Rationing Health Care at the End of Life

Professor Lois Shepherd, University of Virginia

Introduction

While decisions about end-of-life care grab the biggest headlines when a young, beautiful woman, such as Karen Ann Quinlan in the 1970s or Terri Schiavo in the early 2000s, is lying in a vegetative state, every day American families face agonizing decisions about continuing or withdrawing life support for elderly grandparents, premature infants, people of all ages with terminal illnesses like cancer, and victims of extreme trauma. In these situations, family members may insist that everything be done—from therapies of unproven value to those that have even been proven to be ineffective—in their struggle to keep loved ones alive a day or week longer. They will often bankrupt themselves to pay for treatment, and if they have health insurance, they will insist that every penny possible be spent even if it means higher premiums for the next person. There is a feeling in the U.S. that we have the best medicine in the world, so why not take advantage of it? And, despite its obvious limits, in times of crisis we tend to believe that modern medicine will allow us to beat death. Intensely personal and often religious, decisions to pursue end-of-life treatment have known few limits, least of all limits on cost.

While we may like to think of these decisions as also private, since the Quinlan case in the 1970s, the American public has been keenly aware of, and conflicted about, controversial cases involving the continuation of life support for individuals who have no medically realistic hope for a return to consciousness.¹ This conflict has not faded with time, and has arguably grown with the prominence of "pro-life" politics. In 2003-2004, the legislatures of the state of Florida and the U.S. government each passed laws extraordinary in purpose and scope—to require that Terri Schiavo continue to receive artificial nutrition and hydration. While a court ruling that her feeding tube should be removed prevailed in the end, this decision was met with hundreds of protestors outside Ms. Schiavo’s hospice, death threats to the judge and Ms. Schiavo’s husband, and continuous and contentious coverage on cable television. Unquestionably, public interest in the case, and hostility from those who disagreed with the court’s decision, were fueled by the suspicion (unwarranted by the facts) that Ms. Schiavo’s husband would gain financially from her death.² The taint of money in an end-of-life decision rendered it beyond the pale of decency.

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It is not surprising, then, that in cases such as these, when the question of the public expense of providing aggressive medical treatment has arisen, it has as quickly been extinguished. Any suggestion that economic considerations should play a role in these already ethically and emotionally charged situations has never garnered significant public or political support.

Deep-seated aversion to economic, governmental, or any other outside influence favoring decisions to withdraw life-sustaining treatment help to explain how the health care debate of the last year and half was overtaken at one point by the accusation that the federal government would establish death panels for the elderly. The accusation was leveled at a provision in early health care reform legislation that allowed for Medicare reimbursement to doctors for “advance care planning” conversations. While the conversations were entirely optional for patients and completely unscripted, conservative politicians claimed that the elderly would be encouraged to refuse life-saving care in order to contain costs. The provision was quickly eliminated from legislative consideration.

But concerns about future cuts to care at the end of life have remained strong. Even if no expansive governmental health care program to cover the uninsured is adopted this year, the current Medicare program faces impending insolvency. If nothing is done to contain current escalating costs, the program’s trust fund will be depleted by 2017. Just in the last ten years, the average annual cost for health care per Medicare beneficiary has grown from $5,500 to $11,900. Among those costs, expenses at the end of life are incredibly high, with more than one-fourth of Medicare expenses—in 2009, about $143 billion—going to medical treatment in the last year of life. The effectiveness of these expenses can naturally draw scrutiny—after all, the end result of these expenses is—by virtue of the category carved out—death.

These facts have led some to ask: Should we ration health care at the end of life?

Politicians, to be sure, have carefully positioned themselves as far away from the issue as they possibly can. Those in favor of health care reform have insisted that it would come with no rationing of any kind, at the end of life or ever, period. Those against health care reform legislation have claimed to the contrary that any government plan to cover substantial numbers of the currently uninsured must come in the form of cuts to the elderly or those who require expensive treatments to continue living. Few, if any, politicians have been willing to engage in serious, careful debate about limits to publicly financed end-of-life treatment. To do so risks unpopularity, labeling, and misinterpretation.

