Michael Schlander:

Rationing Health Care?
Rational Resource Allocation in the Health Care System

Part 1: Why Rationing will become Inevitable.

In: Med. Welt 50 (1999) 36-41.

Key words

Economics, (Medical) Ethics, Health Care System, Health Care Spending, Rationing, Utilitarianism

Summary

The increase of medical spending has consistently exceeded economic growth in most industrialized nations. Nevertheless, most politicians insist that rationing health care is neither necessary nor desirable. The basic arguments put forward to support this proposition are (1) that it is possible to limit spending to "medically necessary" care, (2) that medical advances will, eventually, make people healthier, thus requiring less medical care, and (3) that rationing is ethically feasible only under morally demanding conditions, including objective decision criteria, and only after prior complete elimination of any wasteful spending. As all three arguments are conceptually flawed or unrealistic, rationing or "resource allocation" decisions will be inevitable. This raises the practical issue who should make these decisions, and the related ethical problem of which set of criteria should be applied. Rule utilitarianism is discussed as a feasible and pragmatic approach to this problem.

Part 2: Spending Decisions by Patients.

In: Med. Welt 50 (1999) 83-90.

Key words

Cost Sharing, Health Care System, Patients, RAND Health Insurance Experiment, Rationing

Summary

The ever rising expenditures for health care have prompted a wealth of patient cost sharing measures. Beyond generating extra-revenue for health care spending, it is expected that a reduction in overall demand for health care services will result in overall reduced cost. It is further hoped that patients ***selectively*** reduce their demand for medically unnecessary and inappropriate services. Existing evidence, in particular from the RAND Health Insurance Experiment, suggests that this expectation may not be realistic. Instead, patients have been found to reduce utilization of services irrespective of their effectiveness, with the possible consequence of impaired health outcomes. Since lower income groups are more likely to be affected, this creates an additional problem with respect to equity considerations. Therefore, it is not recommended to undertake a significant further expansion of cost sharing. For these reasons, cost sharing policies do not provide a solution to the challenge of an optimal allocation of scarce resources in the health care system.

Part 3: Spending Decisions by Third Parties

In: Med. Welt 50 (1999) 140-147.

Key words

Health Care System, Health Insurance, Oregon Health Plan, Protocols, Rationing, Third Party Decision-Makers

Summary

A new class of decision-makers has emerged as a result of the increasing need to contain the rise of health care spending. Different from patients and physicians, third party decision-makers use guidelines and treatment protocols to influence medical decisions. Such rules may be bureaucratic, technocratic or democratic in nature. Expert knowledge and health economics are the basis of technocratic guidelines which can be most useful tools assisting the physician in making medical spending decisions. However, technocratic guidelines are of limited use for comprehensive decision-making on health care resource allocation: they tend to insulate physicians from personal responsibility for their patients; they are unable to adequately capture the variety of medical practice and speed of scientific progress; available health economic evidence does not provide a sufficient foundation for comprehensive technocratic rules; and technocratic rules need democratic legitimacy regarding their underlying preferences and values.

Part 4: Spending Decisions by Physicians.

In: Med. Welt 50 (1999) 210-216.

Key words

Ethics, Financial Incentives, Health Care System, Managed Care, Physician Bedside Discretion, Rationing

Summary

Mainstream medical ethics suggests physicians should not be involved in rationing decisions; rather they should define their role exclusively as patient advocates. This view does not reflect the reality of decision-making by physician and should be rejected as unethical since it it is context specific and does ignore the demand for efficiency: any suboptimal resource allocation inevitably implies incurring opportunity costs. Furthermore, insisting on this position would lead to self-inflicted and counterproductive insulation of physicians from an urgently required public debate on the subject.

The individual physician faces a major challenge coping with resource allocation decisions, as is indicated both by the notoriously limited effectiveness of guidelines and continuous education as well as by the ethical problems of financial incentives for physicians saving costs. This challenge is also caused by the absence of health economic training and the statistical effect of risk variance at the level of the individual practitioner. Therefore, solutions will have to be sought at an intermediate level. Managed care models may provide a possible approach and should be investigated further, in a European environment for instance in the form of physician networks.