

JAMA Forum: For Physicians, a Choice Between Health Care Rationing or Delivering Health Care More Rationally

BY [DAVID CUTLER, PHD](#) on [JULY 3, 2013](#)

The most important health care news of the past year has been the slowdown in the growth of total health care spending. Before the slowdown was apparent, there were repeated calls for massive payment cuts in Medicare and Medicaid and angry debates about the affordability of universal health care. Slower cost growth has allowed even the government to relax a little bit.



David Cutler, PhD

Removing the sense of crisis is welcome, indeed. But it would be a mistake to swing too far the other way. Rather, we need to use the budgetary reprieve to revamp health care so that it can withstand the possible return of cost increases—because if we don't, the alternatives are far worse.

The Dire Scenario

There are many explanations why increases in health care spending have slowed down recently. [One important contribution](#) has been a slowdown in new medical technologies. There hasn't been a mega blockbuster since Lipitor, and even that is off patent.

But suppose that this trend reverses itself. Imagine, for example, that researchers strike innovation gold and find ways to cure 10% of fatal cancers, slow the progression of Alzheimer disease, and regenerate damaged heart

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muscle—all for just \$100 000 per person. The financial consequences: tens of billions of dollars annually in the Medicare population alone. The Medicare program’s rules specify that all services that are “[reasonable and necessary](#)” are paid for; cost is not to be considered.

What would happen? The federal default strategy is to borrow more, so with no change in budgetary policy, the deficit would rise. But at some point, we would run out of borrowing ability.

One possibility at that point is to raise taxes. By international standards, [the United States is a low-tax country](#). The constraint on our taxing ability is not economics but politics. Few politicians are willing to say we need more revenue to fund growing social programs.

If taxes are off the table, that leaves only rationing. We could, for example, decide we will cover some services and not others, as the British do through their [National Institute for Health and Care Excellence](#) (formerly known as the National Institute for Clinical Excellence). Alternatively, we could pay less to physicians and hospitals, block grant Medicaid, and cut back on services, from public health to AIDS funding to the National Institutes of Health. If such reductions are large, as would be needed to offset substantial technological changes, they would limit access to care for poor and elderly individuals and impair our ability to fund development of new treatments.

Another alternative is to turn Medicare into a voucher program: give people a fixed dollar amount and let them buy insurance up to the amount they can afford, using the voucher and their own dollars. This was the proposal of Mitt Romney and Paul Ryan in the last presidential campaign and remains the mainstay of [House Republican budgets](#). Make no mistake, though, this is still rationing, but it rations by income, not need.

Take out the Waste

An alternative to rationing is taking waste out of the system—in essence, paying for the new drugs and therapies by reducing unnecessary care. The idea that there is enormous waste is not in much dispute: a number of studies (see [here](#), [here](#), and [here](#)) estimate that waste in medical care comprises about one-third of total spending.

Take just one example of wasteful spending: despite very clear [clinical guidelines](#) that say labor should not be electively induced in women before 39 weeks’ gestation, [labor is routinely induced at earlier dates](#), predictably resulting in high rates of Cesarean deliveries and admissions to neonatal intensive care units (NICUs). Eliminating this waste would provide enormous capacity for expansion in other areas. Even the rosiest of technological scenarios does not envision spending from new innovations topping one-third of existing costs.

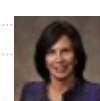
The difficulty with eliminating waste is that one person’s waste is another

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person's profit. Admissions to NICUs are preventable but are well reimbursed. Cutting NICU admissions and the profit they provide hospitals would put pressure on such services as care for indigent people and high-risk patients, as well as research and teaching. We can plead with medical personnel to hunt vigorously for waste. That is partly what happened with [successes](#) in reducing hospital-acquired infections and hospital readmissions in the past few years (financial disincentives helped too). But pleading goes only so far. To modify Upton Sinclair only slightly, "It is difficult to get a man to eliminate something, when his salary depends upon his not eliminating it!"

Thus, if we want to make medical care more rational, we first need to eliminate the profits that flow from use of excessive services. The clearest way to do this is to move reimbursement to a bundled basis. Rather than charge more for each Cesarean delivery and NICU stay, what if each pregnancy were bundled into one payment, from prenatal care to delivery and complications (if any)? How aggressively would hospitals and obstetricians look at their patterns of elective inductions if each one cost money and simultaneously led to worse outcomes?

The Affordable Care Act (ACA) made a start on this, but there is much more to be done. For example, we know that when hospital and physician payments are bundled together for hip and knee replacements, costs per procedure decrease and quality of care improves (see [here](#) and [here](#)). The ACA authorizes yet another demonstration of this system of payment, with the possibility of making this payment system national policy based on the results.

But at this point, no more lessons are needed. There is no reason why Medicare, Medicaid, and private insurers should not proceed immediately to bundle together inpatient care, physician services, and postacute services for the most common acute admissions. Such a change would be relatively straightforward to implement and [would save an enormous amount of money](#). And the evidence so far suggests that quality would improve.

This is where the recent slowdown in health costs is so important. Medicare is not being slashed, Medicaid is not being dismantled, and coverage expansions are going forward. Further, we are witnessing the potential for better care—the declines in hospital-acquired conditions and unnecessary readmissions being prime examples. These improvements are not the least bit surprising to those who understand the power of economic incentives, and they are merely the tip of the iceberg.

The way forward is increasingly clear. We can use the tailwind from slow cost growth to ramp up our efforts to deliver health care more rationally or face rationing of some form if we do not.

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