowledge and judgment are major sources of that authority.[5,6] Clinical judgment is the ability to discern *medical* distinctions that are technically or morally relevant for an individual patient. Clinical judgment, however, is not based on a patient's payer status

or his personal habits. No physician can or should be forced to treat a patient he or she conscientiously cannot take on. Knowing that valve rupture is a life-threatening complication of endocarditis, however, is a *medical* distinction, one that patient AB's physicians knew of before his urgent transfer to hospital B.

The decision whether to operate on AB was made on the basis of socioeconomic cost/benefit considerations. If AB had had adequate health insurance, the surgeon at hospital A might have operated on him. It has been well documented that physicians do more elective surgery in situations of positive financial incentives,[7] but only recently noted that urgently needed care has been refused on the basis of negative financial incentive.[8,9] Resource allocation decisions must be made as social policy choices, in health care institutions and in legislatures, not in medical offices, hospital rooms, or in (most) intensive care units.

### Resource Allocation

Fuchs[10] has pointed out that "resources are always scarce in relation to human wants." The physician's role in resource allocation has been considered in recent decades by those in the growing fields of biomedical and clinical ethics. In this period, a major transition has occurred in the moral stance of the medical profession, from the patient's medical advocate to the patient's liaison for health care.

Biomedical ethics emerged in the 1960s, the same decade in which Medicare and Medicaid were established with the potential for equal and universal access to health care.[11] With few exceptions, ethicists and politicians alike then asserted a "right to health care," and morally excluded the consideration of financial issues from medical decisions. Conflicts of interest would emerge, it was feared, if physicians made allocation decisions that would affect their own pocketbooks. Financial incentives were given toward overutilization rather than underutilization,[12] and were considered ethically safer because patients would not be refused care. And yet, financial incentives have been an accepted reality of medical decision making. Indeed, health policy and administration are based on the fact that most people, including physicians, do more of what they are paid well to do.

The physician's covenant traditionally has been with the individual patient.[13] Before 1965, an indigent patient was treated in public hospitals and by charitable donations of a physician's time. After the establishment of Medicare and Medicaid, ethicists considered it morally unacceptable for a physician to withhold treatment from a patient because of its cost. There was only one ethically respectable role for costs in individual patient care: if costs were unacceptable to the patient himself, then they might be weighed in the decision. Individual self-determination and the Hippocratic notion of the physician as totally responsive to the needs of his or her individual patient have governed medical care for decades. The courts have supported this view of the physician-patient relationship, and have seen the physician as the agent of the individual patient, not of society.[14]

The medical profession has not wanted to accept the role of applying social policy considerations to individual patient care decisions. The ethical solution Hiatt[15] described in 1976 was that society should assume the allocation responsibilities, while physicians worked on behalf of their patients. Necessary constraints would apply to all physicians and would therefore be more equitable.

In most settings, the physician cannot contribute to, much less control, decisions affecting the overall distribution of health care resources. The physician's role in society's allocation of health care resources has been indirect. The role of health care liaison, or gatekeeper, is one that more physicians are being asked to take on. Even though this role does not influence society's distribution of resources, it does authorize the physician to decide which of an institution's or health care network's patients will receive how much medical care. How to continue as every patient's advocate and mete out health care resources fairly to each is still uncertain. It is certain that physicians are being asked to give fewer health care resources to those patients with fewer financial resources.

As medical gatekeepers, primary care physicians are expected to control patient costs by deciding for their patients which treatments they will receive and which subspecialists they will see. Defining cost-effective care is not easy, however[16]; financial incentives to physicians to undertreat medically indigent patients are often implicit in modern health maintenance organization and independent practice association contracts,[17] and are made explicit when patients lack insurance altogether. On paper, the difference between absolutely unavailable resources (dire scarcity) and less available resources (relative scarcity) is straightforward; in practice, this difference has become that between nonpaying and paying patients.

Gatekeeper theory and practice are not taught in medical school.[18] Residency training programs often emphasize "cost containment," although the subtlety of ethics or of cost-effectiveness as analytic tools is rarely taught.[19] Because of the lack of training in the gatekeeper role, and because of an apparent contradiction to the patient advocacy role, *gatekeeper* is a mantle that should be only reluctantly and knowledgeably assumed. Indeed, the financial efficiency that motivates the successful gatekeeper may work against optimal patient care,[20] creating a financial and professional conflict of interest for the physician.[21] If the gatekeeper role is assumed, physicians must prepare appropriate clinical responses to inappropriate insitutional and societal resource allocation.

### Potential Clinical and Institutional Responses to Inappropriate Institutional and Societal Resource Allocation

The realities of constrained resources and social stratification are part of daily practice, but how to consider these realities in clinical decisions poses ethical dilemmas for physicians. Within each institution, ways of asking and analyzing clinical ethical questions—those that are relevant in the care of a particular patient—must be clearly separated from general allocation questions—those that are relevant for the institution or society as a whole.[22]

If, for example, 37-year-old AB has been in intensive care for ten days, and the utilization review coordinator suggests that life-support measures be reevaluated because payment for AB's hospitalization has expired, it is critically important that a discussion among his physicians occur that clarifies and separates the issues of medical indications from the issues of cost containment.

