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## Why We Must Ration Health Care

By PETER SINGER

You have advanced kidney cancer. It will kill you, probably in the next year or two. A drug called Sutent slows the spread of the cancer and may give you an extra six months, but at a cost of \$54,000. Is a few more months worth that much?

If you can afford it, you probably would pay that much, or more, to live longer, even if your quality of life wasn't going to be good. But suppose it's not you with the cancer but a stranger covered by your health-insurance fund. If the insurer provides this man — and everyone else like him — with Sutent, your premiums will increase. Do you still think the drug is a good value? Suppose the treatment cost a million dollars. Would it be worth it then? Ten million? Is there any limit to how much you would want your insurer to pay for a drug that adds six months to someone's life? If there is any point at which you say, "No, an extra six months isn't worth that much," then you think that health care should be rationed.

In the current U.S. debate over [health care reform](#), "rationing" has become a dirty word. Meeting last month with five governors, [President Obama](#) urged them to avoid using the term, apparently for fear of evoking the hostile response that sank the Clintons' attempt to achieve reform. In a Wall Street Journal op-ed published at the end of last year with the headline "Obama Will Ration Your Health Care," Sally Pipes, C.E.O. of the conservative Pacific Research Institute, described how in Britain the national health service does not pay for drugs that are regarded as not offering good value for money, and added, "Americans will not put up with such limits, nor will our elected representatives." And the Democratic chair of the Senate Finance Committee, Senator [Max Baucus](#), told CNSNews in April, "There is no rationing of health care at all" in the proposed reform.

Remember the joke about the man who asks a woman if she would have sex with him for a million dollars? She reflects for a few moments and then answers that she would. "So," he says, "would you have sex with me for \$50?" Indignantly, she exclaims, "What kind of a woman do you think I am?" He replies: "We've already established that. Now we're just haggling about the price." The man's response implies that if a woman will sell herself at any price, she is a prostitute. The way we regard rationing in health care seems to rest on a similar assumption, that it's immoral to apply monetary considerations to saving lives — but is that stance tenable?

Health care is a scarce resource, and all scarce resources are rationed in one way or another. In the

United States, most health care is privately financed, and so most rationing is by price: you get what you, or your employer, can afford to insure you for. But our current system of employer-financed health insurance exists only because the federal government encouraged it by making the premiums tax deductible. That is, in effect, a more than \$200 billion government subsidy for health care. In the public sector, primarily [Medicare](#), [Medicaid](#) and hospital emergency rooms, health care is rationed by long waits, high patient copayment requirements, low payments to doctors that discourage some from serving public patients and limits on payments to hospitals.

The case for explicit health care rationing in the United States starts with the difficulty of thinking of any other way in which we can continue to provide adequate health care to people on Medicaid and Medicare, let alone extend coverage to those who do not now have it. Health-insurance premiums have more than doubled in a decade, rising four times faster than wages. In May, Medicare's trustees warned that the program's biggest fund is heading for insolvency in just eight years. Health care now absorbs about one dollar in every six the nation spends, a figure that far exceeds the share spent by any other nation. According to the [Congressional Budget Office](#), it is on track to double by 2035.

President Obama has said plainly that America's health care system is broken. It is, he has said, by far the most significant driver of America's long-term debt and deficits. It is hard to see how the nation as a whole can remain competitive if in 26 years we are spending nearly a third of what we earn on health care, while other industrialized nations are spending far less but achieving health outcomes as good as, or better than, ours.

Rationing health care means getting value for the billions we are spending by setting limits on which treatments should be paid for from the public purse. If we ration we won't be writing blank checks to pharmaceutical companies for their patented drugs, nor paying for whatever procedures doctors choose to recommend. When public funds subsidize health care or provide it directly, it is crazy not to try to get value for money. The debate over health care reform in the United States should start from the premise that some form of health care rationing is both inescapable and desirable. Then we can ask, What is the best way to do it?

Last year Britain's National Institute for Health and Clinical Excellence gave a preliminary recommendation that the National Health Service should not offer Sutent for advanced kidney cancer. The institute, generally known as NICE, is a government-financed but independently run organization set up to provide national guidance on promoting good health and treating illness. The decision on Sutent did not, at first glance, appear difficult. NICE had set a general limit of £30,000, or about \$49,000, on the cost of extending life for a year. Sutent, when used for advanced kidney cancer, cost more than that, and research suggested it offered only about six months extra life. But the British media leapt on the theme of penny-pinching bureaucrats sentencing sick people to death. The issue was then picked up by the U.S. news media and by those lobbying against health care reform in the United States. An article in The New York Times last

December featured Bruce Hardy, a kidney-cancer patient whose wife, Joy, said, “It’s hard to know that there is something out there that could help but they’re saying you can’t have it because of cost.” Then she asked the classic question: “What price is life?”

