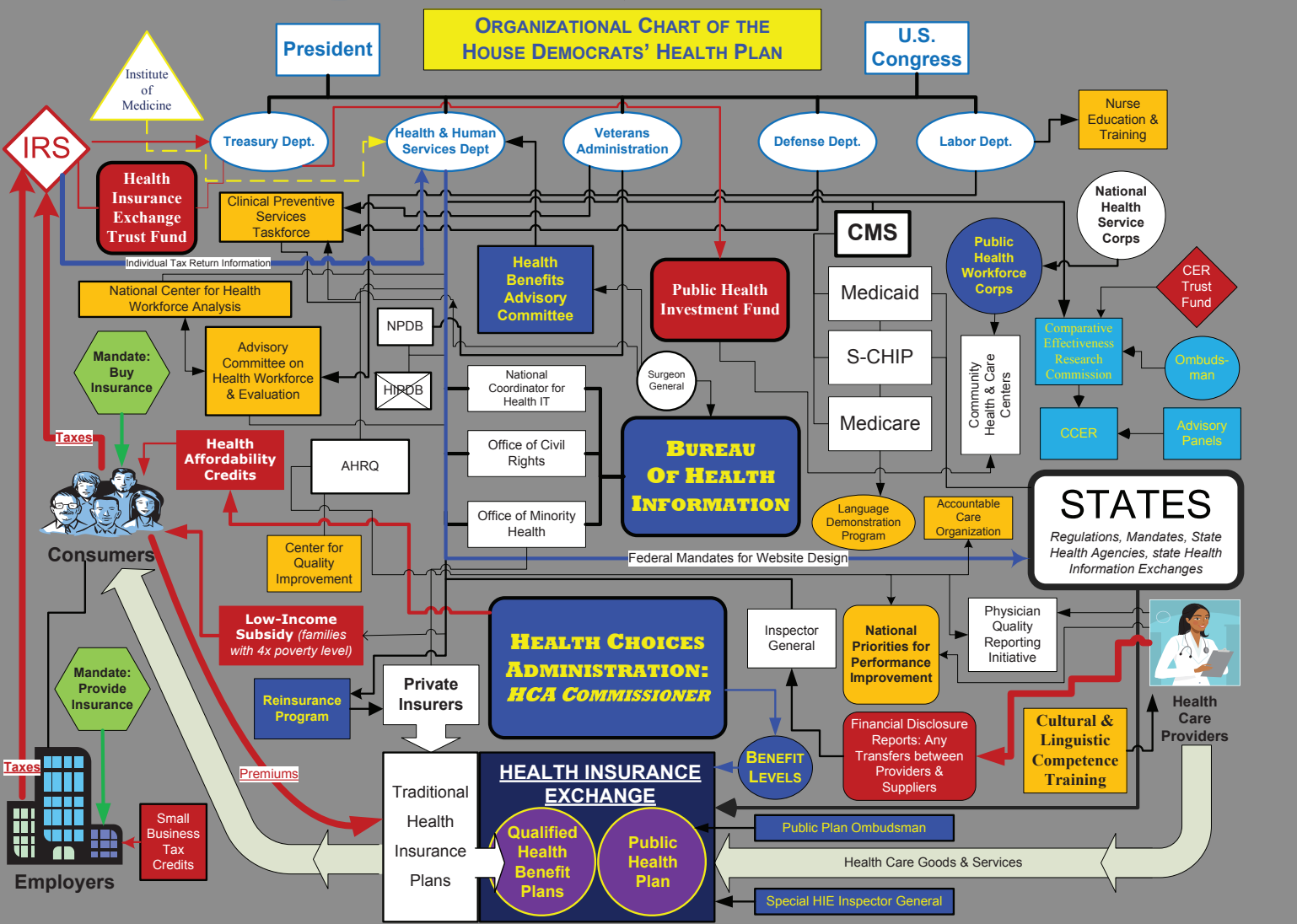


HOW CAN I RATION YOUR MEDICAL CARE?

LET ME COUNT THE WAYS.

It is impossible for President Obama and the Democrats to implement their Big Government health plan without limiting access to care.

by Michael F. Cannon





At a White House “town hall” meeting on health care, a woman named Jane Sturm asked President Barack Obama one of the most important questions of the current health care debate. The answer she got was chilling.

Sturm cares for her centenarian mother, Hazel. At age 100, Hazel was told by her doctor that she needed a pacemaker. One arrhythmia specialist declared Hazel was too old. But another was persuaded, Sturm explains, when he “saw her joy of life.” That was five years ago. Hazel got the pacemaker and is still alive and kicking.

Sturm then asked the president how such decisions will be made under his health plan: “My question to you is, outside the medical criteria for prolonging life for somebody elderly, is there any consideration that can be given for a certain spirit, a certain joy of living, quality of life? Or is it just a medical cutoff at a certain age?”