Individual ethics consultants can assist physicians in bedside discussions of patient care and help resolve these clinical problems.[23,24] The services of ethics consultants have been reimbursed by third-party payers, and clinical ethicists have been appointed to hospital medical staffs. An ethics consultant can help physicians identify the moral aspects of a patient's care and provide decision-making skills for resolving the associated clinical problems. Consulting in AB's case, an ethics consultant might distinguish between medical indications and socioeconomic considerations at the bedside, and pull together the particular clinical, personal, and social details in offering an assess-

ment and advice to AB's physicians.

Institutional ethics committees can provide open forums for multidisciplinary, hospital-wide discussion of ethical problems in hospital policy. If AB has been in the intensive care unit for ten days, it becomes important to discuss hospital policy regarding utilization and allocation of intensive care beds, severity of illness, and inappropriate societal resource allocation. Involving institutional policymakers in committee discussions is critical.

In a case such as AB's, an ethics committee developing policy should investigate the hospital-wide availability of cardiac surgeons, operating room space, and personnel. The committee should construct institutional guidelines to allow physicians to treat acutely ill patients on the basis of their medical need, without regard to their payer status. Finally, the committee should take an active educational role, advising patients of the intent of some third-party payers to restrict access to therapies, from prescription lenses (Medicare) to liver transplantation (health maintenance organizations).

The ethics consultant and ethics committee can and should work together—the consultant to inform the committee about day-to-day issues, such as the scarcity of beds in intensive care units, and the committee to assess, evaluate, and contribute to policies concerning institutional resource allocation.[25,26] With clinical expertise and analytic and communication skills, an ethics consultant can teach committee members about the clinical ethical issues in a patient's case. With its interest in policy, its access to institutional resources, and its community liaisons, an ethics committee can elucidate and, if necessary, seek out any resources that the institution might need. Appeals to legislators and the courts may be necessary; if so, they are most effectively made with the voice of the institution, representing its constituent physicians.

Physicians must take leadership roles in institutional ethics committees, as these committees have a powerful contribution to make to society's resource allocation policies. Institutional policies, like professional regulations and community law, only assume authority with the participation of institutional members. The expertise and creativity of health care administrators are instrumental in creating new resources and in supporting clinicians whose highest priority is the health interests of patients,[27] and who wish to effect the ethical commitment of the institution to deliver needed medical care. Involvement of community members, including professional patient advocates, may minimize the institutional ethics committee's potential bias toward the institution's financial viability, instead of toward sensitive hospital policy. Clear thinking, of course, is the responsibility of those professionals involved, but institutions can ensure that ethics consultants are available to assist with problematic cases and that there are ethics committees to help shape institutional policies.

## CONCLUSIONS

Physicians can appeal inappropriate resource allocation decisions by utilizing basic medical knowledge, clinical skills, and the processes of clinical ethics. In the face of relatively scarce medical resources, physicians can maintain the integrity of their relationships with patients and with society by developing a professionally and ethically acceptable framework for decision making. To describe that framework is a clinical responsibility of health care professionals and a political responsibility of both health care professionals and their institutions. Those with clinical judgment and a primary commitment to patient care are best equipped to undertake those responsibilities and to articulate the ethical values relevant to resource allocation.

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# Gaming the System

## Dodging the Rules, Ruling the Dodgers

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• Although traditional obligations of fidelity require physicians to deliver quality care to their patients, including to utilize costly technologies, physicians are steadily losing their accustomed control over the necessary resources. The "economic agents" who own the medical and monetary resources of care now impose a wide array of rules and restrictions in order to contain their costs of operation. However, physicians can still control resources indirectly through "gaming the system," employing tactics such as "fudging" that exploit resource rules' ambiguity and flexibility to bypass the rules while ostensibly honoring them. Physicians may be especially inclined to game the system where resource rules seriously underserve patients' needs, where economic agents seem to be "gaming the patient," with needless obstacles to care, or where others, such as hospitals or even physicians themselves, may be denied needed reimbursements. Though tempting, gaming is morally and medically hazardous. It can harm patients and society, offend honesty, and violate basic principles of contractual and distributive justice. It is also, in fact, usually unnecessary in securing needed resources for patients. More fundamentally, we must reconsider what physicians owe their patients. They owe what is theirs to give: their competence, care and loyalty. In light of medicine's changing economics, two new duties emerge: economic advising, whereby physicians explicitly discuss the economic as well as medical aspects of each treatment option; and economic advocacy, whereby physicians intercede actively on their patients' behalf with the economic agents who control the resources.

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Pauline Stafford had lung cancer. Before surgery, Mrs Stafford was referred for computed tomography to determine whether the cancer had yet metastasized to her brain. Her insurance did not cover screening procedures, however, and would reject the claim if "rule out brain tumor" were written in the space marked "diagnosis." And so the physician directed his office staff to write "brain tumor," even though the test showed she had no tumor. When Pauline subsequently received in the mail a statement of her insurance benefits she saw the entry under "diagnosis" and concluded the worst. Two days later, after preparing her husband's dinner and typing out his daily business agenda, Stafford hanged herself. On the appeal of a $200 000 verdict against the physician and Neurological Medicine, Inc, the US Court of Appeals upheld the jury's finding that the erroneous entry on the claim form was the proximate cause of Stafford's suicide and ruled that their financial award to her husband was not excessive.[1]

The case of Pauline Stafford is not only a sad story. It captures one of the most vexing dilemmas of medicine's changing economics: physicians are expected to deliver quality care to their patients, including sometimes to utilize costly technologies, yet they are steadily losing their accustomed control over the necessary medical and monetary resources. No longer will insurers cheerfully pay out large sums, simply on a physician's say-so. However, physicians can still exert considerable indirect influence over resources by "gaming the system," using tactics such as "fudging" that enable one to skirt resource rules while appearing to comply with them. In this paper we will see how this awkward situation has come about, why "gaming" can be tempting, why it is hazardous and, most importantly, how this predicament forces us fundamentally to reevaluate physicians' obligations to their patients.

