Dying for Money:

Overcoming Moral Hazard in Terminal Illnesses Through Compensated Physician-assisted Death

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ABSTRACT. A major cause of spiralling *health-care* cost is aggressive treatment of major illnesses by *health-care providers.* The insured patient also demands such an expensive course of action because he pays only a small portion of the cost and is not given a more attractive alternative. If the patient is offered compensation to give up his *de facto* right to aggressive treatment, *insurance* premium can be reduced. Physician-assisted *death* with benefit conversion is discussed as a means for such an exchange.

I

Introduction

IT IS WELL KNOWN that some parties to a contract who have an information advantage over the other parties may engage in post-contractual opportunistic behavior. This behavior is commonly known as moral hazard. In health-care insurance, moral hazard is usually associated with increased use of medical services after insurance (Pauly, 1968). Because the insurer usually cannot tell whether a treatment is motivated by actual need, or by lower marginal cost of services to the insured, there is room for the insured and the service provider to use more services than would be used without insurance. This information advantage on the part of the insured and the service provider thus determines the extent of moral hazard. The greater the information advantage is, the higher the cost of containing opportunistic behavior, and the greater the extent of moral hazard.

When moral hazard cannot be costlessly eliminated, the interest of the insurer is adversely affected if he cannot cover easily his loss from the insured's overuse by increasing the premium. It is as if some property right of the insurer have been converted into *de facto* property right of the insured. The extent of this *de facto* right is defined by the level of successful moral hazard. In other

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words, the gap between the ideal interest of the insurer under perfectly enforced property right (*i.e.*, without moral hazard) and his effective interest under imperfectly enforced property right (*i.e.*, with moral hazard) represents competitively capturable resources (Fung, 1991).

The higher the cost of containing moral hazard, the larger this pool of competitively capturable resources becomes. But these resources are likely to be lower in value than their equivalent market values to the insured because they must be captured in kind and not in cash. Therefore, the insured may be induced to give up his *de facto* property right in exchange for part of the competitively capturable resources, if such an exchange offers him greater utility. In turn, the insurer can keep the rest of the competitively capturable resources. This exchange, a benefit conversion, if successful, can make the insured better off and lower insurance premium for a given coverage.

Deductibles and copayments are incentives designed to contain this *de facto* property right of the insured. Their effectiveness in curtailing moral hazard, however, is limited to minor illnesses (Zweifel, 1988). For major illnesses of a terminal and/or chronic nature, treatment levels typically extend beyond the reach of deductibles and coinsurance. Here, comparable incentives to contain the insured's *de facto* property right do not exist. Not surprisingly, aggressive treatments of major illnesses have contributed significantly to health-care cost explosion.

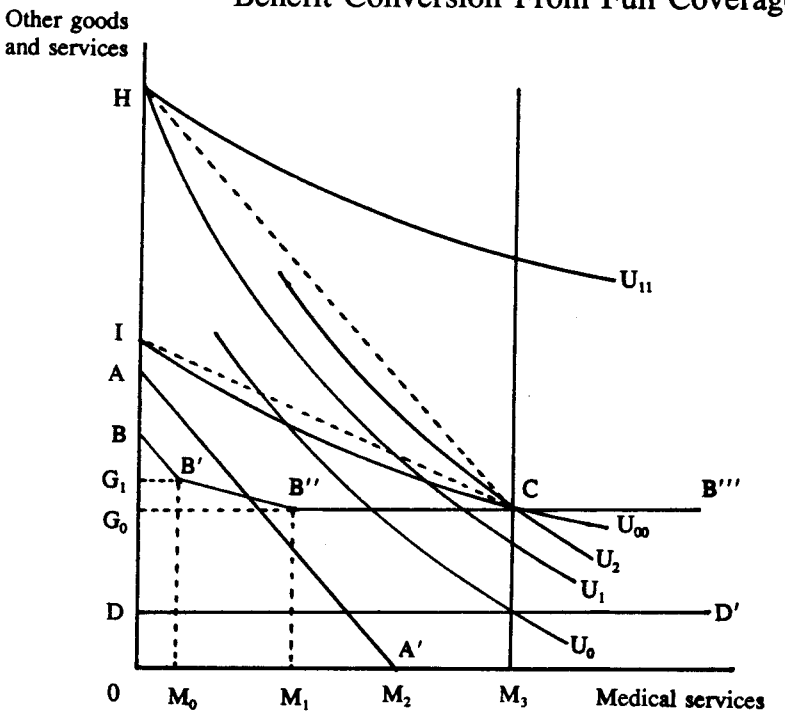
This paper will look at a two-pronged incentive scheme that may curtail overtreatment and the spiralling of health-care costs in major illnesses. This scheme is based on a recognition of the insured's *de facto* property right to competitively capturable resources and the offer of a package of benefits that is more valuable, in some cases, to the insured than a futile resort to more medical treatment.

