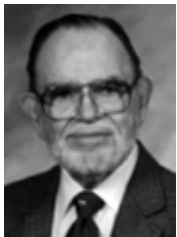




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Rationing of Health Care



By Richard L. Johnson, MD

Dr. Johnson, the former editor of this magazine, was the Medical Society's president in 1978. He recently uncovered a cassette tape about a film he reviewed in August of that year. It was on rationing of health care, and shown at a conference at Sutter General Hospital. The more things change...

This is an excellent film. It is disquieting and provocative. It gives answers and asks questions; many more questions than answers. Probably the best commentary I can make on this film is to ask more questions. Health is politics, big politics, and we, as physicians, must be more interested in politics.

The ever-increasing cost of health care has become a leading concern of many politicians. There are demands for cost containment. Organized medicine prefers the voluntary approach. Certain politicians, including our President, feel mandatory controls are needed. So far Congress has opted for the voluntary approach.

Before we go any farther, let us ask one question, are we spending too much money for health care? After all, health care is one of the leading growth industries. A few years ago health care took three or four percent of the gross national product. Now, it approaches ten percent. It is a labor rich industry, probably the only one hiring more and more people each year. If the auto industry doubled its sales, it would be applauded, but, if it doubled its employees it would be demonized.

Are we spending too much for health care? No one has the answer. At some point in time, society will decide that health care costs too much. What will happen then? Health care will be rationed. Who will do the rationing? Will it be physicians, hospital administrators, health care specialists or just plain bureaucrats? We don't know but the answer will come eventually.

David Mechanic, a professor of sociology at the University of Wisconsin, published a most lucid discussion of rationing of medical care in the current Center Magazine, a publication of the Center for Study of Democratic Institutions. He describes three basic types of rationing of medical care.

Fee for service rationing puts an economic barrier on the consumer. Some devices used by this means are co-insurance and deductibles.

Implicit rationing establishes limitation on the available resources. That is by restricting budgets, limiting the

number of beds, restricting specialists or specialty physicians. Examples are the National Health Services of England and HMOs, especially closed panels like Kaiser.

Explicit rationing refers to direct administrative decisions that lead to exclusions of coverage in health care plans, restrictions to particular sub-populations, limitations on specific procedures, pre-review of certain procedures and utilization review at intervals during provision of services. This sounds like a PSRO. Ours was probably based on the concept of explicit rationing.

The author of this article stresses that in any type of rationing, the sophisticated recipient gets much more than his or her share of services.

Recently I saw a new patient in my office. She was a 66 year-old woman with many complaints. A careful history and a meticulous physical examination plus basic laboratory screening procedures failed to disclose any significant organic disease.

Nevertheless, she had a lot of symptoms that troubled her. During the past year she has seen a family practitioner, internist, allergist, ophthalmologist, otolaryngologist, urologist, gynecologist, orthopedist and neurologist. About the only specialist she missed was a psychiatrist, perhaps the specialty she needed most.

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