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4 Arthur Garson Jr. & Carolyn L. Engelhard, “The Economics of Dying—Myth #4: Most Medical Care Dollars are Spent in the Last Six Months of Life,” Governing, April 1, 2009, available at http://www.governing.com/column/economics-dying. Further details on this spending, its historical context, and comparisons to other countries’ spending is provided later in this paper.
Yet a story President Obama told in the spring of 2009 about his grandmother provided an opening for just such a discussion. Although doctors predicted that Madelyn Dunham, 86 years old, had less than a year to live because of terminal cancer, possibly less than three months, she received a hip replacement after a fall. Hip replacements cost, on average, about $45,000, and take a few months to a year to recover from. While the idea appeared to be that the new hip would improve the quality of her remaining life— and therefore worth the discomfort and risks of surgery posed by her heart condition and cancer—what happened instead is that she died two weeks afterwards as a result of it. President Obama said that, had the surgery not been covered by insurance, he would have paid for it himself, but that the situation did raise the question whether asking society to pay for such treatment is a “sustainable model.” He added, "So that's where I think you just get into some very difficult moral issues."

The story of President Obama's grandmother puts a face to the tough ethical questions to be asked in determining the use of public funds for individuals’ medical care. If the operation had been successful, Ms. Dunham may have been able to attend her grandson’s inauguration; as it happened, she died one day before his election. Who should say whether an operation like this should be performed and whether Medicare should pay for it? By what criteria should the decision be judged?

The idea of explicit limits to health care has never been a popular one. A recent Gallup poll revealed that “93% of Americans say it is either extremely or very important for their health plan to cover any medical test or treatment they and their doctor think is necessary.” This aspect of choice was more important to those surveyed than access to health insurance regardless of medical situation or choice of doctor or hospital.

Most basically, the idea of rationing is that in a situation of scarcity, the needs and wants of all people cannot be met. Instead, choices have to be made to allocate resources among them. As a population, we are much more familiar with the idea of rationing in terms of tangible scarce medical resources rather than simply money. We commonly understand that there are waiting lists and various criteria for eligibility for scarce organs for transplant. We expect emergency room care to be “triaged” and provided to those in most dire need before those who have been waiting the longest. When vaccines for the H1N1 flu virus became available in limited quantities in the fall of 2009, we accepted prioritization for the vaccine, with health care workers and those at greatest risk of serious consequences from the virus being first in line to receive to the vaccine.

The concept of rationing simply because we might choose to spend less money on health care—or rather, fail to continue to spend more and more as price increases for medical treatment continue to outstrip inflation—is one we are less familiar and comfortable with. When

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someone’s life appears to be on the line as a result of such economic choices, we are in uncharted territory.

What follows is a brief summary of some of the facts and figures concerning health spending at the end of life. The remainder of the paper then sets out the main arguments for and against rationing health care at the end of life.

Fast Facts: Medical Spending at the End of Life

Cost Snapshots

Medical spending at the end of life is often discussed by reference to Medicare spending, the federal program that insures people over age 65, people with long-term disabilities, and people with end-stage renal disease.

Medicare spending averages $24,000-$28,000 per beneficiary in the last year of life, compared to $4,000 spent for Medicare beneficiaries who do not die in the year. Much of end of life spending is associated with inpatient hospital care.

Costs at the end of life vary widely by region. A recent study noted a variation of average Medicare spending in the last two years of life from about $29,000 to $81,000 depending on hospital referral region. Such spending variations do not correspond to differences in outcomes, quality, access, or satisfaction with care.

Costs are higher among minorities due to higher use of hospital inpatient services at the end of life.

Costs in Relation to Aging Population

Between 2000 and 2050, the percentage of the population represented by people over age 65 is expected to grow from 10.4% to 18.6%; the percentage of people over age 80 will grow from 1.5% to 4%.

For those who reach the age of Medicare eligibility (currently 65 years), nearly all will have a serious chronic illness or disability prior to death.

For the oldest old (age 85 and older), medical spending in the last year of life is actually less (by as much as half) than for end of life care for those people aged 65-74. This appears to be the

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result of the provision of less intensive hospital-based treatment for people who die at older ages.

**Historical Trends and International Comparisons**
Despite widely-held perceptions to the contrary, the portion of Medicare spending devoted to the last year of life has been stable over the last 40 years, between 26-31%. This percentage of spending at the end of life compared to spending generally for the senior population is similar to the proportions spent in other countries, although there have not been any direct, systematic, international comparisons. Switzerland, which has high health care spending generally, appears to have lower spending in the last year of life (18-22% of health spending for those who are retired).

