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Comparative Health Law

Rationing of Health Care— Who Determines Who Gets the Cure, When, Where, and Why?*

The issue of healthcare rationing has taken on added importance of late as not only the United States but the rest of the world struggle with the problem of adequate medical care for persons in need of or desirous of such care. The problem has been aptly summed up: “[i]nfinite medical needs exhaust finite resources.”¹ There are differing opinions of whether rationing should take place within a given healthcare system, whether this rationing is favorable, and which individuals or entities should be in charge of parcelling out the particular care to particular individuals in particular circumstances. Thus, a key preliminary issue is what exactly is meant by healthcare rationing.

The term “ration” is defined in Webster’s Third New International Dictionary as “to distribute or divide (as commodities in short supply) in an equitable manner”² Healthcare rationing has been defined as “the process by which criteria are applied to discriminate selectively among patients who are eligible for resources that have been previously allocated to various programs.”³

Thus, the need for rationing health care is a reflection of limited medical and financial resources to provide for the healthcare needs and wants of a given population. Given this imbalance between what is available and what is sought, some method of distribution and prioritization must be developed and implemented.

The need for healthcare rationing has become particularly acute given the development of new medical technologies that make it possible to extend the lives of the sick and the elderly. Diseases and conditions that previously led to inevitable or immediate death

* This introductory piece was written by William D. Frazier, Assistant General Counsel at Rush Prudential Health Plans.

1. Richard D. Lamm, *Rationing of Health Care: Inevitable and Desirable*, 140 U. PA. L. REV. 1511, 1523 (1992).

2. WEBSTER’S THIRD NEW INTERNATIONAL DICTIONARY (1986).

3. Robert W. Evans, *Health Care Technology and the Inevitability of Resource Allocation and Rationing Decisions, Part I*, 249 JAMA 2047, 2049-50 (1983).

may now be safely treatable or may be the subject of experimental treatments, which could prove to be both costly and ultimately unsuccessful. It has been stated that the appetite for health care is infinitely expandable, since it is almost always possible to secure some incremental benefit with additional treatment. Unfortunately, services cannot be provided to all who would benefit from them.⁴ Given this virtually unlimited potential to extend every life by a few more hours, costs spiral. Technology creates more need, which requires more technology, all of which increases services and therefore costs.⁵

No matter who pays, the government or a third-party payer such as an employer, insurer, or health maintenance organization, it is clear that not every requested or potentially beneficial treatment will be covered for every potential beneficiary. Assuming a system of increasing medical demands and limited financial resources to pay for these demands, a number of questions arise regarding the system's ability to provide medical care to those "entitled" to such care. These questions include: who determines who is entitled to such care; which types of care are to be given priority; who makes priority determinations; and how much input is the patient allowed in the entire process.

To provide a simple, though hardly all encompassing, example, assume there is a society with a population of fifty. The population is divided into five groups with ten people in each of the following age categories: 0-12, 13-25, 26-45, 46-65, and 66 and over. Assume further that each person has been afflicted with a deadly plague, which, unfortunately, is not a completely unrealistic scenario. A potion exists that has the potential to cure the afflicted individuals, but only ten doses of the potion are currently available. Who are the likely recipients and how will they be chosen?

Maybe the potion should be distributed by the society's medical professionals, perhaps after first exercising the option of "physician, heal thyself," since physicians are presumably best able to determine which patients would most likely benefit from the potion and thus survive. Perhaps the elderly discoverer of the potion wishes to share it with only his or her family and friends. The society may honor its elderly by allowing them first priority. Perhaps the potion will be controlled by the market and made available to the highest bidder.

4. Kelli D. Back, Note, *Rationing Health Care: Naturally Unjust?*, 12 *HAMLIN J. PUB. L. & POL'Y* 245, 250-51 (1991).

5. *Id.* at 246.

Other methods of distribution are also conceivable. The MENSEA elements could gain control and salvage only the certifiable "geniuses." If the potion was seized by a white supremacist, minorities need not bother apply for a cure. It could be that the "fairest" method is a totally random selection process.

Such scenarios are not unrealistic, as evidenced by transplant waiting lists and Medicare eligibility criteria, to mention just two methods of healthcare allocation currently in place. While the definition of rationing refers to dispensing in an "equitable" manner, whether a given allocation system is equitable is often measured in the eyes of the potential recipient.

