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Rationing Health Care: It's a Matter of the Health Care System's Structure

David Orentlicher, MD, JD*

I. INTRODUCTION

As policy experts have long recognized, rationing of health care is inevitable.¹ Not even the wealthiest society can provide every medical treatment that might provide some benefit to some patients. Indeed, even though the United States spends far more on health care than any other country, more than 45 million Americans lack health care coverage and therefore access to even a minimally decent level of medical care.² Nor should a society try to provide any and all treatments that would provide some benefit. Countries face competing demands for their resources, and dollars spent on marginally-beneficial health care might yield greater benefits when spent on education, economic development, or housing.³

Although the need for rationing may be clear, it is far less obvious how a society should allocate its limited health care dollars. Should priority go to

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1. See, e.g., Ronald Dworkin, *Will Clinton's Plan Be Fair?*, N.Y. REV. BOOKS, Jan. 13, 1994, at 20, 22. See also Einer Elhauge, *Allocating Health Care Morally*, 82 CAL. L. REV. 1449, 1459-61 (1994). See generally H. Tristram Engelhardt, Jr., *Toward Multiple Standards of Health Care Delivery: Taking Moral and Economic Diversity Seriously*, ETHICAL ISSUES IN HEALTH CARE ON THE FRONTIERS OF THE TWENTY-FIRST CENTURY 25, 25-29 (Stephen Wear et al. eds., 2000).

2. KAISER FAMILY FOUND., *THE UNINSURED: A PRIMER* 1 (2009), <http://kff.org/uninsured/upload/7451-05.pdf>; Dianne Miller Wolman & Wilhelmine Miller, *The Consequences of Uninsurance for Individuals, Families, Communities, and the Nation*, 32 J.L. MED. & ETHICS 397, 398-99 (2004). To be sure, uninsured persons do receive some care, whether in emergency departments and community health centers or as inpatients in hospitals. However, individuals without health care insurance die sooner and live with a diminished quality of health than individuals who carry health care coverage.

3. Dan W. Brock, *Health Care Resource Prioritization and Rationing: Why Is It So Difficult?*, 74 SOC. RESEARCH 125, 132-33 (2007). See also Daniel Callahan, *What Is the Reasonable Demand on Health Care Resources: Designing a Basic Package of Benefits*, 8 J. CONTEMP. HEALTH L. & POL'Y 1, 6 (1992) (observing that the United States spends twice as much on health care as on education).

the sickest patients, or should it go to the patients who would derive the most benefit from treatment?⁴ To what extent should we rely on the free market to allocate health care (as we do, say, with automobiles), and to what extent should the government guarantee some level of access for people who are too poor to afford necessary care?

In trying to answer these questions, scholars have framed the debate with three key and overlapping questions:

1. *Which considerations should be used in giving some patients a higher priority when health care resources are allocated?* Should access to care be determined by one's ability to benefit from care, the degree of one's need for care, the urgency of one's need, or other considerations?⁵ Not only is it not obvious which criteria are more important, but they often yield conflicting results. We might want to give care to the sickest patients, on the ground that they have the greatest need for care. But often the sickest patients will gain far less benefit from treatment than patients who are healthier. Sometimes, it is too late to heal a patient whose body has been ravaged by illness. With cancer, for example, treating the patient at an early stage is much more likely to provide a long-term remission of the cancer than treating a patient whose cancer has spread throughout the body (i.e., someone with metastatic cancer).⁶

2. *Who should make the rationing decisions?*⁷ Should we rely on a governmental agency, the insurance companies that pay medical bills, treating physicians, or others? Do we want a national commission that can establish uniform rules and ensure consistency from patient to patient, or do we want physicians to make more individualized decisions that can take into account the different circumstances of different patients?

3. *How do we ensure that those responsible for implementing rationing decisions carry out their duty to limit health care spending?* Should physicians be asked to follow formal practice guidelines that incorporate the settled-upon rationing criteria, should the number of hospital beds be reduced to discourage unnecessary hospitalizations, should financial incentives be used to reward physicians and hospitals for appropriate, cost-

4. Sometimes the sickest patients will gain the most benefit from treatment, but not always. *See, infra*, at text accompanying note 6.

5. Council on Ethical & Judicial Affairs, *Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients*, 155 ARCHIVES INTERNAL MED. 29, 30 (1995).

6. *See* Cancer.org, *How is Colorectal Cancer Staged?*, http://www.cancer.org/docroot/cr/content/cr_2_4_3x_how_is_colon_and_rectum_cancer_staged.asp (last visited Mar. 9, 2010). For someone with localized, stage I colon cancer, treatment provides a 93 percent chance of surviving for at least five years. *Id.* For someone with metastatic, stage IV colon cancer, the chance of surviving for at least five years is only 8 percent. *Id.*

7. *See generally* Mark A. Hall, *Rationing Health Care at the Bedside*, 69 N.Y.U. L. REV. 693 (1994).

conscious care?

