The Unbearable Rightness of Rationing

Seeking Just Medical Reform

By Lawrence J. Schneiderman, M.D.

Under the new Affordable Care Act (ACA) Americans will be invited to choose their own personal portfolio of premiums, deductibles, co-insurance, co-pays, vouchers, and so on, requiring them to bet on their future health, much like—but for the most part with even less savvy than—traders betting on the stock market.

Are you feeling lucky? Then save your money and go with the cheapest plan, one with the highest deductible, co-insurance and co-pays—and hope your luck holds out. If, on the other hand, you are chronically ill or one of the “worried well” then, of course, you’ll want the most expensive plan you can afford, one that pays for everything you think you’ll need—medications, office visits, hospitalizations, specialists of your own choosing—along with the highest catastrophic coverage. Can’t be too careful.

Priorities. Health policy makers have been preoccupied with how to pay for health care. Hardly any thought has been given to what should be paid for—as though health care is a commodity that needs no examination as to what health outcomes should receive priority in a just society. Those five words —“priority in a just society”—are encompassed by one word that is excoriated and indignantly tossed aside: rationing, because it “does not fit U.S. political culture.”1 But, as the economist Paul Krugman warns: “America has a long-run budget problem. Dealing with this problem will require, first and foremost, a real effort to bring health costs under control.

Without that nothing will work.” 2 To avoid facing the prospect of rationing, a variety of cost saving proposals have been touted as solutions. These include getting rid of fee-for-service reimbursement, capping malpractice lawsuits, reducing drug company profits, introducing electronic records, emphasizing prevention, improving coordination of chronic care, and so forth. But as the health policy expert Theodore Marmor states, “although certainly desirable in theory...none of these measures is likely to substantially reduce health care spending in the short run, even if they are worthwhile long-term investments that improve quality of care and health outcomes.”3 Moreover, “The illusion of painless savings...confuses our national debate on health reform and makes the acceptance of cost control’s realities all the more difficult”.3

The Decent Minimum. To have any chance of being acceptable, a rationing plan has to be seen as fair. That is, it should persuade the public it is responsive to their individual as well as collective interests and employs easily accessible appeals procedures to resolve disputes. Integral to the rationing plan I propose here—which serves individual needs while recognizing the interdependence of the individual and society—is a definition of what is known as the “decent minimum,” or the basic package of medical treatments everyone should have access to in a just society. My proposal is limited to the topic of medical care, or more
specifically medical insurance coverage. Be assured, I recognize and emphatically support efforts to improve the broader area of health care by addressing the full range of socially controllable factors beyond medicine, such as education, housing, jobs, income, wealth, opportunity, political participation and a sense of community across race, ethnicity, gender, or class that affect health and its distribution.\textsuperscript{3} But, while we await the arrival of the World Health Organization’s definitional utopia of health—“complete physical, mental and social well-being, and not merely the absence of disease or infirmity”—life goes on in this imperfect world, along with illness, disability and death. It is becoming increasingly clear every day that we must do something about the soaring costs of medical treatments. How can this be done? From now on I will use the term ‘medical care’ rather than the broader term ‘health care’ (unless quoting someone else) and will attempt to describe a fair approach to medical priorities, namely what we should do right now for sick patients seeking medical help under conditions that exist today.

**Fairness.** To begin with, Americans will soon learn that they will not get fair treatment under the new ACA. Instead they will get many of the same old inconsistent, unjust rules, regulations and statutes. Even as we expand medical insurance, there are citizens who will get more elaborate coverage than others simply by being members of certain categories, including the military and veterans, the over sixty-five, people with kidney failure, federal government workers, and...prisoners? Yes, prisoners. As the official spokesman for the California Department of Corrections said when a man convicted of armed robbery received a heart transplant: “The courts have told us that inmates have a constitutional right to healthcare. You and I don’t, but inmates do... We have to do whatever is medically necessary to save an inmate’s life.”\textsuperscript{4} This event—presented on 60 Minutes—so vividly exemplifies the injustice of a medical care system that allocates life-sustaining treatments on the basis of arbitrarily anointed categories to which many Americans—insured and uninsured—have responded with outrage.