II

Budget Constraints of the Insured in Major Illnesses

WITHOUT INSURANCE, moral hazard is absent because the limit to medical services is determined by the individual's income and the market price of medical services. This income-price budget constraint is represented by AA′ in Figure 1. This individual's (say John's) income can be spent on up to M_2 units of medical services and nothing else, or up to OA units of other goods and services (other goods for short) and no medical services, or any other consumption bundles of medical services and other goods along the budget constraint AA′. The slope of the constraint reflects the price of medical services in terms of the amount of other goods that must be given up in exchange.

Figure 1
Benefit Conversion From Full Coverage



With health insurance, the budget constraint is transformed in different ways depending on the type of insurance. The transformation for a typical Blue Cross and Blue Shield plan is as follows: First, the vertical intercept of the constraint is lowered by the premium, say AB. Second, a deductible (say BG_1) must be paid by the insured. Because John must pay the market price for his medical services until the total out-of-pocket medical expenses exceed BG_1, BB′ has the same slope as AA′. Third, John must pay for a portion of the market price for any additional medical services beyond M_0 and up to M_1. Since the copayment is less than 100% of the market price, B′B″ is flatter than BB′. Fourth, when the total out-of-pocket expenses for the year exceed BG_0, full coverage takes over. The budget constraint becomes horizontal representing zero copayment and zero private marginal cost of additional medical services (see B″B‴ in Figure 1). For major illnesses, the level of medical services required will typically exceeds M_2. In other words, the insured's demand for additional treatment in

major illnesses is unlikely to be restrained by private cost consideration in any given year. In the next calendar year, however, the deductible and copayment will start over again.

For those who have no private insurance and very little cash income or countable assets (Gordon, 1990), Medicaid is the safety-net public insurance. It does not require any deductibles or copayments. For the qualified, the budget constraint is a horizontal line with a very small vertical intercept (see DD′ in Figure 1). As in B″B‴, there is zero private marginal cost for additional treatment. Because major illnesses tend to be the most financially burdensome, most Medicaid resources are tied up with treating major illnesses. The most typical major illness funded by Medicaid is long-term care, which neither private health care insurance nor Medicare covers. Again, demand for additional treatment in major illnesses is unrestrained by private cost consideration.

The budget constraint for Medicare Part A beneficiaries is more complicated (*Medicare Supplement Insurance in New York State, 1987*). For hospital costs, there is full coverage up to a maximum number of days after a deductible per benefit period. These maximum full-coverage days are usually long enough to take care of major illnesses. For in-patient skilled nursing-care costs, there is also full coverage for a maximum number of days per benefit period (not shown in Figure 1).

Full coverage invites moral hazard from two sources. First, the insured has no incentives to conserve medical services because his private marginal costs are zero. Second, the service provider has no incentive to control access as payment for their services is based on retrospective costs.

To contain moral hazard, (the tendency to over use something since it is covered by insurance) the insurer has placed many constraints on full coverage. These may be (a) prospective pricing, (b) exclusion of certain treatments, and/or (c) caps on total claims.

