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CAUTION URGED IN RATIONING RESEARCH

Remember those long gasoline lines earlier this summer?

Perhaps some of our readers reside in places where the gas crunch didn't hit so badly, but those of us in the Washington, D.C. area were not so lucky. As a result, we won't quickly forget the long lines of frustrated, agonizing motorists. Undoubtedly, our keen recollection is at least in part due to the fact that we ourselves sat in those lines, and we personally underwent the experience involved.

This constituted a vivid, living example of the theory of supply and demand; supply went down and demand went up, with the delicately balanced system thrown completely awry. If the supply falls or can't be increased, and if the demand either continues or expands, then a shortage will result. And the best that anyone can suggest as a remedy is some sort of rationing plan.

All of this is an introduction to another area of "rationing." We had first heard this suggested only within the past year, but have seen it mentioned with increasing frequency in recent months. And that is the idea of "rationing" health care.

In late June of this year, United Press International reported on the release of a Brookings Institute study which stated that health care costs are rising rapidly at a time when the traditional governing control—namely, ability to pay—is being abandoned in favor of the growing belief that no one should have to forgo medical care because of inability to pay.

The author of the study was quoted as saying, *"We must accept the true nature of the cost problem. Once we decide that costs are rising too fast and that, in order to slow them, we are willing to modify the philosophy that costs should not be a consideration in medical care, the next question is, 'How do we want to accomplish the rationing that must take place?' "*

Recognizing that even the idea of rationing health care is an "explosive one" for the medical community as well as the general public, the study points out that only modest economies remain to be achieved by current attacks on waste and fraud. Meanwhile, the demand for care and the cost of care are both soaring.

We might have simply dismissed this Brookings study as some academic speculation and idle theorizing if it were not for several similar reports, projections, and conclusions appearing from other sources. The most startling of these was a full three-page discussion entitled "Is health care 'rationing' inevitable?" which appeared in the weekly newspaper of that bastion of conservatism, the American Medical Association.

This publication labeled the thought as "a somewhat alarming idea," but the message that came through was that ultimately some kind of rationing system will be applied to health care. To quote one of the discussants, *"At some point, society, quite independently of what you and I believe about medicine, will decide that 10% or 12% of the GNP is enough to spend on health care and decide that they aren't going to pay any more. Given that societal decision, then we'll have to decide what the appropriate balance should be between the present marketplace rationing system and the implicit and explicit rationing."*

What does all this have to do with pharmacy and the pharmaceutical sciences? Plenty! Drug products and pharmaceutical service are integral components of health care. Although they account for only a fraction of the health care dollar, they do represent significant costs. Moreover, when government agencies and legislators have looked for places to cut costs in the past, drugs and pharmaceutical services are among the first areas targeted. And when the budget for drug purchase goes down, the drug research budget ultimately is affected as well.

Although "rationing" *per se* would be a new development in the case of pharmaceuticals, we have had some related experiences in which restrictions have been applied or considered in drug development or distribution, due either to the cost or availability of drug products.

For example, each year the question of mass flu immunization programs centers around the cost of such programs *viś-à-viś* their anticipated or projected benefit in terms of health savings to the public. Regarding limited supplies, during World War II shortages of quinine to treat malaria and of the newly developed antibiotic, penicillin, to treat infections caused by battle wounds required a system of priority establishment that certainly approximated rationing. Subsequently, when polio vaccine first became available, the limited supplies required that choices be made as to whom it would be administered.

But in the quest for economy, we hope that the decision-makers recognize that carefully chosen and wisely selected research can often be the most effective route to major economies. For example, countless drugs are now available to use *via* chemical synthesis at a small fraction of their previous cost from biological or botanical sources. In other instances, research has led to the development of greatly improved and more effective agents.

Hence, we must remain vigilant to the need to ensure the continued viability of our drug research effort, so long as it is channeled toward truly productive goals and objectives.

—EGF