**Choices.** Is there an ethical and fiscally responsible way out of this mess? I suggest there might be if we focus on what medical outcomes should be achieved in a just society. We will have to make tough choices, of course, but the choices will be based not on capricious gated communities of eligibility for services. For example, if you hit 65 you suddenly become entitled to Medicare, which will provide substantial coverage for all sorts of organ transplants but not a penny’s help with walking, eating, bathing and other daily tasks by qualified home health care workers, or even by family members who may have to give up their job to attend to these far more common elderly needs. These costs are a major source of bankruptcy and cause severe economic, social and psychological burdens on caregivers.

Recognizing that there has to be a limit to the otherwise boundless demands that can be made on medical care, we must accept that medicine cannot serve every personal need, desire and good. Everyone is not entitled to everything. Everyone is entitled to a decent minimum level of medical care. ‘Decent minimum’ is a concept that arose from the ruins of WWII that leveled British society even as it leveled large swathes of Britain and produced the much maligned (in the U.S.) and highly popular (in the U.K.) National Health Service. Out of that experience, in Britain as well as the rest of devastated Europe, came the concept of Solidarity. We should not allow the word to be defamed by U.S. exceptionalists as “communistic” or “socialistic.” It simply means: we’re all in this together. It’s a concept that would benefit us in this country too.

**What is a decent minimum?** Much is written, but as the former health policy expert in the Obama administration Ezekiel Emanuel said, philosophers have made “a case for a ‘decent minimum’ without specifying anything about the contents of the minimum.”\textsuperscript{5} So let me try. (As you know, physicians rush in where philosophers fear to tread.) In brief, I propose that a decent minimum be a level of medical care that enables a person to acquire an education, seek or hold a job, or raise a family. Or, if the person, because of impaired health, is unable to meet any of these goals, to attain a reasonable level of function within the person’s limits, as well as a reasonable level of comfort, whether it be from pain or other forms of suffering.

Unlike most proposals that are based solely on benefits to individuals (exemplified by debates that range over whether one should favor the worst-off or achieve the greatest aggregate population benefit-cost ratio), this proposal provides for specific, determinate outcomes and highlights the reciprocal obligations of the individual and society. Without the support of society the individual would not prosper; in return, I argue, the individual has a duty to recognize society’s needs for productive citizenry. The success of an individual depends on the success of the supporting society. The success of the society depends on
the productivity and contributions of its individual members.

My proposal is utilitarian, but only partly. It does not base treatments on Cost Benefit calculations or aggregated Quality of Life Years. It is not Plato's Republic or Orwell's 1984. Rather it allows for individual needs and desires. One's education might be short or long; one might work with a shovel or a computer, with a paintbrush or a frying pan, on a construction site or in a taxicab, as a farmer or a pharmacist. We would do away with attempting to enumerate what "basic package" of services and supplies should be covered, how often and how long and in what age or social group, according to politically determined lists. As the philosopher Norman Daniels says: "It is typical of such appeals to lists that there is no rationale offered for why items are on the list." Rather we would choose and cover treatments directed toward achieving the decent minimum goals for each person and supported by empirical evidence. Obviously, workers who perform heavy physical labor, white-collar workers, and people of varying mental abilities would have different treatment requirements. All treatments would be based as much as possible on evidence-based medicine.

An Example. Let's look at the current rationing of end stage kidney disease. One treatment, renal dialysis, presents a problem of limited financial resources—payment for facilities, equipment, supplies, personnel, and treatment time. The other treatment, kidney transplantation, principally involves the limited availability of material resources, namely kidneys. (In fact, in the long run, transplantation costs less than dialysis.) Right now both are covered by the Medicare End-Stage Renal Disease Program enacted by Congress in 1972, which was designed to provide universal access to treatment at no cost to the patient and under no prescribed limitations. Experts at the time predicted that enrollment in the program would level off by 1992 to 90,000 patients at a cost of between $90 million and $110 million annually. How prescient were these experts? By 1991 the program was already spending in excess of $5 billion annually. Today there are more than 341,000 patients on dialysis and approximately 144,000 recipients of kidney transplants at an annual cost of $35 billion. More than 16,000 kidney transplants were performed in 2008, and almost 80,000 Americans are on waiting lists. And the growth in enrollment shows no sign of leveling off. Indeed, it is predicted to rise to more than $54 billion in 2020 to cover approximately 785,000 patients. As soon as financial barriers were removed, renal dialysis and transplantation began to be offered to patients with conditions that had never been envisioned by the original proponents. Patients with multi-organ failure from end stage diabetes, heart disease, liver disease, and even those in permanent vegetative state were placed on renal dialysis.