Prospective pricing contains moral hazard on the part of the service provider by limiting payment to the provider to reasonable charges. Sometimes, it can be so effective that the service provider does not accept the patient. This happens most often under Medicaid. For Medicare in-patient care, prospective pricing is constrained by means of Diagnosis Related Groups (DRGs).

Some treatments are excluded because they are still experimental in nature. That is, their mean result may be less than satisfactory and/or the variance around the mean result may be too large. This rationale for exclusion simply encourages medical research to overcome technological barriers towards full acceptance of a given treatment. This control has not been successful at all because an upper limit to the cost per quality unit of life year has never been imposed by any insurer. Unless such a limit exists, there is no defensible basis for excluding

a perfected treatment simply because it is too expensive, or for denying a treatment that merely succeeds in transforming a terminal illness into a chronic illness with a large lifetime medical bill (Weisbrod, 1991).

A cap on total claims can be imposed on a lifetime basis or per-benefit-period basis. For Medicare Part A hospital costs, there is both a lifetime cap and a per-benefit-period cap. For Blue Cross and Blue Shield plans, there is only a lifetime cap. A cap on total claims will entail moral hazard from both the insured and the service provider.

The much touted cost control scheme practiced by HMO's (Health Maintenance Organizations) is nothing but a combination of prospective pricing and rationed full coverage. Most of its cost saving comes from completely eliminating moral hazard from the service provider.

While a lifetime cap curtails open-ended treatments, there is still no incentive for the insured to refuse treatments before the cap is reached. This conclusion applies to all the insured with typical preferences between medical services and other goods. Suppose John's preferences between medical services and other goods can be represented by a series of downward-sloping non-intersecting indifference curves (see U_i's in Figure 1). Each curve indicates a locus of all bundles that give John the same level of satisfaction. Along each curve, a higher level of medical services must be offset by a decreasingly lower level of other goods, and vice versa, to keep the level of satisfaction constant. Indifference curves that are farther away from the origin indicate higher levels of satisfaction because more of medical services and other goods are available. The general slope of an indifference curve indicates how willing John is to give up medical services for other goods. The flatter an indifference curve is, the more willing John is. Given the relatively steep slope of John's indifference curves (U_i's), he is better off choosing more treatment up to the cap (say M_3) even if treatments may only prolong a miserable existence. In other words, the highest level of satisfaction attained by John given his budget constraints DD′ or B″B‴ is still given by M_3 units of medical services. A lower level of medical services with the same amount of other goods would only place John on a lower indifference curve.

III

Benefit Conversion

THIS BIAS FOR MORE TREATMENT occurs because John has no other means to assert his *de facto* property right resulting from moral hazard. If John were allowed to convert his lifetime cap into other goods at market prices from his B″B‴ budget constraint, his income would go up to OH from OG_0. Given John's

current preferences between medical services and other goods as represented by indifference curves U_i's, he is still no better off at H than at C (*i.e.*, $U_2 > U_1$). But these preferences reflect his current disposition when benefit conversion is not available. When benefit conversion is offered, however, John may be more willing to give up futile treatments for other goods. In other words, his indifference curves may become flatter as represented by U_{ii}'s. With these flatter indifference curves, John is clearly better off at H than at C since U_{11} is farther away from the origin than U_{00}. Even if the conversion ratio were considerably less than the market exchange rate between medical services and other goods, John would still be better off by refusing any treatment than by receiving M_3. Only when the converted benefit falls to G_0I is John indifferent between M_3 and zero treatment.

It is, of course, not necessary to assume that John would change his preferences for benefit conversion to be workable. In a large population, there may be a sufficient number of people with preferences close to U_{ii}.

