# Facing the "R" Word

## While rationing may be a dirty word, it may also be inevitable

**by Ron Howrigon**

Controlling costs is not only the most critical aspect of the problem with healthcare in this country, it is also the most difficult to solve. The fact is we cannot provide the highest levels of care to everyone without breaking the bank. Every country rations care in some form. Some do it by access, some by quality. In the U.S., we do it by income level. As we struggle to reform our healthcare system, we must recognize that we cannot provide universal coverage without cutting back somewhere.

In addressing the issue of healthcare costs, we will need to make some difficult choices about how we want our healthcare rationed. But before we get to these hard choices, some less controversial changes can help: tort reform, raising the Medicare eligibility age, investing in technology, and reducing unnecessary administrative burdens on the healthcare system.

I'll focus briefly on the first two—tort reform and Medicare eligibility. Three major changes to our judicial system would help reduce malpractice-related costs. First, cap punitive damages at $200,000. Second, issues of malpractice should be decided by a panel of judges and judicial physicians who are employed by the court systems rather than by a general jury. In a malpractice case, which puts physicians' standard of care on trial, a jury of peers should be comprised of other physicians. A jury of non-clinical citizens cannot produce an informed verdict, and the protection intended by the Constitution—being judged by a jury of one's peers—disappears. Finally, a policy requiring that the loser pay court costs should help reduce the number of frivolous lawsuits.

Raising the eligibility age for participation in Medicare and taking into account the benefit's income are important steps in curbing healthcare costs. The average life expectancy in this country has been steadily increasing. We need to reflect this change by raising the eligibility age for Medicare from 65 to 66 or 67. This change will produce significant cost savings and help shore up the Medicare fund. Finally, Medicare coverage should be tied to income level. Retirees with significant retirement income should pay an additional premium for Medicare coverage.

To control the spiraling costs of our healthcare system, we need to develop a way to ration coverage through clinical effectiveness and outcomes, rather than by simply cutting access. Currently, our country spends a staggering amount of money on care provided during the final few months of a person's life. We go to heroic measures to extend life, even when the hope of saving that life is non-existent. These efforts by dedicated and talented healthcare professionals, while laudable, are something that we simply cannot afford to cover if we are to provide essential care to everyone. At this point, I can imagine the thoughts running through your mind. Am I suggesting that we just let people die rather than provide care? Who decides who lives and who dies? How can anyone suggest such a thing? Before you jump to judgment, please consider the following.

Every day in this country people die while life-saving care is withheld from them for clinical rationing reasons *and no one objects.* This scenario describes the current process for organ transplants. We have a limited number of organs available for transplantation. The supply of organs is not great enough to satisfy the number of patients that need them. We have developed a rationing system in which candidates are evaluated and then put on a list and prioritized. This system includes factors such as the likelihood of success and the potential for long-term survivability. Many organ transplant protocols will eliminate candidates based on age, comorbidities, and even things like harmful personal activities. For example, an active alcoholic will be removed from the list for a liver transplant. This form of rationing directs the system to logical, non-financial choices of who may live and who may die. It is done in an attempt to maximize the benefit given a limited supply. My question to you is how is rationing a limited supply of organs different from rationing a limited supply of money?

I believe we need to develop similar clinical protocols to help physicians and hospitals know when heroic efforts to extend life should be undertaken *and covered by insurance* and when they should not. I don't think these decisions should be left up to the insurance companies or to the government. I also don't think it's fair to leave them up to individual doctors and families. Rather, I would look to the various clinical specialty societies to develop these coverage guidelines based on the most current data and information. Further, these coverage guidelines would be updated regularly as the science of medicine advances.

I understand that talking about withholding coverage feels very much like withholding care, and that it's one thing to consider in the abstract and quite another when the discussion involves *your* loved one. We want to provide everything to everyone, but I think we have proven that this approach leads to financial ruin and is no longer sustainable. If the system collapses, tens of millions of Americans will be left to their own devices to pay for the healthcare they need, making the current number of uninsured look miniscule.

*Ron Howrigon is president of Fulcrum Strategies, a provider advocacy group that performs a broad range of services for its physician clientele.*