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HIGHLIGHT:

Some say Americans use too much healthcare, that even if reform is achieved, universal access should not mean unlimited access. Tough choices must be made. Others worry that the most needy or least able to fight for themselves will be left waiting. Should healthcare be rationed?

BODY:

PRO No one can fail to be moved by heartbreaking stories of people suffering and unable to get healthcare they want or need. But compassion is a sentiment, not a policy.

We tend to talk about healthcare in the philosophically abstract. "Is healthcare a right or a privilege?" goes the refrain. In reality, it is neither. Healthcare is a commodity--and a finite one at that. There are only so many doctors, hospitals, and, most important, money to go around. After all, every dollar spent on healthcare is one not spent on education, infrastructure, or defense.

President Obama is right about the unsustainable trajectory of healthcare spending. We spend $2.5 trillion per year for healthcare, 17.5 percent of the gross domestic product. Under current trends, that will increase to 48 percent of GDP by 2050. At that point, government healthcare programs like Medicare and Medicaid alone will consume 20 percent of GDP. Quite simply, we cannot provide all the healthcare everyone might want.

Sure, there are efficiency savings to be had here and there. But savings from things like greater emphasis on preventive care, better evidence as to best practices, and electronic medical records are unlikely to be realized for years, if at all. Any healthcare reform will have to confront the biggest single reason costs keep rising: The American people keep buying more and more healthcare. At its most basic, no one wants to die. If a treatment can save our lives or increase quality of life, we want it. Therefore, in the long run, the only way to spend less on healthcare is to consume less healthcare. Someone, sometime, has to say no.

Take just one example. If everyone were to receive a CT brain scan every year as part of an annual physical, we would undoubtedly discover a small number of brain cancers earlier than we otherwise would, perhaps early enough to

save a few lives. But given the scan's cost, adding it to all annual physicals would quickly bankrupt the nation.

False hope. The real debate, therefore, is not about whether we should ration care but about who should ration it. Currently, that decision is often made by insurance companies or other third-party payers. Obama and congressional Democrats want to shift that decision-making power to the federal government. Some, frustrated by the insurance-based rationing of the current system, naively believe that putting the government in charge would mean unlimited access to the care they need and desire. When Michael Moore, in *Sicko,* showcased emotional tales of people denied experimental treatment by insurance companies, he implied that a government-run system would certainly pay for it.

The reality, however, is that every government-run healthcare system around the world rations care. In Great Britain, the National Institute on Clinical Effectiveness makes such decisions, including a controversial determination that certain cancer drugs are "too expensive." The government effectively puts a price tag on each citizen's life--some $44,305 per year, to be exact. That's just a baseline, of course, and, as the British institute's chairman, Michael Rawlins, points out, the agency has at times approved treatments costing as much as $70,887 per year of extended life. But these are approved only if it can be shown they extend life by at least three months and are used for illnesses that affect fewer than 7,000 new patients per year.

Free-market healthcare reformers, on the other hand, want to shift more of the decisions (and therefore the financial responsibility) back to the individual. People should have the absolute right to spend their own money on whatever they want, including buying as much healthcare as they want. And, if they are spending their own money, they will make their own rationing decisions based on price and value. That CT scan that looked so desirable when someone else was paying may not be so desirable if you have to pay for it yourself. The consumer himself becomes the one who says no.

Of course, as a compassionate society, we may choose to help others pay for some care. That's a worthwhile debate to have. But our resources are not unlimited. Choices will have to be made. And, therefore, the real question should be: Who will make those choices?

The only way to spend less on healthcare is to consume less healthcare.

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