A more critical issue about benefit conversion is whether a basically discontinuous life-and-death decision can be analyzed with a continuous preference function. Indifference curves are certainly useful for analyzing substitutions between medical services and other goods in minor illnesses. Even in major illnesses, the level of treatments can range from comfort treatment to aggressive treatment. Without the third-party payment system, an individual who cannot afford aggressive treatment is forced to reduce treatment to secure an adequate amount of other goods. Only when the third-party payment system guarantees a generous cap on medical services is a continuous substitution decision turned into a corner solution. In terms of Figure 1, a rational insured patient when reduced to choosing along B″C is bound to choose the maximum treatment M_3 at C. Benefit conversion simply offers an alternative corner solution, such as H. Even though the choice between H and C is discontinuous, there is no logical reason why they cannot be ranked by indifference curves based on continuous substitutions.

Converting benefits for greater efficiency is based on a well-known economic principle. Namely, a consumer is better off, or at least no worse off, if a payment in kind can be converted into an equivalent amount of cash which can be used to buy anything the consumer chooses. The corollary of this principle is that the consumer may be better off, even if a less than equivalent amount of cash is offered, provided that the freedom in exchange is sufficiently valued. One reason why this principle has not been widely used to reduce benefit overcommitment is because recipients are not trusted to exercise the freedom wisely.

Another important reason why benefit conversion has not been used is because of a failure for policy makers to recognize the *de facto* property right of the

insured to the benefit. When conditions are not favorable for moral hazard, the insured does not have any *de jure* or *de facto* property right because no competitively capturable resources exist. But when the insured can vary his claims because of superior information, he holds *de facto* property right to the competitively capturable resources. Failure to recognize this right can only lead to more claims from the insured because of asymmetric incentives, *i.e.,* payment is made when the covered event occurs but no benefit is received when the covered event does not occur.

These asymmetric incentives are compounded when non-medical benefits are also involved. For example, a person who has been paying payroll taxes all his life will not receive any benefit if he dies at age 64 without any disability or survivors. But if he lives to 200 years old, he will keep on drawing benefits. Where is the economic incentive to shorten longevity? And where is the economic incentive of not having another spouse and adopting young children who could continue to receive benefits after his death?

Here the covered event is old age. And the moral hazard is the injudicious lengthening of old age. Unlike other covered events such as non-terminal illnesses which occur and pass away and must reoccur for the receipt of additional benefits, Social Security coverage for old age is permanent until death. By complementing Social Security with Medicare and Medicaid, the government increases the moral hazard of lengthening old age since death from natural causes is postponed.

The ballooning health-care expenditures for the elderly are largely a result of the postponement of death. Those over 65 years absorb one third of the country's personal health-care expenditures even though they constitute only 12% of the total population (Ansberry, November 13, 1990: A1). Because there is a powerful lobby for open-ended expenditures on postponing death, these expenditures expand by squeezing out competing claims to third-party funding. For example, Medicaid financing of more than half of all nursing-home care of the elderly has reduced the share of Medicaid funding for the non-elderly poor (more than 90% of the total poor) to only about 40% (Callahan, 1987: 151).

Moreover, there is an internal logic to the explosive growth of expenditures on postponing death. More accessible health care through Medicare means more elderly survive to require long-term nursing-home care. Since Medicare does not provide for long-term care, the poor elderly are forced to rely on Medicaid which does. Thus Medicare and Medicaid together have helped extend life expectancy at 65 years from 5 to 15 years on average. Longer life expectancy also means longer entitlement to Social Security. Each of these programs alone would have been a closed-end commitment. Together, they have become an open-ended over-commitment.

Short of brutally cutting back entitlements, this over-commitment can only be curtailed by converting the entitlements into a form which offers higher utility to the entitlee, but carries a smaller cash value than the market-price equivalent of the medical services to be consumed.

IV

Dying for Money?

SINCE LIFE IS UNIVERSALLY VALUED, what incentives can the government offer to entitlement recipients to reduce their claims? Paradoxically, the most powerful incentive the government can offer is the right for the terminally ill to die with dignity.