Allocating Limited Resources. Clearly, then, my rationing proposal would be directed at dealing with limited financial resources by allocating and guaranteeing this life-sustaining treatment first to those in the life-sustaining category of decent minimum. Patients in the function-comfort category would be next in line and the availability of the treatment would depend on previously established financial limits. By contrast, transplantation would be limited by material resources, namely the availability of matching donated kidneys. Already a rationing process has been established by the United Network of Organ Sharing (UNOS) to allocate this limited treatment based on waiting time on the list, blood type antigen matching, and urgency. Astonishingly, given that organ transplantation involves allocation of a limited life-saving resource, weighing and comparing quality of benefit to potential recipients is hardly even considered. The argument presented is that doing so would introduce a "value choice" into decision making. As a result, numbers (physiologic numbers, which determine urgency, and days on the waiting list) rule over quality of life considerations. Ironically, this approach does not avoid making a value choice; rather it clearly is a value choice. Hence, according to UNOS guidelines, a retired 65-year-old hypertensive diabetic with no family responsibilities who has been waiting five years on dialysis should get a kidney ahead of an otherwise healthy 45 year-old school teacher and parent who develops an aggressive glomerulonephritis and has been waiting only one year. By my rationing proposal the latter patient who is in the life-sustaining category of decent minimum would be higher on the recipient list with guaranteed access to the transplant if a suitable one becomes available, competing only with other potential recipients in the same life-sustaining category. The patient in the function-comfort category of decent minimum would rise to the top of the list only after all the suitable and available patients in the life-sustaining category had been given their chance for this limited material resource. (It should be noted that Medicare patients with the fewest obligations and most free time to search about and enroll in more than one center have the greatest opportunity to secure any organ transplant.)
More vs Less. In denying the most aggressive life-prolonging interventions to a patient with end-stage renal disease we should not fall into the “more is better” trap, namely that high-technology medical care, including rib-cracking cardio-pulmonary resuscitation (CPR) and long stays in the intensive care unit (ICU) on a ventilator and receiving renal dialysis before dying, is always superior to low-technology personal care provided by loved ones and skilled medical professionals. We have already witnessed the consequences of this approach. Over the past decade hospitalizations in the last week of life are rising while average time spent in hospice and palliative care is falling. Medicare patients are receiving toxic (and manifestly ineffective) chemotherapy even to the very last week of life. And more and more Medicare patients are being transferred from the ICU not to home or hospice or rehabilitation facilities but to long-term acute care hospitals where they are subjected to the same aggressive and invasive treatments at great cost and with mortality rates that are no better than Medicare ICU survivors.

I emphasize again: My proposal is not age-based rationing. Not all elderly people would fall into the function-comfort category of decent minimum. As we know, in extended families and broken homes, grandparents, uncles, aunts and even close friends may play the primary, essential role in raising children. For these people, a decent minimum would remain in the life-sustaining category as long as the treatment enables them to serve in raising a family. Many Medicare patients, though, would lose guaranteed coverage for certain life-sustaining interventions. But there is a tradeoff. In place of coverage for organ transplants, patients with severely disabling organ failure would have the security of knowing they would be covered for far more common and far less costly needs, like help at home with activities of daily living, either by a qualified home aide or by family members, who would have their lost wages reasonably reimbursed. Many Medicare patients will be unhappy, of course, to lose their previous entitlements. But again the tradeoff should be emphasized to them, many of whom are or will be grandparents. Speaking as a grandparent, I do not think it’s foolishly naïve to suggest that grandparents will forgo organ transplants and other costly, resource-consuming interventions more willingly when they are confident that they, who had their so-called fair innings, will thereby enhance fair opportunity medical benefits not for prisoners but for their children and grandchildren. I can cite my own research, conducted with Richard Kronick, Robert Kaplan, John Anderson, and Robert Langer, in which we found that a substantial majority of patients facing terminal illness, when asked how much of their life savings they would be willing to spend and how much care burden they would want to place on their loved ones, want to limit treatment costs and burdens they place on others.

