

Rationing and Health Care Policy  
Thursday May 11

*Reading:* Wendy Mariner, "Rationing Health Care and the Need for Credible Scarcity: Why Americans Can't Say No," *American Journal of Public Health* 85 (October 1995): 1435-1445.

Peter A. Ubel, "Dose Response: Intelligent rationing by physicians is the first step to a health-care system that society can afford," *The Sciences* (November/December 1999): 18-23.

This, at long last, is the final set of readings for the course. They should help pull together all the issues we have been discussing for the past three weeks. Is health care really a scarce resource? If it is, how should it be allocated? Is allocation the responsibility of doctors, insurers, government agencies, or patients? What is the role of individual responsibility?

Mariner, "Rationing Health Care and the Need for Credible Scarcity": Wendy Mariner, a legal scholar who has specialized in health policy, teaches at Boston University's schools of Law and Public Health. In this article she explores why health care rationing has become one of the most unpopular of all policies in the United States. Be sure to understand the many factors that contribute to this. Is there really a limit on health resources (recall Scheper-Hughes's arguments about whether or not there is a scarcity of organs)? What is the source of the unlimited demand for health resources? Why is it so hard for insurers to impose limits? What is the role of micro- and macro-allocation decisions? Compare her list of possible rationing mechanisms (p. 1441) to those of Annas (paper on rationing organs) or Caspar (lecture on 04/27). Why is each mechanism problematic? What does she think would have to happen before Americans would be willing to accept rationing?

Ubel, "Dose Response": Peter Ubel is a physician, bioethicist, and now director of the Center for Behavioral and Decision Sciences at the University of Michigan. He describes a common tension faced by doctors as they are training: many doctors believe that they should actively ignore questions of cost when caring for patients (optimal medical outcomes should be the only concern), but at the same time they realize that many of their decisions are horrendously cost-ineffective. How can this tension be resolved? He describes various efforts by the state of Oregon in the 1990s to use cost-effectiveness analysis to guide health care decisions. Why was the system easy to design, but difficult to implement? Have QALY's (which Caspar introduced in lecture on 04/27) solved the problem? Is his recommended plan, in which physicians would be guided but not bound by QALY's and CEA, a reasonable one? Would it work in practice?