Though entitlements to Social Security, Medicare, and Medicaid may look like free lunches, they can be claimed only with matching sacrifices from recipients. In order to qualify for Medicaid-funded nursing-home care, recipients must have spent down most of their life savings. Likewise, claims to Medicare must be supplemented by private resources that may otherwise be passed on to the next generation. Worst of all, longer life expectancy may mean longer morbidity for the terminally and/or chronically ill.

For those who take death into their own hands, no mercy has been shown by the diligent enforcers of current US laws. Although no "accomplices" to mercy killing have been convicted of murder, the shadow of criminality has scared away all but the truly desperate.

But by offering the right to die with dignity, an escape valve to the current fiscal over-commitment and concomitant human suffering is created. The government could convert the entitlements into a death benefit equivalent to, say, 60% of the projected medical and non-medical payments which the terminally or chronically ill would have received if they had chosen to die a slow death. The stigma of dying for private gain can be reduced by specifying that at least half of the converted benefits must be devoted to public charity.

Government budgets are not the only casualty of over-commitment. Corporate bottom lines are similarly affected by retiree health-care cost explosion. In 1974, the average Fortune 500 company had 12 active employees for every retiree. Now it has three. General Motors spent $837 million in 1985 on medical bills of its 285,000 retirees or their survivors. In general, the more mature the company, the worse the impact (Nielsen, March 2, 1987: 98).

Since corporations cannot grant retirees the right to die with dignity, their salvation from the retiree health-care cost explosion must await government initiative.

The two-pronged approach of benefit conversion and dignified death ensures that the system would not be abused. When private and public entitlements are converted into death benefits, there is no danger that the terminally ill would spend the converted benefits and then refuse to die. And since healthy elderly cannot easily disguise themselves as terminally ill, there is also no danger of massive influx of volunteers to overwhelm the conversion system.

Granting the right to die with dignity would not be a drastic departure from public sentiment. A recent survey published in the National Law Journal showed that 64% of the respondents felt doctors should not be prosecuted for helping the fatally ill commit suicide (*The National Law Journal*, May 13, 1991: 2).

V

Why Benefit Conversion?

IF DIGNIFIED DEATH with benefit conversion saves resources, wouldn't dignified death alone save even more? After all, the procedure of converting benefit itself would use up resources which could be directly redeployed in its absence.

But benefit conversion both recognizes the *de facto* right of potential volunteers to over-treatment and provides them with a voice to determine how the saved resources should be deployed. This voice is most significant in a third-party payment system. In essence, a third-party payment system is a multi-party prisoners' dilemma game where uncoordinated individual self-restraint in a situation of massive overuse would not result in any appreciable collective benefits. Individuals with severe morbidity may, of course, improve their lots by simply being assisted to die. But there may not be enough volunteers to form a critical mass needed to improve the average lot of all the insured (Fung, 1988). In addition, unless the wishes of volunteers are taken into account, the saved resources might instead be devoted to more futile treatments for those who should have chosen, but refuse to choose, dignified death. If this happens, the altruism of volunteers would come to worse than nothing.

Benefit conversion also provides dying persons with additional means for final positive contributions to the community and their close ones.

VI

Who Will Voluntarily Die?

There is no question that an earlier passage will help contain the seemingly uncontrollable health-care costs. It is estimated that 25–35% of Medicare expenditures in any given year go to only 5–6% of those enrollees who will die within that year (Callahan, 1987: 130), and that 46% of health-care costs in the

last year of life are spent in the last 60 days (Lubitz and Prihoda, 1984: 130). But it is not always easy to determine which patients are hopelessly ill. In ambiguous emergency cases resulting in deaths, the high costs may be a result of treating patients perceived to have a good chance of recovery. These emergency cases, however, should not be confused with chronic high-risk, high-cost, and low-yield cases where diagnostic uncertainty is low. Among those determined to be hopelessly ill, who will voluntarily die?

At first glance, it may appear that those who are poor will offer to die first. Their death will benefit their survivors who, on the whole, may have more urgent survival needs than the survivors of those who are better off.