Sturm no doubt was thinking about horror stories from abroad where governments deny needed medical care to patients due to budget constraints. Henry Aaron is a health economist at the Brookings Institution. In a book on medical rationing, he and his colleagues write:

“In the early 1980s, few British chronic renal failure patients over the age of fifty or fifty-five were dialyzed or received transplants. ... These facts represent a grisly reality—many middle-aged and elderly British patients with renal failure, who could have been treated and lived, went untreated and died. Perhaps even more striking was evidence that many British physicians told their patients—and themselves—that they and the National Health Service were providing optimal care. ... One English consultant in 1980 justified failure to treat the elderly because everyone over fifty-five is ‘a bit crumbly’ and therefore not really a suitable candidate for therapy.” Treatment rates in Britain have improved since then, but remain below those of other advanced nations.

Sturm was probably seeking reassurance that here, in the land of

the free, government would not subject patients to arbitrary denials of care; that Mr. Obama’s health plan would preserve—or even expand—the freedom of American patients to choose their own course of treatment.

Obama replied: “I don’t think that we can make judgments based on peoples’ spirit. That would be a pretty subjective decision to be making. I think we have to have rules.”

Read that again. To be fair, the president ended that last sentence with, “...rules that say that we are going to provide good, quality care for all people.” Naturally, when the president says he wants rules to decide who gets medical care, he wants those rules to promote good, quality care for all people. Who doesn’t want good, quality care for all people?

The problem is that *quality* means different things to different people. So the real question, far more important than the actual rules, is: Who makes the rules? Will government make one set of rules and apply them to everybody, regardless of their unique physiology, their preferences, or whether they have that extra will to live? Or will patients have the freedom to make their own medical decisions, and the dignity that comes with it?

“The problem with explicit rationing, at least from a politician’s perspective, is that it’s too damn obvious.”

Obama’s answer suggests he comes down against letting subjective values enter into the equation. If you don’t meet the medical criteria, well, those are the rules.

A FREE MASSIVE ENTITLEMENT?

The stickiest wicket in the president’s mad dash toward socialized medicine is the issue of how to contain growing health care spending. Though he’s careful never to say so, there is simply no way Obama can contain spending without having government ration access to medical care.

According to the Congressional Budget Office, by the end of this century

overall federal spending will grow from roughly 20 percent of the economy to 40 percent. The main reason is the federal government’s two big health insurance programs, Medicare and Medicaid. To pay just for existing commitments, federal income-tax rates would nearly have to double by mid-century (top rate: 66 percent) and would “more than double” by 2082 (top rate: 88 percent).

Obama wants to commit taxpayers to yet another massive health care entitlement on top of all that. Judging by estimates from the Urban Institute and the Centers for Medicare & Medicaid Services, covering the uninsured will cost some \$2 trillion over the next 10 years. Medical spending, both public and private, would explode—just as it has under similar reforms enacted in Massachusetts.

Yet at the same time, Obama vows that his health plan will be deficit-neutral and reduce the rate of growth of health care spending: “If any bill arrives from Congress that is not controlling costs, that’s not a bill I can support.”

American voters are not likely to tolerate tax rates as high as 66 percent, much less rates that are even higher. Absent market-based reforms, that means the government will have to start denying medical care to patients.

So while Obama is far too skilled a politician to admit that he wants the federal government to ration medical care, that is precisely what he has in mind. The proof is in the bills that Obama is urging fellow Democrats to speed to his desk. That legislation, the debates surrounding it, and the experience in Massachusetts all demonstrate that Obama’s health plan will deploy every tool of bureaucratic rationing at the government’s disposal.

DENYING TREATMENTS

For 18 years, Chuck Dixon had been winning his battle against thyroid cancer. In early 2008, however, the

This chart was put out by the Republican staff of the Joint Economic Committee to display the complexities of the Democrats’ health care plan. (Rep. Kevin Brady)



Chuck Dixon, right, and the author, left, and their family pose at the Grand Canyon. (Photo courtesy: Michael Cannon)

career FBI agent received unwelcome news. The disease had returned with a vengeance. Doctors at Houston's MD Anderson Cancer Center diagnosed anaplastic thyroid cancer, the same aggressive carcinoma that ended the life of former Chief Justice William Rehnquist.

Among the treatments Dixon's doctors recommended was sunitinib (brand name: Sutent), a drug approved by the U.S. Food and Drug Administration to deny oxygen to kidney and gastrointestinal tumors. It was just the sort of treatment decision that, in early 2009, briefly turned the debate over Obama's stimulus bill into a debate over health care.

Nestled inside that legislation was \$1.1 billion for research comparing the effectiveness of different medical treatments so that patients and purchasers could have better information on which treatments work and which don't. Few could object to such evidence, and at present there is a stunning lack of it.

