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# THE NATIONAL POLITICS OF OREGON'S RATIONING PLAN

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by Lawrence D. Brown

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**Prologue:** *Medicaid, a program that pays providers of medical and chronic care on behalf of eligible beneficiaries, was created in 1965 as a part of Lyndon B. Johnson's "Great Society." But in the ensuing years, one of the great inequities of American health care has evolved not between the nonpoor and the poor, but between the insured poor and the uninsured poor. Medicaid provides financial protection against the consequences of illness not to "the poor," but to selected groups of low-income individuals and families who meet its arbitrary and confusing eligibility standards. In 1990, at any given time, 29 percent of adults whose income was below the federal poverty standard (\$6,620) were covered by Medicaid, 14 percent had employer-provided health insurance, and 40 percent had no private or public health insurance. Enter Oregon, and what a New York Times editorial called its "Brave Medical Experiment" (12 May 1990) : providing all its poor population with some health care benefits, rather than the current inequities that bedevil the poor there and elsewhere. If Medicaid was the exclusive preserve of states, as Lawrence Brown underscores in this article, Oregon's exercise in explicit rationing may well have been implemented by now. But since Medicaid is a federal/state enterprise, Oregon must seek a Washington waiver from federal program requirements to implement its proposal. Brown, who holds a doctorate in government from Harvard University, is no stranger to examining or provoking controversy. His critique, coauthored with Catherine McLaughlin, of community-based cost containment initiatives (Health Affairs, Winter 1990) engaged some readers and enraged others with their assessment of the potential of a decentralized health cost containment approach. Brown, a political scientist, is more involved with policy concerns than is common within that discipline.*

In 1989, the state of Oregon passed legislation intended to achieve near-universal coverage by defining a new basic benefit package for a subset of Medicaid recipients, requiring employers to offer at least that basic package to their workers, and creating a pool to extend coverage to uninsurables. Because the basic benefit package would explicitly exclude services deemed to be insufficiently cost-effective, the plan has sparked a lively debate about health care “rationing.” And because the proposed modifications to Medicaid cannot proceed unless the federal government waives certain requirements, the rationing debate is now crystallizing in Washington, D.C. This article tries to explain what the debate is about and indicates its larger policy significance.

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### The Policy Context

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Although it entails complex technical calculations, the Oregon proposal speaks directly to central dilemmas in health policy. Part of the Reagan revolution, still ideologically vigorous in the 1990s, is a pointed social debate about the moral content of public entitlements. Left-of-center analysts tend to view public pensions, welfare, health, and other programs as precious social compacts between government and beneficiaries or as unexceptionable scraps of justice tossed to disadvantaged recipients. Those to the right of center often portray public entitlement programs as an open invitation to excess, as interest group pressures, popular expectations, liberal rhetoric, technological progress, and other expansionary forces encourage everyone to want every need satisfied at the taxpayer's expense. The two sides presuppose and promote different images of equity: to the left, the essence of the policy challenge is to protect social programs against political assault, meanwhile seizing each chance for expansion, however incremental. On the right, fairness implies building into uncontrollable programs brakes that limit their drain on the earnings of the hard-working, forgotten souls who foot the bill.

Despite their wide differences, both left- and right-of-center analysts show a growing fascination with rationing. Conservatives increasingly think it a hard but obvious truth that a society seeking to shrink big government in the face of vast deficits, limited resources, and unreasonable demands must find dependable, defensible ways of saying “no.” Some liberals, fearful that the most vulnerable will be trampled in the self-protective scrambles that follow each political mandate to cut budgets and taxes, view rationing as a rule-governed, politically accountable approach to allocating benefits and costs that may give the disadvantaged a new normative standing in the court of political opinion. Unfortunately, the growing fascination with rationing has not generated increasing rigor in

the use of the term, which seems to carry at least three ambiguously connected connotations.

**Rationing as social allocation.** Some observers think it odd that rationing should now be flashing in neon on the marquee of policy debate. "Rationing," they say, applies to any set of arrangements that allocate benefits and costs within society. Markets ration. So, inevitably, do public budgets. Benefits get withheld as a consequence of decisions about eligibility, scope of coverage, provider payment, or other allocative variables with little (if any) sustained agonizing over the human costs and equity of what ensues. Hard-pressed (or hard-nosed) governments cut eligibility for Aid to Families with Dependent Children (AFDC) and Medicaid, lower welfare payment levels, reduce the benefits paid by unemployment compensation (or their duration), and refuse to appropriate funds to cover more than a fraction of those eligible for food benefits, invoking fiscal necessity, the electorate's disenchantment with taxing and spending, and the conviction that safety nets remain intact and the truly needy will (somehow) get their due. These major, recurrent allocative decisions are rarely framed in public debate as issues of "rationing," but they are that nonetheless. Likewise, the U.S. health care system is (in)famous for rationing by price.<sup>1</sup>

**Rationing as principled rationalization.** Some commentators understand rationing to mean strategies that make existing or proposed allocation schemes more "rational" when judged against some principle, often equity. Theodore Marmor notes that rationing can mean "the rationalization—reordering—of the allocation of resources."<sup>2</sup> Michael Reagan observes that rationing has traditionally been understood to mean an equitable distribution of scarce resources.<sup>3</sup>

**Rationing as cost-effective retrenchment.** Rationing can also mean the deliberate, systematic withholding of beneficial goods or services from some elements of the population on the grounds that society cannot afford to extend them. Such decisions might advance rational planning or an equitable allocation of resources, but their main justification is to respond to perceived crises by making the best of a bad situation. It is this image that has, for better or worse, come to dominate the health policy debate. Prominent commentators, including ethicists, physicians, policy analysts, and even a few politicians, have declared that health care benefits, now dispensed by a miscellany of formal and informal arrangements, will have to be "rationed" in the not-too-distant future. The explanation is that irresistible forces—rising costs, boundless consumer demands, and surging technological innovation—are meeting an ever more immovable object—the unwillingness of public and private purchasers to invest soaring sums in health care services. The system is

burning the candle at both ends: those with adequate coverage can no longer be assured all the benefits they have come to expect, while those without it can no longer depend on the old charitable fail-safes. The broad significance of Oregon's plan lies in its determination to embrace rationing in the sense of cost-effective retrenchment and then use it as a vehicle of principled rationalization of health insurance coverage.

