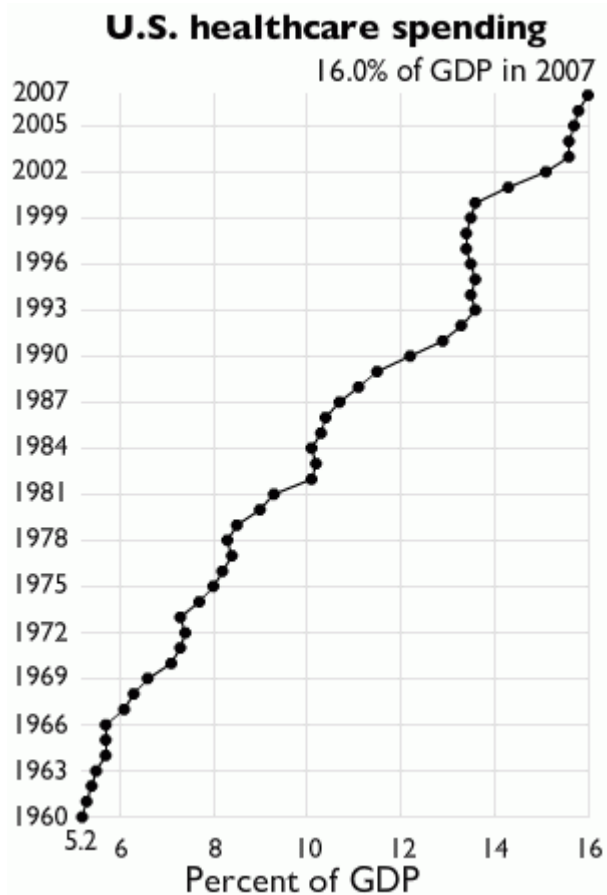


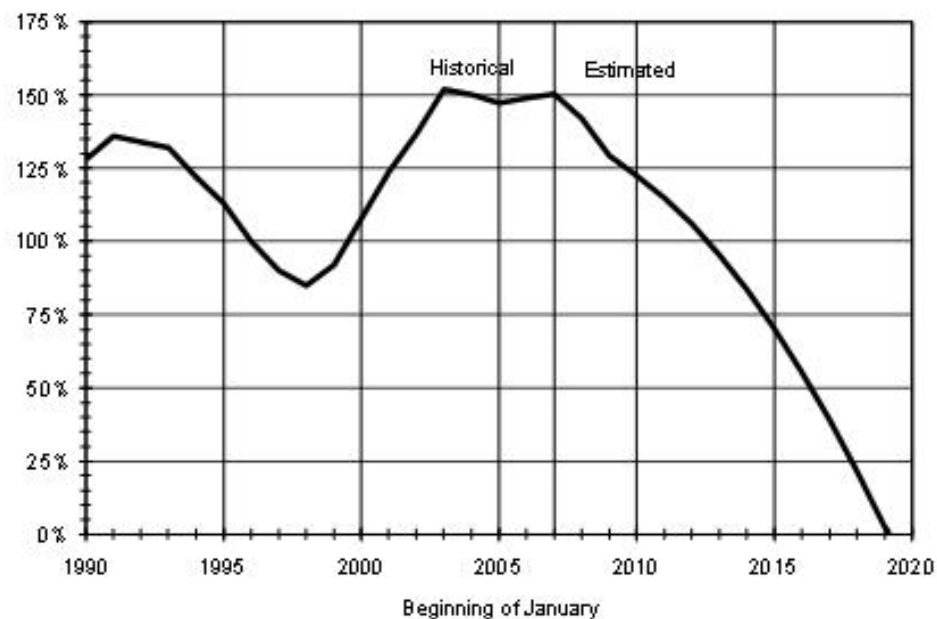
Rising Health Care Cost Charts

Student Handout 1



Source: Organization for Economic Co-Operation and Development Health Data, 2009 <http://www.oecd.org>