In answering all of these questions, writers have advocated two important models—a centralized model in which a commission establishes rationing guidelines for widespread use, and a decentralized model in which rationing decisions are made by health care providers on a case-by-case basis.⁸ This article takes the view that effective rationing policy will depend on a combination of centrally-determined policy and decentralized decision making. Rationing can be best implemented with a centrally-established structure that delegates rationing decisions to physicians but channels those decisions in a cost-effective manner.

II. THE CENTRALIZED MODEL

Under the centralized model, rationing policy is shaped by a single commission or other designated body.⁹ The central commission develops uniform rationing guidelines that can be implemented by health care providers as they take care of patients.¹⁰ Important examples of such commissions include the Oregon Health Services Commission, the United Network for Organ Sharing, and the National Institute for Health and Clinical Excellence in the United Kingdom.

The Oregon Health Services Commission was created by the Oregon legislature in 1989 to implement the Oregon Health Plan, a policy designed to increase coverage to indigent residents of the state. Rather than provide generous health care coverage to some of the uninsured poor, Oregon decided to provide good but more limited coverage to many more of the uninsured poor.¹¹ The Health Services Commission ranks medical treatments in terms of their benefits,¹² the state legislature determines a budget for the Plan every two years, and the state funds as many treatments as it can afford, with priority given to the treatments with a more favorable benefit-cost ratio.¹³ Thus, a single state commission decides how the Health Plan's budget will be allocated among different medical treatments.

The United Network for Organ Sharing (UNOS) establishes national guidelines that determine how organs should be allocated among patients who need a kidney, liver or other organ transplant.¹⁴ UNOS is a not-for-

8. See Council on Judicial & Ethical Affairs, *supra* note 5, at 34.

9. *Id.*

10. *Id.*

11. Thomas Bodenheimer, *The Oregon Health Plan—Lessons for the Nation*, 337 *NEW ENG. J. MED.* 651, 651 (1997).

12. *OR. REV. STAT.* § 414.720 (2003).

13. Howard M. Leichter, *Oregon's Bold Experiment: Whatever Happened to Rationing?*, 24 *J. HEALTH POL. POL'Y & L.* 147, 149-50 (1999).

14. UNOS.org, *Who We Are*, <http://www.unos.org/whoWeAre/> (last visited Mar. 9, 2010).

profit, membership organization of transplant programs and other interested parties, and it issues policies to rank patients in terms of priority when people die and their organs are donated for transplantation.¹⁵ Thus, for example, when a liver becomes available, the highest priority is given to someone who lives in the local geographic area, who developed liver failure recently and suddenly, and who is expected to die within seven days without a transplant.¹⁶

The National Institute for Health and Clinical Excellence (NICE) decides whether drugs and other therapies are cost-effective enough to justify coverage by the United Kingdom's universal health care system, the National Health Service.¹⁷ Established in 1999, NICE evaluates new and existing treatments and calculates their cost per quality-adjusted-life-year (QALY).¹⁸ If the cost is not too high, NICE will recommend that the treatment be covered by the National Health Service.¹⁹ Very expensive cancer drugs that extend life for only a few months may not receive a recommendation from NICE.²⁰

There are several advantages to the centralized model:

1. *The centralized model allows for a public, transparent process with broad input from stakeholders.* Rationing decisions can have profound implications—indeed, they literally can mean the difference between life and death. Because they have the potential for affecting people in a critical way, it is important that everyone have a chance to participate in the shaping of rationing policy.²¹ Without broad participation in a transparent process, the legitimacy of rationing decisions can easily come under question. If rationing decisions are made behind closed doors by a small group of people or privately by individual physicians, those who must go without medical care will wonder whether they were treated fairly.

2. *The centralized model avoids a compromise of the duty of physicians to their patients.* In the view of many scholars, physicians have an essential,

15. DAVID ORENTLICHER ET AL., *BIOETHICS AND PUBLIC HEALTH LAW* 403 (2d ed. 2008).

16. *Id.* at 405, 407.

17. Robert Steinbrook, *Saying No Isn't NICE—The Travails of Britain's National Institute for Health and Clinical Excellence*, 359 *NEW ENG. J. MED.* 1977, 1977 (2008).

18. *Id.* at 1979. The quality-adjusted-life-year (QALY) is a metric that allows policymakers to compare the effectiveness of different treatments. If a treatment provides an additional year of life at full quality, it produces one QALY. If a treatment provides an additional year of life at one-half quality, it produces one-half of a QALY. See David C. Hadorn, *The Oregon Priority-Setting Exercise: Quality of Life and Public Policy*, 21(3) *HASTINGS CTR. REP.* 11, 13 (1991).