Last November, Bloomberg News focused on Jack Rosser, who was 57 at the time and whose doctor had told him that with Sutent he might live long enough to see his 1-year-old daughter, Emma, enter primary school. Rosser’s wife, Jenny, is quoted as saying: “It’s immoral. They are sentencing him to die.” In the conservative monthly *The American Spectator*, David Catron, a health care consultant, describes Rosser as “one of NICE’s many victims” and writes that NICE “regularly hands down death sentences to gravely ill patients.” Linking the British system with Democratic proposals for reforming health care in the United States, Catron asked whether we really deserve a health care system in which “soulless bureaucrats arbitrarily put a dollar value on our lives.” (In March, NICE issued a final ruling on Sutent. Because of how few patients need the drug and because of special end-of-life considerations, it recommended that the drug be provided by the National Health Service to patients with advanced kidney cancer.)

There’s no doubt that it’s tough — politically, emotionally and ethically — to make a decision that means that someone will die sooner than they would have if the decision had gone the other way. But if the stories of Bruce Hardy and Jack Rosser lead us to think badly of the British system of rationing health care, we should remind ourselves that the U.S. system also results in people going without life-saving treatment — it just does so less visibly. Pharmaceutical manufacturers often charge much more for drugs in the United States than they charge for the same drugs in Britain, where they know that a higher price would put the drug outside the cost-effectiveness limits set by NICE. American patients, even if they are covered by Medicare or Medicaid, often cannot afford the copayments for drugs. That’s rationing too, by ability to pay.

Dr. Art Kellermann, associate dean for public policy at Emory School of Medicine in Atlanta, recently wrote of a woman who came into his emergency room in critical condition because a blood vessel had burst in her brain. She was uninsured and had chosen to buy food for her children instead of spending money on her blood-pressure medicine. In the emergency room, she received excellent high-tech medical care, but by the time she got there, it was too late to save her.

A *New York Times* report on the high costs of some drugs illustrates the problem. Chuck Stauffer, an Oregon farmer, found that his prescription-drug insurance left him to pay \$5,500 for his first 42 days of Temodar, a drug used to treat brain tumors, and \$1,700 a month after that. For Medicare patients drug costs can be even higher, because Medicare can require a copayment of 25 percent of the cost of the drug. For Gleevec, a drug that is effective against some forms of leukemia and some gastrointestinal tumors, that one-quarter of the cost can run to \$40,000 a year.

In Britain, everyone has health insurance. In the U.S., some 45 million do not, and nor are they entitled to any health care at all, unless they can get themselves to an emergency room. Hospitals

are prohibited from turning away anyone who will be endangered by being refused treatment. But even in emergency rooms, people without health insurance may receive less health care than those with insurance. Joseph Doyle, a professor of economics at the Sloan School of Management at [M.I.T.](#), studied the records of people in Wisconsin who were injured in severe automobile accidents and had no choice but to go to the hospital. He estimated that those who had no health insurance received 20 percent less care and had a death rate 37 percent higher than those with health insurance. This difference held up even when those without health insurance were compared with those without [automobile insurance](#), and with those on Medicaid — groups with whom they share some characteristics that might affect treatment. The lack of insurance seems to be what caused the greater number of deaths.

When the media feature someone like Bruce Hardy or Jack Rosser, we readily relate to individuals who are harmed by a government agency's decision to limit the cost of health care. But we tend not to hear about — and thus don't identify with — the particular individuals who die in emergency rooms because they have no health insurance. This "identifiable victim" effect, well documented by psychologists, creates a dangerous bias in our thinking. Doyle's figures suggest that if those Wisconsin accident victims without health insurance had received equivalent care to those with it, the additional health care would have cost about \$220,000 for each life saved. Those who died were on average around 30 years old and could have been expected to live for at least another 40 years; this means that had they survived their accidents, the cost per extra year of life would have been no more than \$5,500 — a small fraction of the \$49,000 that NICE recommends the British National Health Service should be ready to pay to give a patient an extra year of life. 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.