### PHYSICIANS' OBLIGATIONS, OTHERS' RESOURCES

We can be brief in exploring the origins of the problem, for that groundwork has been laid elsewhere.[2-4] It begins with physicians' obligations of fidelity to their patients. Traditionally, fidelity is necessary because patients are vulnerable. They may have physical, emotional and intellectual infirmities; their usually minimal medical knowledge requires them to trust in the physician's expertise; and treatment often requires them to expose personal intimacies and sometimes to incur substantial risk. Physicians therefore are obligated to be medically competent and to promote the patient's interests, even above their own.[4]

Over the years, medical competence has come to include not only the duty to keep abreast of new information, but to use appropriate technologies, such as x-rays or biopsies.

If physicians, as an aid to diagnosis, ie, judgment, do not avail themselves of the available scientific means and facilities for the

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collection of the *best* factual data upon which to arrive at the diagnosis, the result is not an error of judgment but negligence in failing to secure an adequate factual basis on which to support that diagnosis or judgment.[6p178],[7-9]

Furthermore, in requiring the physician simply to "take the x-rays, or have them taken,"[10] and to keep patients in the hospital as long as is medically necessary (regardless of insurers' reimbursement decisions),[11] courts have shown little or no interest in who owns the x-ray equipment or hospital bed, or who must pay the staff who tend them. "Whether the patient be a pauper or a millionaire, whether he be treated gratuitously or for reward, the physician owes him precisely the same measure of duty, and the same degree of skill and care."[6p1,12p677] While it is unclear just how far physicians' legal duties to use technologies actually reach (eg, the physician is not required to purchase the patient's prescription medications out of his or her own pocket), the physician is usually well-advised to use whatever technological resources are clearly part of the standard of care.[4]

Morally, it has similarly been routine to believe that physicians in the clinical setting "are required to do everything that they believe may benefit each patient without regard to costs or other societal considerations."[13p1573] The physician's duty is to the patient, not to society or to insurers.[14-16]

In essence, then, physicians have been expected virtually to commandeer other people's money and property for the benefit of their patients. For many years such economic indifference was plausible. Insurance, both private and government, was structured to insulate patient and provider from worrying about costs.[16] Reimbursement was retrospective and usually generous, and cost-shifting (providers' practice of raising charges to paying patients in order to cover nonpaying patients) covered many of the uninsured who found their way into the health care system.

In reaction to three decades' explosive expansion in health care expenditures, however, the "economic agents" who furnish the medical and monetary resources of care are no longer willing to stand as silent partners funding whatever physician and patient choose to do. Government, business, insurers, institutional providers such as hospitals and health maintenance organizations, and virtually everyone else with a major financial stake in health care now control their resources with a striking array of cost-containment and profit-producing measures, ranging from managed care and intensive utilization review to caps on coverage and restrictions on eligibility. The physician thus finds himself or herself increasingly trapped between traditional mandates to deliver unstinting resources to patients and a progressive loss of the power to do so.[4-17] And if physicians try to avoid this predicament by becoming themselves owners of the relevant resources, they can create formidable conflicts of interest between themselves and their patients.[4]

## GAMING: DEFINITION, DEVICES

While physicians have lost much of their direct control over resources, in fact they retain considerable indirect control. Where economic agents' resource rules seem to impede care, the physician can usually find ways to game the system, to bypass those rules while still appearing to honor them and thereby to secure resources that were not, technically at least, intended for this patient.

This room for manipulation has two sources. First, all resource rules leave room for interpretation. They must be articulated with language, and language is inherently vague, as it uses a limited number of verbal concepts to capture the infinite variety of experience. Reimbursement based on diagnosis-related groups, for example, requires the physician to state the patient's diagnosis. Yet in fact, it is often possible for the physician to describe his patient's condition in a variety of ways. The physician might describe the patient's episode as a "probable transient ischemic attack" or as a "possible stroke," depending on which will yield better reimbursement.[18,19]

Second, resource rules must leave flexibility for individuality of care. Medically, patients and their illnesses are too complex and diverse to be described adequately by any "cookbook" or computer.[14] And legally, insurers or hospital administrators who dared to dictate the daily details of care might be accused of practicing medicine without a license[20] or, at least, could increase their own exposure to tort liability.[11] Therefore, they often are willing to accede to the physician who insists that a patient needs some particular intervention,[21] or at least to negotiate some mutually acceptable course of care.[22]

Between the resource rules' unavoidable vagueness and their necessary flexibility, then, the creative physician can invent numerous ways to game the system. Not all manipulation of resource rules counts as gaming, of course. When resource rules are substantially ambiguous, the physician might simply select whichever fully correct description of the patient's condition will produce the most favorable application of the resource rules. For a Medicare patient with multiple medical problems, for instance, one can list renal failure rather than diabetes or hypertension as the "principal diagnosis," thereby maximizing the hospital's diagnosis-related group reimbursement.