**The political context.** If rationing is everything (social allocation), then it is nothing that can be isolated and discussed as a pointed strategy of intervention. But if rationing means principled rationalization or cost-effective retrenchment, it (and the issues it raises) are all too pointed, a source of torment to delicate political sensibilities. How then might the political system carry rationing from theory into practice?

In the private sector, rationing remains largely an exotic object of fascination addressed in luncheon symposiums and after-dinner speeches. Business executives tend to be of two minds on the matter: on the one hand, rationing means tackling "hard choices" (which they suppose to be good); on the other, it sounds suspiciously regulatory, perhaps downright un-American. In any case, the fragmentation and cost shifting that pervade the private sector mean that few employers could anticipate savings that would exceed the organizational, political, and legal costs of introducing a full-fledged rationing scheme for their work forces. The public sector is a more concentrated payer, however, and has more motive and opportunity to entertain rationing than do its corporate counterparts. The \$110 billion Medicare budget is theoretically the most inviting place to start, and some critics of the large, growing fraction of the health care budget spent on prolonging the lives of old-old people would like to see theory put into practice. Millions of organized, attentive, elderly voters disagree, however, and most of those promoting the rationing of health services to the aged are policy analysts, not political leaders.

Medicaid, the other major public health entitlement program, is another story. Though less expensive than Medicare, the costs of Medicaid are shared between the federal government and the states, which multiplies the players with a stake in cost containment. Beset all at once by a decade of devolution of federal responsibilities, curtailment of federal aid, federal mandates to provide more services to more recipients, electoral mandates to tax less, and (now) faltering economies, the states struggle annually with Medicaid costs that are the fastest-rising items in many state budgets and second only to education in total dollar size. The states, then, face a powerful incentive to slow the growth of Medicaid costs, and their federal partner has equally strong reasons to let them take the lead—and the heat—in doing so. The federal system is, after all, the laboratory of innovation: Junior may blow up his room with his chemistry

set, but no one ever said that making federalism work was easy. Both levels of government know that Medicaid recipients are mostly unorganized, politically unsophisticated, and of little electoral consequence (with the partial ironic exception of Medicare beneficiaries who are also on Medicaid). And, Medicaid tends to be a less salient source of revenue than is Medicare for most providers, who are slower to defend the former than the latter. Despite many efforts to cut and otherwise fix the program, there is broad agreement in Washington and in state capitals that Medicaid, though a crucial source of care for some of the poor, is financially broke and conceptually confused. As a general strategy of systemic reform, rationing may or may not be inevitable, but it was surely in the political cards that one of the states would come to embrace the notion as an answer to its Medicaid woes and seek to put it into practice.

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### **Oregon Enters The Laboratory**

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Since 1982, Oregon has been vigorously debating strategies to cover the medically uninsured. Oregon Health Decisions, a nonprofit educational foundation formed in 1983, and a grandly titled Citizens Health Care Parliament convened various statewide and community meetings on the problem and issued position papers and reports. In 1987, emboldened by this collective cogitation, the state put itself at the head of the rationing revolution by refusing further to fund certain transplants under Medicaid on the grounds that most such procedures buy a small increment of additional life, of doubtful quality, and at high cost and that the money recouped from such suspect endeavors could be better used elsewhere. Soon after this decision was adopted, a boy denied a transplant died, and Oregon's tentative adventure in rationing entered the national spotlight. Undeterred, state leaders argued that Oregon had tackled the hard choices everyone faces nowadays and resolved to refine the logic of the transplant denials. In 1989, the state legislature, under the leadership of its president, John Kitzhaber, a physician and liberal Democrat, enacted a broad scheme that would (among other things) end Medicaid coverage for services deemed to be of limited benefit to few recipients and shift the savings into more cost-effective services for existing and new Medicaid populations. An eleven-member Health Services Commission and Oregon Health Decisions sponsored eleven public hearings, forty-seven town meetings, and a telephone survey to learn the values and preferences of average citizens about the relative priority of medical situations and treatments. Enlightened by the voice of the people, the commission compiled a list of medical procedures and applied to it a Quality of Well-Being Scale that measures the cost of services and their contribution

to longevity and quality of life. On 2 May 1990, the commission issued a "Cost/Utility Ratios Report" that listed about 1,600 medical procedures in order of priority.

For various reasons explored below, the list and indeed the whole strategy proved to be controversial, and the commission decided to return to the drawing board. On 20 February 1991, it released a new rank-ordered list, this one containing about 800 items. Next, an actuary will attach cost coefficients to individual items, and the legislature will ponder its fiscal preferences and draw a line at some point along it. (By law, it cannot rearrange items on the list.) Procedures above the line will stay eligible for Medicaid payment; those below will no longer be covered by the program. Savings on the less effective procedures (and from managed care programs Oregon is promoting) are intended to enable the state to expand Medicaid eligibility, now set at only 58 percent of the federal poverty level, to 100 percent, thereby bringing at least 118,000 more Oregonians into Medicaid. The scheme, its creators contend, breathes life into the much-touted but elusive notion of a set of minimum adequate benefits and uses public monies to promote the greatest good for the greatest number. Moreover, Oregon has passed two other pieces of legislation to take effect if (and presumably when) the Medicaid reforms are implemented. One requires employers who do not now cover their workers to provide the newly defined basic benefit package or face additional payroll tax liabilities. The other creates a pool to provide coverage for uninsurables. The three-pronged scheme aims to bring the state close to universal coverage (97 percent).

If Medicaid were exclusively a state program, Oregon's rationing plan might be in effect today. But the proposal permits the state to modify or eliminate services deemed "basic" by the federal Medicaid law and to make other departures that require a waiver by the federal government. Early inquiries to the Health Care Financing Administration (HCFA) about an administrative waiver under the demonstration authority conferred by Section 1115 of the Social Security Act met a cautioning response: apparently, that authority has never been used to permit the elimination of mandated Medicaid services.<sup>4</sup> The state then turned to Sen. Bob Packwood (R-OR) and Rep. Ron Wyden (D-OR), strong supporters of the plan, to win a legislative waiver. For a brief interval in 1989, prospects looked bright. Without objection, the Senate Finance Committee voted to grant a waiver, which then moved to the full Senate as part of that year's budget reconciliation. Alarmed, Sara Rosenbaum, policy (now health) director of the Children's Defense Fund, joined forces with Rep. Henry Waxman (D-CA), chair of the Health and Environment Subcommittee of the House Energy and Commerce Committee and

considered the leading legislative expert on Medicaid, and Sen. Albert Gore, Jr. (D-TN), who has a deep interest in medical ethics and has authored major legislation changing federal rules for the procurement and allocation of transplantable organs. Waxman intimated that he had concerns about the fairness of the proposal, and Gore circulated a "Dear Colleague" letter in which he pledged to fight the measure should it reach the Senate floor.<sup>5</sup> As it happened, however, the overloaded lawmakers decided to drop from consideration all "extraneous" additions to the budget bill, ending Oregon's chance for a legislative waiver in 1989.

