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President's Page
The "R" Word

No, not Radical or Republican. Not Redistribution or Re-alignment. Not the Rich, Romney or Ryan. Not even Re-admissions, Re-credentialing or Re-certification (although don't get me started; I could write a whole President's Page on that one). The R word I am talking about is Rationing! There, I said it! So far, so good. I haven't broken out in a rash, cold sweat or started to wheeze, but we'll see how this goes.

In healthcare reform, the Rationing R word is so devastatingly toxic, so nuclear that it has tanked many political careers and many attempts at healthcare reform. Hillary Clinton's efforts at healthcare reform in the early '90s initially come to mind. Thunderous echoes of “Death Panels” are still fresh and reverberate across the spectrum of digital media discourse. Perhaps no issue in American politics so polarizes our nation. Yet it is exactly this divide that we must cross if we ever are to have meaningful reform. As I write this President's Page, we are just two weeks away from the US Presidential election, an inflection point that will decide which direction our ongoing healthcare reform will follow. Both parties agree that change is a must. However, irrespective of the divergent political rhetoric or even the outcome of the election, the establishment of limits to what is paid for by government funded health plans is an inevitable, un-welcome truth. Effective health system reform never will manifest unless rationing (or whatever one wants to call the concept) is a key element, be it legislative or regulatory. Now, many of you know me to be fairly conservative in my political outlook, so you know I don't make that statement lightly!

A veritable economic tsunami of crushing costs of medical care is crashing toward us. The numbers speak for themselves and are very sobering. Total healthcare spending in the United States is between 18 percent and 19 percent GDP. That equates to $2.6 trillion, or roughly $8,000 per person. Some have estimated that, conservatively, total healthcare spending could grow to 30 percent of GDP by 2030. The federal government's spending on health care consumes 4.8 percent of the nation's economic production and is expected to eat up 9.2 percent in 25 years, according to estimates from the Congressional Budget Office. All this is before the advent of Obamacare and Medicaid expansion. This growth rate clearly is not sustainable.

Our modern word “rationing” is derived from the Latin “rationem,” meaning a “reckoning, calculation or proportion.” In 1550, it meant “reasoning.” In 1666, it began also to be used as the relation of one number to another, as in ratio. In 1702, the French used the word as a “fixed allowance of food.” All these examples and derivative meanings refer to something finite and limited. Today, “rationing” is defined as the controlled distribution of scarce resources, goods or services. Health care is a scarce resource and all scarce resources are rationed in one way or another.

Our current system of health care is no different. Rationing is alive and well in the US healthcare system in 2012. Those who feel that rationing is absent in our country are just kidding themselves. It is an illusion that many so desperately try to protect. Rationing is so commonplace and familiar that we don't recognize it as such. Rationing of health care occurs because we have limited resources, be it providers, money, supplies, or hospitals. The most obvious example is transplantation, which has faced rationing for decades. In cardiac transplantation, for example, 2,000 to 2,200 hearts are transplanted each year in the United States, although the actual potential recipient pool of end-stage heart failure patients dwarfs this number at a conservatively estimated 100,000. Each week around the country, transplant teams of physicians, nurses and coordinators present potential candidates for listing in an exquisitely regulated organ rationing system. This process is in place because of the obvious limitation of a scarce healthcare resource (the donor heart); similar processes are in place for other solid organs. Even if an organ is available, candidates for this waiting list must pass financial muster. Transplant

committees must consider the short- and long-term financial scenario of the candidate. It is routine for the patient's financial status to be presented along with the clinical information in making the decision whether to list. If the insurance plan fails to cover the full costs of the expensive long-term immunosuppressive meds, transplant committees must take this into consideration and limit (i.e., ration) the availability to this list, so as not to waste the full potential of transplants. Under rare occasions of enhanced need, hospitals and blood bank systems ration the availability of certain blood types to the most ill. When hospital beds are full, bed availability informally is rationed through curbside communication among the intensivist, admitting physician, ED physician, on-call nursing supervisor, and bed control. Similarly, many communities have mass casualty plans in place should a disaster such as an H1N1 epidemic, a Katrina or a dirty bomb strike, and limited ICU beds have to be rationed among victims. The well-recognized tradition of triage is a formal process of rationing that is performed in almost all urgent and emergency care settings. Through triage, clinicians ration patient treatment efficiently when resources are insufficient for all to be treated immediately. Clearly, medical rationing (the controlled distribution of a scarce resource) is firmly embedded in what we do on a daily basis.