Similarities across countries in spending in the last year of life appear greater than differences, although outliers exist. While about half of patients age 65-74 die in hospitals in most countries, only a quarter of such patients do so in Sweden. Like the U.S., other countries experience lower medical costs for the oldest old; the largest decline related to age has been noted in Taiwan, where medical expenses for the over 85 population is only 27% of that for patients age 65-69; in the U.S. it is 66%.

**Against Rationing: Rationing health care at the end of life is unnecessary and/or unethical.**

Arguments against rationing health care at the end of life fall into three different approaches.

A. There is nothing wrong with spending large amounts of money on health care, including at the end of life.

There are some who argue that the current, increasingly insistent focus on controlling health care costs is misguided. There is nothing new about this latest “crisis” in health care costs—a crisis in American medicine was declared as long ago as the early 1960s,7 and there have been a number of such declarations since. According to this view, we should not be alarmed by the fact that health care costs represent a larger and larger portion of GDP (from approximately 5% of GDP in 1960; to 13.7% in 1993; 16.2% in 2007; and to an expected 20.3% by 2018).8 Such an increasing devotion of resources to improving the health and longevity of Americans should not be assumed to be a negative. Costs are not necessarily “out of control” nor does the mere fact that we spend so much on health care mean that such spending is “wasteful” or should be spent on something else. Instead, it reflects the wealth of America—we are indeed fortunate that we are able to devote so many resources to improving health. Writing in 1993, Doug

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Bandow of the Cato Institute argued, "There is nothing strange. . . about Americans devoting an increasing share of their incomes on medical attention as they grow more prosperous. Surely there is at least as much justification for spending a marginal dollar on health as on a nicer car, more recreation, or another beer." More recently, this position has been expressed by Burke Balch, director of a center for ethics at the National Right to Life Committee.

Among those who oppose rationing health care, however, this is probably not a dominant view, at least not explicitly. It is hard to ignore the evidence that health care costs are having a damaging effect on those who bear them—whether federal, state, or local governments (which must make difficult trade-offs between health care and public safety, highway transportation, education, and the like), businesses that provide health insurance to employees (General Motors being the prominent example of a company suffering competitive global disadvantage because of employee and retiree health care costs), or individuals who, even if they are insured, often forgo care because they cannot afford the expense of care that insurance does not cover. (Out-of-pocket medical expenses have been blamed for over half of personal bankruptcies in recent years.) Moreover, the evidence is clear that the populations of other industrialized countries enjoy comparative or better health outcomes for a much lower per capita cost.

B. Cost-savings at the end of life can be achieved by “rational care” rather than by rationing care. Other opponents of rationing acknowledge the need to rein in the ever-spiraling increase in health care costs but argue that it can be done without the need for bureaucrats or others to place limits on care. Proponents of “rational care at the end of life” would generally support greater use of advance directives and hospice care, and a reduction in the provision of unnecessary, ineffective, or “futile” care. They would encourage physicians to engage in more conversation with terminally ill patients and to be more upfront and honest about realistic treatment goals—in contrast to current somewhat abysmal practices in this regard. They would also point to the fragmentation of much end of life care in hospitals where specialists, while providing high quality treatment for the care of a particular organ system, for example, are not a part of a system of coordinated care that aims to meet the treatment goals of the whole patient.

An example of the savings that might be achieved by such end-of-life treatment reforms can be found in the experience of Gundersen Lutheran Hospital in LaCrosse, Wisconsin, which has made a special commitment to helping patients to engage in conversations about their wishes regarding end-of-life treatment and to document those wishes in advance directives. While the rates at which the general population completes advance directives has remained low since their introduction in the 1970s—somewhere between 15 and 30 percent of the population has

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completed one today—in LaCrosse, 96% of adults who die in the city’s hospital have completed an advance directive. Lower costs for end of life treatment appear to have followed. The average cost of care for a patient in the last two years of life is $18,000 in LaCrosse, compared to the national average of $26,000. In some places, it is much higher than that, over $75,000. Cost savings such as these, however, are not what motivated the program; according to hospital officials it was established instead as “part of good patient care.” In fact, Gundersen’s advance directives program costs the hospital millions of dollars a year because it does not receive reimbursement for the advance planning services it provides.