The Financial Outlook for Medicare



Source: U.S. Department of Health and Human Services
<http://www.hhs.gov/asl/testify/2008/04/t20080401b.html>

Note-taking handout for “Ethics of Health Care Rationing” Student Handout 2

This video news segment focuses on the financial feasibility of treating people without medical insurance. It illustrates the difficulty doctors, hospitals, and ultimately public and private insurance programs have in trying to treat all patients equally and to the fullest capabilities. Some of these people are American citizens and some are undocumented workers from Mexico. But the financial effect on the hospital is the same; it is becoming increasingly difficult to treat all patients the same way.

Directions: Access the following link

<http://www.pbs.org/wnet/religionandethics/episodes/august-8-2008/ethics-of-health-care-rationing/16/> from *Religion and Ethics Newsweekly* of August 8, 2008 entitled, “Ethics of Health Care Rationing.” As you watch the video take notes on a separate sheet of paper on the following questions:

1. Explain why Pastor Kevin McBryde had to go to UTMB (University of Texas Medical Branch) for treatment of his lymphoma.
2. For what reason does Dr. Kirk Smith give for treating Pastor McBryde even though he has no medical insurance and no money?
3. How has this situation caused a dilemma for the hospital and its medical staff?
4. According to Dr. John Stobo, what circumstances made it difficult for the hospital to treat patients who had no insurance? What did the hospital do to reduce its costs and still continue to treat these patients?
5. Summarize why Dr. Avi Markowitz feels it IS ethical to deny treatment to undocumented patients with no medical insurance.
6. Summarize why Dr. Smith feels it is unethical to deny treatment to undocumented patients with no medical insurance.
7. What does Dr. Smith feel is needed before anyone is denied health care?
8. How does Dr. Markowitz feel about providing extensive health care to people who have only a few months to live?

9. Do you think all patients, regardless of their ability to pay should be treated equally by hospitals and medical care professionals? If not, where would you draw the line? Who would and wouldn't you treat?



Rationing Health Care at End of Life Student Handout 3

Directions: In this activity, you will work in your group reviewing the main points of the section you were assigned. You will note that the issues surrounding rationing are answered with a simple “yes” or “no.” Review the main points of your assigned section and its accompanying article to get a full understanding of your assigned position. Develop a short presentation for the class.

Positions against rationing End-of-Life-Care: where “rationing” health care is decided by someone other than the consumer.

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

- The “crisis” over high health care costs is nothing new and has been at issue since the 1960s.
- The rise in health care costs as a percentage of GDP is only a reflection of improved health and longevity of people.
- The vast wealth of America allows us to spend large amounts of money on health care. Our spending reflects the wealth of the nation and we are fortunate to be able to do so.
- It is difficult to know when to reduce any amount of health care since no one knows when a person will die or if they will die in spite of the care provided.

Source Material: “Medicare Vote an Important Victory in Pro-life Fight against Rationing”
Burke J. Balch, National Right to Life Committee
http://www.nrlc.org/News/2003/nrl12/medicare_vote_an_important_victo.htm

Cost savings at the end-of-life can be achieved by *rational* care rather than *rationing* care.

- Patients can receive good care through advance planning (known as advanced directives) and hospice rather than hospital care, which is more expensive.
- Cost savings can be achieved through rational health care that treats the whole patient by addressing pain relief and comfort rather than specialized care that exclusively treats the disease or illness.
- Although they incur some expense for doctors, advanced care directives prove to be less expensive in end-of-life care than advanced medical care with no plan.

Source Material: “Testing, Testing”, Atul Gawande, the New Yorker
http://www.newyorker.com/reporting/2009/12/14/091214fa_fact_gawande

Targeting end-of-life health care for rationing would be unethical and only result in a small savings.