This initial skirmish made plain the identities of the contending sides and their likely lines of attack. The state contracted with a Washington, D.C., consulting firm to help write the waiver application and enlisted prominent Washington lawyers to help win its case. The Children's Defense Fund rallied the American Academy of Pediatrics, the National Association of Community Health Centers, the U.S. Catholic Conference, the National Association of Children's Hospitals, and other groups in opposition. Waxman, wary of the plan but mindful of the sensibilities of subcommittee colleague Wyden, declared that he awaited further details and would study them closely. Gore, who had first trained a critical eye on Oregon in 1987 when it began denying Medicaid reimbursement for transplants, put a top staffer on the issue and began lambasting the plan in a range of forums.<sup>6</sup> Gail R. Wilensky, administrator of HCFA, opined that the Department of Health and Human Services (HHS) could grant an administrative waiver only if the plan were shown to be both budget-neutral and consonant with major tenets of the Medicaid law; neither judgment could be made until the specifics—the state's list of procedures, the line drawn among them, and the money to be spent—were presented. Meanwhile, numerous critics—of the approach in general and of the original list in particular—from academe and affected interest groups raised objections within and outside Oregon. The Health Services Commission then returned to the drawing board until February 1991. Now the rest of the scheme—pricing by actuaries, debate by the legislature, drawing of the line, and presentation of a formal waiver application—is expected to proceed. The resolution, of course, remains to be seen. Nonetheless, the progress of the debate sparked by the plan in Washington may offer some insight into the current and likely future of the politics of rationing in the U.S. health care system.

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### Lists And Lines

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Not surprisingly, given its complexity and oft-reiterated determination to make hard choices, the Oregon plan evokes disagreement along many

lines. The most salient controversies, however, fall under one or more of three headings—issues of who is to be the object of rationing, what is to be rationed, and how rationing outcomes are to be determined.

Who. One of the most contested elements of the plan is its scope. As a means of laying the conceptual and financial foundation for universal coverage, Oregon would ration Medicaid services for poor mothers and children in that program; aged, blind, and disabled recipients are exempt. Critics protest that the included groups constitute about 70 percent of recipients but only about 30 percent of the budget—hardly an adequate or equitable base for a fair sharing of burdens. “Those people who most need more health care expenditures will be the only ones subject to the new limits,” argues Bruce Vladeck.<sup>7</sup> Tom Higgins asserts that the plan amounts to “discrimination on the basis of class, age, race and sex.”<sup>8</sup>

Critics also agree on the explanation for this constricted rationing, namely, a distasteful and transparent coalition-building strategy to get the plan through the state legislature. Every group in a position to derail the plan was won over: long-term care and other Medicaid services for the aged were exempted, satisfying the senior citizens and nursing home lobbies; most psychiatric care was excluded, mollifying the mental health lobby; providers were promised both their “necessary” costs and immunity from professional liability should they decline to order unreimbursable services, which won their respectful attention and support. The state’s vaunted “hard choices,” say the critics, turned out to be all too easy: the most needy, vulnerable, and disorganized, those least equipped to squeak, get the castor oil.

Proponents bridle at this cold-eyed view of their work. Services for the elderly are mostly exempt, said Packwood, not because “the elderly have been successful lobbyists, but because most of the services that they need are *social services*,” which the index of cost-effectiveness is not designed to evaluate.<sup>9</sup> An aide to Wyden likewise remarked in an interview on the state’s strong tradition of community-based custodial care and declared that “no one knows how to rank order such quasi-medical services.”

Moreover, rejoin the proponents, critics obsessed with poor women and children ignore the larger goals of the plan. Health coverage in Oregon, as in the rest of the country, is now three-tiered: the privately insured and those enrolled in public programs have their needs addressed, while many go entirely without coverage. By allocating funds more sensibly within the second (public) tier, policymakers might generate savings with which to absorb into it virtually all the uninsured.” Political realities require that one find—or at least make a great show of searching for—savings from a reallocation of existing resources. Once the public is convinced that hard choices have been taken, it might be willing to spend

more to expand coverage while cutting very little.

Unfortunately, an oppressive Medicaid orthodoxy now sustains a system that, in Kitzhaber's words, "denies all services, no matter how effective, to some people, while insuring access to virtually all procedures, no matter how ineffective, to others."<sup>11</sup> Expansions in Medicaid mean little if states respond by cutting eligibility for benefits or by reducing payments to providers, thereby diminishing access. Oregon designed a "comprehensive proposal," said an aide to the Senate Finance Committee; why dismiss it *a priori* simply because its broad-ranging package of employer mandates and coverage for uninsurables also includes a new way of covering poor women and children on Medicaid? The Medicaid lobby's stalwart defenders of the status quo dodge an enormous, emerging problem. "This is what the country will have to face generally," predicted Wyden. "What are our priorities and how do we make sure our citizens have access to a decent quality, affordable benefit package rather than, as today, Cadillacs and nothing?" Wilensky also found it admirable that Oregon was "looking at the whole population, and aiming at universal coverage in a way that's fiscally manageable."