The Right to Choose. After reading all this, my fellow citizens might complain: Wait a minute! This is the good old U.S.A. What’s happened to freedom of choice?

Suppose someone wants more than the decent minimum, is willing to pay for it, and it is not medically futile. My answer would be: We should permit it.

Won’t there be different levels of medical care if we allow this? Yes.

Isn’t this unethical? In my view, no. Not in the United States, which will always grant moral space for the affluent hypochondriac who demands a tranquilizing MRI.

To be discouraged? Yes. Unethical? No. For if all citizens have at least sufficient medical care, namely a decent minimum that enables them to participate in society, then inequalities can be ethically justified for those who wish to add to their decent minimum by paying for a more expensive and elaborate medical intervention on their own, as long as their extra privilege does not deny others of their right to a decent minimum.

A concern we cannot ignore, however, is that private luxury medical care will inevitably lead to the deterioration of government-provided medical care. We will see how this plays out as the United States struggles to add single payer universal medical care to its mix of private insurers. In contrast, many other countries are moving in the opposite direction. Some day we probably will meet in the middle.

Problems and Objections. First of course, the R-word, rationing, the proverbial third rail in the halls of Congress: Touch it and you’re dead. At least your legislation will be, witness the instant defeat of the mild effort to have Medicare reimburse physicians’ time to discuss end-of-life treatment alternatives, including advance directives. “Death panels,” shouted the opposition. “Pulling the plug on grandma!” “We cannot have rationing!” declare politicians who complacently enjoy their own medical insurance and overlook the irrational rationing that takes place all around them. Yet, even The Economist acknowledges, “Every health system rations in some way or other; the demand for health care is always greater than the resources available. The question is whether rationing is done openly and as sensibly as possible—or done implicitly, through murky pricing, bureaucratic fiat or denial of care.”
Another problem will be making distinctions between a person’s qualifications for life-sustaining versus function-benefit versions of the decent minimum. I believe ambiguity in this area will be rare. For most persons the qualifications of gaining an education, seeking or holding a job or raising a family will be obvious and incontestable. But to retain the confidence of the public a “fair procedure” must be put in place that is transparent, reasonable and accountable, one that responds to changing social conditions. I suggest that under these circumstances the party seeking eligibility for the most aggressive level of decent minimum coverage should have access to an impartial adjudicatory process, which would decide under which decent minimum guidelines the patient qualifies. This could be carried out by the same procedures that will allow patients to appeal denials of health insurance claims under new federal regulations or by health courts that provide an alternative for resolving medical liability claims.

Another potential objection arises from what may be regarded as my proposal’s utilitarian criteria serving as the basis for medical rationing. I remind you that individual choice is not limited; hence personal autonomy is respected. But, unavoidably, critics will raise the alarm that any sanctioned measuring of the quality of a person’s usefulness to society will lead straight to the totalitarian state. There is not only the risk of a person’s merit being narrowly defined, and therefore the person being judged as merely a means to an end, but there is also the risk of discrimination against those who face obstacles to education, raising a family, and employment, such as minorities and the poor. The only defense against the possible perversion of a good idea for sinister ends is the old-fashioned dictum: *Ablusus non tollit usum*. The abuse of a procedure should not foreclose its use. Just because something is misused doesn’t mean it can’t be used correctly. Our free society periodically has been threatened and indeed has been harmed by demagogues, but has proved the resilience of its democratic values again and again. The strength lies in our culture, which, as Thomas Friedman reminds us, has defied totalitarianism because of its ultimate commitment to “individual freedom, free markets, rule of law, great research universities and a culture that celebrates immigrants and innovators.”

