Ch. II-6 Rationing of Medical Services

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ISSUE: You have just had a very heated argument with a colleague about rationing of medical services. Do we need to ration medical services in the Neuro-ICU?

WHY ARE MEDICAL SERVICES RATIONED?

Conventional wisdom suggests that it's impossible for any country, no matter how developed, to provide unlimited health care services to its citizens. Even if provision of all needed health care goods and services was theoretically possible, it would mean that other basic social goods and services which require resources to produce, e.g., education, public safety or infrastructure, might not be available as a result. Given this fact, medical services need to be rationed, which means that sometimes potentially beneficial services may be actively withheld from patients based on scarcity.

Rationing is not exactly the same as patients not having access to medical services due to living in a medically underserved area (such as many rural regions in the US), although the end result may be the same, i.e., patients do not receive potentially beneficial services. Resource allocation is sometimes used instead rationing, perhaps because it sounds less disagreeable.

HOW ARE MEDICAL SERVICES RATIONED?

Economists have observed that although health care spending world-wide increases with increasing per capita income, all countries ration medical services. However, per capita spending levels at which services are rationed and the methods of rationing differ. The exact rationing methods depend on the politics of health care delivery. In general, there are two different approaches to rationing medical services:

- Government non-price rationing
- Market price rationing

Government non-price rationing refers to a system where the government oversees the provision of health care and decides how to ration medical services. Rationing can be accomplished by explicitly limiting access to certain treatments based on age or proof of benefit, e.g., renal replacement therapy may be withheld in patients over a certain age threshold or an experimental therapy may not be provided to anyone. An implicit method of rationing services is by limiting the supply of services, e.g., the government may control the number of magnetic resonance imaging systems or hip replacement surgeries, which means that patients are placed on waiting lists and may wait for weeks to months for those services.

Market price rationing means rationing based on ability to pay the market price; wealthy patients can access many more services than poor patients. In the US, both types of rationing occur. Medical treatments and services are not limited by the US government if patients are able to pay for them out of pocket or through insurance. Extremely wealthy patients may be able to obtain virtually any treatment or service if they are paying out of pocket, but those who rely on insurance do experience some forms of rationing, either through the amount of out of pocket expenditures (i.e., deductibles or co-pays) or by having to pay out of pocket to access services or providers not covered by their plan.

Those living in poverty in the US have variable access to health care services through Medicaid. Medicaid is a governmental program paid for by federal, state, and local taxes. The eligibility for and scope of the program varies state by state. In general, US citizens or permanent residents who meet their state's eligibility criteria are entitled to specific services including preventative care, dental and vision care, and provider office visits. The federal government encourages states to provide certain services under Medicaid, e.g., vaccinations, family planning and pregnancy coverage, and health homes, by matching state costs at a higher rate than other services. Thus, medical services for the poor are rationed, but the alternative is not receiving these services or relying on charity care.

HOW ARE PRICES SET IN THE MEDICAL MARKETPLACE?

An important (and controversial) topic relevant to market price rationing of health care is that of how prices for drugs, medical devices, and medical services are set. In a partially regulated capitalist society such as the US, there is a tendency to let the market set prices, which sometimes results in very high prices for drugs, devices, and medical services. The new drugs referred to as "biologicals" are a prime example of this, as one year of therapy can cost tens of thousands of dollars. Insurance companies and the governments of some countries (not the US) which provide care to large numbers of patients may successfully negotiate with drug and device companies to decrease prices.

ARE THERE MEDICAL SERVICES WHICH SHOULD BE PROVIDED EVEN IF PATIENTS ARE UNABLE TO PAY?

Because the consumption of medical services increases with wealth, it appears that some medical services are viewed by patients as discretionary. One could argue, however, that due to the great societal and individual impact of not providing public health services (e.g., vaccines) or preventative medical, dental, or vision services, such services should not be viewed as discretionary and contingent on the individual's ability to pay. In the US, only emergency care is considered a moral right, i.e., must be provided even if patients are unable to pay (and if the facility has such capability – if it doesn't, it needs to stabilize and transfer the patient). This concept was formally codified in 1986 in the Emergency Medical Treatment and Labor Act (EMTALA), which is discussed in Ch. IV-7.

DOES RATIONING OCCUR IN THE ICU?

There are two related concepts in resource allocation: macroallocation and microallocation. Macroallocation refers to societal level resource distribution rules, i.e., proportions of funds allocated to education, defense, infrastructure, etc. Microallocation refers to individual level resource allocation, i.e., whether a patient will be able to receive a treatment or obtain an ICU bed. The lack of ICU beds resulting in discharges from ICUs at a time when the patient may still benefit is a very common type of rationing at the micro level.

WHAT ARE THE ETHICS OF RATIONING?

Distributive justice is a philosophical concept which attempts to use ethical principles to guide the allocation of scarce societal resources. With respect to health care and medical services specifically, three different principles of distributive justice may be applicable:

- Utilitarianism
- Egalitarianism
- Prioritarianism

Utilitarianism is based on maximizing societal level impacts of individualized resource distributions based on concepts such as quality-adjusted life-years (QALYs). Using this idea, medical services that are costly and would not provide a high enough QALY would not be provided to individuals. This approach is problematic given the inherent difficulty with quantifying quality of life across patients and across time. Despite this, QALYs are used in some countries to make medical service rationing decisions, sometimes in combination with other principles discussed below.

Egalitarianism focuses on all individuals being equal and, therefore, approaches like selection by lottery or first-come, first-serve would be applicable. Unfortunately, this approach is inherently difficult as well, because patients are not equal with respect to the medical need or potential benefit from services – hence the concept of triage, which is the basis of scarce critical medical service allocation. In critical situations when resources are scarce, e.g., war, services are provided to those who can clinically benefit the most and are withheld from those who will not be benefited no matter what.

Prioritarianism is another resource allocation concept in which decisions are made based on potentially maximizing the individual's normal life cycle, i.e., services may be withheld from older patients at the end of life in favor of younger patients. Again, this concept as a sole basis for resource allocation of medical resources falls short.

WHAT CAN BE DONE TO DECREASE RATIONING OF MEDICAL SERVICES?

As the preceding discussion illustrates, rationing in health care is unavoidable, and there is no "one size, fits all" solution to how best to do it. While it may seem like this issue is not relevant at individual clinician level, in the least, as bedside providers, we can help decrease cost of healthcare by being cognizant of wasteful use of resources and choosing cheaper but equally beneficial drugs and treatments for our patients.

SUGGESTED READING/REFERENCES

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