Estimates of the number of U.S. deaths caused annually by the absence of universal health insurance go as high as 20,000. One study concluded that in the age group 55 to 64 alone, more than 13,000 extra deaths a year may be attributed to the lack of insurance coverage. But the estimates vary because Americans without health insurance are more likely, for example, to smoke than Americans with health insurance, and sorting out the role that the lack of insurance plays is difficult. Richard Kronick, a professor at the School of Medicine at the [University of California, San Diego](#), cautiously concludes from his own study that there is little evidence to suggest that extending health insurance to all Americans would have a large effect on the number of deaths in the United States. That doesn't mean that it wouldn't; we simply don't know if it would.

In any case, it isn't only uninsured Americans who can't afford treatment. President Obama has spoken about his mother, who died from ovarian cancer in 1995. The president said that in the last weeks of her life, his mother "was spending too much time worrying about whether her health insurance would cover her bills" — an experience, the president went on to say, that his mother shared with millions of other Americans. It is also an experience more common in the United

States than in other developed countries. A recent Commonwealth Fund study led by Cathy Schoen and Robin Osborn surveyed adults with chronic illness in Australia, Canada, France, Germany, the Netherlands, New Zealand, the United Kingdom and the United States. Far more Americans reported forgoing health care because of cost. More than half (54 percent) reported not filling a prescription, not visiting a doctor when sick or not getting recommended care. In comparison, in the United Kingdom the figure was 13 percent, and in the Netherlands, only 7 percent. Even among Americans with insurance, 43 percent reported that cost was a problem that had limited the treatment they received. According to a 2007 study led by David Himmelstein, more than 60 percent of all bankruptcies are related to illness, with many of these specifically caused by medical bills, even among those who have health insurance. In Canada the incidence of bankruptcy related to illness is much lower.

When a Washington Post journalist asked Daniel Zemel, a Washington rabbi, what he thought about federal agencies putting a dollar value on human life, the rabbi cited a Jewish teaching explaining that if you put one human life on one side of a scale, and you put the rest of the world on the other side, the scale is balanced equally. Perhaps that is how those who resist health care rationing think. But we already put a dollar value on human life. If the Department of Transportation, for example, followed rabbinical teachings it would exhaust its entire budget on road safety. Fortunately the department sets a limit on how much it is willing to pay to save one human life. In 2008 that limit was \$5.8 million. Other government agencies do the same. Last year the [Consumer Product Safety Commission](#) considered a proposal to make mattresses less likely to catch fire. Information from the industry suggested that the new standard would cost \$343 million to implement, but the Consumer Product Safety Commission calculated that it would save 270 lives a year — and since it valued a human life at around \$5 million, that made the new standard a good value. If we are going to have consumer-safety regulation at all, we need some idea of how much safety is worth buying. Like health care bureaucrats, consumer-safety bureaucrats sometimes decide that saving a human life is not worth the expense. Twenty years ago, the [National Research Council](#), an arm of the [National Academy of Sciences](#), examined a proposal for installing seat belts in all school buses. It estimated that doing so would save, on average, one life per year, at a cost of \$40 million. After that, support for the proposal faded away. So why is it that those who accept that we put a price on life when it comes to consumer safety refuse to accept it when it comes to health care?

Of course, it's one thing to accept that there's a limit to how much we should spend to save a human life, and another to set that limit. The dollar value that bureaucrats place on a generic human life is intended to reflect social values, as revealed in our behavior. It is the answer to the question "How much are you willing to pay to save your life?" — except that, of course, if you asked that question of people who were facing death, they would be prepared to pay almost anything to save their lives. So instead, economists note how much people are prepared to pay to reduce the risk that they will die. How much will people pay for air bags in a car, for instance?

Once you know how much they will pay for a specified reduction in risk, you multiply the amount that people are willing to pay by how much the risk has been reduced, and then you know, or so the theory goes, what value people place on their lives. Suppose that there is a 1 in 100,000 chance that an air bag in my car will save my life, and that I would pay \$50 — but no more than that — for an air bag. Then it looks as if I value my life at  $\$50 \times 100,000$ , or \$5 million.

The theory sounds good, but in practice it has problems. We are not good at taking account of differences between very small risks, so if we are asked how much we would pay to reduce a risk of dying from 1 in 1,000,000 to 1 in 10,000,000, we may give the same answer as we would if asked how much we would pay to reduce the risk from 1 in 500,000 to 1 in 10,000,000. Hence multiplying what we would pay to reduce the risk of death by the reduction in risk lends an apparent mathematical precision to the outcome of the calculation — the supposed value of a human life — that our intuitive responses to the questions cannot support. Nevertheless this approach to setting a value on a human life is at least closer to what we really believe — and to what we should believe — than dramatic pronouncements about the infinite value of every human life, or the suggestion that we cannot distinguish between the value of a single human life and the value of a million human lives, or even of the rest of the world. Though such feel-good claims may have some symbolic value in particular circumstances, to take them seriously and apply them — for instance, by leaving it to chance whether we save one life or a billion — would be deeply unethical.