The critics spurn these arguments. To confine rationing to medical services for poor women and children because the state's chosen quality scales do not encompass quasi-medical services for other populations amounts to asserting that the means justify the end. If the goal is to instill a new cost-effectiveness in Medicaid, then a proposal that excludes 70 percent of the budget from its reach is ludicrous. If the state wants to show off its hard choices on health care, it could impose the scheme on its state employees (including legislators) and would need no federal waiver to do so. Those elements of the "comprehensive proposal" that create an employer mandate and a state pool for uninsurables bear no logical or economic connection to rationing of acute care services to poor women and children. The scheme might violate existing federal laws—among which, contends the Children's Defense Fund, are those governing age discrimination, civil rights, rehabilitation, and protection of experimental human subjects.<sup>12</sup>

This inequitable rationing plan, argued an aide to Senator Gore, ignores the policy lesson of the repeal of the catastrophic coverage provisions added in 1988 to Medicare: "The American people were saying 'don't put all the burdens on one group's back.' Congress ultimately decided that when it comes to fixing our health care system, it is wrong to single out any one group to pay the bill, even if the group is well off. Why then is Oregon saying it is ok to single out poor women and children on Medicaid to pay its bill?" And (this aide continued) it would lead to blatant anomalies: "Imagine a hospital room with two beds and two

children, one a Medicaid recipient, one the child of a state employee. Each needs a very costly procedure or he'll die, and the procedure is below the line. For the Medicaid child, the state spends only 38 cents on the dollar, but Oregon would say: 'Gee, sorry, we'd like to do it but we've gotta let you die so we can provide basic care for others.' For the other child, with the same diagnosis, prognosis, and procedure, the state pays 100 cents on the dollar and it says: 'Of course you can have it.'

Finally, equity aside, opponents ask: how can the state squeeze from 30 percent of the Medicaid budget savings sufficient to expand the program's eligibility from 58 percent to 100 percent of the federal poverty level? Why should Medicaid's federal protectors take on faith well-meaning speculation that the plan is a political prelude to a new generosity to be manifest in new spending for the disadvantaged and uninsured? The more plausible strategic response would seem to be severe cuts in the services now funded for poor women and children and (then) to be mandated for the newly eligible. In other words, the state's political expediency in defining "who" implies irresponsible clinical curtailing of "what."

**What.** Oregon's plan would give the state discretion to eliminate payment for any service below the legislature's cutoff line. The state would make the list, cost it out, draw the line, and if the results mean refusal to cover services defined by federal Medicaid rules as basic, so be it. A waiver permitting such procedures, critics charge, jeopardizes benefits that could mean life or death to society's most vulnerable people. Nor, they add, is there reason to believe that the current federal Medicaid list of basic benefits contains any substantial measure of "fat."

Proponents argue that the same comprehensiveness that they would introduce into the debate about coverage should govern social thinking on the scope of services eligible for reimbursement. The case for rationing gains force from the mindless clinical application of procedures—some minor but overused, others exotic but unavailing—that cannot justify their high cost by their record in enhancing health or prolonging useful lives. Savings reclaimed from such wasteful medical acts could buy sizable amounts of comparatively cheap and beneficial preventive and primary care for large numbers of people (including poor women and children). In today's hard budgetary times, no service should claim immunity from close cost-effectiveness scrutiny. "Gore makes it sound like there's a constitutional right for everyone to have transplants," grumbled a Senate Finance Committee staffer. After weighing systematically, as Oregon did, "the very small number of individuals who would benefit, the low probability of individual benefit in many cases, the poor quality of life post-procedure and the high costs of the procedures *and* after care," society might well decide to exchange transplants for broader insurance

coverage, expanded preventive services, or both.<sup>13</sup> Low-tech procedures deserve the same high-beamed scrutiny. The basic question, said an aide to Wyden, comes down to this: "Is there any fat in the current benefit package? For example, if current law says children are entitled to a certain number of visits under the Early Periodic Screening, Diagnosis, and Treatment Program, and the Health Services Commission thinks it should be half that number, is that a problem?" Is the current Medicaid benefit package so morally or clinically sacrosanct that no state should be allowed to change it in any significant way?

In the eyes of the plan's proponents, those who protest that rationing might somehow deny someone something of medical benefit are disingenuous. A case by-case "entitlement" approach is the natural enemy of rationing; indeed, this is the misguided notion that has made rationing necessary. To the individuals, families, and providers directly involved, clinical benefits are almost never too small to justify enormous sums of someone else's money; it is precisely the "logic" of such decisions—unavoidable at the individual level, irresponsible at the social level—that rationing is designed to change. For years theorists across the ideological spectrum have talked glibly of the need to define and implement "minimum adequate standards universally." Here at last is a plan that does exactly that; why should the federal establishment flinch at giving it a chance in one state? "We've expanded Medicaid a lot," remarked a Senate Finance Committee staffer who supports the plan. "The real issue now is between those who are entrenched in Medicaid and its entitlements and those who want to try a new approach."

Critics reply that Oregon, in pretending that fiscal imperatives have driven it to elaborate rationing by lengthy lists and arbitrary lines, is the disingenuous party. Comparisons with other states are odorous. Figures assembled by Waxman, Gore, and the Children's Defense Fund indicate that in fiscal year 1989, Oregon spent less than half the national average of state general funds used as state Medicaid matching shares; that it ranked forty-sixth of fifty states on Medicaid spending as a percentage of all state spending; that Oregon, in Gore's words, "by simply increasing its effort to that made by most states, could add 250,000 new Medicaid beneficiaries with the full package of services it provides now;" that it could easily afford to do so, having recently returned \$300 million in surplus funds to the taxpayers, a sum that could have been committed (at least in part) to Medicaid at a thirty-eight/sixty-two matching ratio; that the state has done little with utilization review or other measures to reduce waste in the program; that Oregon vies with Arizona for the highest administrative costs in Medicaid (leading Washington critics to joke that all those, underoccupied bureaucrats explain how the state came

up with its plan); and that most of the “explosion” in the state's Medicaid costs lies precisely in the exempted realm of hospital and nursing home care for the aged (indeed, some observers contend that heavy use of case-managed home care services for the aged and disabled is precisely what accounts for the state's high Medicaid administrative costs). Benefit/cost balancing in Medicaid is a tough struggle in every state. Oregon surrendered and embraced the false faith of rationing before it ever truly began to fight. If the state's politicians, so proud of their valor in the teeth of the hard choices to which Medicaid has forced them cared to show genuine courage, they could exhort the electorate to spend more on the program and improve its management. To the critics, of all fifty states Oregon least deserves the waiver it seeks. Indeed, the very fact of its seeking it virtually guarantees it will abuse it.

**How.** The logic of the list can be no more powerful than the logic of the methods used to generate it. Critics charge that Oregon's methodology is as weak a reed as can be imagined. Vladeck called the approach a “misbegotten mishmash of second-rate policy analysis and cynical budgetary politics.”<sup>14</sup> To Gore, it amounts to “playing God by playing with spreadsheets.”<sup>15</sup> Higgins thinks it “a scheme [Jonathan] Swift might have produced...prone to produce absurd results because it is rationing by rote rather than situation.”<sup>16</sup> Waxman (perhaps intending the unkindest cut of all) derided it as a “Gramm-Rudman”: method of rationing. William B. Schwartz and Henry J. Aaron, authors of *The Painful Prescription*, a major source of academic and professional interest in the supposed inevitability of rationing, complain that the compression of more than 10,000 standard coding categories into a much smaller “manageable” number requires that dissimilar conditions be homogenized, which makes the categories misleading for decision making and ensures inequities. They urge serious students of rationing to “back away from the Oregon plan before it gives a promising approach an irretrievably bad name.”<sup>17</sup>

Proponents acknowledge that the plan's cost-effectiveness gauges are inherently crude and oversimplified but contend that they are an important beginning, refinable over time, and that they not only ask hard questions but supply sound answers. They rely on measures of outcomes and well-being, not simply on physicians' decrees about what is medically appropriate. They put teeth in population-based planning, usually honored more in the breach than the observance, founded as they are “not . . . on an individual's needs but driven by the needs of the population as a whole.”<sup>18</sup> They check and balance technocracy with democracy: the dozens of town meetings at which citizens discussed the issues built consensus by means of an overtly public process. Any number of cavils could be directed at (for example) the diagnosis-related groups (DRGs)

and resource-based relative value scales (RBRVS) that pay providers in Medicare, but policymakers readily embraced these schemes once the need for change grew acute. To Oregon, the costs of maintaining Medicaid in the context of a three-tiered system, and the impotence of present assumptions and allocation methods to correct the situation, are no less immediate problems and the cost-effectiveness scale a no less worthy analytic point of departure. Like DRGs and RBRVS, these techniques get policy moving and leave it, though not perfect, better than before. Why not innovate, gain experience, and make mid-course corrections—in other words, replace deadlock with incrementalism at its best? Society has learned a lot about the cost-effectiveness of medical procedures in recent years; why refuse to put that knowledge to use? Oregon's efforts, Kitzhaber has declared, have “advanced the debate more in...ten months than all the think tanks have done in ten years.”<sup>19</sup>

The critics disagree. That a start to repairing Medicaid's many problems must be made somewhere does not mean that it should be made just anywhere. Population-based planning may be desirable in principle but not if it means glossing over gross inequities among individual cases. To be legitimate, grass-roots democracy must be representative of those with a stake in the agenda; as Rosenbaum of the Children's Defense Fund emphasized with some heat: ‘To ask 1,000 healthy upper middle class people with no risk to their benefits what they'd take away and when they'd pull the plug is silly. And how many poor children were at those meetings?’ Nor is every policy question automatically elucidated when dropped directly into the lap of the people. Would one decide troop movements in Iraq or how to bail out savings and loans by convening random soirées across the country? Are questions about what medical procedures claim sufficient cost-effectiveness to warrant Medicaid coverage any less complex or any better resolved by cracker-barrel philosophy? Diagnosis-related groups and relative value scales try to contain Medicare costs by manipulating providers' reimbursement, by putting them newly at risk. Oregon's Medicaid scheme puts all the risk on the poorest group of program recipients while promising providers not only their “necessary” costs but also exemption from professional liability if they decline to order uncovered services. The methods used mock true cost-effectiveness by weighing cost too heavily in the formula. Nor are available data up to the job to which Oregon would put them. “Garbage in, garbage out,” sneered two in-state critics.<sup>20</sup>

The most damning commentary on the state's methods, some critics say, was the fate of the original list, unveiled publicly on 2 May 1990, greeted by catcalls and brickbats, and towed back to the shop for a nine-month overhaul. Skeptics, unmoved by proponents' protestations

that the list was always understood to be a preliminary cut designed to promote discussion and revision, urge that the Edsel cease production. "Why not have two lists?" asked an aide to Gore. One list would contain "what clearly *doesn't* work, the other would have everything else; Blue Cross-Blue Shield already does this." Others contend that any list issuing blanket proscriptions of ineffective procedures is fallacious; there is no clinically sound, fair shortcut around detailed inspection of concrete individual cases.

Other antagonists suggest that all of these methodological particulars miss the real point of the exercise, which is to indulge the state's peculiar cultural animus. One critic asserted that "the zeitgeist is different in Oregon," and proceeded, tongue not entirely in cheek, to caricature a Shangri-La setting where Marlboropeople and their above-average kids hike, swim, fish, and hunt in pristine streams and forests primeval; where the poor, the lame, and the sick are snubbed as nasty, brutish, and short on self-reliance; and where once the two-minute warning sounds on life's little playing field, the good citizen limps stoically off to the sidelines to down a draught of hemlock. On this view, Oregon's rationing methodology is less instructive to policymakers than to sociologists seeking curious subnational variations on American folkways.

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### Waivering And Wavering: The Political Prospects

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Because Oregon's revised service list has only recently appeared, the state has not yet applied for a formal waiver of federal Medicaid rules. Thus, most potential political principals are now standing back, reserving judgment until the list and the line that separates the alleged wheat from the chaff are publicly announced and officially proposed. Waiver politics are therefore necessarily fluid and speculative. A review of the four most plausible prospects, however, suggests that many hard political choices lie ahead for both Oregon and the federal government.

**The path of nonresistance.** One possible outcome, which opponents of the plan find especially distasteful, might be posed as a political riddle: How can a controversial plan with at most two single-minded and prominent legislative supporters make its way easily into law? The plan's critics cite several factors. First, the scheme's main champion, Packwood, is a well-liked senator in a powerful committee position (senior Republican on the Finance Committee). Why should his colleagues (and for that matter, interest groups critical of Oregon's proposal) risk enmity that could surface on future issues of direct significance to them and their states over a matter that affects only Packwood's home state and that stands very high on his personal agenda? And why should they countermand

the judgment of the rest of Oregon's House and Senate contingent, all of whom have defended the plan, though less vocally and visibly than has Packwood? "The normal rules of legislative comity encourage accommodating others on issues that aren't pressing for oneself," explained an opponent who has worked to mobilize members against the Oregon plan.

Second, proponents in Oregon built their coalition well. When the state, working through Packwood, sought (and nearly won) a legislative waiver in 1989, virtually all of the heavyweight interest groups within the state stood firm in support. National organizations that should (say the critics) have known better hesitated to break public ranks with, and thereby embarrass, their Oregon affiliates, and some national legislators were content to experiment with a scheme that was widely endorsed by the main interest groups within the only state affected by it.