- Rationing end-of-life health care unnecessarily and randomly targets a vulnerable population—the elderly and the sick.
- If end-of-life is defined as those with less than a certain number of months to live, it's difficult to identify this population and potential treatments in advance, since we can't predict when they will die.
- The free-market system and cutbacks in government funding have already created a form of rationing. We don't need more.
- Other examples of rationing that exists now are organ transplants, vaccines, and emergency room care. Not all people qualify for such treatments.
- Some states have instituted rationing in the form of a "certificate of need" which limits expansion of new health care facilities in an effort to curb health care costs by limiting supply. But this can negatively affect entire communities because no or inadequate health care facilities will be available to them.
- Other certificate of need programs limit non-beneficial care or care that is no more beneficial than less costly care. But in delivering health care today, physicians simply don't know whether one treatment is more effective than another or if it's even effective at all.

Source Material: "Rationing' Health Care: What Does It Mean?" Uwe Reinhardt, The New York Times, July 3, 2009. <http://economix.blogs.nytimes.com/2009/07/03/rationing-health-care-what-does-it-mean/>

Comparative Effectiveness Research

For some people, comparative effectiveness research is superior to not rationing health care because it can control costs by allowing doctors and patients to make medical decisions based on the effectiveness of medications and treatments. Supporters of comparative effectiveness research say it is superior to rationing because it doesn't target vulnerable segments of the population. Comparative effectiveness research is not widely used to date, but some ideas are to make this information available to doctors and patients so that they can make decisions in the context of treatment for the patient. Public and private purveyors of health care may use the research to determine medical coverage decisions.

Comparative effectiveness research is preferable to rationing even if cost is taken into account because:

- Comparative effectiveness research compares different drugs or treatments in randomized tests to determine which one is most effective.
- If one medication or treatment is not as effective as another, government and/or private health care insurance companies would only cover the one most effective. This looks like rational health care.
- If government and/or private health care insurance companies base their decision based on cost, this looks more like rationing health care.

- Using comparative effectiveness research would not unfairly single out a certain demographic population, such as the elderly or sick, to receive less care.
- Comparative effectiveness research does not pit one patient population against another, such as old vs. young or very sick vs. moderately sick.
- Comparative effectiveness research does not limit treatment to a particularly vulnerable portion of the population such as the terminally ill, except in the sense that treatments are limited to everyone if they are deemed to not be effective in improving the quality of life.

“Giving Teeth to Comparative-Effectiveness Research—The Oregon Experience,” Somnath Saha, Darren D. Coffman & Ariel K. Smits, *New England Journal of Medicine*, Feb. 3, 2010. <http://content.nejm.org/cgi/content/full/NEJMp0912938v1>

Positions for rationing End-of-Life-Care: Few people will actually come out and say they favor rationing health care at the end-of-life or any other time. It is a position fraught with political risk and social condemnation. However, proponents of rationing say it is unavoidable and inevitable and that it exists now, but on a random, unsystematic way. Focusing on rationing at the end-of-life is far preferable to our current system. For this argument, “end of life” is defined as the end of particular person’s life regardless of their age or cause of dying. This includes a child with incurable cancer, a newborn with a fatal condition, or a person who has lived a natural life span. Proponents of rationing end-of-life-care usually speak in terms of how to better allocate taxpayers dollars. But it’s important to note that the same rationing policies used by the government could be used by private insurers to reduce costs and maximize their profit.

Costly expenditures that only achieve marginal gains in extending life should be rationed.

- Health care costs for end-of-life-care are extremely high. Substantial savings could be achieved by limiting aggressive and ultimately ineffective treatment.
- Not enough savings can be gained by just being responsive to patient and family desires in advanced directives. There needs to be limits on expensive and ineffective treatments at the end of life.
- Only taxpayer paid health care should be rationed. If individuals have the ability to pay for their own treatment, there should be no government-imposed limitation.
- If the government spent less on expensive treatments for those who only have a few months to live, it would provide more funds to those who might live for several decades.