According to proponents of this view, government could have a role in encouraging and supporting these kinds of reforms in end-of-life health care management through financial incentives and other regulation. For starters, we could bring back the provision in the early health care reform bill that was deleted in the face of charges that it created “death panels.” That provision allowed Medicare to reimburse doctors for the time they spend talking with patients about their goals for medical care. The “advance care planning consultations” eligible for reimbursement would take place, at a patient’s option, every five years or earlier if a patient’s health condition changed substantially. This misunderstood and ultimately defeated provision is an example of the kind of government initiatives that would encourage more humane and more patient-directed end-of-life care that would also be less expensive.

C. Targeting end-of-life care for rationing would be unethical and result in only small cost savings, even if some limits to publicly financed health care are unavoidable.

A very different viewpoint comes from those who may accept that rationing is necessary, but do not believe that rationing care at the end of life is the best way, ethically or economically, to allocate health care resources. They see rationing at the end of life as unnecessarily and arbitrarily targeting a vulnerable population. Moreover, if by “end of life” we mean those with less than a certain number of months to live, that population is largely unknowable and the treatments that will be unsuccessful difficult to identify in advance.

To the extent proponents of this view are open to other forms of limits on health care, they point out that rationing already takes place in the U.S. health care system, primarily on the basis of ability to pay. Rationing is what happens in a market system—those who cannot afford a share of finite goods are limited in what they can purchase and therefore receive. This understanding of rationing is a reminder of existing limits on health care for many lower income individuals and families.

But even if we are to understand rationing as a decision to deny care made by someone other than the consumer there are still examples of current rationing activities in health care that we seem able to live with. The most obvious are in transplants, vaccines, and emergency room care, where pre-determined criteria are established for distributing scarce resources. Less obvious

are long-standing “certificate of need” programs, in effect in 38 states, which limit expansion of new health care facilities in an effort to curb health care costs by limiting supply. More recently, emphasis has been placed less on controlling the supply of facilities and more on eliminating care that either is nonbeneficial or that is no more beneficial than less costly care. In the delivery of health care today, in many, many instances, physicians simply do not know whether one treatment is more effective than another, or actually effective at all. This has led to recent attention on, and federal dollars allocated to, “comparative effectiveness” research, which compares different drugs or treatments in randomized trials.

To date it is not clear how the results of comparative effectiveness research will be used. Will the results simply be disseminated to physicians and patients to allow treatment decisions to be made in the context of the physician-patient relationship? (This looks like “rational” health care.) Alternatively, will public and private payors use the research results to determine coverage decisions? For example, if a study shows that one treatment is not as effective as another, will government health plans like Medicare, or private health plans, following government lead, deny coverage for the first treatment option? (This looks like rationing.) This looks even more like rationing if comparative effectiveness research takes cost into account, determining that certain treatments, while of some effectiveness, are not worth the additional cost over other treatments.

Some would argue that making coverage decisions based on comparative effectiveness (even when cost is taken into account) is far preferable to rationing care at the end of life. Comparative effectiveness coverage limits would not unfairly single out a certain demographic of the population, such as the elderly, to receive less care. Proposals for such age-based rationing, as made by Daniel Callahan and discussed below, are objectionable as ageist and sexist (because women live longer than men). Similarly, rationing on the basis of comparative effectiveness does not pit different patient populations against one another (old vs. young, very sick vs. moderately sick). Nor does it limit treatment to a particularly vulnerable population, such as the terminally ill, except in the sense that treatments are limited to everyone when they will not be effective in improving quality or length of life.

Proponents of broad-based rationing on the basis of effectiveness as opposed to rationing at the end of life also point out that the savings to be achieved at the end of life are actually quite small. This is in large part due to the fact that many of the most expensive treatments that are performed near the end of life are not known to be ineffective in advance—in other words, “[s]ince there are no reliable ways to identify the patients who will die, it is not possible to say accurately months, weeks, or even days before death which patients will benefit from intensive

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interventions and which ones will receive 'wasted' care."¹⁴ With respect to savings to be achieved by limiting care to the elderly, they would point out that the oldest old (85 years and older) already receive less intensive, less hospital-based care when they are dying. Their medical treatment expenses in the last year of life are actually half that of individuals who die between the ages of 65 and 75.

**For Rationing:** Rationing is unavoidable and inevitable; rationing at the end of life is far preferable to our current system of rationing.

