Cite this article as:
A Etzioni
Health care rationing: a critical evaluation
*Health Affairs* 10, no.2 (1991):88-95
doi: 10.1377/hlthaff.10.2.88

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Commentary

Health Care Rationing: A Critical Evaluation

by Amitai Etzioni

Most advocates of health care rationing recognize that deciding the level of resources a country should dedicate to health requires a value judgment. However, many who favor rationing health care add some factual statements that seem to justify “objectively” the need to ration. For example, they state that health costs have risen more rapidly than has the overall rate of inflation, but they neglect to mention that this is typical of services compared to the price of commodities and hence does not indicate any particular problem in this sector. Even the observation that Americans pay more for the same services than, say, the British do (that is, that Americans get less health care per dollar spent) is not necessarily an indication that we are spending “too much” on health care, but possibly that we produce health care inefficiently. Victor Fuchs has argued that the increase in health care expenditures “has a particularly traumatic effect on other sectors.” However, this is far from self-evident. If a shortage of funds exists for some sector, say, housing for the homeless, this cannot be blamed on any other specific sector. Indeed, the shortage might as likely be caused by the defense sector, the rising interest we pay on the national deficit, or the fact that we have not found ways to increase the growth rate of the economy.

It is often implied, if not stated, that the rise in the proportion of gross national product (GNP) spent on health care in the United States indicates a “crisis.” However, typically no reasons are provided to support any particular percentage (say, 9 percent) as the “proper” level of health care expenditure, while some other figure (say, 15 percent) is, on the face of it, excessive. In short, arguments that the United States is spending “too much” on health care are based in part on value judgments and must be evaluated accordingly. In this Commentary, I critically examine the ethical reasons advanced both for rationing health care and for supporting an ethic of self-denial.

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The argument that society should interfere in people's decisions to purchase more health services has to be assessed differently according to which resources people are using to make these purchases: personal funds, insurance pools, or taxpayers' monies. As long as a person uses his or her own dollars, our society abides by the code of “consumer sovereignty,” which dictates that we should not as a society seek to influence people's choices unless there is a compelling social need. Thus far, we allow people to buy basically anything they wish, even if their choices are useless, tasteless, or even unhealthy. We ban only a few select items commonly labeled “drugs” or “controlled substances.” Is there an ethical rationale for adding some items of health care, such as hip replacements for those above age eighty, to the list of controlled substances?

It might be argued that if Americans continue to increase their spending on health services, soon they will be “short” all other things. But if and when this becomes the case, they will feel the pinch and will be free to rearrange their mix of purchases in some other way.

Several economists have argued that Americans buy more health care than they would if they had to pay for it directly, because they use “third-party” dollars through various insurance plans. True, these purchases drive up the price paid for health insurance (premiums). To the extent that those insured pay premiums directly, there seems no reason within our kind of system to interfere—even if this leads to some “distortions” in what people buy. After all, economists do not argue against other insurance schemes, such as life insurance policies, in which consumers' “bad” judgments are often much more evident.

For most insurance plans that are paid for in full or in part by employers, proper control mechanisms are already in place. When employers judge that the costs of premiums are too high, they either provide less costly, more limited insurance or negotiate with their employees to choose between more meager health benefits but increases in other areas (for example, salary) or vice versa.

Finally, concerning the use of tax revenues, there is no reliable, objective, or scientific guide to determine the “right” way to distribute tax dollars among defense, education, welfare, health, and other major areas of public expenditure. Statements pressing us to spend more on welfare, foreign aid, or some other need reflect different social philosophies and personal values. Since we as a society cannot come to any detailed consensus on these matters, we use the political process to work out an agreed pattern of allocation. For nearly twenty-five years now, the consensus has been to allocate a growing proportion of our tax revenues
to health expenditures.

Is this policy out of step with the freely and properly expressed wishes of American voters? Far from it. A June 1988 poll showed that 67 percent of Americans favored increasing government spending on health care, compared with a mere 26 percent who favored more spending on space programs; 35 percent supported spending less on the military and defense; and only 3 percent were in favor of reducing government spending on health care. When voters, elected representatives, and public policies proceed hand in hand, no one should set them asunder without a compelling reason. As I argue here, no such reason seems evident.

Alternatives To Health Care Rationing

Is American society so hard-pressed that it should consider rationing health care? Or should we ask our infirm and elderly to, in effect, put themselves out on the ice and quietly freeze to death, as Eskimos are said to do, to stop soaking up more health services? If ration we must, it seems unethical to ration resources used to sustain life without first considering curtailing other expenditures of much less merit. Examples abound, but we might start by cutting back on some recent large budget increases for exploration of Mars and other space expeditions—$15.1 billion for fiscal year 1991—or, better yet, the $30 billion military stockpile of obsolete tools and rotting uniforms that exists in our defense industry.

If we are to rationalize the distribution of resources, why only “straighten out” our health care budget? Why not rationalize the whole government budget and look for nonhealth items that could be curtailed with much less sacrifice of people’s needs and preferences? The problem lies in our present political system. Congress is so dominated by special interests that allocations are driven more by who pays most for the enormous costs of reelection than by any other criteria. One constructive policy idea after another is perverted by these pressures.