“Opportunity Costs,” Norman Daniels, *Health Care Cost Monitor*.
<http://healthcarecostmonitor.thehastingscenter.org/normandaniels/opportunity-costs/>

Rationing should take a rational look at who best can be served by rationing, those with terminal illnesses or younger people who have a better chance of survival.

- More life years would be saved by rationing end-of-life-care because the savings could be allocated to those who would benefit more, those who have a better chance of living. The \$100,000 of chemotherapy for a terminally ill patient in the final year of their life. The average yearly cost of treating a healthier patient is \$5,500 per year.
- There are over 37 million Americans without health care insurance. It is estimated that as many as 45,000 deaths in America are associated with a lack of health care insurance.
- Most uninsured patients receive their health care at emergency rooms, the most expensive form of health care. Yet, even emergency room care is not as good a safety net for the uninsured as some might think. A recent study in Wisconsin found that victims of severe auto accidents who didn't have health insurance received 20% less treatment and were 37% more likely to die of their injuries than people with insurance.
- Rationing end-of-life health care for the uninsured would free up more funds for younger uninsured patients. These tough choices need to be made.
- Rationing end-of-life health care doesn't mean abandoning patients. Pain relief, comforting care and support would be provided.

“Why We Must Ration Health Care,” Peter Singer, The New York Times, July 19, 2009
<http://www.nytimes.com/2009/07/19/magazine/19healthcare-t.html>

Expensive interventions should be rationed for people after they reach a certain age.

- Rationing health care for people who are over the age of a natural life span could make funds available for younger people who have longer to live.
- Though never spoken openly, most people secretly hold the view that a death is less tragic for an 80-year old, than for 14-year old because the 80-year old has had the opportunity to live out a full life span, while the 14-year old has not.
- Surveys show that when given an “either or choice,” most people, including older people, would favor giving health care to a younger over an older person.
- Age-based rationing treats people equally because over time, everyone ages. When young they receive priority, and less so as they age.
- Medical practices that strive to extend people's lives don't always focus on the quality of older people's lives. They can be subjected to prolonged discomfort in the attempt to keep them alive.

“The Rationing Debate: Rationing Health Care by Age: The Case For,” Alan Williams, British Medical Journal, Mar. 15, 1997. <http://www.bmj.com/cgi/content/full/314/7083/820>

Debriefing questions after presentations:

- Is it financially practical to provide advanced health care to someone who is terminally ill? Is it ethical or moral not to provide such care? Explain.

- Should doctors and hospitals ration health care for people who are terminally ill in order to bring medical costs down? Explain.
- Medicare is projected to go broke in the next seven to nine years. Should the federal government ration Medicare benefits to some now so that others may have health care in the future? If yes, what criteria should the federal government use? If no, how should the federal government address the impending bankruptcy of Medicare?
- The possibility of rationing end-of-life-care is being considered for government sponsored health care programs and by private insurers. Who would you prefer making these decisions, the government or private insurers or neither? Explain why.
- Summarize the program known as “comparative effectiveness research.” How does it work? Why is it seen as a viable alternative to rationing? How does it have components of rationing and rational care in it?
- Do you think the government should reimburse doctors and hospitals that provide advanced directives to patients even though such a proposal was accused of creating a government “death panel?” Explain.



A Rational End-of-Life Health Care Policy

Student Handout 4

Overview:

Health care costs as a part of GDP have more than tripled in the past 50 years. Some feel this is only a result of improved health and people living quality lives longer. Others feel the looming Medicare deficit will wreak havoc on the future of health care in America if something isn't done to reduce costs. You have been assigned to serve on a task force to develop a rational end-of-life health care policy. Your policy should address the following questions:

- Do you believe health care should be rationed in any way? Explain your reasoning.
- What segments of society would receive rationed or no care, (if any).
- How will your policy reduce end-of-life costs?
- How will you justify your plan to the segment of society most affected?
- What financial responsibility will businesses have? What financial responsibility will individuals have? What financial responsibility will the government have?
- Other thoughts, insights, or ideas: