

# Virtual Mentor

American Medical Association Journal of Ethics  
April 2011, Volume 13, Number 4: 209-210.

## FROM THE EDITOR Confronting the “R” Word

As it has become more and more obvious, over the last several decades, that we cannot continue to afford our current medical care delivery system, the “r” word—rationing—has elicited extreme rhetoric and aroused much concern. Rationing is the controlled distribution of resources, goods, or services that are in short supply. In the United States, health care, much of which is privately financed, is one of our scarcest resources. In the private sector, health care is limited—which is to say, rationed—in free-market fashion: you get what you, or your employer, can afford. In the public sector, health care is rationed by long waits in emergency rooms and high patient copays coupled with low payments to physicians that discourage some from accepting Medicare and Medicaid patients.

In July 2009, Peter Singer wrote that the case for explicit health care rationing in the United States starts with the difficulty of thinking of any other way in which we can continue to provide adequate health care to people on Medicaid and Medicare, let alone extend coverage to those who do not now have it. Health-insurance premiums have more than doubled in a decade, rising four times faster than wages. Health care now absorbs about one dollar in every six the nation spends, a figure that far exceeds the share spent by any other nation. According to the Congressional Budget Office, it is on track to double by 2035 [1].

Rationing health care means getting better value for the billions we spend by limiting which treatments are paid for with public money. No one wants to be the one who is denied health care, an expensive pharmaceutical, or a physician’s time and focus. But when public funds subsidize or pay fully for health care, we have to try to get the best possible value for our money. Some form of health care rationing is both desirable and inescapable. How do we change our thinking and practice to both protect patients from falling by the wayside, of having their care “rationed,” as they fear, and continue to provide them with care?

In this issue, we examine a number of different ways to understand and implement rationing in our health care system. The clinical cases deal with issues that arise when patients’ perception of what constitutes necessary care is at odds with what is medically indicated for management, when changes in evidence-based medicine alter our ideas about providing cost-effective care, and when we try to assign a price to human life and health. We also look at how physicians have dealt with the rising

costs of running a practice in the face of decreasing payments by rationing their time with patients—and ultimately, spending less time at home.

What all this comes down to is that we as a society are at a crossroads. As President Obama has said, the health care system is broken. We have to change how we think, how we spend, and what we expect. As physicians, we have to help our patients understand that the era of offering tests and services “because they are covered” is over. The new era will be one of relying on comparative effectiveness (and perhaps even cost-effectiveness) analysis and being called upon to justify services that are not recommended by the results of those studies. In the end, rationing is not about taking away from our patients something they truly need, but being able to give more of what we have to more people.

### **References**

1. Singer P. Why we must ration health care. *New York Times*. July 15, 2009. <http://www.nytimes.com/2009/07/19/magazine/19healthcare-t.html>. Accessed March 23, 2011.

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