Gaming does not begin until the physician pushes harder against a proper fit between language and reality. He may fudge, using florid descriptions to exaggerate the seriousness of the patient's condition to a utilization review officer who has been reluctant to authorize hospitalization,[23] or he or she might install an intravenous line in a patient who has no need for intravenous medication, solely to ensure such a utilization review authorization. There are many methods and degrees of fudging, short of outright lying, and many physicians have expressed willingness to resort to such tactics on occasion.[23]

At the extreme, the stretch and push of fudging merges into the flagrant dishonesty of fraud. The plastic surgeon may say that this patient's rhinoplasty was "necessitated" by a (fictitious) ski accident. The internist may file claims for tests that were never performed or for patients who do not exist, or may secure payment several times for a single procedure (*Wall Street Journal* December 6, 1989: A-1, A-8).

Gaming is not only easily available. It is now sorely tempting, because it seems to offer escape from an impossible situation by allowing physicians to secure indirectly what they no longer control directly. The physician still manages to extract the hospital admission or the costlier therapy, despite third parties' refusals or reluctance.

## THE CASE FOR GAMING

Gaming is particularly tempting in two kinds of situations. First, many patients lack adequate health care coverage. Almost 40 million Americans have no medical insurance. Where formerly many of these people had at least some gratuitous entry into the health care system, the disappearance of cost shifting has left many of these people either in overcrowded public hospitals or without care altogether. Beyond this, many insurance policies are not comprehensive. An infant recovering from meningitis may be medically ready to leave the hospital receiving oral antibiotics, for example, but if his or her 14-year-old, illiterate mother is unlikely to adhere to the necessary outpatient regimen, the physician may want to "find" some further "medical problem" that "requires" a longer inpatient stay. The purely medical orientation of most insurance rules leaves little room for such medically significant social problems or for the psychosocial component of

many medical problems.[8] Similarly, many physicians are disturbed by insurers' traditional refusal to cover screening tests and other important preventive care. Even insurance coverage that is basically adequate can precipitate problems. Many patients, unaccustomed to paying for medical care and now facing higher cost sharing or reduced coverage, may pressure their physicians to waive their copayments or to "get the insurance to pay" for services not covered by their policies or health maintenance organization plans.

Second, patients do not always receive even the resources to which they are entitled. Some insurers have developed a truly awe-inspiring array of tactics by which to avoid or delay making the payments they owe.[9] In other cases an unsophisticated utilization review clerk may deny approval to reimburse hospitalization for a condition that clearly requires it, as where a patient has a clinically obvious even if atypical presentation of appendicitis. Or in some instances the physician may question the patient's health care policy at a fundamental level. A health maintenance organization may lure subscribers with promises that "we provide all the care you'll ever need," yet fail to disclose an assortment of coverage limits, incentive systems, and barriers to care.[8,9] Where there is good reason to suspect that the payer is "gaming the patient," the physician may be sorely tempted to dodge its rules.

Note, patients are not the only ones whose needs may be ill-served by resource rules. Hospitals, too, can suffer where payers refuse to pay, or where they must care for too many indigent patients. Likewise, physicians' fees are increasingly the targets of cost containment. We can argue that physicians need to take their own incomes seriously as a moral issue,[10] and that greed can never justify gaming. We may also agree that physicians and hospitals ought to provide at least some uncompensated care for indigent patients, yet we must acknowledge that these obligations are not unlimited. It is unfair to expect providers alone to make up for the broader society's lack of a comprehensive health care system.

## THE CASE AGAINST GAMING

Though gaming can be powerfully attractive in a system that leaves many patients with inadequate health care resources, and that still expects physicians generously to deliver resources that they no longer fully control, it also carries formidable moral and medical hazards. It can violate principles of nonmaleficence, veracity and justice.

Nonmaleficence is the principle of avoiding harm. Gaming can harm the very patient it is intended to help, as sadly evidenced by the case of Pauline Stafford. Even if we argue that the immediate harm to Stafford could have been avoided if the physician had explained his 'creative accounting' system ahead of time, an important indirect harm could thereby be done to her trust for him. If he is so cheerfully willing to lie for her, perhaps he is equally willing to lie to her. Moreover, such an explanation can place the patient in a very awkward position. One who does not morally approve of such deception must either challenge the physician's integrity outright, or must be an uneasy silent accomplice to the dishonesty. Further, if a physician exaggerates the seriousness of a patient's condition to utilization review officers on the telephone, he or she may have to write those exaggerations in the chart, thus jeopardizing the patient's future care. Similarly, a psychiatrist who identifies a patient's illness according to the most serious, best-reimbursed diagnosis, he may needlessly stigmatize the patient elsewhere in life.

Other patients, too, can be directly harmed. If a physician gains entry for a patient into a crowded coronary intensive care unit by (mis)describing the patient's exertional angina as "unstable," some needier patient may be denied admission. Physicians can even hurt themselves. If an adverse medical outcome happens later to lead to litigation, even altruistically motivated fudging could undermine that physician's credibility in the eyes of a jury.

Everyone can be harmed by gaming. Where physicians routinely game their way around an undesirable resource rule instead of openly challenging it, they may help to perpetuate unwise policies. Thus, if insurers' refusal to cover reasonable screening tests is as medically and economically counterproductive as many physicians believe, surely it is better to challenge this policy than to preserve it by pretending to honor it.