**In Conclusion.** I offer this as an ethical way to prioritize medical care reform—a communitarian as well as individualistic approach that is consistent with United States culture and traditions. It supplies what is missing today in the endless debates promoting one or another cost control gimmick that often defies common sense. It appeals to what evolutionary psychologists call our “innate sense of fairness,” and provides what I believe is a simple, ethical concept of rationing that people can understand and accept as fair. If other approaches are preferred in dealing with the inevitable problem of medical rationing and resource allocation, they will need to show they will do a better job of balancing idealism with realism and compassion with practicality. The national failures are all around us. The hard-nose, practical United States crudely monetizes medical care, while more compassionate countries vainly struggle to maintain social welfare solvency. Sooner or later we are all going to have to do something better than what we are doing now.

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**References**

**Letter From The Chair**

*W. Douglas Morgan, UCSB*

Important progress is being made——First, those of us over 70.5 years have to take Mandatory Required Distributions (MRD’s) from our UC deferred compensation program accounts. Through the combined efforts of all involved, these MRD’s can now be tailored to meet your state tax withholding and timing requirements. Recall that Fidelity previously used only 10% of your federal withholding for state income tax. In California with state income tax rates above 8% of total income, this was clearly inadequate. The next issue of New Dimensions has further details on this topic——Second, with the support of the University Committee on Faculty Welfare (UCFW), the Health Care Facilitator program (HCF) on all campuses will be continued into the future. The HFC funding was previously killed by the UCOP Executive Budget Committee apparently unaware of the work they do. If you have any questions or problems with your health care insurance, you should contact your campus HCF. ([http://atyourservice.ucop.edudirectories_contacts/healthcare_facilitator.html](http://atyourservice.ucop.edudirectories_contacts/healthcare_facilitator.html)) The purpose of the program is to help retirees and family members understand and obtain the full benefits and services available from UC-sponsored health plans. The HCF fills the information and assistance gap between plan members and the health insurance system. Each of these topics (MRD’s and HFC) is included in the Joint Benefits Committee (JBC) April 2013 report ([http://cucea.ucsd.edu/reports/](http://cucea.ucsd.edu/reports/)) and will be discussed in more detail at the April CUCEA and CUCRA meetings.

Of special note at the April meeting is the early-bird workshop (Wednesday from 7:30 to 9:00 am) where Sue Barnes from the Davis Retiree Center will lead a discussion on “How to Establish a Retirement Center.” She will be joined by other Center Directors to give direction on the process.

The University is still looking for ways to reduce health care costs. The rebidding of many health plans currently underway includes an option for a self-funded medical plan using UC Medical Centers and doctors. Other “levers” to contain health care costs from the Health Care Benefits Task Force include offering a health plan exchange for retirees in Medicare supplement plans (Yes we heard about this last year!), and decreasing UC contributions to premiums for dependents. The JBC has been alerted!!!

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**NEWS ITEMS**

This is a new feature of the Newsletter. The objective is to highlight news of relevance and broad interest to emeriti. Suggestions and comments for inclusion in this section are most welcome. Please forward them to the Editor (mcaserio@ucsd.edu).

**October 2012 CUCEA Meeting at UCSC**

The fall meeting of CUCEA was hosted by UC Santa Cruz, November 1, 2012. Chancellor George Blumenthal welcomed everyone at the opening of the joint CUCEA/CUCRA session and shared interesting information on “sustainable agriculture” at UC Santa Cruz. There was also a presentation by Gary Griggs, Director of the Institute for Marine Sciences that revealed the breadth of involvement of the Santa Cruz campus in the Marine Sciences for education, research, and public service.

Another highlight was a tour of the McHenry Library. It recently underwent a major remodel and addition and is now a library like no other. It houses the Global Village Café in the foyer for students to “think, drink, read and feed.” Also nearby is the pride of Special Collections, the Grateful Dead Archive, which contains fascinating memorabilia of this renowned rock band of the 1960’s. While there is no obvious audio component to the archive, there is no lack of sound in the library as it is designed to facilitate group study and conversation – a far cry from the traditional library where you can neither speak, eat, nor sleep.

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**April 2013 CUCEA Meeting.** The host campus is UC Riverside, April 23/24.

