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An idea alien to both worlds: why health care rationing is not acceptable in the USA and Russia

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Abstract

The simple idea of rationing appears unacceptable both for the relatively poor "socialist" health care in Russia and for the most expensive USA health care. In Russia the idea of rationing is unacceptable, because the Constitution promises free and unlimited medical care. Therefore, discussion is blocked from the top. In the USA the idea is unacceptable, because citizens are understood as having the right to free choice of legal access to any care, without intervention of a 'death jury'.

We analyse the similarities and differences in the arguments rejecting explicit rationing in health care in the USA and Russia. We describe the legal framework in Russia related to rationing, and the results of a qualitative study of the understanding of the concept of rationing by Russian doctors and of the practices in Russian health care organizations to limit the use of expensive diagnostic and treatment options.

While the Russian Constitution promises free medical care, unlimited, legally there are limits imposed by the quota of specific treatments, limited access to care abroad, and problematic access to drugs not included on the essential drug list for inpatient care. Explicit rationing is not rejected by society or by the medical profession. In medical organizations the more explicit techniques are a second opinion by a committee (physicians' commission), especially in the case of prescription of drugs and diagnostic tests. Physicians tend to behave as medical professionals do: provide more care to people in greater need.

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Introduction

The health care systems in the Russian Federation (RF) and the United States (US) are strikingly different. While the US system is based on the rights of the person and his/her ability to pay for care, the RF system is nominally egalitarian, promising in the Constitution equal access to health care based on need only. The US libertarian approach is softened by the moral obligation to help those in need. In the RF the unlimited promise of health care is limited by the provision of drugs only in hospital care and some other lower level regulations constructed to channel the demand for expensive care.

At the very different levels of funding for health care, both systems are under pressure to control costs. In the US, reform addresses both health care coverage and skyrocketing costs. There is no health care reform in the RF, but number of national scale projects initiated over the last 20 years to upgrade some sectors and services without significant changes to the system, and keeping the cost of the system low.[1] In both countries, resource-centred rationing is practised, as it is everywhere. It is simple, because it is not connected to a comparison of individual patients; e.g. aesthetic surgery and tattoo removal is not covered. Individual level rationing –rationing based on the qualities of the individual patient and his needs – is more complicated [2] and its application is the litmus test for the acceptance of rationing.

Methods

We systematically review the literature related to rationing both in the US and the RF. We searched MEDLINE using the query: "rationing AND (russia*[ti] or russia*[ab] or russia[mh] OR united states[mh] OR america*[ti] or america*[ab]) AND 2000:2018[dp] NOT latin". A total of 607 items were found and screened for relevance and 24 included in the review. Additional articles were included through snowballing.

We use the semi-structured in-depth interview to study the opinions and decision making by doctors in the RF. We interviewed physicians (internal medicine, gynaecology), junior and senior, and physicians in top managerial positions in hospitals in 2017. Interviewees were selected in an affluent region (Moscow) and in the less affluent provincial region in the European part of the

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1 'Why is there no reform of the Russian health care system? [Rus]' in E.G. Yassin (ed), *XVI April International scientific conference on the problems of the development of the economy and society*, vol 4 (Higher School of Economics) <https://www.hse.ru/mirror/pubs/lib/data/ access/ram/ticket/85/152524462241f47b9f10be143331d86c895ab2444d/XVI%20%D0%9A%D0 %BE%D0%BD%D1%84.%D0%9A%D0%BD.4.pdf>

2 'How should we use age to ration health care? Lessons from the case of kidney transplantation', 58 *Journal of theAmerican Geriatrics Society* 1980

RF. We did work in two organizations in Moscow (outpatient polyclinic and acute care hospital) and in three organizations in the region (outpatient polyclinic, city hospital, small city hospital). A total of 28 interviews were summarized for this analysis.

Rationing agenda in the USA and the RF

In general, both in the US and in the RF, rationing is not a subject of open debate, nor of systematic judicious practice. The only large exception in the USA is the Oregon Health Plan – an exemplary project of explicit rationing.[3] Over 30 years it attracted enormous attention and ignited a great deal of discussion, but it still is the only well-designed plan built on the principles of evidence-based selection of the services covered.[4] It is an example of the effort to achieve rationing, not as the limits to care imposed by a physician, but as a citizens' agreement on the use of public resources.[5]