Governments implicitly place a dollar value on a human life when they decide how much is to be spent on health care programs and how much on other public goods that are not directed toward saving lives. The task of health care bureaucrats is then to get the best value for the resources they have been allocated. It is the familiar comparative exercise of getting the most bang for your buck. Sometimes that can be relatively easy to decide. If two drugs offer the same benefits and have similar risks of side effects, but one is much more expensive than the other, only the cheaper one should be provided by the public health care program. That the benefits and the risks of side effects are similar is a scientific matter for experts to decide after calling for submissions and examining them. That is the bread-and-butter work of units like NICE. But the benefits may vary in ways that defy straightforward comparison. We need a common unit for measuring the goods achieved by health care. Since we are talking about comparing different goods, the choice of unit is not merely a scientific or economic question but an ethical one.

As a first take, we might say that the good achieved by health care is the number of lives saved. But that is too crude. The death of a teenager is a greater tragedy than the death of an 85-year-old, and this should be reflected in our priorities. We can accommodate that difference by calculating the number of life-years saved, rather than simply the number of lives saved. If a teenager can be expected to live another 70 years, saving her life counts as a gain of 70 life-years, whereas if a person of 85 can be expected to live another 5 years, then saving the 85-year-old will count as a gain of only 5 life-years. That suggests that saving one teenager is equivalent to saving 14

85-year-olds. These are, of course, generic teenagers and generic 85-year-olds. It's easy to say, "What if the teenager is a violent criminal and the 85-year-old is still working productively?" But just as emergency rooms should leave criminal justice to the courts and treat assailants and victims alike, so decisions about the allocation of health care resources should be kept separate from judgments about the moral character or social value of individuals.

Health care does more than save lives: it also reduces pain and suffering. How can we compare saving a person's life with, say, making it possible for someone who was confined to bed to return to an active life? We can elicit people's values on that too. One common method is to describe medical conditions to people — let's say being a quadriplegic — and tell them that they can choose between 10 years in that condition or some smaller number of years without it. If most would prefer, say, 10 years as a quadriplegic to 4 years of nondisabled life, but would choose 6 years of nondisabled life over 10 with quadriplegia, but have difficulty deciding between 5 years of nondisabled life or 10 years with quadriplegia, then they are, in effect, assessing life with quadriplegia as half as good as nondisabled life. (These are hypothetical figures, chosen to keep the math simple, and not based on any actual surveys.) If that judgment represents a rough average across the population, we might conclude that restoring to nondisabled life two people who would otherwise be quadriplegics is equivalent in value to saving the life of one person, provided the life expectancies of all involved are similar.

This is the basis of the quality-adjusted life-year, or QALY, a unit designed to enable us to compare the benefits achieved by different forms of health care. The QALY has been used by economists working in health care for more than 30 years to compare the cost-effectiveness of a wide variety of medical procedures and, in some countries, as part of the process of deciding which medical treatments will be paid for with public money. If a reformed U.S. health care system explicitly accepted rationing, as I have argued it should, QALYs could play a similar role in the U.S.

Some will object that this discriminates against people with disabilities. If we return to the hypothetical assumption that a year with quadriplegia is valued at only half as much as a year without it, then a treatment that extends the lives of people without disabilities will be seen as providing twice the value of one that extends, for a similar period, the lives of quadriplegics. That clashes with the idea that all human lives are of equal value. The problem, however, does not lie with the concept of the quality-adjusted life-year, but with the judgment that, if faced with 10 years as a quadriplegic, one would prefer a shorter lifespan without a disability. Disability advocates might argue that such judgments, made by people without disabilities, merely reflect the ignorance and prejudice of people without disabilities when they think about people with disabilities. We should, they will very reasonably say, ask quadriplegics themselves to evaluate life with quadriplegia. If we do that, and we find that quadriplegics would not give up even one year of life as a quadriplegic in order to have their disability cured, then the QALY method does not justify giving preference to procedures that extend the lives of people without disabilities over procedures that extend the lives of people with disabilities.