Few will come right out and say that they favor rationing care at the end of life. It is a position fraught with the risk of severe popular and political backlash, as evidenced in the health care reform debate of last year, when politicians painstakingly distanced themselves as far as possible from the very suggestion. Nevertheless, arguments in favor of rationing health care at the end of life can and have been made.

When the phrase “end of life” is used, different meanings might be intended. Under one meaning, “end of life” means the end of a particular individual’s life, no matter what the person’s age or cause of dying. This category would include a child with incurable cancer or a newborn with a fatal condition, as well as a person who has lived a natural life span. Under a second meaning, what is meant is old age, or the end of a natural life span, rather than the end of a particular individual’s life. There are arguments in favor of rationing at the end of life understood in both senses.

A. We should limit costly expenditures that only achieve marginal gains in extended life.

As already noted, the costs spent on the last few months of life are extremely high. Many believe that substantial savings can be achieved by putting limits on aggressive, and ultimately ineffective medical treatment at the end of life. While some people (position b, above) believe similar savings can be achieved without rationing and by being more responsive to patient and family needs and desires, others argue that limits on payment for some of those treatments are the only effective way to go. The high cost of newly developed, and marginally (if at all) effective cancer drugs has received recent attention as a particular target for imposed limits.¹⁵

Proponents of rationing at the end of life focus on several key points. First, when we talk about health care rationing, we are generally talking about how to allocate taxpayer dollars. If individuals are able and willing to pay for expensive and marginally beneficial drugs when faced with a terminal illness, there would be no government-imposed limitation on their doing so. But when taxpayer dollars are used to pay for care, the government needs to allocate those dollars in the best, most effective, and fairest way of all. As Peter Singer, Princeton ethicist and

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advocate of rationing, has written, “If the U.S. system spent less on expensive treatments for those who, with or without the drugs, have at most a few months to live, it would be better able to save the lives of more people who, if they get the treatment they need, might live for several decades.”

The idea then is that more life years can be saved with rationing at the end of life, not fewer. Our current system, with its large numbers of uninsured or underinsured individuals, allows many lives to be lost because of lack of treatment. One study, recently published in the American Journal of Public Health, estimates that as many as 45,000 deaths in America per year are associated with lack of health insurance. Emergency rooms do not provide the safety net for the uninsured that many people imagine. A recent study in Wisconsin found that victims of severe automobile accidents who lacked health insurance received 20% less treatment and were 37% more likely to die of their injuries than people who had insurance. Of those who died, the costs of saving them were estimated to be $220,000 per person; since they were relatively young, with an average age of 30, the estimated cost per year of life saved (assuming an average life span) would have been $5,500, a drop in the bucket compared to, say, palliative (rather than curative) chemotherapy at up to $100,000 per patient with terminal cancer. Such chemotherapy is increasingly given even in the last few days or weeks of life even though it is unlikely to benefit patients in any way. In fact, one large study showed that for some kinds of cancers (lung and pancreatic), patients receiving hospice care and no chemotherapy lived significantly longer than those receiving chemotherapy and no hospice.

Those who argue that we need to take a careful look at the savings to be achieved by limiting nonbeneficial or marginally beneficial treatment at the end-of-life certainly don’t support abandoning such patients. Pain relief, comfort, supportive, and other forms of care should be provided. And support for rationing of some kind at the end of life has nothing to do with euthanasia, which involves intentionally hastening death. Rather it is about making choices, openly and explicitly, and preferably with the involvement of all interested stakeholders, about how to best allocate health dollars to provide for better and longer lives for more people.

The deaths of people who lack insurance or other means of paying for care are relatively hidden from view, and do not seem to be a result of anyone’s choice. But advocates of rationing at the end of life argue that they are a result of choice, a choice to have a health care system that allows

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19 Singer, “Why We Must Ration Health Care”
20 Sarah Elizabeth Harrington & Thomas J. Smith, “The Role of Chemotherapy at the End of Life: ‘When is Enough, Enough?’” *Journal of American Medical Association*, June 11, 2008. See this article for support of the remaining facts provided in this paragraph as well.
such deaths to occur rather than one that engages in the difficult, but necessary task of figuring out, with transparency and fairness, what price to put on a life.