The exceptional position of the Oregon Health Plan does not mean that elements of rationing do not exists elsewhere in the US. Under the pressure of rising health care costs, managed care and capitated care are the prevailing responses intended to help with rising costs. By design, these forms of care as well as gatekeeping by primary care physicians have elements of rationing.[6] All benefit packages are incomplete, and what is not listed, may be deemed implicitly rationed. It became obvious when patients went to court complaining that they had not received the care required. At its extreme, proponents of rationing include as rationing any case when a person has been refused treatment because of the high cost of the treatment. The proportion of people in the US who somehow miss out on health care due to cost is 17%.[7] The pessimistic view is that unless resources for health care face an actual shortage, US society will not embrace rationing.[8]

When the US public is polled about health care reform, most are displeased with the current state of the system, and most agree that universal coverage is

3 'The Oregon Health Plan: to cover all diagnostic visits', 268, *JAMA :The Journal of the AmericanMedical Association*, 790

4 'Rationing medical care: rhetoric and reality in the Oregon Health Plan', 164, *CMAJ : Canadian MedicalAssociation Journal =Journal de l'Association medicale canadienne*, 1583

5 'Should physicians be gatekeepers of medical resources?' [BMJ Group], 27 *Journal of Medical Ethics*, 268

6 'Rationing: a transatlantic perspective', *46, The British Journal of General Practice : The Journal of the Royal College of General Practitioners*, 543

7 'Who can't pay for health care?' [Blackwell Science Inc], *20, Journal of General Internal Medicine*, 504

8 'Rationing health care and the need for credible scarcity: why Americans can't say no', 85 *American Journal of Public Health*, 1439

needed, but when rationing and managed access by queuing are mentioned, support for such variants is low.[9] Many physicians in the USA reject the possibility of rationing, and a majority declares that they provide all beneficial therapies without regard to cost.[10] In a poll of a sample of US physicians, 67% supported cost containment, but 54% objected to the use of cost-effectiveness in clinical decisions.[11] This last large proportion should not surprise us, because the question was not about cost-effectiveness reasoning in the design of the coverage plan, but about the use of 'cost-effectiveness data to determine which treatment will be offered to patients'. This split of opinion by US physicians reflects the split in US society. A large number of US citizens believe that health care is a service to purchase and inequality in access to health care is normal. The other large number tend to think that healthcare is a social good and must be available for people on roughly equal terms. Discussion of cost containment, and reduction in the use of low value care is difficult because it 'easily oversteps the bounds of political correctness in a nation whose media ... convey political debates on public policy in terms of sound bites.'[12]

It was the hope that 'comparative effectiveness research' would smooth the way to acceptance of health technology.[13] Unfortunately, this did not happen. This does not mean that US physicians do not somehow prioritize care. Even more: primary care physicians in the US believe that their patients receive too much care, and the cost of care may be reduced without rationing necessary care.[14] This understanding led to the initiatives "less is more" and "choosing wisely" encouraging the voluntary cancelling of unnecessary/low value care by physicians.[15] , [16] The reduction of potentially ineffective care is a major theme

9 'Americans' views of health care costs, access, and quality' [Blackwell Publishing Inc], 84, *The Milbank Quarterly*, 623

10 'The ethics and reality of rationing in medicine' [American College of Chest Physicians], 140, *Chest*, 1625

11 'The moral psychology of rationing among physicians: the role of harm and fairness intuitions in physician objections to cost-effectiveness and cost-containment' [BioMed Central], 8, *Philosophy, Ethics, andHumanities in Medicine*: PEHM 13

12 'Health reform in america' [Engage Healthcare Communications, LLC], 1, American Health & Drug Benefits, 8

13 'Comparative effectiveness research: a cornerstone of healthcare reform?' [American Clinical and Climatological Association] 121 *Transactions of the American Clinical and Climatological Association* 141

14 'Too Little? Too Much? Primary care physicians' views on US health care: a brief report', 171, *Archives of Internal Medicine*, 1582

15 'Less is More: Modern Neonatology' [Rambam Health Care Campus], 9, *Rambam Maimonides MedicalJournal*, e0023

16 'Beyond the "Choosing wisely": a possible attempt' [BioMed Central], *42, Italian Journal of Pediatrics*, 55

in US medicine, but there has been no progress in achieving it during the current health care reform.[17]

Most difficult questions arise in relation to expensive cancer care, potentially lifesaving. It is clear that no one health care system provides equal and unlimited access to this type of care. The fragmented US system provides patients with more expensive drugs, but the 'socialized' UK system is fairer.[18] Access to low value expensive cancer drugs is explicitly limited in UK, and in the US access to the most expensive drugs is painted as a major attractive element of the system.[19]