It follows that any concern with efficient allocation of resources among societal needs requires first and foremost a major movement of political reform. Much more would be achieved for the economy if instead of rationing health care or anything else, we would ban private financial contributions to congressional campaigns, as we have done for presidential elections; extend the terms of members of the House of Representatives to four years; limit campaign periods; and make a few other such changes widely endorsed by public interest groups and experts.

But, even if these reforms were achieved, we still would not have, nor should we seek, the central planning advocated by some of the champions of rationing. Such planning is a logical outgrowth of trying to ensure that
every public dollar is spent where it will bring the largest marginal utility. When we replace individual choice with guidelines, someone has to decide what is in and what is out. Our experience during Prohibition, in the war against drugs, and with guidelines already introduced into health care has taught us that direct federal control is highly troubling. If and when there is a compelling public need, limited and indirect interventions work best. For instance, one may reduce the number of new hospital beds that can be reimbursed rather than centrally determining the use of each bed, or cap the annual growth rate of health funds available per region, adjusted to changes in population size, age, and other attributes, instead of rationing specific services. Far from being a radical idea, this is now being done, and more such plans are being recommended.7

Finally, if for some reason savings must come from the health sector, surely we must first reduce the estimated 22 percent of our health care dollars spent on billing and other administrative tasks; reduce the many billions spent on unnecessary medical procedures, such as many cesarean sections and cataract operations; and curb defensive medicine—say, by limiting the amount lawyers can collect in malpractice suits or the extent to which we maintain people in persistent vegetative states.8 Some argue that these cuts would lead to one-time savings but that rationing would lead to continued savings. While this is true for at least some of these cuts, it is morally unacceptable to cut life-extending procedures before tackling those with no such implications.

Reallocation Versus Prevention

Different authorities on the subject have their own ideas of what they would cut first once they achieved health care rationing. One recommendation that has gained a wide following and deserves special examination is the suggestion that we spend too much on high-tech acute care and not enough on preventive measures. As a typical example, cases such as the following are often cited: A homeless person lives on a street near a hospital. Occasionally, especially when the weather is cold, he is brought to the emergency room, is tested in a variety of ways, and often ends up in the intensive care unit. After rehabilitation, he returns to the street. The cost of his hospital care is immense and said to be irrational. It would be much more efficient to provide him with decent housing or even welfare, thus preventing a good number of his illnesses and saving on the use of high-tech acute care. More generally, it is often argued that it is much more efficient to provide drug education than to deal with “crack” cocaine babies; to prevent teen pregnancies than to deal with underweight, premature, and malnourished infants; and to regulate guns than
to cope with the victims of violence.

When one examines these claims critically, one first notes that their inner logic is unquestionably true. Prevention is more economical and humane than post hoc treatment. However, the lack of available funds often is only part of the problem, and hence, the idea that we would be better off if we transferred funds from acute to preventive care is not necessarily so in many situations. Homelessness, drugs, teen pregnancies, and violence are the results of highly complex sociological, psychological, and political forces. They cannot be corrected by simple reallocation of funds. Coping with these social problems is best not perceived at all as part of preventive health care but as part of general societal restructuring and moral recommitment. Thus, for example, while it is true that hospital emergency rooms in many cities are overloaded by people with gunshot wounds, that does not mean that one should take on gun control as part of health care; otherwise, the whole world’s defects would be encompassed in preventive health care. The health care system unfortunately must take these social problems, by and large, as given.

The Quest For Value In Health Care

Aside from hearing that we are purchasing too much health care and health care of the wrong kind, we are also told that we are obtaining worthless item. It is said that we are driven by an irrational quest for immortality or silver bullets that will kill off all disease and that we are, in effect, paying ever more for meaningless services, for health care that extends life without any consideration of its quality.

In evaluating this claim, one must distinguish between extending lives of no discernible quality, and those lives judged by some select observers (but not by patients) to be of insufficient quality. The first kind is found in patients for whom there is no consciousness—no ability to function as a human being, to work, create, care for others, or sense that one is receiving care. A case in point is the more than 10,000 Americans considered to be in a persistent vegetative state, many of whom are maintained in nursing homes. In such cases, there seems to be some moral justification in discontinuing health services. Similarly, a case can be made for curtailing the much more common and costly surgical and other medical procedures performed on people at the very end of their lives. In these cases, patients should be placed in hospices to ameliorate pain and extend care rather than being subjected to extensive surgical or other medical interventions. Certainly, procedures that committees of physicians judge “futile and inhumane” should not be provided.

Yet, termination of such services is opposed on the grounds that it
might push us down a slippery slope, whereby once we stop giving services
to some, we will soon stop giving them to elderly but functioning people,
the disabled, minorities, and others. To guard against such slippage, we
must draw clear lines of demarcation. For instance, we would “pull the
plug” only at the discretion of two physicians, according to certain clear
guidelines, which can be legitimated by a living will and expressed in laws
and procedures, as in hospital review committees. To prevent slippage
also requires public education to introduce new concepts of dying and to
nurture acceptance of pulling the plug under carefully designated condi-
tions rather than routinely “doing all one can for a loved one.”