**October 2013 CUCEA Meeting.** The host campus is UC San Francisco

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**The 2009-2012 Biobibliographic Survey**

The Survey is nearing completion and the results should be available by the April 23/24 CUCEA meeting at UC Riverside – ready for distribution to the campus Chancellors, key UC administrators, the President’s Office and, perhaps, the Regents. This is the fifth CUCEA survey
of University-related activities of UC emeriti faculty, and the first to cover a three-year rather than a two-year period. You may well ask what purpose these surveys serve.

We know that a high percentage of emeriti faculty continue to contribute to the mission of the University by remaining involved in ongoing research or by teaching classes and mentoring students. Emeriti are also involved in campus service and/or work in their communities. The surveys document the nature and extent of these contributions. It is a record of the continuing value of emeriti to the mission of the University. For reasons given below, wider recognition of this value is needed.

The University remains under severe budget pressures. Economies and savings are being pursued just about everywhere, including health and retirement benefits. The costs of retiree benefits to the University are substantial, but it is critical for all UC retirees that these benefits be sustained. Perhaps the most compelling argument we can present in support of this position is to provide the evidence that emeriti continue to carry out the mission of the University and, in fact, that much of this work is *pro bono*. The survey that CUCEA has asked all UC emeriti to complete will provide a strong foundation for making the case to the University leadership that retirees are a valuable asset, that should be protected and preserved. It is in the University’s best interest to do so.

Update on Online Education

The topic of UC’s limited efforts in online education was featured in the October 2012 issue of this newsletter. Since then, the topic has become front-page news due to Governor Jerry Brown’s insistence that UC step up its efforts in this domain. The Governor rarely attends Regents’ meetings, but he was a powerful presence at the November 2012 meeting with a message that UC has to reduce education costs. He argues that without a radical change within higher education, costs will continue to rise with no realistic way to meet them. For the University to meet enrollment demand, increase access and graduation rates without raising costs, UC has to make a significant change in the way it delivers the curriculum to undergraduate students. He was outspoken in his support for online education as a way to achieve this goal. He compared UC to the US Postal Service - - “a venerable institution being upended by digital change.” The objective would be for faculty to teach more students, provide students with greater access to credit courses online, and reduce costs through economies of scale.

The Regents and the UC administrative leadership have responded positively to the Governor’s proposals, although the faculty response has been far more restrained. There are some major obstacles that have to be dealt with, not the least of which is the need to facilitate intercampus and intersystem transfer of online credits. It may sound absurd, but there is currently no way for a student on one campus to take an online course offered by another campus and have the course credit automatically transferred to the student’s transcript. Also, for the faculty to develop effective online courses, they need time, adequate funding, encouragement from colleagues, and a supportive faculty governance system.

President Yudof is committed to making the online frontier a success. That said, the UC Education Online project, funded and managed through OP has not progressed as hoped for. Revenues from non-UC students have not materialized, and the few courses offered so far hardly make a dent in the overall curriculum. Recently, OP launched a new venture called “UC Innovative Learning Technology Initiative (ILTI). This is a long name for a program to develop online or hybrid courses. Requests for proposals are out, although the funding source remains unspecified. Maybe this is where Governor Brown could be most helpful by providing funds to ensure that his proposals and OP initiatives become reality. Meanwhile, State Senator Darrell Steinberg has introduced a bill (SB520) that offers “an online lifeline" to students unable to get needed core courses at UC, CSU or CCC campuses. The needed courses would be offered through “other" online providers. Interesting!

Understanding Your Medical Health Care Costs

If you find your monthly Medicare Premium Statements confusing, a recent article on Medical Health Care Costs for UC Retirees in Medicare by Joel Dimsdale might help you understand them (http://cucea.ucsd.edu/reports). Costs are a moving target, changing yearly based on several variables, including the annual *maximum* amount UC contributes to the individual retirees medical coverage. Most or all of this covers the premium UC pays to the retirees chosen health plan. Regarding Medicare costs, the retiree does not pay for Medicare Part A but the retiree is responsible for the standard premium for Medicare Part B. Provided the retirees medical plan costs do not exceed UC’s maximum coverage, UC uses the difference to reimburse the retiree for some or all of the Part B premium. This is not the total picture, however, because Part B (and Part D) premiums also depend on the retiree’s
“Modified Adjusted Gross Income” or MAGI reported on the retiree’s IRS tax return from two years ago. The monthly bill refers to these costs as Income Related Monthly Adjustment Amounts (IRMAA). If, for example, the retiree’s MAGI in 2011 exceeded $85,000 (or double that for couples), then extra MAGI-associated costs are likely, and will appear as additional PART B and D monthly premiums in 2013. The Dimsdale article explains this and illustrates it with tables of data for two representative health plans. The tables are not easy to follow but if you stare at them long enough clarification will come.