We also cannot ignore other limited resources – specifically, money and doctors – that are required to deliver health care. As indicated previously, our current trajectory of healthcare spending clearly is not sustainable. Our financial resources are finite. We also have a physician shortage of 50,000 in this country, and the American Association of Medical Colleges predicts that by 2025, that number will swell to 130,000.

The most common examples of rationing in US healthcare however are implicit, and, as such, are not readily recognized. Or perhaps more realistically, the truth is that we don't want to consciously and publically acknowledge that rationing is occurring. To borrow a quote from the movie “A Few Good Men,” “You don't want the truth because deep down in places you don't talk about at parties,...” Prior-authorizations and co-payments are rationing tools designed to discourage and limit the delivery of care. Rationing takes place whenever an insurance company denies a treatment. Self-rationing occurs when a patient chooses an over-the-counter remedy for symptoms instead of going to the doctor where they will have to pay a co-pay. Access to our broader healthcare network is rationed under the guise of money and time. We're all familiar with the expression, “Time is money.” That is exactly how we pay for the health care we receive – by spending our money and our time – and often in combinations in inverse proportions. Those who have money (or access to money through insurance) receive health care, while those who don't go without or must wait a long time to access the system. And the more money you have, the more healthcare services you can consume, and faster. Those who have no money or are covered by poorly paying insurance plans must pay for their care with their time, be it a long wait in an ED or a long wait for an appointment to see a private physician or one in a charity clinic. Many physicians limit the number of patients they see from poorly paying plans such as Medicaid, with openings for new patients available only months in the future.

According to a 2009 Merritt Hawkins report, the average wait time is 2 months for a new patient primary care visit in Massachusetts, which, ironically, is the only state that offers universal health coverage. In the rest of the country, the wait averages 3 weeks. As I have said many times, coverage is not the same as access, and access to a waiting list is not access to health care. In Texas, only 19 percent of primary care physicians in Dallas County accept new Medicaid patients, and that number is in a free fall, even before a possible Medicaid expansion. In a few years, how long will a patient have to wait to see a PCP under a Medicaid plan in Dallas? The current mantra in the political healthcare world is “the right patient, for the right treatment at the right time.” Timeliness of health care is getting as much attention as the quality, and appropriately so. The time element in health care is definitely a quality factor. The longer one has to wait to access the system, the greater the chance for a poor outcome.

On the other end of the spectrum, an extreme form of rationing that is increasingly prevalent for those who can afford it is the concierge system. For on average $1,500 to $2,000 a year, individuals

can eliminate the time component in the healthcare payment system and have almost immediate access to physicians, either through a same-day office visit, or digitally via e-mail or phone. The problem with this system is that instead of carrying the typical 2,500 patient caseload for the average PCP, concierge physicians limit their patients to around 750 patients. This worsens the physician shortage, creating even longer wait lists for those whose lack of funds limits their access to the system. Again, that same law of healthcare economics is preserved: money and/or time. Total access to health care over the short term is a fairly fixed dynamic, and is more or less a zero sum game. Increasing access to one group through a concierge system decreases access to another group with traditional insurance.

We do ration health care in this country, and we must come to grips with that reality. We must acknowledge that our system of rationing is one of the most unfair and most inefficient in the world. "Fairness" arguments are made from both sides of the consumer spectrum. We all are familiar with arguments of how "unfair" it is that some people have limited access to health care and others do not. But passionate arguments also can be made about how "unfair" it is to spend 30 percent of our limited healthcare financial resources (Medicare) on patients in the last year of life, and that these dollars could be spent more "fairly" and "efficiently." Another type of inefficiency in healthcare rationing in the United States is the ubiquitous "prior authorization" song and dance that we physicians must go through for most any diagnostic or therapeutic procedure we want to do for our patients, just short of blowing their nose. Every day, my fax machine is filled with medication pre-auth form requests that drive me crazy. These "processes" are put in place to serve as barriers that limit (ration) the diagnostic and therapeutic services that we provide for our patients. Our time is much better spent providing care as opposed to dealing with this inefficient rationing exercise. As I like to say, "more patient, less paper."