While third-party payers, such as insurers, have been accused of improper "hidden" rationing of health care through an experimental exclusion, such exclusions are generally based upon medical criteria. If medical criteria were not applied to "limit" coverage, the result could lead to seemingly undesirable consequences: other insureds would pay increased premiums to cover the liver transplant of a chronic alcoholic whose cirrhosis made a transplant necessary. Further, even if medical care was made available to all without cost, limited technological resources would result in delays—it could be too late by the time an ailing patient gets to the front of the line leading to the operating table.

Thus, the rationing of health care, whether express or "hidden," may be accomplished through a number of methods. A healthcare system could rely on market rationing, which operates to distribute health care based upon a patient's ability or willingness to pay for such care. A given system could rely on the government or bureaucracy to "override" market factors and apply other criteria. In such systems, as well as systems where third-party payers or other entities are the decision makers, medical services and patients may be prioritized in different manners. Just when the "ideal" system of rationing is finally installed, the legislature or the judiciary could require further adjustments.

In selecting the individuals who will receive a given treatment, assuming that the treatment cannot be made available to all who need or could benefit from the treatment, one may rely on medical criteria and attempt to determine who would benefit most from the treatment. Recipients may be chosen according to some equation of social worth, with the societal value of each person's life being the criterion. Eligibility requirements may operate to prioritize the potential recipients of care, especially with respect to those services covered by third-party payers. Age could be a determining factor,

in which case expensive, high technology treatments affording questionable and limited benefits may be withheld from the elderly. If all of the former seem unfair, an egalitarian lottery could be utilized. Such an eminently neutral system could in practice yield quite unsatisfactory results.

The key determinant in other systems may not be who is covered but rather which services are covered. Such a "prioritizing" of healthcare benefits is already used in Oregon's Medicaid program. In Oregon, healthcare services have been prioritized, with only those above a given "priority" level being funded based on three relevant factors: "1) the cost of services; 2) their anticipated effects on longevity and quality of life; and 3) the expected duration of the effects."⁶ Richard Lamm quotes Oregon Health Decisions, a grassroots citizens' advocacy group: "It is necessary to set priorities in health care, so long as health care demands and needs exceed society's capacity, or willingness, to pay for them. Thus, an "adequate" level of care may be something less than "optimal" care."⁷

Some commentators have questioned whether healthcare rationing is desirable or even necessary.⁸ The desirability of a given system of rationing obviously depends upon both the particular system being critiqued and the vantage point of the analyst. Joseph Califano has decried healthcare rationing as a "macabre dance of despair" and characterizes rationing as "[w]anting to play God rather than service Him"⁹ However, this criticism is not only unrealistic but ironic. Newly developed technologies and medical advances extend lives beyond "normal" limits, thus enabling healthcare providers to "play God" in a manner of speaking. These are among the major factors that have contributed to the present scenario of expanded medical "needs," which then necessitates rationing.

Whether healthcare rationing is viewed as a necessary evil or heralded as a method of distributing limited resources to the "de-

6. Lamm, *supra* note 1, at 1520.

7. *Id.* at 1514 (quoting OREGON HEALTH DECISIONS, QUALITY OF LIFE IN ALLOCATING HEALTH CARE RESOURCES 2-3 (1988)). For more information about Oregon Health Decisions, see Howard M. Leichter, *Political Accountability in Health Care Rationing: In Search of a New Jerusalem*, 140 U. PA. L. REV. 1939 (1992); Jack H. Nagel, *Combining Deliberation and Fair Representation in Community Health Decisions*, 140 U. PA. L. REV. 1965 (1992).

8. Joseph A. Califano, Jr., *Rationing Health Care: The Unnecessary Solution*, 140 U. PA. L. REV. 1525 (1992); Robert G. Evans, "Rationing" Health Care: The Loaded Alternative, *FRONTIERS OF HEALTH SERV. MGMT.*, Fall 1987, at 31.

9. Califano, *supra* note 8, at 1525.

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“serving” or “worthy,” it already exists in some form not only in the United States but in other countries as well. As medical technology advances further, the need to prioritize healthcare services as well as recipients will become greater. While rationing can take any number of forms and can be achieved through a number of methodologies, the issues will always be: Who selects? Who benefits? Who must wait? Who will survive?