19. Steinbrook, *supra* note 17, at 1979-80 (reporting that NICE generally employs a cut-off of \$34,400 per QALY, with some willingness to approve more expensive therapies).

20. *Id.* at 1977.

21. See generally Leonard M. Fleck, *Just Health Care Rationing: A Democratic Decisionmaking Approach*, 140 *U. PA. L. REV.* 1597, 1617-34 (1992).

professional obligation to advocate on behalf of their patients' needs without taking into account the needs of other patients.²² Just as lawyers vigorously advocate on behalf of their clients, doctors should vigorously advocate on behalf of their patients.²³ While rationing decisions must be made, they are for society, not physicians, to make.

If physicians take on the role of rationer, it will undermine a key element of the patient-physician relationship. Because of their vulnerability and lack of expertise, patients must be able to trust in their physicians to look out for their interests.²⁴ Trust is the glue that binds doctor to patient. But if physicians are simultaneously worrying about the interests of other patients, real trust is no longer possible.²⁵

3. *The centralized model promotes consistency and fairness across different patients.* If the responsibility for making rationing decisions is divided among many institutions or individuals, different patients will be treated differently depending on their particular decision maker.²⁶ Consider, for example, the situation in which physicians are responsible for making rationing decisions on a case-by-case basis. When faced with the question whether cardio-pulmonary resuscitation (CPR) should be administered to a terminally ill patient in the event of cardiac arrest, some doctors will view CPR as unjustified given its low likelihood of meaningful benefit;²⁷ others will take the view that life has infinite value and should be preserved if at all possible.²⁸ But if treatment decisions vary from doctor to doctor, public trust will be undermined. Patients will be much less willing to accept an adverse rationing decision if they know that other patients like them are treated more favorably by other physicians.

22. Robert M. Veatch, *DRGs and the Ethical Reallocation of Resources*, 16 HASTINGS CTR. REP. 32, 38 (1986).

23. *Id.* at 38; Norman G. Levinsky, *The Doctor's Master*, 311 NEW ENG. J. MED. 1573, 1573-74 (1984).

24. David Orentlicher, *Health Care Reform and the Patient-Physician Relationship*, 5 HEALTH MATRIX 141, 147 (1995) [hereinafter *Health Care Reform*].

25. See Daniel P. Sulmasy, *Physicians, Cost Control, and Ethics*, 116 ANNALS INTERNAL MED. 920, 922 (1992).

26. *Id.* at 921.

27. For most of these patients, CPR will not be successful in restoring a heartbeat, or even if the patient is resuscitated, the patient may die within a short period of time while still in the hospital. See Susan J. Diem et al., *Cardiopulmonary Resuscitation on Television—Miracles and Misinformation*, 334 NEW ENG. J. MED. 1578, 1579, 1581 (1996) (finding CPR success rates from only a few percent to as high as thirty percent).

28. F. Tyrer et al., *Factors that Influence Decisions About Cardiopulmonary Resuscitation: The Views of Doctors and Medical Students*, 85 POSTGRADUATE MED. J. 564, 566 (2009) (finding that physicians' personal beliefs and values influence their decisions about CPR).

III. THE DECENTRALIZED MODEL

Under this model, there is no attempt to create a single approach to rationing. Rather, physicians and other health care providers are allowed to make rationing decisions on a case-by-case basis. This is the “bedside” approach to the rationing of health care. Proponents cite several arguments in favor of this model:

1. *Centralized decision making is not feasible for most decisions.* In theory, it might make sense to rely on a national commission to develop rationing rules for physicians and hospitals to implement, but there are far too many rationing decisions that doctors face for them to rely on formal guidelines. As I have written previously:

There are literally thousands, if not millions, of different medical decisions that must be made for patients. If someone suffers a head injury, when should x-rays[, CT scans or MRI scans] be performed? . . . If a person has chest pain, when should an EKG or [endoscopy] be performed? When should patients with difficulty breathing be admitted to the hospital? When should patients who have gallstones have their gall bladder removed? . . . Which patients should be in an intensive care unit? If there is not room for everyone who needs intensive care in the intensive care unit, who should have priority? Which patients with coronary artery disease should undergo bypass surgery and which should be treated with medication? How long should patients remain in the hospital after delivering a baby, undergoing an appendectomy or receiving a kidney transplant? To what extent should the guidelines take into account individual variation from patient to patient? . . . Even if detailed guidelines could be developed, many of them would likely become outdated by the time they were issued. Medical knowledge is constantly evolving, so only reasonably general guidelines can account for changes in information and technology. . . ²⁹

Even in the Veterans Affairs health care system, where centralized decision making plays a key role, there are more decisions that are left to decentralized decision making than to centralized decision making.³⁰

2. *Decentralized decision making responds to the “tragic choices” problem.* As discussed above,³¹ proponents of centralized decision making cite its transparency as a virtue. The public will have input into the decision

29. David Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L. REV. 155, 168-69 (1996).

30. See generally Steven M. Asch et al., *Comparison of Quality of Care for Patients in the Veterans Health Administration and Patients in a National Sample*, 141 ANNALS INTERNAL MED. 938, 938 (2004) (observing that the VA’s practice guidelines cover a “relatively narrow scope” of clinical practice).