The real question I pose for society, politicians and physician providers is, are we going to keep our head buried in the sand, ignore the facts and accept this underground system of implicit rationing with all its issues of fairness and inefficiency? Truly, American-style medical rationing is the dirty little secret of US healthcare, our own medical version of "don't ask, don't tell." Or are we going to drag this issue out of the closet and face reality that we do ration care in the US, albeit implicitly? We must address this problem openly and directly by replacing our current system of implicit rationing with a system of ***explicit*** rationing through government funded health plans which would set limits on what would be paid for that is more efficient, transparent, and dare I say more *fair*.

How would we do this? Many look abroad for models of health system reform that our country should adopt. The secret to these systems is that they openly address and embrace a system of organized rationing (controlled distribution of a scarce resource) at a societal level. Economic tools such as the Quality Adjusted Life Year have been developed to assist in this direct and active system of rationing. These rationing decisions are made by weighing the cost of the treatment against the potential improvement in the insured's health. The problem is this parameter incorporates a societal value element into the calculation, and that can vary by culture, country, state, and even time, and can be very subjective. For example, The United Kingdom has NICE, the National Institute of Clinical Excellence. (Gotta love that acronym especially when dealing with a subject such as rationing!) The UK has established cost-effectiveness limits using the QALY metric for therapies beyond which its publically funded government health system, National Health Service, will not venture. For NICE, in dollars, that limit is $50,000 for QALY. To put this in perspective, in the United States, annual PAP smears for low-risk women have a QALY value of $700,000; yearly mammograms for women aged 40–49 roughly is $150,000, and dialysis is $50,000.

Another example is the booming surgical therapy for end-stage heart failure: left ventricular assist devices. In 2011, the QALY figure for this device is roughly $170,000. Remember, there is a conservatively estimated 100,000 patient yearly market for this device just in the US. Using the NICE guideline, the procedure would found not to be cost-effective compared to medical therapy and would not be paid for, even though it clearly is life saving. Is this appropriate, or, dare I ask, moral? Would this

be right for our country? And how and who would make these decisions? I don't know, but at least the Brits acknowledge the limits of their resources and are addressing them. Let's admit it; we physicians at times shake our heads with exasperation when considering the appropriateness of offering expensive life-extending therapies to terminal patients who have limited duration and quality of life.

Our recent Affordable Care Act directly implemented a fairly profound mechanism of rationing, although many will deny that is indeed what it is. The Independent Payment Advisory Board (or IPAB – think MedPAC on steroids) will use comparative effectiveness research to help determine payment levels for various interventions. Labeled a "death panel," the IPAB has been a political hot potato. Say what you may about Obamacare, at least the authors recognized the necessity of incorporating an element of rationing into the reform effort.

Is this the right path to institutionalized rationing for our country? Can society accept the controlled distribution of scarce medical resources provided by government funded health plans? This is not a simple subject to address. We as a society do not do well with government control, always fanatically clinging to an entitled sense of choice. For physicians it will have to involve acceptance in more equal measure a sense of duty not only to the patient, but also to society as a whole. The patient-physician relationship cannot exist in a vacuum. However, I firmly believe it is a discourse that physicians should be at the forefront at both the national and individual patient level. Nonetheless, it is difficult to have a comprehensive discussion on this topic if we cannot even accept that we have limits to what we can provide as a society in regard to health care. We must be able to wrap our arms around the fact that we cannot provide everything to everyone all the time. It is even more difficult to envision effective healthcare reform if we cannot openly and transparently discuss the controlled distribution of ever scarcer medical resources – rationing – without being demonized. It doesn't matter if you are an R, or a D, meaningful health system reform will not be realized until we as a society, and especially we physicians, accept the idea of rationing the very precious and limited resource that is health care.

The discussion must begin with the de-stigmatization of a reality, of an unwelcome truth.

We first have to be able to use the entire word – not just one letter.

(See, that wasn't so bad. I didn't implode or spontaneously combust!)