B. We should limit expensive interventions beyond a natural life span.

Others in favor of rationing at the end of life focus less on the high cost and marginal benefits of life extended by weeks and months, and instead favor limiting expensive interventions for people after they reach a certain age, or at least explicitly making advanced age one of the factors to be considered in allocating scarce medical resources. Part of the justification for age-based rationing is, as with the form of rationing favored above, that fewer life years (or months or weeks) are achieved by medical interventions at this age. But there is also the intuitive and widely held view that it is less tragic for an 80 year old to die than a 14 year old. Why? Because the older person has had the opportunity to live out a natural life span, while the latter has not. Age, in a word, matters. And it actually matters to a lot of people. Alan Williams, a British economist in favor of age-based rationing, writes, "Surveys of public opinion commonly find that most people, if pushed into a tight situation, would give priority to the young over the old when distributing a given amount of health care benefit. . . . When the views of older respondents in such surveys have been reported separately, they too give priority to the young over themselves."21

Advocates of rationing on the basis of age also point out that such rationing treats people equally, as everyone (if fortunate enough) ages. It is current rationing, on ability to pay, that is unequal, failing to give all Americans an opportunity to achieve a natural life span.

Even if rationing on the basis of age is not necessary now (a disputed point), proponents of this view insist that it will be in the future. Philosopher Daniel Callahan, probably the best known American advocate of age-based rationing, decries medicine's quest to make people live longer and longer, rather than focusing on the quality of people’s old age. Our appetite for greater and greater life extension is limitless, yet the extra life purchased is often beset with chronic and debilitating conditions, such as dementia. More saliently, it comes at a cost to younger generations. Medicare spending now costs over $480 billion per year and accounts for 13% of overall federal spending. We should not allow it to take up a greater and greater share of our health care resources on an illusory quest to beat death. That money is better, and more fairly, spent on allowing younger people to live out a natural life span. Callahan writes, "[A] good society ought to help young people become old people, but is under no obligation to help the old become indefinitely older. The latter is a fiscal black hole, abetted by endless new and costly technologies."

Looking for Rational Care, Rather than Rationing, at the End of Life

Atul Gawande, surgeon and health care writer for the New Yorker, has a number of interesting pieces relating to the question of rationing. He is one of the more outspoken advocates of “rational” care rather than rationing. See Atul Gawande, “Testing, Testing,” The New Yorker, Dec. 14, 2009, in which he argues in favor of health care reform legislation’s almost shotgun approach of trying a number of different cost-savings initiatives that will not limit quality or effectiveness of care; Atul Gawande, “The Cost Conundrum: What a Texas Town Can Teach Us About Heath Care,” The New Yorker, June 1, 2009, in which he tries to pinpoint the reasons for the huge difference in health care costs in two Texas towns; and a short NPR interview of Gawande by Ari Shapiro, available at http://www.npr.org/templates/story/story.php?storyId=112502210, in which rationing in the context of health care reform is discussed.

http://www.boston.com/bostonglobe/editorial_opinion/oped/articles/2009/05/08/a_rational_talk_about_rationing_care/

Accepting Rationing Generally, But Not Targeted toward End of Life Care

Dan Brock, “Rationing: Why It is Ethical,” Health Care Cost Monitor, July 16, 2009. Brock, a medical ethics professor at Harvard Medical School, makes the case that it is unethical not to ration health care because of the enormous resources that are and will be spent to produce only minimal benefits—resources that would produce greater benefits for the population by spending them elsewhere, such as on education or infrastructure.
http://healthcarecostmonitor.thehastingscenter.org/danbrock/why-it-is-ethical/

Uwe Reinhardt, “‘Rationing’ Health Care: What Does It Mean?” The New York Times, July 3, 2009. The author, a Princeton economics professor, is a well-known advocate for universal health care. In this article he explains that rationing already takes place in America, on the basis of ability to pay. He characterizes Congress’ and the Obama administration’s efforts in health care reform as working to eliminate or reduce rationing.

Louise B. Russell, “Expensive Procedures Can Be Cost Effective, Too,” Health Care Cost Monitor, Jan. 8, 2010. This article points out that while big bills at the end of life get our attention, we have to pay equal attention to the aggregate of many small ones. Certain routine preventative medicines or screenings are prescribed for many patients but only actually save the lives of a few, at costs in excess of $400,000 for every year of life saved.
http://healthcarecostmonitor.thehastingscenter.org/louiserussell/expensive-procedures-can-be-cost-effective-too/
Somnath Saha, Darren D. Coffman & Ariel K. Smits, “Giving Teeth to Comparative-Effectiveness Research—The Oregon Experience,” New England Journal of Medicine, Feb. 3, 2010. This article argues that comparative-effectiveness research can be used to substantially lower health care costs in addition to improving care. It discusses the state of Oregon’s experience in expanding the pool of people covered by Medicaid by reducing covered services based on public input. (The Oregon experience is the best known example of transparent and explicit rationing of health care resources in the country, and has drawn both support and criticism.)
http://content.nejm.org/cgi/content/full/NEJMp0912938v1