A procedure often cited as a candidate for elimination is kidney
dialysis. Some patients do choose not to have it; however, most prefer
to be fettered to a machine three times a week for four hours or so and
suffer the side effects rather than being dead. What is ethically unaccept-
able about that decision? That it is economically not troubling we have
already seen. Indeed, it would be highly troubling to refuse services to
people who can recover to a significant extent, say, to 85 percent capacity.
If we refuse treatments such as kidney dialysis and hip replacements, what
shall we refuse next? While there is a clear line of demarcation between
serving those who are only biologically alive, there is no such line
between kidney dialysis, hip replacements, and many other clearly ben-
eficial procedures. If we curtail these services, to what morally more
compelling purposes are we to dedicate these “saved” resources?

Beyond rationing by force, some ethicists, especially Daniel Callahan,
have called for self-imposed limitations on how much health care we
consume. He argues that it is morally inappropriate to soak up ever more
resources in the vain pursuit of ever more years. The ethic of enough
is-enough is a kind of latter-day counter-culture idea mixed with tradi-
tional notions of acquiescence.

### Three Matters Of Equity

Economists have sensitized us to the important observation that
changes in the total pile of resources available (due to slower economic
growth, recession, inflation, or rationing) will affect different subpopula-
tions differently. In plain English, when the amounts of feed available
change, some oxen starve, some get gored, and some feed more lavishly.
The question of which social groups are likely to be hurt by or to benefit
from health rationing and self-limitation must be systematically included
in any evaluation of the suggested measures. I examine this question from
three viewpoints: intergenerational equity, consumers versus providers,
and the well-off versus the poor and near-poor.
Conflict among generations. Callahan explicitly calls for stopping all but ameliorative care for the terminally ill (painkillers, nursing, and emotional support), especially for those in their late seventies and older. Great Britain, in effect, follows his recommendation for many of its elderly. Based on per capita figures, dialysis is provided to only about one-tenth the number of patients over age sixty-five who are treated in other advanced countries. Like all allocations, bans, or prohibitions based on an irrelevant criterion—be it race, religion, gender, or age—rationing health care to the elderly is clearly discriminatory. For health care to be nondiscriminatory, services should be allotted according to patients' ability to benefit from the resources as determined by medical criteria.

Consumers versus providers. A surprisingly large proportion of the discussion of health care costs focuses on consumers and much less on providers. However, the image of a consumer-driven market in which providers must keep their profits down to stay competitive is at best only partially applicable to health care. Most of the decisions about health care consumption—which tests to order, how long to stay in the hospital—are made not by consumers but by providers.

For this reason, to curb costs, one must focus on providers. In the past five years, doctors' salaries have risen 30 percent, compared with an average 16.3 percent increase in wages for all other full-time workers. In 1988, the average U.S. physician earned $144,700 per year, putting physicians in the top 3 percent of the American income scale. Limiting the excessive profits that physicians enjoy is a question that must be addressed before one argues for, say, curtailing bone marrow transplants.

Effects on the poor and near-poor. Rationing is often introduced to enhance fairness or social justice and ensure that all consumers have access to select products that are deemed essential. Thus, when gasoline is in short supply, rather than allocating it by higher prices—which, in effect, means that the rich will be able to buy all the gasoline they wish while the poor will walk—providing each individual with x gallons (more for those who need cars for their work) enhances social justice. It should be stressed, however, that health care rationing as commonly discussed is radically different. It denies the poor and near-poor, penalizes the middle classes, and, as a rule, does not curb the rich, because it generally takes place through refusals to reimburse for certain treatments rather than through rationing of the actual service. Thus, when Oregon decided to ration bone marrow transplants, it cut reimbursements for those on Medicaid. Those who could pay the $100,000 bill out of their own pockets, or move to neighboring California, could have the transplant.

Rationing merely extends the prevailing class structure to health care. In effect, of course, class structure is already in place in health care, but
health care rationing will extend its reach. During the 1980s, the living standard of the poor declined, while the rich grew richer. The question is whether at this juncture we should seek to extend the misery of the poor, especially in matters of health, or whether, if we must cut health care, we should look for approaches that would not impose extra burdens on the most vulnerable members of our society.

Conclusion. Many arguments in favor of health care rationing are based on implicit assumptions that we can have a society in which resources are allocated according to some economist's notion of efficiency and in which the "marginal" dollars are spent where they bring the greatest benefit. In a society dominated by special interest groups, profiteering, and monopolistic behavior within the health care professions, and with a growing role for profit-making corporations in the health care area, rationing will have very different consequences. It will tend to hurt the poor and the elderly but not necessarily benefit the health care of any other group, while waste and abuse will continue unabashedly in this and other sectors. Curtailments that do not endanger lives should be on the cutting block before we resort to rationing health care.

NOTES