Gaming also offends veracity. Virtually every act of gaming features some duplicity, for by definition gaming is an attempt to bypass resource rules while still appearing to honor them. We need not belabor the importance of honesty. It is a basic tenet of moral integrity, of respect for other persons, and of successful communication and cooperation in a community.[11] Furthermore, no resource system can long survive widespread abuse and dishonesty, nor can physicians expect to retain either their professional integrity or, equally important, their clinical autonomy, if they treat with duplicity those who own the medical and monetary resources essential to their patients' care.[12] While the wrong is blatant where the physician games for personal gain, it is also formidable when done to help the patient.[4] It is therefore, difficult to defend even the marginal duplicity of fudging, and probably impossible ever to justify outright fraud.

Finally, gaming can offend both contractual justice and distributive justice. Contractual justice concerns fair exchange, honest dealing, and keeping one's promises.[1] Here we especially note the contract between patient and payer. The patient, perhaps through his or her employer, has paid a specified amount for a designated, and limited, list of services. Admittedly, the physician plays an important role in this contract. He or she recommends medical services to the patient and often controls the patient's access to them through his power of prescription. The physician even controls the patient's access to third-party reimbursements, as insurers require the physician signature attesting to what was done, and why.

However, this does not entitle the physician to override, undermine or otherwise "correct" the contract between patient and insurer solely because he personally has judged it to be inadequate. So long as our health care system is based on free enterprise and voluntary negotiation among competent individuals and groups, widespread gaming represents not only an assault on legitimate agreements, but an invitation to economic anarchy. Contractual justice is better served when bad contracts are openly challenged than when they are covertly undermined.

In government insurance, too, recipients' entitlements are created, also with express limits, through a kind of contract among citizens and their legislators. Where policies are unwise or inadequate they should be corrected not by a gaming that undermines both the social decision and the democratic process by which it was made but, rather, through public discussion.

Gaming can also offend distributive justice, the basic fairness with which scarce resources are allocated.[1] Scarcity means that not everyone can have everything that he or she needs. Therefore, even the fairest possible system for distributing health care resources will have unfortunate consequences in individual cases. Gaming is tempting in such cases because, if successful, it can help those individuals to avoid those consequences. Yet, if the overall distribution system is just, these individuals who extract more than their share, even for the worthwhile goal of better health, are unjustly freeloading at others' expense. If scarce resources are to be

distributed fairly, all must cooperate.

Even in societies like the United States where the health care distribution system is far from just, distributive justice would still ask the physicians to refrain from gaming to gain extra resources for their own patients. Gaming, if widespread enough, can destroy any system of resource rules. Unless the distribution system is so seriously unjust it warrants classic civil disobedience or even revolutionary overthrow, it is usually better to preserve order through that system even while one remedies its faults through open political processes.[13]

In sum, then, although there are powerful reasons to game resource rules where one's patient seems to be denied a needed or even entitled resource, moral principles of nonmaleficence, veracity and justice would oppose gaming. Fortunately, a better answer is available from two sources: a practical look at the actual mechanics of health care financing, and a moral reexamination of physicians' traditional fidelity obligations to their patients.

## ECONOMIC PRACTICALITIES

Practically, a physician's inclination to game is often based on empirical assumptions that commonly are, in fact, incorrect. The physician may assume, for example, that a current denial of funding constitutes a permanent denial. However, in most cases this is not actually true. All utilization review systems have mechanisms for appealing lower-level decisions and, more importantly, it is rare for prospective review to result in a flat denial of funding for care that a physician seriously argues is necessary. Usually, either the physician's original plan is accepted after further discussion or else some mutually agreeable compromise is negotiated.[11]

Similarly, where funding actually is denied or unavailable, a physician may assume that further care for the patient is thereby precluded. This assumption, too, is often erroneous, for it may be possible to find or invent alternative options. If an elderly widow is medically ready for discharge from the hospital but lacks adequate support services at home, the better remedy is to arrange for those home services, not to hold her indefinitely in a costly inpatient facility. A bit of inventiveness in recruiting family and friends can often solve the problem even in the absence of designated funds or formal programs for home care.

Even absent such alternatives, a denial of money does not entail a denial of care. When Medicare's hospital payment has been exhausted, the patient is not automatically discharged. The denial of further funding means only that continued hospitalization must be funded from somewhere else, whether by seeking money from a charitable organization, by adding to the hospital's burden of uncompensated debt, or even by expecting the patient to pay where he or she is obligated and able to do so. Similarly, a Medicaid refusal to cover well-baby care is not a denial of care to the baby, but of payment to the physician.

In these ways, the gaming that the physician may feel so urgently necessary is, as a matter of fact, quite avoidable. Gaming is often selected not because there is no other way to secure a needed resource, but because it is more obvious or convenient than searching for alternatives. Of course, there usually are alternatives: one can appeal, invent, negotiate, find money elsewhere, or provide services at no cost.

But here we encounter a major moral challenge. To demand this level of effort seems still to presume, as in our traditional view of fidelity, that the physicians are personally responsible to deliver resources to patients, regardless of the costs to themselves or others. In the new economics of medicine, this requirement now seems untenable. We need to reexamine traditional obligations of fidelity as they concern resources.

## FIDELITY RECONSIDERED

Our expectation that physicians should generously deliver other people's money and property to their patients is largely a product of history. Until relatively recently, physicians mostly had only their own care and concern to offer. As medical technologies emerged, generous third-party coverage, plus cost-shifting, generally made it possible for physicians, patients, courts and moral observers all to ignore costs. And yet, in the cold light of current resource constraints, it makes little sense to maintain this moral and economic anachronism.