31. See Fleck, *supra*, note 21.

making process, and they will understand the rules by which rationing decisions are made.

However, it is not clear that society can tolerate a transparent process for rationing.³² According to Calabresi and Bobbitt, choosing which people have priority when dealing with life-and-death decisions causes too much social conflict.³³ As a result, public and transparent processes to make the decisions ultimately break down.³⁴ The history of dialysis for kidney failure illustrates this thesis well. Dialysis once was rationed in this country, and hospitals created committees to allocate the limited dialysis slots among patients in need.³⁵ But the committees' choices were highly controversial, and Congress responded by guaranteeing coverage under Medicare for any person who needs dialysis.³⁶

Because it is too difficult to establish rationing policies openly, society employs subterfuges that try to hide the fact that rationing decisions are being made. Thus, for example, when faced with the high cost of providing care to a patient with a dismal prognosis, physicians might withhold care on the ground that it would be "medically futile" to continue providing treatment. By invoking medical futility, physicians can create the impression that they are making their decision on the basis of objective, scientific considerations rather than on the basis of non-medical value judgments about the appropriate allocation of scarce resources.³⁷

A number of efforts at rationing illustrate the tragic choices problem. Consider, for example, the debate over comparative effectiveness research. Policy experts observe that many health care dollars are spent inefficiently because for many medical problems, we do not have sufficient data to tell us which among different treatment options is the most effective. Studies may tell us that several drugs are better than a placebo, but studies may not tell us which of the drugs is the most effective. Accordingly, when identifying key reforms for the U.S. health care system, experts see an important role for research that compares the effectiveness of different treatment options.³⁸ During the health care debates of 2009, however, many people worried that comparative effectiveness research would be used to deny care to patients on the basis that it was too expensive to provide the

32. GUIDO CALABRESI & PHILIP BOBBITT, TRAGIC CHOICES 17-18 (1978).

33. *See generally id.*

34. *Id.* at 18-19.

35. DAVID ORENTLICHER, MATTERS OF LIFE AND DEATH 71 (2001).

36. *Id.* at 123-24; Roger W. Evans et al., *Implications for Health Care Policy: A Social and Demographic Profile of Hemodialysis Patients in the United States*, 245 JAMA 487, 487 (1981).

37. ORENTLICHER, *supra* note 35, at 158.

38. *See* Alvin I. Mushlin & Hassan Ghomrawi, *Health Care Reform and the Need for Comparative-Effectiveness Research*, 362 NEW ENG. J. MED. e6(1), e6(1) (2010), <http://content.nejm.org/cgi/reprint/362/3/e6.pdf>.

care.³⁹ As a result, elected officials pledged to prevent such use of the research.⁴⁰

The Oregon Health Plan's effort to ration health care is similarly illuminating about the tragic choices problem. As mentioned, Oregon decided that it would try to cover more of the poor with a basic level of coverage rather than continue its practice of providing some of the poor a more generous level of care. Under the plan, anyone with a family income below the federal poverty level would be eligible for Medicaid.⁴¹ While the state did undertake a public process to decide which treatments would be covered and which treatments would not be covered, and while it published its list of covered and uncovered treatments, it did not actually implement a program that entailed meaningful rationing of care.⁴² In fact, the "basic" plan it developed offered more generous services than typical private-sector insurance policies.⁴³

Decentralized decision making can overcome the tragic choices problem by letting physicians make rationing decisions implicitly as they go about their daily routine. When physicians face resource constraints, they adjust to those limits and accommodate their treatment decisions to the constraints. Thus, for example, physicians in the United States recommend more procedures than physicians in England, with physicians in both countries believing that they generally provide appropriate care.⁴⁴ The U.S. physicians believe that British physicians provide too little care, while the British physicians believe that U.S. physicians provide too much care.⁴⁵ Physicians appear to internalize their cost constraints when determining standards of care, thereby allowing themselves to shape their practices in terms of the resources available to them.⁴⁶ This adjustment of practice to resources need not jeopardize the quality of care. As discussed below, when physicians face reasonable resource constraints, they can accommodate to those limits without compromising patient welfare.

39. Barry Meier, *New Effort Reopens a Medical Minefield*, N.Y. TIMES, May 7, 2009, at B1.

40. See, Mushlin & Ghomrawi, *supra* note 38, at e6(1) (describing prohibitions in both House and Senate bills against the use of comparative-effectiveness research results in making coverage decisions).

