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Public Sector Reports

Rationing and Access

by Gerald A. Faverman and Peter Pratt

For many, rationing has become to health care what obscenity has become to art, the perversion of a noble endeavor. Rationing is the ultimate admission that our health care system cannot meet the needs of all of our citizens. It is an admission that most of us are not willing to make just yet. Unwilling to admit that rationing exists, we find it more comforting to say that some people "lack financial access" because that seems to mean that public officials did not have responsibility or choice in the matter: After all, the logic runs, our pluralistic system of financing and delivering health care runs on its own track, outside the realm of choice and without the need for design or plan. Rationing, however, means **making choices**. It is not rationing, then, that we abhor; it is making conscious choices to ration.

When we never give persons access to care in the first place, that is not perceived as rationing; it is only when we take something away from people that we call it rationing. When the working poor do not receive the health care they need, it is an access problem; when the rest of us are denied the health care we desire, it is rationing.

HOW MUCH HEALTH CARE DO WE REALLY NEED?

Whether or not we admit it, then, our health policy reflects our attitude that lack of access for millions of persons is a small price to pay for making sure that the rest of us receive the health care we think we need. It is the perceived needs of those of us who can readily obtain health care that are presenting the big problem. A comprehensive study published in the *New England Journal of Medicine* by Arthur Barsky, M.D., concludes (1) that, by all objective measures, Americans are healthier than they have ever been and live longer, and (2) that this collective improvement in health has been accompanied, strangely enough, by a diminished sense of well-being. In other words, we are healthier, but we think we are less well. Medical science seems to have done little to make us feel better, and yet, addicted, we demand more and more care.

Because most of us don't pay for it directly, health care has become a luxury we can afford and cannot get enough of: For every one-percent increase in the GNP, health care expenditures rise 6 percent, virtually the same ratio as the increase in consumption of luxury boats, furs, expensive wines, and foreign travel. When the money is provided, desire becomes need. This is, of course, a profligacy long fueled by the wealth invested in our health care system, in which quantity equals quality and payment comes regardless of benefit to the patient and the public.

What does this insatiable need have to do with access? Everything. We say that health care is a right for all, but in practice this means that some people have a right to every conceivable luxury in health care service, whether they need it or not, and others have a right only to the emergency room. This enormous gap must be bridged.

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THE TRAP OF HIGH-TECH MEDICINE

This insatiable desire for medical care finds its fullest expression in our romance with high-tech medicine. When we say that our health care system delivers the best care in the world, we mean that we have the most technologically sophisticated health care: We can do more for a given individual than any other nation can. But should this be the criterion by which we determine that our system is the best? This is a criterion based on technological capability, not on responsiveness to the health needs of our **entire** population. What about those without access to even basic health care? What about the infants dying in Detroit at a shameful rate? Our pride in high-tech medicine's ability to keep someone alive at any cost should never exceed our horror that Detroit's infant mortality rate is as bad as Jamaica's and Cost Rica's. We do not have unlimited dollars to spend on health care, and so the deployment of every advance in high-tech medicine is a trade-off that may well deprive thousands of basic health care.

INDIVIDUAL RESPONSIBILITY

The supreme irony of our misguided love affair with unfettered medical advance is that an individual's environment and behavior have much more to do with how healthy one is and how long one lives than advances in treatment and technology. Because of its past success, medical science today plays a smaller role in good health than one might imagine. Thomas McKeown, a noted Canadian health policy analyst, puts it bluntly: "A moderate or heavy smoker would probably live longer by giving up smoking and giving up doctors than by retaining both." Individual responsibility and public health and environmental programs are the keys to health, not medical technology.

WHAT NEXT?

We must return to the fundamental principle of public policy: Do the greatest good for the greatest number. Hence, we must reorient the system away from exotic specialty care toward comprehensive primary care. Reorganizing the health care delivery system to meet a standard of justice and morality suitable for a democratic society is the key assignment on the agenda of the nineties. The wise stewardship of public resources is the challenge for the decade ahead. Increased access and astute rationing are part and parcel of this stewardship.

Addressing these problems means recognizing that lack of access and rationing are two sides of the same coin, and that our steadfast belief in the value of high-tech medicine is incompatible with both expanding access to everyone and providing people with the health care they truly need.