Third, there is wide sentiment in Congress that Medicaid has become a costly mess and that any reasonable demonstration of a break with business as usual should be encouraged. "Their attitude is 'We gotta try this sometime'," said Rosenbaum. Kitzhaber gets credit for "having called the question," noted a critical Senate aide, who added wearily that such calling of the question is "all that Senate Finance seems to care about." If Oregon shows the political courage to lead toward "reform," why should other state delegations block its path?

Fourth, critics charge that the Bush administration is eager to contain Medicaid costs, more concerned about the budget deficit than about the poor, and dependent on Packwood's support in Senate Finance for a range of initiatives. It has referred warmly to the Oregon plan in budget statements.<sup>21</sup> Concerted pressure from the White House and Packwood might, critics contend, convince HHS Secretary Louis W. Sullivan and HCFA Administrator Wilensky that an administrative waiver should be issued. Or a Bush/Packwood alliance might win over enough waverers to enact a legislative waiver.

Fifth, the leading opponents face some strategic disadvantages. One (Gore) is not on a committee of jurisdiction; the other (Waxman) is identified in some minds with the Medicaid orthodoxy Oregon would challenge. Both are respected legislators, but neither has limitless political capital. Resources invested in a fight to save Oregon from itself will be lost to Waxman in broader battles over national Medicaid policy (in which, moreover, he will want the support of fellow liberal and committee member Wyden) and to Gore if he revisits national transplant policy.

This hypothetical convergence of supportive forces, critics fear, could soon yield Oregon a waiver and thereby register a small but significant victory for the conservative assault on public entitlements. President Reagan always wanted to make Medicaid into a block grant program

giving wide discretion to the states, observed Waxman in an interview. Oregon's waiver would be a powerful precedent for that policy departure.

The nonresistance scenario assumes that a majority of legislators will remain ignorant of, or indifferent to, the more disturbing aspects of Oregon's proposal. Opponents of course are working to invalidate this assumption. They believe that once brought fully to light, several aspects of the plan—especially the limited scope of the population to which it applies, controversy over the list and the line, and the questionable validity of the state's methodology and the uses it makes of it—will trigger doubts about equity and efficacy alike. Nor have the critics been slow to communicate their concerns via legislative hearings (perhaps eventually, as Waxman has suggested, in Oregon itself); requests to the congressional Office of Technology Assessment (OTA) for a thorough expert appraisal of the proposal; repeated public speeches and articles (Gore's preferred mode of attack); the mobilization of a range of groups, including those that now have second thoughts about their earlier silence; assaults on Oregon's record on both benefits and costs in Medicaid; identification of alternative cost-saving stratagems (for instance, attention to overprovision and better targeted efforts to find and reduce ineffective procedures); and insistent reiteration that the proposal is not one state's affair but rather a precedent with ramifications across the federal system. All aim to cultivate a high degree of principled and practical discomfort with the Oregon plan. If the discomfort index rises high enough for a sizable block of legislators, HHS might withhold its administrative blessing, unity may collapse within Oregon's delegation in Washington (and perhaps at home), and one or both houses of Congress could decline to bring the controversial scheme to a vote. Some strategists contend that time itself is the strongest enemy of the nonresistance scenario, for with each day more legislators have more occasions to contemplate more problems in the plan.

**What Washington nixes, Oregon fixes.** If the original scheme fails to fly, perhaps Oregon could refine and perfect it, answering the critics and winning a waiver. Such major revisions would risk upsetting the political coalition that now supports it. Despite the supporters' reminders that the revisions in Medicaid are but a means to the larger end of universal coverage, the exclusive concentration of rationing on poor women and children and the explicit exemption of other Medicaid recipients strikes most critics as flatly inequitable. But the same considerations that produced this outcome complicate its redress. If poor mothers and children are exempted along with everyone else, rationing self-destructs for want of an object. To include the elderly (and perhaps other groups) would turn advocates into adversaries, and if cohesion collapses at home it

probably cannot long be kept intact in Washington. Besides, the state has admitted that its methods do not work for valuing nonacute, custodial care for elderly medicaid recipients.

The list and line that define what is to be covered present other tradeoffs. Wherever the line is drawn, services deemed ineligible for reimbursement no doubt will include something of some benefit to someone, as providers, consumers, academics, and the media will explain in colorful detail. The higher the line, the louder the outcry. But the higher the line, the larger the savings with which to help finance the expansion of Medicaid eligibility to 100 percent of federal poverty. The politics and economics of the proposal clash.

If a rank-ordered list looks attractive only until a line is drawn through it, perhaps Oregon could adopt new rationing methods. Given the attacks on the scope of application, adequacy of data, and relative weightings of cost, curing, caring, and other relevant variables in the index now in use, perhaps the state should follow Gore's plausible advice by limiting rationing to a list of procedures that are, by informed consensus, entirely futile or nearly so. This course, however, would reduce rationing's bang to a whimper: states are already expected to withhold Medicaid payment for care that is not medically effective, and, again, if little is lost from the allowed list, little is gained for redistribution to the uninsured third tier.

**Trojan horse for universal coverage.** Those who sympathize with the Oregon plan view the critics' warnings as inflammatory, indeed defamatory. They insist that the guardians of Medicaid orthodoxy have persistently misconstrued the state's intentions and deliberately cast them in the worst possible light. Broad powers to ration care could do heavy damage if entrusted to the wrong hands, but Oregon's mercies are tender. Kitzhaber, after all, is a very liberal Democrat, one who understands that in politics one must sometimes appear cruel in order to be kind.

The plan's supporters in Washington offered several intriguing conjectures about what game the state is "really" playing. Some argue that a comprehensive evaluation embodied in a cost-effectiveness list is the only way to gain political leverage over costly, marginal, mandated services that provider lobbies—chiropractors and podiatrists, for example—would successfully defend if they were assaulted seriatim. In the words of one sympathizer, "There are lots of Medicaid options, it's an incredible list. This approach could take some pressure off the state legislature. Hand it over to the citizenry and the Health Services Commission—let them get rid of these heavily-lobbied services. If the options go, you can give basic benefits to more people. It's more politically palatable to do it this way: 'Let the people decide!'"

True friends of universal coverage must awaken to political reality.

