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Pediatric Research Bill: Obamacare's Road to Rationing?

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Later this month, the House of Representatives could consider legislation regarding pediatric research.[1] Legislation regarding this issue (H.R. 1724) was first introduced in April, and a new version of the bill (H.R. 2019) was introduced in May.

Although largely similar, H.R. 1724 would require the director of the National Institutes of Health (NIH) to provide a justification for any existing grants studying health economics, and would prohibit new grants until "a federal law has been enacted authorizing the National Institutes of Health to use funding specifically for health economics research."[2] Press reports indicate that H.R. 2019 excludes the restrictions included in H.R. 1724 "in order to please Democrats who favor the research."[3]

This is a mistake. The House should ensure that H.R. 1724's proposed restrictions on health economics research remain in any NIH-related legislation that comes to the House floor. To do otherwise would provide tacit approval to Obamacare's road to government-rationed health care.

Proposed Restriction a Necessary Protection. The provision omitted from H.R. 2019 would have instituted an important and necessary protection on taxpayer-funded research on cost-effectiveness in health care. In recent years, the federal government has funded numerous such studies. For instance, a June 2011 Government Accountability Office report examining projects funded by the "stimulus" highlighted NIH grants studying the cost-effectiveness of various medical treatments, including:

- "A Comprehensive Model to Assess the Cost-Effectiveness of Patient Navigation,"
- "Cost-Effectiveness of Hormonal Therapy for Clinically Localized Prostate Cancer;"
- "Clinical and Cost-Effectiveness of Biologics in Rheumatoid Arthritis," and
- "Cost-Effectiveness of HIV-Related Mental Health Interventions."[4]

Liberals Favor Cost-Effectiveness Research. Setting aside the wisdom of using taxpayer funds to examine the cost-effectiveness of various treatments, such research could eventually be used to deny patients access to certain kinds of care. Quotes from key policymakers reveal how some would use cost-effectiveness research as a way for government bureaucrats to block access to treatments that are deemed too costly:

- Former Senator Tom Daschle (D–SD), President Obama's first choice for Secretary of Health and Human Services, wrote in 2008 that "we won't be able to make a significant dent in health-care spending without getting into the nitty-gritty of which treatments are the most clinically valuable

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and cost effective. That means taking a harder look at the real costs and benefits of new drugs and procedures."[5]

- In a 2009 interview with *The New York Times*, President Obama argued that "the chronically ill and those toward the end of their lives are accounting for potentially 80 percent of the total health care bill out here.... There is going to have to be a very difficult democratic conversation that takes place."[6]

- Former Medicare Administrator Dr. Donald Berwick, in his infamous 2009 interview, strongly argued in favor of taxpayer-funded cost-effectiveness research when stating that "the decision is not whether or not we will ration care—the decision is whether we will ration with our eyes open."[7]

Lawmakers have already expressed their desire to use cost-effectiveness research to restrict access to certain treatments. A report prepared by the House Appropriations Committee in 2009, discussing "stimulus" funding for the types of projects highlighted above, noted that thanks to the research funding, "those items, procedures, and interventions that are most effective to prevent, control, and treat health conditions will be utilized, while those that are found to be less effective and in some cases more expensive will no longer be prescribed."[8]

Road to Rationing. Although research comparing the relative merits and costs of medical treatments may sound appealing, past experience has demonstrated that such research can, and often is, used as a blunt tool by governments to restrict access to certain kinds of care. At a time when genetic advances have opened the door to personalized medical treatments, Obamacare has moved health policy in the opposite direction, expanding the federal bureaucracy in an attempt to micromanage the health care system.[9]

Imposing the restrictions on cost-effectiveness research included in H.R. 1724 would represent a good first step in restoring the balance between federal bureaucrats and patients.

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