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Will Health Care Rationing Follow the Stimulus Bill?

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The American Recovery and Reinvestment Act, known informally as the "stimulus" bill, appropriated $1.1 billion to create a Federal Coordinating Council for Comparative Research. The provision is one of the most controversial in the 1,000-page measure.

The coordinating council, a 15-member board of federal employees, will advise Congress and the president on how to use the stimulus funds. Grants will be made to analyze the "comparative effectiveness" of specific treatments, medical devices, surgical interventions, and drugs.

Advocates of the comparative research approach hope information derived by comparing treatments will discourage the use of ineffective and costly treatments, eventually saving money for the health care system.

Although few would argue knowing how one clinical treatment compares to another is inherently bad, critics fear government would use the information to ration care by, for example, refusing to make reimbursement payments for more effective, albeit more expensive, therapies.

Creating 'Politburo of Health'

This is a "profoundly intrusive violation of the doctor-patient relationship," said Robert E. Moffit, director of the Center for Health Policy Studies at The Heritage Foundation.

"Such an agency is akin to a Politburo of Health—an unaccountable, faceless bureaucracy," Moffit added.

Dr. Scott Gottlieb, a resident fellow at the American Enterprise Institute, recently authored a brief on comparative effectiveness research. He found pitting one treatment against another has ramifications for future research.

"Comparative effectiveness research would lead to slower adoption of effective technologies, hinder the discovery of new benefits from existing products, and halt investment in novel research," Gottlieb said.

Rationing 'Inevitable'

Linda Gorman, director of health care policy at the Colorado-based Independence Institute, who has authored a paper on health care rationing in Oregon, says rationing is inevitable under such programs.

"Committees of experts are in the business of making decisions for others," Gorman

noted. "For instance, in Britain the National Institute for Clinical Evidence (NICE) is charged with deciding which treatments the British National Health Service will pay for and which it will not. NICE considers a treatment cost-effective only if the cost per quality adjusted life year is about $35,000 or less.

"The result," Gorman added, "is that many advanced cancer treatments and other therapies available in the United States and on the European continent are judged too costly and not available to patients in Britain. Their choices are far different than the choices that people making decisions for themselves or other individuals would make."

Taking Decisions from Patients

Experts fear once the comparative effectiveness of a given treatment is known, the natural tendency will be for government to begin weighing costs versus benefits, instead of allowing physicians and patients to do so themselves. Taken to the extreme, comparative effectiveness could be used to prioritize which conditions are treated aggressively and which ones Medicare will not pay for.

Karen Ignagni, president of America's Health Insurance Plans, a trade association representing insurers, acknowledges the notion of using comparative effectiveness as a cost containment tool is controversial.

"We want to encourage innovation," Ignagni said. "The challenge of comparative effectiveness is doing it in a way that preserves innovation, preserves access, but also gets to that right care, right time, right setting. However, taking cost out of this discussion is the equivalent of putting our heads in the sand."