Oregon in 1991 is not Massachusetts in 1988, marching resolutely into a broad state-mandated expansion of benefits. Most states in 1991 do not resemble Massachusetts in 1988; indeed, today even Massachusetts is a shadow of its former political self. Supporters' proud talk about the "overtness" of the Oregon plan and its elaborate consensus building seems to boil down to this: in most states Medicaid is costly and controversial, and few electorates will agree to its expansion until they conclude that inefficiencies in the program have been squeezed hard. It is sad that the middle class focuses disproportionately on "wasteful" care rendered to "welfare" types (poor women and children), but the price of ignoring this sentiment is a continued policy stalemate. Oregon's tough-mindedness buys political trust—a crucial resource that can then be invested in policies that end up taking little or nothing from the poor while authorizing new state (and federal) funds for a bigger, better Medicaid program. The whole plan, then, can be viewed as a subtle ploy by which political leaders persuade the voters of Oregon to eliminate the third (uninsured) tier while spending more (or-at any rate no less) on the second.

Advocates wish that the plan's critics would be satisfied with these protestations of sincerity, but few expect this. Congress is likely to insist on that best protection against excesses of delegation, "safeguards and specifics." Washington proponents have wrung grudging acquiescence in Oregon to "waiver language" that would, among other provisions, insist that the new system "honor a standard of health benefits which meets the basic needs of the eligible population," including outpatient and inpatient care and health promotion and disease prevention services; require HHS to monitor benefits and end the waiver "at any time the benefit level became inadequate;" and make clear that the waiver is "Oregon specific."<sup>22</sup>

Having bent this far, the state will be hard pressed to resist a further descent down the slippery slope, and the next point of capitulation would be financing. The original public rationale for rationing held that elimination of cost-ineffective care for (some of) the Medicaid population would yield savings sufficient to fund all (or much) of an expansion of program eligibility to an estimated 77,000 Oregonians. Today, few believe that the state, under pressure from a range of interest groups and Washington monitors, will leave enough services below the reimbursement line to save much money, and meanwhile, revised estimates of the number of new Medicaid eligibles have nearly tripled, to 200,000. Conservatives who embraced rationing as a better use of existing resources would seem to be in for a surprise.

Unless Oregon's waiver proposal is budget-neutral (that is, avoids new federal Medicaid dollars), HHS cannot (in its opinion) grant an admin-

istrative waiver. But if the proposal were budget-neutral, it would lose a crucial legislative supporter, Wyden, who has so far stood united with the rest of the state delegation but who has also warned that his support cannot be taken for granted. Wyden will press for significant sums of new state and federal dollars; “protections...in black and white” for basic services; and a credible list. Because Wyden's defection from the supportive coalition would inflict heavy damage (and because his continued support might mute committee colleague Waxman's opposition), proponents may have little choice but to accede to firm federal strings attached to both policy and purse.

In short, Oregon's only practical hope of winning a waiver may mean promoting liberal dreams concealed within the Trojan horse of rationing. On this scenario, the political logic of waivering leads the state to cut little or nothing, add 200,000 new recipients to Medicaid, markedly increase state and federal spending on the program, raise reimbursement to providers, mandate that most employers offer private health coverage to most workers, sweeten the mandate with tax credits for complying employers, create a state pool for uninsurables, and enter history as the first mainland state to adopt a workable plan for universal coverage.

**Declare victory and stay home.** Oregon probably cannot win a waiver for its original rationing plan. Efforts to smooth its rougher edges while preserving its basic form and content may be insufficient to appease liberal critics. Efforts to transmute it into an appealing vehicle of universal coverage jeopardize conservative support. The hard choices disclosed by waiver deliberations may be intractable. The state might then finally decide to congratulate itself for courage, invention, and rigor; blame rigid Washington meddlers for vilifying motives and impeding innovation; fold its cards and abandon the quest for a waiver; and expound at bitter length in book and speech on what might and should have been. The state has sunk heavy costs into its scheme and, having yet to draw its line along its list, has in a sense not yet begun to fight. But neither have its opponents. HCFA Administrator Wilensky put the odds at fifty-fifty that the state would indeed file a formal waiver application.

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### **Policy Implications: Earning The Right To Ration**

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The Oregon tale unfolds, and one can only guess at its likely end. Nevertheless, the tentative verdicts on Oregon's notions in Washington cast light on some dilemmas in U.S. cost containment policy and on the role of rationing within them.

Recently, rationing has been elevated to the pantheon of fashionable solutions—competition, managed care, prudent purchasing, and more—

that policymakers intermittently embrace as all-American answers to uncontrollable health care costs. Having won theoretical prominence, rationing was bound to be fitted into practical form sooner or later. Nor is it surprising that it should emerge within the laboratory of federalism under public sponsorship (Medicaid is a major source of fiscal distress among concentrated state payers), in a political culture relatively unencumbered by Medicaid's traditional norms, and under the leadership of a physician. (Doctors, after all, are taught to "just practice medicine" and then are blamed for the costs of doing so, and sometimes view rationing as the new social rules that will take them off the hook, relieving them of cost/benefit decisions in individual cases.) Nor can one dismiss the concerns that inspired the Oregon plan or the hard questions it raises: universal coverage, improved cost-effectiveness in medical procedures, better use of scarce resources, a tilt toward prevention and primary care, and the definition of minimum adequate benefits are central policy issues, and the state's effort to make cost-effective retrenchment a means to principled rationalization of insurance coverage is ambitious and audacious. Unfortunately, however, these goals probably cannot be realized—by rationing or otherwise—within the existing health care system in Oregon or elsewhere in the United States. The basic lesson of the Oregon tale is that the hard choices the state purports to tackle admit no sensible resolution without a set of antecedent hard-harder-choices that would obviate the need for an Oregon plan by shifting the rationing debate onto a very different conceptual footing, one imperfectly addressed by the three images of rationing usually invoked.

A balanced appraisal of rationing begins with a striking cross-national fact. Other Western democracies manage to cover almost all of their populations and achieve some stability in their health spending without the melodramatic, apocalyptic debate about rationing that has emerged in the United States, a nation that has done much less to extend health benefits and contain costs. Much of the U.S. fascination with rationing derives from the sense that the steady march of technological innovation makes it inevitable, an argument vigorously advanced by Aaron and Schwartz's widely noticed study of medical rationing in Great Britain. But an American/British comparison has costs as well as benefits: these two nations sit at opposite points on a continuum of national health systems whose "normal" middle ground is occupied by numerous nations that tend to spend about 2–3 percent more of gross national product (GNP) on health care than does Britain and about 2–3 percent less than does the United States.<sup>23</sup> The present and likely future uses of rationing in these more normal settings—France, Germany, Scandinavia, the Low Countries, and others—have been little studied. Before leaping to conclusions

about the inevitability of rationing in general, or any particular form of it, analysts might well contemplate these rich mines of evidence.