But it is equally likely that those whose illnesses cause severe morbidity will choose to die first. And morbidity does not discriminate between income classes. Without physician-assisted death, they are likely to drag on while draining scarce health-care resources. If the benefit conversion ratio is subject to bid, the most morbidly ill may choose to go first even at a very low conversion ratio. Morbidity may even encourage those who are not insured under any scheme to die voluntarily.

Given the same illness and morbidity, however, those who are older and with no dependents may be more willing to die first. With benefit conversion, death can become an act of active altruism for those who have not been able to give generously to their favorite charities when they are alive. By choosing to end a miserable existence in their final days and donate the converted benefits to charities, they can now trade for a more meaningful life in the fond memories of the still living.

VII

Who May Object?

IS BENEFIT CONVERSION plus dignified death Pareto optimal? It is if nobody suffers or objects to this arrangement. Who are those who may have material interests at stake?

First, those health-care providers whose livelihood depends on postponing death in major illnesses with half-way technology (Weisbrod, 1991: 533) will be hurt. These technology treat symptoms but fail to affect the course of illnesses.

Second, life insurance companies which must pay out death benefits earlier and receive fewer premium payments may suffer.

But these are transitional problems that will solve themselves over time. Less research and development will be devoted to, and fewer doctors will be trained for, half-way technology. Insurance premium can be adjusted to account for the lower life expectancy.

Third, pro-lifers and medical ethicists may have legitimate concern about the issue of active termination of life without informed consent. But by legalizing physician-assisted death, the government can also stipulate rules and safeguards under which the procedure can be performed.

Fourth, relatives may dislike the ease with which their loved ones can terminate their lives. But since death no longer has to be secretive, relatives can at least be involved in the final decision. Although they may still disagree, they can at least respect and understand the rationale for the fatal choice.

VIII

Benefit Conversion as a Resolution of Tragic Choices

WHEN A MATTER OF LIFE AND DEATH is involved, allocation of resources often evokes a sense of tragedy. Choices are tragic (Calabresi and Bobbitt, 1978: chapter 1) in these cases because there are conflicts in ethical principles. Veatch (1986) listed four ethical principles relating to health care given to patients: (1) patient-centered beneficence—that one's actions should benefit the patient; (2) autonomy—that the patient's right to self-determination should be respected; (3) full beneficence—that resources should be used to do the most good; and (4) justice—that resources should be distributed to provide all with an equal opportunity for health.

Benefit conversion coupled with dignified death go a long way towards resolving these conflicting principles. Because resources released from one patient's refusal of medical treatment (autonomy) can be specifically requested to be used for other patients or beneficiaries with greater need (full beneficence), autonomy and full beneficence need not conflict. Once the patient is allowed to choose death, the care-giver does not have to impose treatment for fear of malpractice liability. Thus, patient-centered beneficence is also satisfied. Since benefit conversion is equally available to all who are insured, and the amount of converted benefits varies only with the severity of the illness, justice is also served. All that remains to be done is to educate the terminally or chronically ill how to allocate the converted benefits once death is chosen.

Because these four ethical principles are largely taken care of, the sense of tragedy connected with death and denial of treatment to the hopelessly ill can be mitigated.

IX

Compensated Dignified Death vs Other Death Alternatives

HOW DOES DIGNIFIED DEATH with benefit conversion compare with alternative approaches to ending life suggested by other writers? Although all of them

address some aspects of health-care cost containment, patient autonomy, and better allocation of medical resources, none address all these issues simultaneously. The comparative merits of these alternatives are briefly discussed below.

1. **Physician-assisted death without benefit conversion.** Although physician-assisted death itself would respect patient autonomy and release resources for alternative uses, full beneficence is compromised because patients' *de facto* right to competitively capturable resources is not recognized. Only when terminal patients can help decide on how the released resources are used can full beneficence be realized.

2. **Living-will death.** It respects patient autonomy, but applies only to patients who have lost their medical competence. Patients with terminal cancers, for example, who are medically competent cannot avail themselves of this alternative. Again, patients' *de facto* right to competitively capturable resources is not recognized.

