In Praise of Hassles: Why "Rationing through Inconvenience" May Be More Ethical than Other Mechanisms for Allocating Care

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Date : January 10, 2020

Nir Eyal, Paul L. Romain, & Christopher Robertson, *Can Rationing through Inconvenience Be Ethical?* 48 **Hastings Ctr. Rep.** 10 (2018), available at SSRN.

An unfortunate reality of all healthcare systems is that, left unchecked, demand for medical services will inevitably outpace available supply. On the one hand, there will almost always be one more intervention that might, at least in theory, improve a patient's condition or avert a future harm. On the other hand, in a society with multiple urgent priorities—education, poverty reduction, and national defense to name just a few—devoting all available resources to health care is neither possible nor desirable. Moreover, some healthcare resources are finite in an absolute sense; for example, there are simply not enough transplantable organs for everyone in need.

In light of this conundrum, no matter how much the public tends to bristle at the concept of "rationing," setting limits on access to health care is ultimately unavoidable. In a few situations, limit-setting mechanisms are explicit and transparent; examples include the national system for allocating transplantable organs, or insurers' use of formularies to limit the cost of prescription drug coverage. Often, however, healthcare rationing occurs implicitly, with limited public scrutiny. Examples of implicit rationing include governmental decisions about which healthcare services to fund, or a healthcare professional's judgment about whether to prescribe a particular drug or refer a patient to a hospital.

In a provocative and thoughtful article, *Can Rationing through Inconvenience Be Ethical*, Nir Eyal, Paul Romain, and Christopher Robertson consider a critical, but often overlooked, form of implicit rationing—the use of "burdensome arrangements" such as "application processes, forms, waiting periods, and the like," that make accessing health care inconvenient. To the extent "rationing through inconvenience" has received attention, they note, it has typically been to condemn it. At best, it is considered a waste of time and energy; at worst, it is attacked as a harmful barrier to care. However, they argue that, "under certain conditions, rationing through inconvenience may turn out to serve as a legitimate and even a preferable tool for rationing," as compared to other available alternatives. (P. 11.)

For purposes of their analysis, Eyal et al. define "rationing through inconvenience" as "a nonfinancial burden (the inconvenience) that is either intended to cause or has the effect of causing patients or clinicians to choose an option for health-related consumption that is preferred by the health system for its fairness, efficiency, or other distributive desiderata beyond assisting the immediate patient." *(Id.)* In other words, their focus is on barriers that have the effect of nudging patients to make socially desirable choices, as opposed to barriers that are imposed for other reasons, such as to increase profits for third-party payors. They identify six considerations relevant to assessing the advantages and drawbacks of these measures.

First, they note that, like other forms of indirect rationing, rationing through inconvenience preserves patient choice. No one is denied care entirely, but a patient seeking a rationed service can access it only if she (and/or her provider) is willing to jump through various hoops. One advantage of this approach is

that, “[p]atients who perceive the greatest benefits from a treatment” are more likely to be willing to undergo the burdens associated with obtaining it. “By separating individuals who are willing to accept inconvenience to procure a good or service from ones who are not,” they argue, “rationing through inconvenience gathers that information and applies it to personalize rationing policy.” (P. 14.)

Second, they argue that rationing through inconvenience may be less regressive than relying on financial incentives, such as cost-sharing mechanisms, because all people, regardless of income level, “have twenty-four hours in a day, a limited attention span, and a body that can be in only one place at a time.” (P. 15.) They recognize, however, that rationing through inconvenience can sometimes impose disproportionate burdens on disadvantaged populations, as a result of factors like limited paid medical leave, inadequate transportation, or lack of access to nearby care facilities. In light of this potential, they call for “[f]ormal, periodic assessments” to evaluate the impact of particular strategies on different populations, as well as the use of “ameliorative measures” to reduce any disparities found. (P. 16.) For example, they suggest that, in some cases, adverse impacts on disadvantaged populations might be ameliorated by “maintain[ing] a plurality of optional inconveniences—stand in a long line or fill out a long form, for example.” *(Id.)*

The third consideration they address is largely a negative one—the fact that inconvenience, perhaps by definition, involves wasted time and effort. This waste is incurred not only by the patient but also, in some cases, by health care professionals, who may need to divert attention away from other patients to satisfy procedural requirements (for example, completing prior authorization requests). The impact of inconveniences on health care providers also can give rise to a conflict of interest, as physicians may recommend against treatments that involve significant burdens for them.

Fourth, the authors suggest that rationing through inconvenience often has the advantage of being highly salient to patients. Unlike costs, which “are often opaque to the patient,” inconveniences such as waiting in line and filling out forms are painfully obvious to those who experience them. They point out, however, that inconveniences are not always apparent in advance; moreover, the salience of inconvenience “is a double-edged sword” because it can lead to the underuse of necessary services and “it can also make rational priority setting less acceptable to the public.” (P. 18.)

Fifth, they suggest that rationing through inconvenience is arguably preferable to rationing through cost because it avoids “put[ting] a price on people’s bodies, or health, or on professional integrity.” *(Id.)* On the other hand, they note that rationing through inconvenience raises other concerns about respect for persons: “Mobilizing our aversions to standing in line, to listening to annoying muzak on the phone, and jumping out of bed earlier exploit our bodily vulnerability to inconvenience—or our psychological and physical need for comfort.” *(Id.)* The significance of these concerns, however, depends on the extent of the inconveniences involved.

Finally, they argue that, because “the deliberate imposition of inconvenience may be outrageous to the public,” efforts to ration through inconvenience may often be adopted on a less-than-transparent basis. For example, a public hospital may simply “fail to invest in added resources that would have alleviated long waits for a certain service,” without any opportunity for public scrutiny. (P. 19.) On the one hand, they suggest that this lack of transparency is arguably a significant ethical problem. On the other hand, “some obliqueness in resource allocation” may be necessary in a society where rationing, although inevitable, “remains hopelessly unpopular.” *(Id.)*

In conclusion, the authors suggest several areas for future research on the effects of rationing through inconvenience. For example, what types of rationing through inconvenience is already in use? When do these mechanisms actually lead patients and clinicians to make more socially desirable choices about health care? How can the disutility associated with these mechanisms be measured? What are the

effects of these mechanisms on individual and population health?

By bringing attention to the common, but under-explored mechanism of rationing through inconvenience, this article is an important addition to the literature on health care prioritization. The authors' careful analysis persuasively demonstrates that inconvenience can be a useful mechanism for allocating limited resources, and that in some cases it may be superior to other methods currently in use. However, it also shows that, like co-payments and other financial disincentives, imposing costs in the form of time and effort can also have a downside. Ideally, once armed with the research data Eyal et al. have called for, policy makers will be better equipped to strategically use inconvenience to achieve socially desirable goals.

Cite as: Carl Coleman, *In Praise of Hassles: Why "Rationing through Inconvenience" May Be More Ethical than Other Mechanisms for Allocating Care*, JOTWELL (January 10, 2020) (reviewing Nir Eyal, Paul L. Romain, & Christopher Robertson, *Can Rationing through Inconvenience Be Ethical?* 48 **Hastings Ctr. Rep.** 10 (2018), available at SSRN), https://health.jotwell.com/in-praise-of-hassles-why-rationing-through-inconvenience-may-be-more-ethical-than-other-mechanisms-for-allocating-care/.