In the RF, funding for health care is insufficient, but health care access is declared to be unlimited and there is no discussion in professional or lay media about balancing the budget through exclusion of low value interventions. In the comparative study, RF physicians are more prone to provide life-extending care to dying elderly dementia patients than their European colleagues.[20] This may reflect the strong demand by RF law to provide life-supporting care in all circumstances. This demand does not mean the banning of rationing. In practice, when providing health care through scarce resources, physicians tend to provide it to nice patients, who 'deserve' it.[21]

The practice of rationing in the RF

The Soviet health care system was large and poor. Modern technology was supplied only to a small number of Moscow's exemplary centres. Most physicians in the USSR had no idea about what was available and had no possibility to refer patients to these centres. The decision to hospitalize a patient at such a centre belonged to the staff of the centre and was regulated by internal documents. Party bosses were treated in special well-equipped hospitals, and had access to all the technology available in the country. The inequality of access to health care was a major source of discontent during last Soviet years, though some steps towards equality of access had been taken during Perestroika. The situation was mainly restored in the mid-1990s by the creation of the "Kremlin hospital". While the selection of technologies for their cost-effectiveness was not legally possible, numerous practices and solutions are in essence rationing

17 'Potentially ineffective care: time for earnest reexamination' [Hindawi Publishing Corporation], 2014, *CriticalCare Research and Practice* 134198,

18 'Expensive cancer drugs: a comparison between the United States and the United Kingdom' [Blackwell Publishing Inc], 87, *The Milbank Quarterly*, 789

19 'UK drug appraisal process is restricting access to cancer drugs, say charities', 354, *BMJ*, i4465

20 'Doctors' authoritarianism in end-of-life treatment decisions. A comparison between Russia, Sweden and Germany' [BMJ Group], 27, *Journal of Medical Ethics*, 186

21 'Systemic barriers accessing HIV treatment among people who inject drugs in Russia: a qualitative study' [Oxford University Press], 28, *Health Policy and Planning* 681

practices or may be viewed as rationing. It appears that Russian society as well as the medical professionals accept the practice of rationing despite it not being named and not being described as a system.

In efforts to protect the best medical centres from degradation in the difficult 1990s, the RF Government created a special line of funding of "high technology"/expensive care. It took 10 years before the mechanism of regulating access mostly to Moscow located "high technology" centres for patients from every region was introduced in 2005. These "quotas" for hospitalization were distributed centrally to serve the needs of the regions. The number of quotas was (and still is) insufficient for patients from all around the country, as well as for the participating hospitals, because of limited funding. To get access to quota care, a patient has to go through a chain of selection procedures, the last one taking place in the participating speciality hospital. It is in essence a process of rationing based on the need, age and predicted results of the treatment for a specific patient.

A variant of expensive care – transplantology. The Ministry of Health provides quotas for transplantology to selected hospitals, and these hospitals select the patients and manage the queue themselves. Despite the absence of national statistics, we believe that most patients in the queue do not survive to transplantation, as well as the fact that many are not included in the queue.

Some interventions are not available in the RF. For serving patients who cannot receive the necessary care some funding is reserved in the national health care budget. Again, there is a commission assembled from representatives of the specialist hospitals. The commission decides whether a specific patient is eligible for getting access to these limited funds, or whether the treatment mode available in the national centre is sufficient. Every year these limited funds do not get used in full. Again, people accept this way of distributing limited resources.

A major restriction in RF health care is the non-provision of drug therapy in outpatient care. Free drugs are provided only for inpatient care and in outpatient care as part of social subsistence. There is a list of "life-saving and important" drugs by generic name, which limits drug provision in hospitals. The access to other drugs, not included on the list, is possible, but limited by the obligatory second opinion of the colleagues' commission. These limits, imposed on access to drugs, are quietly accepted by patients and physicians, probably because they are very similar to the limits of the Soviet period. The methods for preparing this drug list were approved by the Government in 2014[22] and this regulation is the only one mentioning a cost-effectiveness evaluation of the drugs and evaluation of their influence on the budget. It is notable, because no one federal

[22] *On approval of the regulation for preparation of the lists of the medicines and minimal assortment of medicines needed for health care [Rus]* (Government of the Russian Federation)

law contains a provision of a drug or any other intervention depending on its cost.

If access to drugs is limited, what kind of treatment is recommended by the Russian guidelines? Traditionally, medical associations draft their guidelines according to the best recent documents approved by international medical associations. The Russian guidelines may recommend treatments that are not provided free and not affordable for the totality of patients. The guidelines rarely offer advice to physicians on how to limit the range of patients who may benefit from treatment. A good example is the expensive antiviral drugs for treatment of hepatitis C. While in the US guidelines limit the use of a therapy, unaffordable according to the budget, to a specific subgroup of patients, in the RF the guidelines just contain information about an effective therapy. Some of the Russian guidelines vaguely advise that a treatment option should be selected taking accessibility into account. When the US, Spanish and some other medical associations and health care systems more or less openly advise on how to limit access, the RF guidelines advise physicians simply to deliberate.