The economic agents who provide health care's resources are not "intruders"[8] into the physician-patient relationship. In many ways, they make that relationship possible. The wisest, most skilled physician can do little without tools. And where the necessary tools are costly and scarce, and are owned or paid for by third parties, then physician and patient alike have an obligation to respect these agents' legitimate interests and resource restrictions.

If physicians are not obligated to deliver to their patients are that which they neither own nor control, then what do they owe? They owe what is their to give: their professional competence and loyalty as always and, in the new era of resource restrictions, their best efforts at advising and advocacy. Physicians have always owed their patients medical advising and medical advocacy, of course, but now we must add an economic dimension, on both a clinical level and a profession-wide level.

On the clinical level, physicians need to advise their patients more closely concerning the economic changes in health care. In an important sense, patients are the "ultimate payers" for health care. As employees, they forgo salary or fringe benefits or cover the rising cost of health insurance; as consumers, they pay higher prices for products as businesses try to recoup the increasing cost of employees' health benefits; as taxpayers they see rising taxes or reduced government services as a deficit-ridden government seeks to trim what expenditures it can; as patients, they must directly pay higher copayments and deductibles and bear the medical consequences of cost-care tradeoffs. It is therefore fitting that patients play a much greater role in choosing whatever tradeoffs must be made.

To make these judgments, patients must know the price-tags on their medical options. And this requires that physicians themselves become far more aware of the actual costs of care. They must be open about their own fees, and must try to learn the costs of the medications, tests, and other care they prescribe.[14] While this task may seem onerous, it is now necessary, for patients are entitled to know and to help decide the ways in which medicine's changing economics (including the conflicts of interest that this can create between patient and physician[1,2,5]) will affect their care. Where patients know more about their costs from the outset, they may even be less likely to pressure physicians inappropriately to "get the insurance to pay" for that screening test or cosmetic surgery that is expressly excluded by their policy.

Advocacy, like advising, is not a new concept in medicine. But when applied to economics, it carries some new responsibilities. Contrary to common views, advocacy does not require the physician simply to deliver resources to the patient. Rather, an advocate is "one who pleads, intercedes, or speaks for, or in behalf of, another."[7] While the physicians do not necessarily control or own the resources they seek for their patients, they can vigorously intercede on their patient's behalf.

Economic advocacy is no longer a personal favor that the physician may or may not choose to do for the patient. It is an

important part of the physician's job, because otherwise the patient will have little or no access to essential monetary as well as medical resources. Thus, while we can no longer say that physicians owe their patients other people's resources, they do owe their own efforts to secure resources. The duty is now gaining recognition in common law. In one case, Herbert Chew, a steel company worker who had undergone surgery, asked his surgeon, Dr Meyer, to document for his employer that Chew's absence from work was medically necessary. Meyer reluctantly agreed to have his secretary complete the necessary forms but, despite several inquiries and proddings from Chew, did not in fact send the forms until after Chew had been fired from his job for failure to furnish that very documentation. The Maryland Court of Special Appeals noted that the physician's promise constituted an undertaking that, although perhaps gratuitously made, carried a duty to discharge the promise in a proper and timely manner.

The court also found another important basis for liability. In earlier times, the court argued, the plaintiff's claim might well have been summarily rejected, on the basis that a physician's obligation ordinarily did not extend beyond their duty to use their best efforts to treat and cure. The traditional scope of the contractual relationship between physician and patient, however, has expanded over the years as a result of the proliferation of health and disability insurance, sick pay, and other employment benefits. Today, the patient commonly, and necessarily, enlists the aid of his or her physician in preparing claims for health and disability. Such forms ordinarily require information possessed solely by the treating physician as well as the physician's signature attesting to the bona fides of that medical information.[39,40]

The physician therefore, the court concluded, has a duty to assist the patient in such economic matters.

As a profession, physicians have further duties of economic advising and advocacy, namely, to help policymakers to write medically credible resource rules and to help change those that are not. Fortunately, such advisory efforts are already underway.[1,2,6]

## CONCLUSION

In the end, then, I cannot recommend gaming as a strategy for coping with the admittedly frightening changes in medicine's economics. It is short-sighted, medically and morally hazardous, and usually unnecessary. Our real moral challenge now is to explore more closely the duties—and the limits—of economic advising and advocacy. Just as physicians should not be expected to commandeer others' money and property, so is it unreasonable to expect literally limitless efforts in appealing odd resource rulings, locating new sources of funding, or providing free care. Our agenda for the future, then, must be not only to explore more closely the new fidelity of medical ethics, but also to consider how to forge a more rational health care structure, one that will not call for physicians so constantly to battle resource rules in order to secure care for their patients.

Major themes in this article are taken from my volume entitled, *Balancing Act: The New Medical Ethics of Medicine's New Economics*, forthcoming in 1991 in the "Clinical Medical Ethics" series edited by H. T. Engelhardt and S. Spicker, Kluwer Academic Publishers, Dordrecht, the Netherlands, and are published herein with permission of the publisher.