A draft report on the stimulus bill, however, explained the larger purpose of that \$1.1 billion. After research demonstrated which treatments worked best for the average patient, other treatments "will no longer be prescribed." Under pressure from Republicans and the medical industry, Democrats quickly backtracked. They added language assuring that the government would not use the research to deny those other treatments to all the non-average patients out there.

Such assurances aside, government rationing of particular services is both the Left's intent and an inevitable consequence of their reforms. Obama told Jane Sturm of his desire for non-subjective coverage rules directly. Massachusetts has tasked a legislative commission with developing "evidence-based purchasing strategies" to help contain the rising cost of its universal-coverage scheme.

Obama's first pick to head his health reform efforts—former Senate Majority Leader Tom Daschle—advocates creating a federal agency like Britain's National Institute for Health and Clinical Excellence (NICE), which denies patients care if the treatment they need to live exceeds the agency's arbitrary valuation of the patient's remaining lifespan. Daschle's rationing board would impose decisions on both the public and private sector. The president's proposal for a Soviet-style "Independent Medicare Advisory Commission" is a precursor to Daschle's idea. Daschle acknowledges that such matters are "not so clean cut" and that "doctors and patients might resent" having those decisions taken out of their hands.

One person who might have had those decisions taken out of his hands was Chuck Dixon. No rationing board would have approved sunitinib to treat his anaplastic thyroid cancer. Clinical trials are ongoing, but the evidence of benefit that a government rationing board would demand just isn't there.

As it happens, Dixon's private Medicare "supplement" policy covered

his sunitinib.

It didn't work. Neither did the sorafenib (brand name: Nexavar), nor the radiation, nor the chemo. Chuck Dixon succumbed to his cancer on Sept. 23, 2008, surrounded by his family.

Chuck was my father-in-law. Had a federal rationing board denied him his choice of treatment, the government he served for four decades would have stolen his dignity at the same time cancer was ravaging his insides.

Should patients like Chuck be able to order up endless, expensive and experimental treatments on the taxpayers' dime? Of course not. But that argues for letting you control your health care dollars and choose the health plan that provides the level of treatment you want, not for letting federal bureaucrats decide how much your life is worth or substitute their judgments for yours.

The problem with explicit rationing, at least from a politician's perspective, is that it's too damn obvious. What member of Congress wants to stand for re-election amid 30-second ads claiming he's denying care to cancer patients?

As a result, politicians much prefer to let price controls do their dirty work for them. More than half of all U.S. medical spending is already subject to government price controls. The ability to control prices for medical services and health insurance enables politicians to ration medical care while avoiding responsibility for the consequences.

HIDDEN RATIONING

In 2007, Deamonte Driver began to



Deamonte Driver died after an infection in his tooth spread to his brain. (Children's Defense Fund)

complain of a toothache. His mother was having difficulty finding a dentist for Deamonte and his brother, whose teeth appeared to be in even worse shape.

Maryland's Medicaid program guarantees its enrollees dental coverage, yet it pays dentists so little that only one in six dentists participates in the program. Many families, such as the Drivers, cannot access care until it is too late to save a tooth—or a child.

In fact, Deamonte's situation was more severe than his brother's. An infection in Deamonte's abscessed tooth, which could have been prevented with a simple, inexpensive extraction, spread to his brain. Multiple brain surgeries costing Medicaid some \$250,000 failed to stop it. Deamonte Driver died at the age of 12, as the *Washington Post* put it, "for want of a dentist."

House Democrats hope that stricter price controls will pay for about one-third of their \$1 trillion health plan, in part by moving another 17 million or more Americans into price-controlled government programs.

Other ways of tinkering with government price controls, however, are much more fashionable than simply ratcheting down the price levels.

MAKE DOCTORS THE BAD GUYS

When Obama told Jane Sturm that he wants coverage decisions to be governed

by objective "rules," it was a bit of a gaffe. When asked about government rationing, Obama usually sticks to the script, saying something like, "The government isn't going to make your medical decisions. We are going to give you information about what works and give your doctor the incentive to do the right thing." Loosely translated, that means, "I want to adjust the government's price controls so that your doctor has a financial incentive to deny you care."

Medicare and Medicaid traditionally pay doctors a set fee for each additional consultation, test or treatment. Obama wants to move those price controls closer to the payment system used in Canada and the United Kingdom, which pay doctors and hospitals a flat fee to provide all the medical services a patient would need for an entire year. Instead of encouraging doctors to provide more services, Obama wants a system that encourages doctors to ration care by letting them keep whatever money they do not spend.

There is nothing wrong (and a lot that's right) with paying doctors this way, provided that other payment systems are free to compete. When government imposes a Canadian-style payment system and then prohibits competing payment systems—which is precisely what the Massachusetts commission proposes to do—you get the kind of "grisly" rationing that takes place in Britain.