National health care law in the RF introduced a special type of prescriptive document – standards. The standard for the management of a condition is a table describing the interventions, the proportion of patients receiving it, and the number of doses/applications. Care should be provided in agreement with these standards. The medical organization receiving payment from an insurance company should treat patients in agreement with the standards.[23]

How do Russian physicians do it?

Most practices of rationing in Russian hospitals are institutionalized in some way. The prevailing form is the approval of expensive treatment or diagnostic test by the commission of leading hospital specialists chaired by the hospital chief physician. In a large organization, additional steps of control exist – by a department head, or a leading specialist. Officially, this practice is introduced for control of the appropriateness of interventions, not for rationing. The positive outcome is more or less obvious to physicians: without such a control physicians tend to respond to patients' demands by increasing testing and prescription with the obvious result –overloading, long queues and exhaustion of funds. Commissions cancel up to 30% of requests from attending physicians using the argument that the test or treatment is not indicated, not necessary in the case presented. Talking about the limits imposed, whether

[23] 'Russian experience and perspectives of quality assurance in healthcare through standards of care' [Elsevier], 5, *Health Policy and Technology*, 5

permanent or temporary, physicians underscore that if the test is really needed, it will be approved by the commission and provided for the patient.

At the same time, physicians complain that there is a massive burden of paperwork and consultation accompanying the arrangement of access to the expensive/limited test, service or treatment. Another outcome of these barriers, reported by some physicians in the outpatient setting, is the feeling that you belong to a team playing against the patient, putting an unnecessary burden on the patient and his physician.

In Moscow hospitals, the control commissions check a sample of patients' records to control compliance with the standards and to fine physicians for unnecessary tests and treatments. Paraclinical departments provide information on the overuse of expensive tests and impose limits on the number of tests for the department per period. Hospital managers tend to describe physicians, who order more tests, as having lower qualifications.

Another specialist with a role in saving resources, correcting prescriptions and advising physicians in Moscow is the clinical pharmacologist. Surgeons interviewed are very positive in relation to correction of drug therapies by pharmacologists, leading to better efficacy and saving resources.

Moscow physicians in general are very positive towards the idea and practice of saving resources by limiting access to unnecessary or less necessary interventions. Many physicians, especially surgeons, approve treatment by protocols of the majority of patients for the sake of quality and rational use of resources. Some outpatient physicians, especially in Moscow, underscore that standards of treatment help and protect them from over-demanding patients. Other physicians comment that standards at the same time impose unnecessary tests and treatments, thus increasing the workload and the costs. A major line of tension is that a treatment prescribed by the standards is not adequately funded.

In provincial hospitals the processes of cost control are less formal; more decisions depend on a chain of command, and the pressure of costs originated from services bought from outside the hospital is higher. The standards prescribing the content of care should be met somehow, otherwise cases may be not paid for by the insurance companies. Collegial decisions are described by physicians as a positive experience, as a way of providing the care required, as they understand it. It appears that the less formal cost control in provincial organizations is less effective, than in Moscow, but the problem may be another one – provincial hospitals have fewer resources. They have many doctor and nurse positions vacant, old and unreliable equipment. As a result, their work is an everyday struggle to limit care for the sake of having sufficient resources for those who need it most. Physicians list the patients who are preferred: severe cases, mothers with children, compliant patients, bosses and other people recommended by the hospital chief or colleagues. Older patients are mentioned only to contrast the preferred others. The physicians interviewed were usually reluctant to describe these preferences.

In general, in Moscow and in the provinces, physicians understand their practice not as a practice of rationing, but as an everyday service to patients, to overcome the limits imposed. Only some of the physicians interviewed protested against the limits imposed by the standards or drug lists.

Conclusion

While in the US, a significant proportion of the population is negative in relation to health care rationing, a not negligible proportion of physicians are ready to embrace it. The health care system – insurers and providers – employs elements of care organization, provision and coverage, which are rationing in essence.

In the RF the rationing debate is suppressed, and the corpus of national legislation explicitly bans the rationalization of health care spending based on cost. At the same time, the health care system has a number of elements designed to lower the cost of care and suppress the use of expensive services. Physicians accept these elements of the system and work with them, trying to trick the system in order to provide better care.

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