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gonadotropin-releasing hormone agonist — a finding incompatible with a diagnosis of 3β-hydroxy-Δ⁵-steroid dehydrogenase deficiency in the ovary,[6] where the same enzyme is necessary for the synthesis of estrogen.[11] These findings are not easily reconcilable with the diagnosis of late-onset 3β-hydroxy-Δ⁵-steroid dehydrogenase deficiency. Our studies have led us to conclude that the adrenal steroidogenic defect that we find in about half the women with hyperandrogenism results from a previously unrecognized defect in the regulation of steroidogenesis. We have hypothesized that this is an abnormality in the regulation of the androgen-forming enzyme P450c17α, which has both 17α-hydroxylase and 17,20-lyase activity — an abnormality that can occur in the adrenal glands or ovary, either alone or together.[5,12]

The optimal pharmacologic therapy of hirsutism is predicated on the accurate establishment of its cause. Hirsutism in the polycystic ovary syndrome is traditionally treated with a combination of estrogen and progestin. This treatment lowers plasma free testosterone levels by reducing serum gonadotropin levels and increasing the levels of sex hormone–binding globulin. Antiandrogens may be required to reverse hair growth in some women with hirsutism. These agents, which act primarily by inhibiting the binding of androgens to the androgen receptor, include spironolactone, flutamide, and cyproterone acetate (not available in the United States). In contrast, the administration of small doses of glucocorticoids is the treatment of choice for women with well-documented late-onset congenital adrenal hyperplasia. In such women, the administration of glucocorticoids typically corrects adrenal androgen secretion, reduces hirsutism, and restores fertility.

The salutary response of hirsutism to specific pharmacologic therapy in women with late-onset congenital adrenal hyperplasia warrants the cost of an ACTH test in selected patients. At times, however, an abnormal response to the test cannot be interpreted unequivocally to represent a steroidogenic block. The therapeutic implications of such mild steroidogenic abnormalities remain to be established.

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## THE TROUBLE WITH RATIONING

SUDDENLY everyone is talking about rationing. First brought to public attention in this country by Schwartz and Aaron's study of the allocation of hospital services in the United Kingdom,[1,2] rationing is now widely advocated as the only effective way to control health care costs.

The argument goes like this: An aging and growing population, rising public expectations, and the continual introduction of new and expensive forms of technology generate a virtually unlimited demand for medical services, which inevitably exhausts the resources we are willing and able to devote to health care. Sooner or later we will be forced to limit expenditures by restricting services, even those that are beneficial. Of course, we are already restricting services through our failure to provide health insurance to many who cannot afford it, but we now must confront the necessity of explicitly denying certain services to insured patients — at least to those whose insurance is subsidized by government or business.

On the surface it is a persuasive argument. Many observers now seem convinced that the question is not whether but how we will ration health services.[3] A closer examination of the problem suggests, however, that rationing is not necessary, nor would it be likely to work without major changes in our health care system. Furthermore, as even some of its strongest advocates admit, a fair and workable rationing plan would be, to say the least, difficult to design.

The supposed necessity of rationing rests on the assumption that no other expedient can prevent for long the continued escalation of health costs. Advocates of rationing usually acknowledge the growing evidence of overuse of services, inefficient use of facilities, and excessive overhead and administrative expenses. They may even accept the proposition that substantial elimination of such defects might reduce the cost of health care by as much as 20 or 30 percent. But they maintain that any reforms of this kind would produce only a one-time savings that

would soon be nullified by a resumption of the inexorable rise in costs.

This argument, it seems to me, fails to recognize the crux of the problem. New forms of technology and insatiable demand are not the fundamental causes of cost inflation, nor are overuse, inefficiency, duplication, or excessive overhead expenses. They are simply the manifestations of a system that has built-in incentives for waste and inflation. It is the way we organize and fund the delivery of health care that rewards the profligate use of technology and stimulates demand for nonessential services; it is the system that allows duplication and waste of resources and produces excessive overhead costs. Change certain features of the system, and you will not only reduce costs in the short run, but moderate the inherent forces causing inflation. As a result, future costs will rise at a slower, more affordable rate without the need to restrict essential services and without loss of quality. To avoid rationing, what we require most is not more money but the will to change those aspects of the present system that are responsible for the present cost crisis. In a subsequent editorial I will discuss what might be done to control costs and avoid rationing. My purpose here is to explain why, even if there were no alternatives, rationing would probably not be acceptable or workable. I will also suggest that unless the funding of health care were to become far more centralized and prospectively budgeted than at present, rationing would not control costs.

To be seen as fair and therefore have a chance of acceptance by the public and the medical profession, a rationing plan needs to have medical and ethical, not simply economic, justification. To be medically justified, rationing decisions have to be personalized, because no two patients are exactly the same and the anticipated benefits of a given procedure vary from patient to patient. As Schwartz and Aaron[4] have recently pointed out in a convincing critique of the method of rationing initially proposed by the state of Oregon,[5] any plan to assign priorities to specific medical interventions on the basis of cost–benefit considerations must take into account individual circumstances, balancing costs against potential benefits in each patient. Thus, for example, it would make no sense simply to approve or disapprove all kidney transplantations, or to assign the procedure a single overall priority rating. In some patients a kidney transplant might have an excellent chance of substantially extending life and improving its quality while saving money as well, but in others a transplant would be worse than useless. Setting out formal guidelines to cover all the clinical circumstances under which kidney transplantation might or might not be worthwhile would be a complex task. The same would be true of bone marrow transplantations, coronary bypass operations, total parenteral nutrition, magnetic resonance imaging, or any other procedure that might become the object of rationing. With each procedure, the cost–benefit assessment depends so heavily on individual circumstances that it is almost impossible to devise medically sound rules applicable to all patients. In fact, the task is so formidable that no one has yet offered a practical suggestion about how personalized rationing might be carried out systematically and on a wide scale. In a recent interview reported in the *Boston Globe*,[6] Dr. Schwartz said, "I don't know that any scheme [of rationing] will be satisfactory." With that candid opinion by one of the most thoughtful students of the subject I emphatically concur.