3. **Death by complicity.** Tacit cooperation from physicians subject them to unknown but potentially ruinous liability and forces patients to die without the blessings or understanding of relatives and friends. It turns what could be a dignified passage into a sneaky escape. Patients' *de facto* right to competitively capturable resources is denied by default.

4. **Death by comfort treatment only after age 65.** This approach (Callahan, 1987) would release resources from aggressive treatment but will prolong morbidity and make patients feel abandoned without just compensation for their *de facto* right to competitively capturable resources. Patient autonomy and involvement of close ones are also denied. Moreover, while acute-care costs are reduced, non-medical entitlements such as Social Security benefits and Medicaid-financed nursing-home care must still be honored.

X

A Duty to Die?

IF COMPENSATED DIGNIFIED DEATH is such a positive-sum game, would not a right to dignified death become a duty to die? Certainly some of the family caregivers would put pressure on the terminally ill to be relieved of the burden of care-giving. But such pressure should not be any greater than those already experienced by people who have other rights but are not exercising them. We have a right to vote, and we are pressured to vote, but many of us do not. The rich are expected to share their wealth for worthy causes, but many would rather spend it on private indulgences.

Still, terminal patients are particularly vulnerable to subtle or overt pressure from those who can benefit from their earlier death. And, in spite of strict pro-

cedural safeguards, human frailty may still compromise them and lead to possible abuses. But these are not sufficient reasons for inaction since the world is full of slippery slopes (Fung, 1988).

XI

Summary and Conclusions

BECAUSE OF ASYMMETRIC INCENTIVES, patients with terminal illnesses have no incentives to forego expensive but ineffective treatments, especially when routine treatment brings about only prolonged morbidity. To make incentives symmetric, terminal patients should be allowed to convert projected expenditures on futile treatments, and other entitlements, into death benefits if they choose physician-assisted death instead. If death can be voluntarily chosen, and can confer benefits to the still living, the sense of tragedy from death is lessened and the bond of intergenerational community is strengthened.

When 25–35% of Medicare expenditures go to only 5–6% of those enrollees who will die within the year, how well we manage terminal treatments determines how successfully health-care costs can be contained. If futile attempts to prolong life are not resisted, health-care reforms can be nothing but stop-gap measures. But unless voluntary deaths can be easy and dignified, terminal patients would not choose them over futile treatments.

Physician-assisted death with benefit conversion has many advantages over other death alternatives because it a) recognizes patients' *de facto* right to competitively capturable resources arising from high cost of containing overuse of medical services; b) respects patients' autonomy; c) allows patients to decide on the best way to reallocate scarce resources; d) transforms a seemingly meaningless act of death into a generous act of community-building; and e) involves relatives and friends in the final decision.

There is, however, no sign that dignified death will be legalized anywhere and any time soon. There are powerful lobbies against any semblance of legalized dignified death. Two state referendum initiatives have already been defeated. Even less likely to be enacted is the concept of entitlement conversion. On the contrary, federal and state governments are actively promoting institutions and passing laws to facilitate the spending down of life savings and life-insurance death benefits to pay for the out-of-pocket portion of health-care costs. In the case of life-insurance death benefits, some state insurance commissioners are writing regulations to create a sellers' market for converting death benefits into "living benefits" by setting minimum payments and encouraging competition (Dunn, February 19, 1990: 140). In the case of life savings, the Congress has

passed laws to facilitate the tapping of home equity through reverse mortgages (Weinrobe, December 8, 1988: A16).

Even without legalization, the hopelessly ill will continue to seek early final exit. Their desperate attempts will pose a serious challenge to law enforcement much as illegal abortion did before *Roe vs. Wade*. The popularity of Humphry's how-to-die manual *Final Exit* and the controversy created by media coverage of Dr. Kevorkian's medicides indicate that there is a pent-up demand for dignified death. But unless final exits are regulated and compensated, the sense of unmediated tragedy and unfair distribution of scarce resources will continue.

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