

## Who Will Ration My Health Care?

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Rationing of health care is a hot button phrase. It sets off alarm bells in most people’s minds. Recall the infamous “death panels” as part of the healthcare reform debate of 2009 and slogans like *who will pull the plug on grandma?* Rationing is, however, a fact of modern life. The only question is who will do the rationing?

The word ration comes from latin *ratio* meaning to think or reason. In relation to goods or services, particularly those in limited quantity like doctor- or nurse-hours, rationing means balancing a variable and apparently limitless **demand** with a fixed and diminishing **supply**. Someone—a person or group—or something—a system or process—must create balance. Without rationing, those first in line would get all the goods or services, and everyone else would get none.

### Choices for *Rationer* of Healthcare

There are a number of possible choices for the “rationer” of health care services. Under the current system, all those listed below have some effect on the balancing (rationing) decision but none seeks balance.

#### *Doctors and other providers*

Doctors are the drivers of specific demand and therefore they are the drivers of cost. [Waldman & Schargel 2003] The patient has the belly pain, but the doctor ‘decides’ whether you need surgery for over \$25,000 or a 25cent pill.

Doctors affect the balance but they do not ration. All care providers are socialized to an ethos that demands the best for their patient regardless of all other factors, including *cost*. Doctors drive demand based first on their patients’ *medical* best interests and then second for their personal *financial* best interests. The current healthcare system puts these two at cross-purposes.

Most medical centers use volume-based incentives. These can be directly financial as in private practice or the RVU (relative value unit) system in most University Hospitals. In both environments, the more the doctor does, the more the doctor gets (financially). This tends to encourage *unnecessary* tests and procedures as well as up-coding (excessive charging).

In a managed care arrangement or as Klienke calls it “managed cost,” [Klienke 1998] a health care organization gets a fixed pot of money. The less it spends, the more it keeps (as profit). Here, incentives discourage *necessary* tests and procedures.

Whether fee-for-service or managed cost, as long as the game is “won” based on the *volume* of provider activities or performance as it is called, the *outcomes* for patients will suffer. That is why the British “pay-for-performance” approach does not work. [Pearson & Rawlins 2005]

### ***Institutions***

Institutions that provide care such as hospitals and medical centers are in an even more confusing, contradictory and precarious position than the doctors. Yet, they must make rationing decisions every day.

Most in-patient medical care is provided by not-for-profit organizations. Though their tax status is not-for-profit, they must generate revenues in excess of costs or they go out of business. This excess (not called “profit”) is needed to pay for unreimbursed costs such as mandated-but-unfunded care and regulatory compliance, maintenance and improvements, and unexpected expenses.

All hospitals that receive State or Federal health funds, which means almost all of them, are mandated—required by law—to provide care to various groups of people who have no funding source. In other words, by law, they must provide their services free to the patient, but at large costs to themselves. Without the “excess” (profit) mentioned previously, hospitals will not make payroll.

In my own institution in 2007, unfunded mandates alone cost  $\approx 15\%$  of the total hospital budget. Imagine any other business trying to stay open when they are *required by law* to lose 15% or more every year.

Consider the rationing decisions the hospital CEO must make. [Waldman et al 2006] How badly are the services needed that lose the most money? How do I keep nurses and doctors happy when they are required to spend so much time doing paperwork and regulatory compliance? How can I get more privately insured patients into my institution, so I can have enough “excess” to compensate for the legally mandated losses? When we get sued, how do I protect my hospital and my employees at the same time? Such rationing decisions would tax the Wisdom of Solomon.

### ***Payers***

Payers are the major rationers of medical care. They control the flow of dollars and thereby balance supply of medical services with the demand, based on their financial best interest.

All payers, whether for-profit organizations such as Tenet and HCA, not-for-profit insurers like Blue Cross/Blue Shield, or government insurers such as Medicare & Medicaid, face the two-master dilemma. [Waldman 2010] These two *masters* are the clients or patients, and the stockholders or voters.

In the case of for-profit payers, the rationing decision always seeks to spend the least money possible and thereby retain as much as possible of their premium payments so they can maximize wealth creation for the stockholders. Thus, they seek to delay or deny health care service in order to spend as little as possible. Their rationing decision always favors the *money master* over the optimal *medicine master*.

The same principle applies to not-for-profits and government agencies. Even though they do not have shareholders, they must live within its constraints of their corporate budget. They ration care seeking always to choose the cheapest short-term solution over all others, even if providers have good medical reasons to want more expensive care.

For all payers, whether private or government, the balancing choice—the rationing decision—consistently favors the financial bottom line over the patient.