Beyond these practical difficulties, attempts to ration medical services in our present health care system would create serious ethical and political problems. Doctors would find themselves in the uncomfortable position of having to deny services to some insured patients they would ordinarily have treated in accordance with accepted medical practice. In a system with a fixed global health care budget established by national policy, as in the United Kingdom, physicians forced to withhold potentially useful services from their patients because of costs at least can be assured that the money saved will be appropriately spent to help other patients and that all publicly financed patients will be treated more or less alike. But this is not so in a disorganized and fragmented health care system like ours, which has multiple programs for the care of publicly subsidized patients and no fixed budget. When medical resources are uniformly limited for all, physicians can ethically and in good conscience allocate services to the patients most likely to benefit, but in the absence of clearly defined limits they feel morally bound to do whatever might be of benefit.[7] For rationing to be perceived as equitable, public insurance programs like Medicare and Medicaid would need to have fixed budgets committed to health care, and a method of allocation that was uniformly applied. Present political realities make these conditions unlikely, and therefore I believe that a public rationing plan would not be ethically or politically acceptable at this time.

Even if a workable, medically sensible, ethically and politically acceptable rationing plan could be devised, it would not save money in the long run. The present health care environment generally encourages — virtually requires — physicians and hospitals to be expansive rather than conservative in providing medical services. Aggressive marketing, not the prudent use of resources, is the prevailing imperative. Any limitation of a medical service by rationing would place economic pressures on health care providers to protect their revenues by expanding the delivery of other services that are not rationed. In an open-ended, competitive system with more and more new physicians, new forms of technology, and new health care facilities entering the market, it is inevitable that costs will continue to escalate despite targeted restrictions on the delivery of certain services. Each decision to restrict services might temporarily reduce costs in one part of the system, but no single decision or group of

decisions could stop for long the relentless progress of inflation in the rest of the system. With no overall cap on expenditures there would be no way to keep costs under control except by an endless series of rationing decisions that would cut ever more deeply into the body of accepted medical practice. The gap between optimal care and what the regulations allowed would widen. Sooner or later strong general opposition to further cuts would arise, and it would become apparent that rationing is not the solution to the U.S. health care crisis — at least not without more fundamental reforms in the system.

Our cost crisis, and the limitations on access that result from high costs, stem from an inherently inflationary and wasteful health care system. Rationing is not likely to be successful in controlling costs unless we deal with that basic problem. Given the huge sums we are now committing to medical care as compared with other developed countries, we should be able to afford all the services we really need, provided we use our resources wisely. Concerted attempts to improve the system rather than ration its services are the next sensible step. Even if reform of the system should prove to be an insufficient remedy, it would still be necessary for the ultimate acceptance and success of any rationing plan.

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# SOUNDING BOARD

## ESSENTIAL NATIONAL HEALTH RESEARCH

### A Key to Equity in Development

THE Commission on Health Research for Development, an independent international initiative, was launched in 1987 to study the status, effect, and needs of research on the health problems of developing countries. The commission has now released its final report, *Health Research: Essential Link to Equity in Development* (New York: Oxford University Press, 1990).

Among the commission's key findings is the fact that although the problems of developing countries are the focus of only 5 percent of the world's expenditure on health research, those countries suffer 93 percent of the burden of premature mortality, as measured in potential years of life lost.

Acute respiratory-related infections — including measles and whooping cough — are responsible for 7.4 million deaths a year in the developing world. Diarrheal diseases cause 5 million deaths. Although modern Western medicine has rendered pregnancy and childbirth relatively free of danger in the industrialized world, half a million women die each year in developing countries from complications of pregnancy.

The commission's report addresses the issue of the inadequate transfer and adaptation of scientific knowledge and technology from the First World to the Third World. But it also examines the reality that the unique circumstances of countries and regions within countries render direct transfer inappropriate and ineffective. The commission concludes that the solution lies in building the capacity of developing countries to conduct and act on their own research in the areas most pertinent to the health of their citizens. With that capacity, countries can address their own health priorities in a strategic and ongoing way and can contribute substantially to the world's ability to cope with the issues that transcend national borders.

It has been recognized that behavioral, cultural, ecologic, and economic conditions all play a part in defining the unique health profile of every country and region. The commission therefore stresses a broadened definition of health research to accommodate a multidisciplinary approach to problem solving. Health research, it concludes, must entail more than epidemiologic studies and biologic laboratory work. In order to apply even proved solutions in diverse settings, one must conduct social and field research in the location where the problem lies. Health researchers, in this view, include groups beyond university scientists and clinical professionals. People such as project leaders and front-line community health workers also participate in health research.

The commission calls such multidisciplinary, country-based activity "essential national health research." The commission's recommendation is that every country, no matter how poor, must engage in essential national health research to guide health policy and management decisions; otherwise, precious resources for health will be wasted. Central to the concept of essential national health research is a critical but often neglected link between health research and policy making. Even in industrialized countries, health research is rarely guided by any strategic, unified agenda, and critical health priorities are neglected by the research community.

The commission's agenda has already been embraced by working groups for essential national health research in Bangladesh, Brazil, Egypt, Mexico, Mozambique, the Philippines, Thailand, and Zimbabwe. The commission's report and its broader implications were part of the technical discussions of the 43rd

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