Robert D. Truog, “Screening Mammography and the ‘R’ Word,” The New England Journal of Medicine, Dec. 24, 2009 (published at NEJM.org on Nov. 25, 2009). In the fall of 2009, a government task force raised the recommended age for women to obtain annual screening mammography from 40 to 50. Truog says this is rationing and should be understood as such (as in “call a spade a spade”), for how else can we engage in reasoned discussion about controlling health care costs.

Accepting or Advocating Rationing at the End of Life


Norman Daniels, “Opportunity Costs,” Health Care Cost Monitor, The Hastings Center Daniels, professor of ethics and Harvard School of Public Health, points out the opportunity costs of paying for expensive and only marginally beneficial interventions that achieve few health-adjusted life years. The article is especially useful in giving a concrete example—the cost of a new left ventricular assist device for the heart that is of unproven effectiveness and can cost between $500,000 and $1.4 million per Quality Adjusted Life Year (a common measurement used by health economists). Paying for devices such as this one means forgoing better access to therapies that might prevent heart failure, such as better access to blood pressure and lipid screening.
http://healthcarecostmonitor.thehastingscenter.org/normandaniels/opportunity-costs/

Govind Persad, Alan Wertheimer, & Ezekial Emanuel, “Principles for allocation of scarce medical interventions,” The Lancet, Jan. 31, 2009. This is the article that opponents of health care reform drew upon to claim that Ezekial Emanuel, head of bioethics at the National Institutes of
Health and brother of White House chief of staff Rahm Emanuel, was a proponent of rationing on the basis of age and disability. He and his co-authors instead develop a “complete lives system,” which combines four principles: youngest-first, prognosis, lottery, and saving the most lives. This account does not, importantly, argue for allocating health care generally under these principles, but is specifically referring to scarce medical resources such as organs and vaccines.

http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2809%2960137-9/abstract

Peter Singer, “Why We Must Ration Health Care,” The New York Times, July 19, 2009. Pulling together compelling facts and narratives, Singer, professor of bioethics at Princeton University, makes the case that we must ration health care to save lives. This article includes a discussion of the “quality-adjusted life-year,” or QALY, that is used by health economists to compare cost-effectiveness of different treatments and used in some countries, such as Britain, to make coverage decisions about medical treatments paid for by public money. It is a concept that draws criticism as being discriminatory of people with disabilities.


Alan Williams, “The Rationing Debate: Rationing Health Care by Age: The Case For,” British Medical Journal, Mar. 15, 1997. Williams, a British economist, argues for rationing on the basis of age in order to satisfy intergenerational fairness. We should recognize a natural life span (what he calls “fair innings”) and limit expensive medical treatments for the elderly in order to make resources available to help younger people achieve their own natural life span. In particular, he is in favor of the National Health Service’s consideration of age in making coverage decisions.

http://www.bmj.com/cgi/content/full/314/7083/820

Sources that present more than one side of the debate or add context.

Chris Mooney, “Rational Choice?” Sage Crossroads, July 14, 2003. This article reviews the arguments in favor of and against taking age into account in allocating health care resources, specifically discussing Daniel Callahan’s work. http://www.sagecrossroads.net/node/329

Jill Lepore, “The Politics of Death,” The New Yorker, Nov. 30, 2009. This article explains the connection between the right-to-life movement and our concerns about rationing health care, especially at the end of life. It discusses in some depth the public reaction to the Karen Ann Quinlan case and the legal arguments in favor of and against the removal of her ventilator. Lepore makes the case that we have had, since the 1970s at least, a fear that the government is going to conspire "to hold over us the power of life and death."

“Should Healthcare Resources be Subject to Rationing?” ProCon.org. This website provides a very useful collection of excerpts from proponents and opponents of rationing health care.
http://euthanasia.procon.org/viewanswers.asp?questionID=000205

http://healthcarecostmonitor.thehastingscenter.org/category/rationing-cost-effectiveness/