DUMPING THE 'SICKIES'

Price controls imposed on health insurance premiums enable an even more opaque form of government rationing that eliminates comprehensive health plans and encourages private insurers to avoid or shortchange the sick.

Congressional Democrats want to force insurers to charge a 20-something marathoner the same as his roommate, who makes occasional trips to the ER because he doesn't control his diabetes. And even if the roommate's 50-something father sports three poorly managed chronic conditions, insurers could charge him no more than twice what they charge the marathoner.

One problem with this price control is that the marathoners aren't going

to sit still while the government forces them to pay \$10,000 for a \$5,000 policy. To minimize the implicit tax, healthy people will flock to the least-comprehensive insurance plans. The most comprehensive plans will be hit by "adverse selection," which means their risk pools will become sicker and their premiums will rise until those plans disappear entirely.

That's what happened in the health insurance "exchanges" at both Harvard University and the University of California, according to Obama advisor David Cutler and his colleagues. That rations care by forcing patients, including healthy people who would have preferred comprehensive coverage, to pay for more of their care out of pocket.

Nor will insurers sit still while the government forces them to sell a \$50,000 policy for \$20,000. Insurers will find ways to avoid that losing proposition, either by rationing care to their \$50,000 customers or avoiding them altogether.

In 2008, Aetna eliminated coverage of 12-hour-a-day nursing care for people like 11-year-old Shelby Rogers, whose spinal muscular atrophy confines her to a wheelchair. Shelby's parents selected the Aetna plan through the price-controlled Federal Employees Health Benefits Program. An Aetna spokesman admitted the company dropped the benefit because it caused sick people to flock to its plan. Aetna reinstated the benefit amid negative publicity yet may revoke it again next year, because the government's price controls will continue to punish Aetna until it does.

Done properly, "dumping the sickies" can improve your bottom line *and* hurt your competitors. Sierra Health Services and Humana each operate prescription-drug plans in Medicare's price-controlled Part D program. In 2007, Sierra alleged that Humana telephoned Humana's sickest enrollees to encourage them to switch to Sierra.

NO CARE FOR THE UNPOPULAR

The Democrats' price-control regime would still allow insurers to charge smokers more than non-smokers, of course, which points to yet another way that government will ration medical care:



by eliminating coverage for unpopular services or unpopular people. When money gets even tighter in government programs, will it really be fair to spend as much on smokers as we do on people who are, you know, blameless for their illnesses? We can expect people to make the same argument, with an even less Christian attitude, when it comes to AIDS patients.

Conservatives will approve of many rationing-by-popularity decisions, such as blocking taxpayer funding of abortions. But what about rationing care to unpopular people, as Massachusetts is doing?

To cope with the rising cost of its health reforms, Massachusetts has eliminated insurance subsidies for 30,000 legal immigrants. Legal immigrants play by the rules and pay the same taxes as U.S. citizens. While citizens can get some of their tax dollars back from the Commonwealth of Massachusetts in the form of insurance subsidies, low- and middle-income immigrants now get nothing back—even though they are subject to the same requirement to purchase health insurance. Having paid Massachusetts tax rates, some will no longer be able to afford coverage, which means the commonwealth is leaving many immigrants with less access to care than if the government had just left them alone.

LYING TO OURSELVES

There is no escaping the need to ration medical care. Someone has to make those resource decisions. The great advantage of letting consumers make those decisions armed with market prices is that fewer people must go without, because innovation reduces the cost of care.

That's not what happens when government rations medicine. But don't worry. Government rationing won't hurt as much as you think. As they do in Britain, we'll just keep telling ourselves that we're getting *optimal* care. •

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THE TOWNHALL ON...

ObamaCare

"Imagine that your two best friends are British and Canadian tobacco addicts. The Brit battles lung cancer. The Canadian endures emphysema and wheezes as he walks around with clanging oxygen canisters. You probably would not think: 'Maybe I should pick up smoking.' The fact that America is even considering government medicine is equally wacky."

Deroy Murdock
National Review

"As a first take, we might say that the good achieved by health care is the number of lives saved. But that is too crude. The death of a teenager is a greater tragedy than the death of an 85-year-old, and this should be reflected in our priorities. We can accommodate that difference by calculating the number of life-years saved, rather than simply the number of lives saved"

Peter Singer
"Why We Must Ration Health Care"
New York Times Magazine

"The Congressional majority wants to pay for its \$1 trillion to \$1.6 trillion health bills with new taxes and a \$500 billion cut to Medicare. This cut will come just as baby boomers turn 65 and increase Medicare enrollment by 30%. Less money and more patients will necessitate rationing. The Congressional Budget Office estimates that only 1% of Medicare cuts will come from eliminating fraud, waste and abuse."

Betsy McCaughey
Wall Street Journal