Government agencies have an escape that others do not. When they run out of funds, they simply deny payment. The author has that exact experience while providing care in California during 1983. After submitting a bill to MediCal, I received a letter stating the following. “Due to a cash flow shortage, MediCal will be unable to pay its providers for services rendered in June and July. We wish to warn providers so they can adjust appropriately.” Of course, providers and hospitals cannot simply forward that letter to the IRS.

The government rations by two mechanisms: a) which diagnoses and treatments it will pay *for* and b) *how much* it will pay for each.

Newspapers describe balancing decisions by insurers as “negotiations.” That is...disingenuous. Insurers, whether for-profit, not-for-profit, or government, announce their reimbursement schedules and ‘negotiations are over. What should a provider do if a patient needs something medically but the reimbursement is below the cost-to-deliver-the-service? Should I refuse to do a heart catheterization on a critically ill baby because the State pays only \$387? That is the actual reimbursement.

## **Cost and “Effect”**

The Healthcare Bill of 2010 (PPAHCA: Patient Protection and Affordable Health Care Act) creates cost-cutting commissions. These are government agencies that reputedly will assess the effectiveness of various health care treatments, whether drugs or procedures, and approve those considered cost-effective. Therapies not so deemed would be unavailable.

Cost/effectiveness measured by the government is NOT the same as what the average person calls “cost/effective.” The positive effects we want—what we would call effective—occur over decades. Government looks only at short-term cost (immediate outlay during this budget cycle). Incredible as it may seem, government has virtually *no data* on benefits, either short term or long-term. It never calculates long-term financial implications such as productivity gains or avoided costs. Finally, Government looks only at effectiveness for populations, not for individuals.

In Great Britain, they never say that they deny someone health care classified as cost/effective. They ration care by queueing. When my 79-year-old English mother needed a hip replacement, she was approved for one: 26 months later. Any competent doctor knows that keeping a 79-year old overweight woman immobile guarantees some disaster such as a pulmonary embolus, pneumonia, further obesity and death before she gets a new hip (before they have to spend the money).

President has proposed Dr. Don Berwick as Director of Medicare and effectively (after passage of HR 3590), the “Rationer-in-Chief” of U.S. healthcare services. Despite Dr. Berwick’s impressive intellectual stature, his appointment is frightening to this author both as a physician and as a patient. Dr. Berwick sees England’s National Health Service and its NICE (National Institute for Health and Clinical Excellence) as models we should adopt here. He ignores the mounting evidence of their failures. Just like former Senator Tom Daschle, who was proposed as Director of HHS and then withdrew, Dr. Berwick is committed to central (government) control as the solution both for cost reduction and for quality enhancement.

Rationing (balancing) decisions determine what treatments will be paid for and which will not. If a patient needs what is classified as *not cost/effective*, he or she doesn’t get that care. If the patient’s condition is life-or-death, the patient dies. Whether you like or detest the phrase “death panel,” effectively that is what a cost-cutting commission is. To see how this might play out, read Daniel Putkowski’s novel “Universal Coverage.” It was fiction when he wrote it but is quickly becoming fact.

### ***The Individual Patient as Rationer***

Most people feel both ill informed and powerless to make rationing decisions. They lack both the necessary information as well as viable choices.

If you want to buy a car, you can check Consumer Reports, government gas mileage charts, service history, complaints and lemon law filings, and comparative prices, all online from your home computer.

If you need a hernia repair or are having a baby, the same types of information are not available to you. You cannot compare outcome data, surgical complications, prior or pending lawsuits, and certainly not prices. Long-term cost/effectiveness data is unavailable primarily because *such data does not exist*. Under these circumstances, how can any consumer make an intelligent rationing decision?

Even if one had the requisite information, in today’s healthcare system, what power (decision-making capability) does the consumer/customer/client/patient have? The truth is: very little. Suppose that Dr. A has a higher success rate but is more expensive than Dr. B. Dr. B will be on the insurance approved panel and Dr. A will not. You might want Dr. A, but you will get Dr. B.

### ***Who Should Ration My Health Care?***

Rationing is necessary in healthcare and will occur. The key question is not who or what will determine the supply-demand balance? The operative question is whose *rules* will govern the rationing decision: yours, the Government’s, the doctors’, the insurance companies’, all of the above?

Whose rules should determine balancing decisions? The answer is: ours (the Public). In turn this requires that we the Public achieve consensus on several contentious but critical questions described in the book “Uproot U.S. Healthcare,” transmit our consensus to the Federal government-*by plebiscite*—and demand that the U.S. healthcare system be OUR system, based on our rules.

Who should ration my health care? I should.

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