In broad terms, the Canadian and most Continental systems share several interdependent features: universal coverage for uniform benefits (national health insurance), structured negotiations between purchasers and physicians over fee schedules for reimbursement, global budgets for hospitals (again accompanied by structured negotiations), serious planning for and control over the location of hospitals and the diffusion of technology, judicious cost sharing, and—a part of this larger policy framework of truly hard choices—limited rationing, meaning queuing for elective procedures and, apparently, sometimes for urgent ones too.

A comparative view suggests that within an articulated policy framework of controls on supply and demand, rationing may be one limited but useful tool among others, but that—to address the American fallacy—it cannot substitute for such a framework. Without universal coverage and uniform benefits, deliberate, public decisions about who should get what tend, as in Oregon, to expose pointed, unanswerable questions of equity. In the 1980s, Medicaid became a central, albeit implausible, health policy battleground and has remained so. Conservatives pursue cutbacks (and, increasingly, rationing) as a means of cutting costs at the expense of suspect welfare types too weak to fight back. Liberals, unable to reach the uninsured and unwilling to take on Medicare, have found in Medicaid, especially its provisions for children and pregnant women, one of the few remaining targets of policy opportunity and are not about to give tight-fisted states carte blanche to let a computer printout set coverage. This relatively minor piece of the aggregate cost problem has come to bear a huge symbolic weight in the clash of philosophies of public entitlement, a clash that settled on Medicaid because U.S. health politics offer no more attainable arena. Oregon's fixation on Medicaid does nothing to fix this imbalance.

Rationing that manipulates in one public program the basic benefits of one subset of recipients caught in a political cross-fire between the resentment of the privately covered and the envy of the uninsured is so arbitrary and so obviously driven by the generic features of the present system that the ensuing “hard choices” look hard only because the structure of choice is so convoluted. National health insurance would eliminate the multiple tiers that fuel unproductive political frictions, the purchaser fragmentation that dictates cost shifting, and the huge administrative overhead that supports fruitless competition. Such a system can debate the clinical merits and cost-effectiveness of treatments and procedures while preserving fairness. Such a system can, probably must, allow variations on “tiers” with respect to amenities and ease of access, but

publicly insured people are not at risk of losing basic benefits enjoyed by the privately insured simply because for the former, care is sustained by despised general revenues, while for the latter, it is subsidized by popular tax expenditures.

A system that tries to protect social resources by linking the payment of physicians to the relative complexity and other properties of medical acts listed in a fee schedule is preferable to one that ties the coverage of individuals to all-or-nothing decrees about cost-effectiveness as embodied in an Oregon priority list. The latter approach drives to a new extreme the growing American proclivity to distrust both politicians and providers and to turn instead to experts and the people themselves for policy decisions.<sup>24</sup> This approach sets heavy burdens on the wrong shoulders. The voice of the people is usually too vague to speak clearly to concrete coverage decisions. To encourage average citizens to endorse, in general, withholding of care that they would shrink from denying to themselves, or to others in particular medical cases, is mischievous. And, given limitations of data, uncertainties of method, disparities in professional opinion, and difficulties in distilling heterogenous circumstances into a manageable number of homogeneous categories, experts are rarely expert enough to hand down an acceptable rationing scheme. Fee schedules—lists that permit the manipulation of payment on cost-effectiveness or other grounds without requiring coverage cutoffs—put politicians, providers, and purchasers where they belong: at the center of debates that should be informed but not dominated by expert and public opinion.

Systems that work to avoid supply-side excess by imposing global budgets on hospitals and by planning and constraining the expansion and diffusion of beds and technology check cost increases by inhibiting duplication, overuse, and induced demand. When, as in Oregon and the rest of the United States, such measures are few and weak, rationing speaks not of hard choices taken against inexorable forces but rather of the quick fix invoked for want of political will. In the US. health policy debate, cost-effectiveness has begun to come into its own as a political resource, enabling programs that can credibly wear its mantle to stand out from the crowd. But to date its impact has been largely asymmetrical: useful in justifying the expansion of programs (especially preventive, primary, and nutrition benefits), but seldom significant in eliminating services. The Oregon tale shows why; grafting supposedly cost-effective rationing methods onto the periphery of a pervasively cost-ineffective system is a cost-ineffective social endeavor in that it incurs high normative costs to win small fiscal gains. Critics can fairly charge that Oregon surrendered to rationing without waging a serious war on the supply-side sources of rising health costs.

Systems that are willing to make deliberate and comprehensive decisions about benefits and costs can introduce, expand, or fine-tune cost sharing as a marginally useful tool of cost containment, as most Continental nations do. In the United States, cost sharing is too often the first and last refuge of desperate purchasers who can think of no better strategy and who do not scruple to shift as many costs as possible to employees (given the tightness of the labor market, union strength, and other factors), whatever the damage to affordable coverage for workers and their families. These opportunistic allocations, like the cycles that afflict public benefit packages, are a form of “rationing” at which the United States is already highly adept, but one that lacks the planned, deliberate, needs-based, and equitable character of “true” rationing.

In the normal middle range of nations, rationing seems mainly to entail queuing for elective procedures, which extends occasionally to waits for urgent treatment too. Like cost sharing, rationing is a flexible strategic tool within a larger policy framework with diverse, interconnected means of fiscal discipline over health care costs. No such society views rationing as a free-standing technical solution; all insist that it proceed subject to protections for equity within a coherent setting of constraints on supply and demand. Beyond these generalities, much remains to be learned about how much rationing occurs, how it works, what forms it takes, what populations it most affects, and what savings it yields. Such research is far less in fashion than such trendy pursuits as (say) the development of medical practice guidelines, but potentially far more valuable.

Viewed in cross-national context, Oregon's contribution is mainly to show that, at least today in the United States, rationing is not a profound but rather a spurious issue, a problem (to recall Ludwig Wittgenstein's famous formulation) not to solve but to dissolve. The United States should worry less about rationing and more about constructing a rational policy framework whose watchwords are budgeting, planning, regulation, and negotiation. If the polity declines to make these hard choices, rationing cannot save it from itself. American policymakers have not earned the right to ration health care, and the very policies that would earn it would eliminate much of the urge to exercise it.

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