



Michael P. Halter,
FACHE

When Is It OK to Ration Healthcare?

We must rationally and fairly make decisions about life-saving resources.

Q. *Operating under tremendous economic pressures, hospitals make determinations every day regarding the allocation of valuable resources such as ICU beds, selection of medications for formularies, and the frequency with which services and tests are ordered. While most experts believe some form of rationing is needed, the absence of equitable guidelines that are evidence-based has resulted in a patchwork of "bedside rationing" practices that are inconsistently applied across healthcare organizations. As the financial strain on hospitals continues to build, what can be done to decrease such disparities?*

A. Rationing of healthcare occurs at many levels, from governmental budgetary decisions to organizational decisions such as formularies to clinical decisions by individual physicians. Critical care services now cost Americans more than 1 percent of our gross domestic product and 20 percent of hospital costs, up from 8 percent in 1980 (Health Aff 2003; 22 [1]; Crit Care Med 2001; 29 [10]). With costs rising so rapidly, many hospitals and their medical staffs are under increasing pressure, both implicit and explicit, to rein in costs, particularly those associated with critical care.

For example, in a 2002 survey of members of the Society for Critical Care Medicine, more than half of respondents indicated that their hospitals or organizations limited the supply of a medication, and about a third reported limited supplies of intensive care unit beds. In addition, 75 percent of respondents indicated that, in the face of organizational limits, they would withhold a medication, test, or service from a patient who might receive limited benefit from it in order to give it to a patient they felt would benefit more.

Most of us, at some level, feel that care is being rationed. Every time we decide to hire another nurse for the cardiovascular unit instead of the oncology unit, or add an MRI machine instead of another ICU bed, we know that our decisions will ultimately impact whether a particular patient gets a particular treatment or service. Many people could benefit, even if only marginally, from increased use of health resources (the newest antibiotic, 10 more minutes of a nurse's time, etc.). But no healthcare organization can afford to provide all patients with all treatments that may have a potential for benefit, nor are there specific guidelines that indicate the optimal and equitable use of these treatments. We

have to make decisions about how to allocate life-saving healthcare resources in ways that are rational and fair.

The Values, Ethics, and Rationing in Critical Care Task Force, of which I serve as a member, was formed to study and address this issue. Affiliated with the Brown Medical School, the VERICC Task Force consists of members from the National Institutes of Health, Harvard Medical School, Johns Hopkins University, San Francisco General Hospital, and other leading medical institutions from throughout the United States and Canada. The task force has defined rationing as "the allocation of healthcare resources in the face of limited availability, which necessarily means that beneficial interventions are withheld from some individuals." We are currently working to collect data on how medical professionals think about and practice rationing of critical care, and to develop strategies for rationing in ways that are fair and ethical.

To assist in this process, VERICC has developed a computer-based model that can be used by hospital administrators, ICU physicians, nurse managers, and other healthcare decision makers to determine the relationship between personnel, capital, and other inputs to ICU cost and patient outcomes. Based on both existing data about the impact of health resource allocation and some key parameters from an individual organization, this model will allow us to evaluate how different choices that we might make within our organization will have different impacts on key measures of quality and cost. This tool should be widely available in 2005 via the VERICC Web site at www.vericc.org.

Ironically, the seemingly conflicting mandates to cut costs and improve quality can actually help us make rationing decisions. Because we are increasingly forced to justify resource allocation based on empirical data from outcomes research and cost-effectiveness studies, as well as evidence-based guidelines, we are also being forced to explicitly confront the impact of those decisions and to bring medical rationing out of the closet.

However, despite this focus on data and clinical evidence, we should never make the mistake of trying to create an entirely inflexible system for resource allocation—clinical judgment will always be central to these decisions. Patients differ widely, and any systematic approach to rationing that ignores clinical judgments about the best approach to a particular circumstance either would unethically ignore important differences between individual cases or would be so complex as to be unworkable. Any systematic approach to rationing will necessarily be supplemented by physician decisions about how general rules can be reasonably applied to the patient in the hospital bed.

Rationing decisions are and should be an important part of clinical decision making in every healthcare organization. Our institutions will definitely have to continue to do more with less. In a 2003 survey of hospital CEOs, ACHE found that reimbursement, personnel shortages, capacity, and care for the uninsured were among the top issues confronting hospitals. As we struggle to address these painful realities, we will have to make difficult judgments. Indeed, a system that failed to ration would quickly run out of resources, compromising our ability to

deliver healthcare at all. The ethical risk lies in the avoidance of rationing judgments, rather than in the development of rational methods to optimize healthcare while treating all patients fairly. ▲

*Michael P. Halter, FACHE,
is chief executive officer of*

*Hahnemann University Hospital
in Philadelphia.*

Hahnemann University Hospital
230 N. Broad St.
Mail Stop 300
Philadelphia, PA 19102-1121
(215) 762-7167

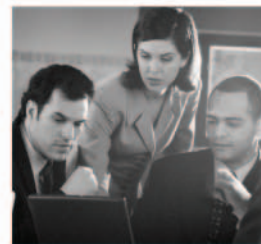
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