This method of preserving our belief that everyone has an equal right to life is, however, a double-edged sword. If life with quadriplegia is as good as life without it, there is no health benefit to be gained by curing it. That implication, no doubt, would have been vigorously rejected by someone like [Christopher Reeve](#), who, after being paralyzed in an accident, campaigned for more research into ways of overcoming spinal-cord injuries. Disability advocates, it seems, are forced to choose between insisting that extending their lives is just as important as extending the lives of people without disabilities, and seeking public support for research into a cure for their condition.

The QALY tells us to do what brings about the greatest health benefit, irrespective of where that benefit falls. Usually, for a given quantity of resources, we will do more good if we help those who are worst off, because they have the greatest unmet needs. But occasionally some conditions will be both very severe and very expensive to treat. A QALY approach may then lead us to give priority to helping others who are not so badly off and whose conditions are less expensive to treat. I don't find it unfair to give the same weight to the interests of those who are well off as we give to those who are much worse off, but if there is a social consensus that we should give priority to those who are worse off, we can modify the QALY approach so that it gives greater weight to benefits that accrue to those who are, on the QALY scale, worse off than others.

The QALY approach does not even try to measure the benefits that health care brings in addition to the improvement in health itself. Emotionally, we feel that the fact that Jack Rosser is the father of a young child makes a difference to the importance of extending his life, but his parental status is irrelevant to a QALY assessment of the health care gains that Sutent would bring him. Whether decisions about allocating health care resources should take such personal circumstances into account isn't easy to decide. Not to do so makes the standard inflexible, but taking personal factors into account increases the scope for subjective — and prejudiced — judgments.

The QALY is not a perfect measure of the good obtained by health care, but its defenders can support it in the same way that [Winston Churchill](#) defended democracy as a form of government: it is the worst method of allocating health care, except for all the others. If it isn't possible to provide everyone with all beneficial treatments, what better way do we have of deciding what treatments people should get than by comparing the QALYs gained with the expense of the treatments?

Will Americans allow their government, either directly or through an independent agency like NICE, to decide which treatments are sufficiently cost-effective to be provided at public expense and which are not? They might, under two conditions: first, that the option of private health insurance remains available, and second, that they are able to see, in their own pocket, the full cost of not rationing health care.

Rationing public health care limits free choice if private health insurance is prohibited. But many countries combine free national health insurance with optional private insurance. Australia, where I've spent most of my life and raised a family, is one. The U.S. could do something similar. This



would mean extending Medicare to the entire population, irrespective of age, but without Medicare's current policy that allows doctors wide latitude in prescribing treatments for eligible patients. Instead, Medicare for All, as we might call it, should refuse to pay where the cost per QALY is extremely high. (On the other hand, Medicare for All would not require more than a token copayment for drugs that are cost-effective.) The extension of Medicare could be financed by a small income-tax levy, for those who pay income tax — in Australia the levy is 1.5 percent of taxable income. (There's an extra 1 percent surcharge for those with high incomes and no private insurance. Those who earn too little to pay income tax would be carried at no cost to themselves.) Those who want to be sure of receiving every treatment that their own privately chosen physicians recommend, regardless of cost, would be free to opt out of Medicare for All as long as they can demonstrate that they have sufficient private health insurance to avoid becoming a burden on the community if they fall ill. Alternatively, they might remain in Medicare for All but take out supplementary insurance for health care that Medicare for All does not cover. Every American will have a right to a good standard of health care, but no one will have a right to unrationed health care. Those who opt for unrationed health care will know exactly how much it costs them.

One final comment. It is common for opponents of health care rationing to point to Canada and Britain as examples of where we might end up if we get “socialized medicine.” On a blog on Fox News earlier this year, the conservative writer John Lott wrote, “Americans should ask Canadians and Brits — people who have long suffered from rationing — how happy they are with central government decisions on eliminating ‘unnecessary’ health care.” There is no particular reason that the United States should copy the British or Canadian forms of universal coverage, rather than one of the different arrangements that have developed in other industrialized nations, some of which may be better. But as it happens, last year the Gallup organization did ask Canadians and Brits, and people in many different countries, if they have confidence in “health care or medical systems” in their country. In Canada, 73 percent answered this question affirmatively. Coincidentally, an identical percentage of Britons gave the same answer. In the United States, despite spending much more, per person, on health care, the figure was only 56 percent.

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This article has been revised to reflect the following correction:

Correction: July 19, 2009

An article in The Times Magazine this weekend about the argument for rationing health care in the United States misstates the number of years it would take under the current system for the country to spend nearly a third of what it earns on health care. It is 26 years from now, or 2035, not 15 years.

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