41. Lawrence Jacobs et al., *The Oregon Health Plan and the Political Paradox of Rationing: What Advocates and Critics Have Claimed and What Oregon Did*, 24 J. HEALTH POL. POL'Y & L. 161, 163 (1999).

42. *Id.* at 162, 165.

43. *Id.* at 167.

44. HENRY J. AARON & WILLIAM B. SCHWARTZ, *THE PAINFUL PRESCRIPTION: RATIONING HOSPITAL CARE* 37, 48-49, 59, 64, 100-02 (1984). To be sure, British physicians also acknowledge that resource constraints limit the care they provide at times. *Id.* at 37, 67.

45. *Id.* at 66.

46. *Id.* at 36, 111, 127.

3. *Decentralized decision making allows for individualized decision making.* Centrally-determined rationing guidelines may work for most patients, but they will provide a poor fit for other patients. Patients can be different in important ways, and people rightly worry that a rationing guideline may not work well for everyone. Consider in this regard the failure of an important guideline for the treatment of diabetes. In 2006, the National Committee for Quality Assurance (NCQA) adopted a standard calling for the aggressive control of blood sugar.⁴⁷ Data suggested that tight control would reduce the chances of long-term complications of diabetes, including heart disease, kidney failure, and loss of vision.⁴⁸ Two years later, the NCQA withdrew the standard after data demonstrated that the new standard caused significant harm to some patients.⁴⁹

4. *Decentralized decision making preserves a more traditional, more comfortable role for physicians.* As discussed above, the centralized model for rationing rests on a view that physicians should assume the lawyer-like role of patient advocate, zealously promoting the interests of their own patients and letting others decide how health care should be allocated among different patients when limits on society's resources mean that only some of the patients can be served.

Yet, as William Sage has observed, physicians do not see themselves as lawyer-like advocates. Rather, they think of themselves as judge-like decision makers.⁵⁰ Physicians regularly have to balance the needs of their patients with the limits of their society's resources, and they see this as an appropriate part of their professional responsibility.⁵¹ Moreover, writes Sage, the physician as zealous advocate may not be the kind of doctor that patients want. Patients rely on their physicians to provide them with honest, authoritative advice, not to make one-sided, often exaggerated arguments for one particular course of action.⁵²

IV. CENTRALIZED CONTROL OF STRUCTURE; DECENTRALIZED DECISIONMAKING

As the discussion of the two models indicates, both have their virtues; both have their drawbacks. In the end, though, it simply is not feasible to pursue a centralized approach to rationing. Practice guidelines are important, but medical decisions are too many, too varied, and too nuanced

47. Barry Meier, *Diabetes Case Shows Pitfalls of Treatment Rules*, N.Y. TIMES, Aug. 18, 2009, at B1.

48. *Id.*

49. *Id.*

50. William M. Sage, *Physicians as Advocates*, 35 HOUS. L. REV. 1529, 1578 (1999).

51. *Id.* at 1578.

52. *See id.* at 1616.

to be reduced to formulas that can guide physician decision-making at the bedside.

That said, there is an important role for centralized planning. Even if a national agency cannot provide comprehensive standard policies, a national policy can provide a standard structure that will foster appropriate rationing decisions at the bedside. In other words, we will need to rely on individualized decisions by physicians, but we also will need to channel the rationing decisions of physician in the right direction by implementing nationwide changes in the structure of our health care system. Currently, physicians practice under a fee-for-service system of compensation that rewards the provision of more care rather than better care, and in a health care system with substantial capacity that allows for generous levels of care. There is plenty of opportunity to provide too much care, and insurers will compensate physicians for doing so. Accordingly, the system's structure invites practice patterns of excessive treatment. Rationing policy is thus forced to push back against strong currents favoring increased spending. Rather than trying to swim upstream, it is better to change the current's direction. Appropriate limits on health care spending can be realized by restructuring the health care system in a way that invites cost-effective care.

The idea here is analogous to the "invisible hand" of the free market. As the experience in the U.S.S.R. and other centrally-planned economies illustrate, governments or commissions fail when they try to determine which goods to produce and how many to produce. But governments can structure the market with antitrust rules, securities regulations and other policies to channel economic decisions in a productive direction. Similarly, government can structure the health care system with policies to channel rationing decisions in a cost-effective direction. Perhaps the most important policies include the adoption of resource constraints and the implementation of compensation methods that do not encourage excessive care.

V. POLICIES FOR COST-EFFECTIVE CARE

Adopting real resource constraints. Because most patients carry health care insurance to pay the bulk of their medical expenses, patients and doctors are insufficiently sensitive to the costs of care. As long as patients pay only a small portion of the costs of their care, they will want more care than is socially desirable.⁵³ And as long as physicians are paid more for doing more, they will offer more care than is socially desirable.⁵⁴

It is thus an axiom of American medicine that supply creates its own demand. The greater the number of hospital beds available in a community,

53. Brock, *supra* note 3, at 134.

54. *Id.*

for example, the more likely it is that people will be admitted for hospital care.⁵⁵ Similarly, people are more likely to die in a hospital in communities with greater hospital capacity.⁵⁶ However, the increased use of hospital care does not confer any medical benefit: death rates are the same in communities with lower and higher hospital capacity.⁵⁷

High use of hospital care may not confer any health benefit, but it does come at considerable cost. It is far more expensive to take care of patients by admitting them to the hospital than by providing outpatient care in a physician's office. Moreover, there is good reason to believe that many unnecessary procedures, especially cardiovascular surgeries, are performed in this country.⁵⁸ Ideally, hospital care would be reserved for patients who truly need to be in the hospital for surgical intervention or other medical care.

One could try to reduce inappropriate admissions by developing practice guidelines or by having insurers implement pre-admission screening. But those approaches have not been very effective.⁵⁹ On the other hand, studies suggest that more appropriate utilization of hospitals can be achieved simply by reducing the number of hospital beds. As indicated, when there is more room for inpatients in a community, physicians admit more patients to the hospital; conversely, when hospital capacity shrinks, physicians admit fewer patients to the hospital. Importantly, the lower levels of inpatient care do not appear to result in any harm to patient health.⁶⁰ Rather, with the smaller capacity, physicians adjust their practice patterns and do a better job of reserving hospital care for patients who really need it. In Richmond, Virginia, for example, hospital capacity per capita shrunk by more than one-third between 1996 and 2009, yet the metropolitan area developed into a community providing relatively high-quality, low-cost care.⁶¹ The

55. Elliott S. Fisher et al., *Associations Among Hospital Capacity, Utilization, and Morality of U.S. Medicare Beneficiaries, Controlling for Sociodemographic Factors*, 34 HEALTH SERVICES RES. 1351, 1356 (2000).

56. *Id.*

57. *Id.* at 1358.

58. See Elliott S. Fisher & John E. Wennberg, *Health Care Quality, Geographic Variations, and the Challenge of Supply-Sensitive Care*, 46 PERSP. BIOLOGY & MED. 69, 72 (2003); See also CHRIS L. PETERSON & RACHEL BURTON, CONG. RESEARCH SERV., U.S. HEALTH CARE SPENDING: COMPARISON WITH OTHER OECD COUNTRIES 13 (2007), digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1316&context=key_workplace (reporting that the rate for coronary artery bypass surgery and other revascularization procedures for patients with coronary artery disease is seventy-seven percent higher in the United States than the average for economically-advanced democracies, and sixty-four percent higher than Germany, the country with the second-highest rate of revascularization procedures).

59. Orentlicher, *supra* note 29, at 179-86.

60. *Id.*

61. David Leonhardt, *Health Cuts with Little Effect on Care*, N.Y. TIMES, Dec. 30, 2009,

Veterans Affairs health care system also evolved into a higher-quality, lower-cost system as it was reducing its hospital capacity.⁶²

The ability of doctors to make appropriate adjustments in their practice patterns when capacity shrinks applies not only to the number of hospitalizations but also to the level of care once patients are admitted to the hospital. In a study of intensive care utilization, researchers found that decreasing an intensive care unit's capacity by almost half led to fewer patients being admitted to intensive care and more patients being treated in regular hospital units.⁶³ Nevertheless, there was no increase in patient deaths or other serious consequences.⁶⁴ Notably, the hospital did not issue any guidelines for its physicians to help them decide which patients would have priority for intensive care.⁶⁵ Physicians simply recognized that they had to use a higher threshold for admission to the intensive care unit, and they did so without any worsening of patient outcomes.

These results are not surprising. They are consistent with an international study in which researchers compared the efficiency of different countries' health care systems.⁶⁶ That is, the researchers identified the level of health for each country that would exist in the absence of any health care spending (the minimum level of health) and the maximum level of health that could be achieved with the country's health care resources.⁶⁷ They then measured how much of the potential improvement in health quality was actually being achieved in the countries and how much the countries were spending on health care.⁶⁸ From these data, the researchers could calculate a ratio of health improvement to health care spending. Countries with higher ratios were higher-efficiency countries, and countries with lower ratios were lower-efficiency countries.⁶⁹ The United States ranked among the top-third of countries worldwide, but behind most of the Western European countries, Australia, Canada, and Japan.⁷⁰ We clearly do not get the biggest bang for our health care bucks; with a more efficient system, we could spend less and achieve the same outcomes in terms of improving or

at B1.

62. Jonathan B. Perlin et al., *The Veterans Health Administration: Quality, Value, Accountability, and Information as Transforming Strategies for Patient-Centered Care*, 10 AM. J. MANAGED CARE 828, 828-30 (2004).

63. Daniel E. Singer et al., *Rationing Intensive Care—Physician Responses to a Resource Shortage*, 309 NEW ENG. J. MED. 1155, 1156 (1983).

64. *Id.* at 1159.

65. *Id.* at 1158.

66. David B. Evans et al., *Comparative Efficiency of National Health Systems: Cross National Econometric Analysis*, 323 BRIT. MED. J. 307, 307 (2001).

67. *Id.* at 307-08.

68. *Id.*

69. *Id.* at 308.

70. *Id.* at 309.

maintaining people's health.

It would not be sufficient to limit only the number of hospital beds. Other resources need to be capped as well. Surgeons can perform many operations in outpatient clinics, and physicians can overspend on unnecessary diagnostic tests and procedures. Accordingly, it would be important to restrict the number of outpatient surgical suites, the number of MRI scanners and the number of other health care facilities.

Salary or capitation-based compensation. When physicians are paid more to do more, they will do more. Fee-for-service compensation encourages the provision of more services. Thus, for example, when a walk-in medical clinic switched from a fixed salary to paying physicians a percentage of the revenues generated by the blood tests and radiologic studies ordered by the physicians, the physicians ordered more blood tests and x-rays.⁷¹ When physicians are paid a salary or a fixed fee per patient (capitation), they no longer have a financial incentive to perform more procedures. If all physicians were compensated by salary or capitation, physicians would be less likely to recommend surgery for patients who do not really need an operation, and fewer surgeries and other procedures would be performed.

There are other ways to restructure physician compensation to generate more prudent use of health care dollars. If the compensation gap between surgeons and non-surgeons were narrowed, fewer doctors would enter surgical fields and more doctors would become internists and pediatricians. Patients would spend more time with doctors who prefer to treat illness with medication and less time with doctors who prefer to treat illness with more expensive surgical procedures.

Fee-for-service compensation not only encourages the provision of unnecessary care; it also discourages the provision of high-quality, low-cost care. Hospitals that have implemented effective programs to promote early intervention and greater preventive care find that their revenues drop, often to the point that they lose money while providing higher-quality, lower-cost care.⁷² In a system in which physicians are paid salaries and hospitals receive fixed budgets, health care providers will profit from the high-quality, low-cost care that now is a financial loser.

For salary and capitation to replace fee-for-service compensation,

71. David Hemenway et al., *Physicians' Responses to Financial Incentives. Evidence from a For-Profit Ambulatory Care Center*, 322 NEW ENG. J. MED. 1059, 1060 (1990).

72. Ian Urbina, *In the Treatment of Diabetes, Success Often Does Not Pay*, N.Y. TIMES, Jan. 11, 2006, at A1 (reporting on diabetes centers that focused on preventive care but were forced to close because reimbursement rates were too low); David Leonhardt, *Dr. James Will Make It Better*, N.Y. TIMES MAG., Nov. 8, 2009, at 46 (describing how a hospital lost \$329,000 when it improved the quality and lowered the cost of its care for premature babies).

physicians need to become part of health care organizations that either can employ them on a salaried basis or can take on the size needed to assume the risk of capitated payments.⁷³ Thus, many experts advocate the development of “accountable care organizations” to promote higher-quality, lower-cost care.⁷⁴ That is, rather than practicing alone or in small, specialty groups, physicians would join large, multi-specialty groups. These accountable care organizations not only facilitate the switch from fee-for-service medicine to salary or capitation,⁷⁵ they also provide other advantages for patient care. Instead of different physicians individually assuming responsibility for only a small part of a patient’s care, the organization would assume full responsibility for the patient’s care. In this model, patient care is improved and costs are lowered in part because it is easier to implement capacity constraints and eliminate fee-for-service compensation when physicians work in large groups.⁷⁶ In addition, the larger, integrated organizations have the ability to coordinate patient care more effectively and to invest in information technology, the development of patient management protocols, and other initiatives that can yield more cost-effective care.⁷⁷

VI. LESS DESIRABLE POLICIES FOR COST-EFFECTIVE CARE

A number of writers have suggested other strategies to encourage cost-effective care. In this section, I will discuss two of these alternatives and explain why I do not think they are very useful.

Financial incentives for patients. As mentioned above, patients who carry health care insurance will want health care even when its benefits are not sufficient to justify the costs of the care. If, for an example an MRI scan costs \$1,000 and the patient only has to pay \$100 of the cost, the patient

73. *Health Care Reform, supra* note 24, at 159-60, 195. Capitated payments can be used just to cover the physician’s own services, but physicians might still overspend on diagnostic tests and referrals to specialists. To ensure that physicians are sufficiently cost-conscious, a health care system could pay global capitation fees to physicians and hospitals to cover all the costs of their patients’ care. When global capitation fees are used, it is important for health care providers to assume responsibility for a substantial patient population. There always will be a small number of patients with very high medical costs. As long as the providers of care can spread those costs over a large patient base, capitation fees are feasible. But if providers had a small patient population, a few very expensive patients could drive the practice into bankruptcy.

74. See Elliott S. Fisher et al., *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*, 26 HEALTH AFFAIRS w44, w44 (2007).

75. Leonhardt, *supra* note 72, at 33. When health care experts cite model health care systems in the United States, like the Mayo Clinic, the Cleveland Clinic or Intermountain Health Care, they typically point to health care organizations that pay their physicians a salary.

76. Fisher et al., *supra* note 74, at w44, w53.

77. *Id.* at w53.

will want the scan as long as the total benefit of the scan (in economic terms) is more than \$100. But from a societal standpoint, it would not make sense to perform the scan unless the total benefit is more than \$1,000.

To counteract the tendency of patients to desire too much care, some experts believe that health care insurers should adopt greater incentives for patients to become more cost-conscious of their care. Thus, for example, employers are offering health care plans with “health savings accounts.” Under these plans, the employer or employee funds the employee’s health savings account with between one thousand and twenty-five hundred dollars, and the employee uses the account to pay the first thousand or twenty-five hundred dollars in health care bills.⁷⁸ Because employees retain the unspent dollars for future use, they have an incentive to be more cost-conscious when seeking health care.

When individuals bear a greater responsibility for the costs of their care, they are less likely to seek care, and consequently, health care costs are reduced.⁷⁹ However, there are two key concerns with financial incentives for patients. First, when patients reduce their demand for medical care because of its costs, they do not just reduce their demand for unnecessary care. They also may reduce their demand for important care.⁸⁰ Non-physicians are not well-equipped to distinguish between essential and optional care. Second, when patients face major surgeries or other very expensive care, the financial incentives of health savings accounts will not be relevant. Whether a hospital would charge fifteen thousand dollars or twenty-five thousand dollars, the individual’s health savings account will be fully emptied.⁸¹

Globally negotiated fees for health care providers. In this approach, fee-for-service compensation is retained, but insurers or the government negotiates standard fees for physicians and hospitals. With some variation based on geographic area, all physicians and hospitals are paid the same amount for each service. Other countries, including Germany and Japan, use this approach, and citizens of those countries enjoy lower prices for health care services than do U.S. citizens.⁸²

78. COMM. FOR ECON. DEV., QUALITY, AFFORDABLE HEALTH CARE FOR ALL: MOVING BEYOND THE EMPLOYER-BASED HEALTH-INSURANCE SYSTEM 24 (2007), http://www.ced.org/images/library/reports/health_care/report_healthcare07.pdf.

79. Melinda Beeuwkes Buntin et al., *Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality*, 25 HEALTH AFFAIRS, w516, w523 (2006).

80. *Id.*; Orentlicher, *supra* note 29, at 188.

81. COMM. FOR ECON. DEV., *supra* note 78, at 15, 25.

82. Jonathan Oberlander & Joseph White, *Systemwide Cost Control—The Missing Link in Health Care Reform*, 361 NEW ENG. J. MED. 1131, 1132 (2009). In the view of some experts, higher prices for health care services are the main reason why health care costs are higher in the United States than in other countries. See also Gerard Anderson et al., *It's the Prices, Stupid: Why The United States Is So Different from Other Countries*, 22 HEALTH

The problem with this approach is that lowering fees encourages physicians to maintain their income by increasing the volume of the services they provide. For instance, patients in Japan, where fees are tightly controlled, visit a physician 3.5 times as often, spend 3.6 times more days in the hospital for each admission, and have access to nearly 3 times as many CT scanners as do patients in the U.S.⁸³ Real health care reform entails cost containment, but it also entails appropriate levels of care. We need changes in the U.S. health care system that will address both cost and quality; globally-negotiated fees only target the cost side of the equation.

VII. CONCLUSION

Because it is not feasible to develop formal rationing guidelines for physicians to implement, the rationing of health care must be left largely to physicians as they make treatment decisions for their patients. But even if physicians cannot be guided by formal standards, their decision making can be channeled in the direction of more cost-effective care by limiting the resources at their disposal and eliminating their personal incentive to provide high-cost care. The invisible hand of a properly-structured health care market can generate the kind of cost-effective care that is needed in this country.

AFFAIRS 89, 89 (2003); PETERSON & BURTON, *supra* note 58, at 16.

83. PETERSON & BURTON, *supra* note 58, at 7, 9, 15.