Bottom line is: the Part B premium in 2013 will be the sum of the standard premium for 2013 ($104.90) plus the MAGI surcharge (income dependent). UC will reimburse some, none, or all of the standard Part B premium depending on whether UC’s maximum medical coverage for the individual is or is not exceeded by the retirees health plan costs.

In Memoriam

CUCEA lost two valuable and long-time CUCEA officers in 2012, John Craig (UCSF) and Moses Greenfield (UCLA). Their deaths were briefly reported in the October 2012 newsletter but we have since posted a more detailed tribute to each of them on our website: [http://cucea.ucsd.edu/awards/memorials.shtml](http://cucea.ucsd.edu/awards/memorials.shtml). It is fitting to add a further word of tribute that more directly concerns the roles they played in CUCEA.

John Craig (1920-2012) began his service to CUCEA shortly after he achieved emeritus status in the Department of Pharmaceutical Chemistry at UCSF. He was the UCSF Representative to CUCEA from 1997 until he became Vice-Chair of CUCEA (2002-2003) and Chair the following year (2003-2004) followed by two years as Past-Chair. In 2006 he became CUCEA’s Historian until 2012 when his health deteriorated. He is remembered as a voice of logic and reason throughout his years with CUCEA. His grasp of the issues and insight into how the several UC entities (Academic Senate, the Regents, UCRS, and the UC Administration) impacted the welfare of retirees was of continuing value to CUCEA. He brought lots of “institutional memory” to the table mixed with friendly skepticism, keen intelligence and good humor.

Moses Greenfield (1915-2012) was one of the cofounders of CUCEA and in fact convened the first organizational meeting held on the Berkeley campus on October 29, 1987. (See the April 2011 newsletter for a historical perspective of CUCEA [http://cucea.ucsd.edu/reports/newsletters/shtml](http://cucea.ucsd.edu/reports/newsletters/shtml)). He served as Chair-Elect then Chair from 1989 to 1991. He is perhaps best known for his dedicated efforts along with Charles Berst to initiate the Biobibliographic Surveys of the research, teaching and service activities of UC Emeriti on each campus. The main purpose was (and is) to inform the chancellors and other administrators that emeriti are active in retirement in UC’s interests. The first survey appeared in the late 1990’s and revealed a remarkable level of activity. The project has now become an established periodic undertaking for which MO Greenfield deserves our deep appreciation. In 1997 MO was named “Honorary Lifetime Member” of CUCEA for his “Dedicated Early Leadership in the Founding of the Emeriti Council (CUCEA).”

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AWARDS

UC DAVIS

Professor Eldridge Moores (Geology) has been named 2012-2013 UC Davis Distinguished Emeritus Professor. This title is awarded on the basis of outstanding contributions following retirement in teaching, research and service. Dr. Moores’ accomplishments since retirement in 2003 include publication of his co-authored textbook, *Structural Geology (2nd Ed)*, and the popular science book, *Bedrock: Writings on the Wonders of Geology.* He served four years as vice president of the International Union of Geological Sciences, and circled the globe 16 times to encourage international cooperation in the earth sciences and the sustainable use of resources. His efforts have brought greater awareness nationally and internationally to natural hazards, including earthquakes, landslides, floods, and tsunamis.

UC Davis Emeriti Association has also named four recipients of the 2012-2013 Edward A. Dickson Emeriti Professorships. They are:

George Bruening, Professor Emeritus of Plant Pathology, for his recent work “Exploring Plant Pathways in the Recognition of Virus Invasion.” This is a continuation of his research focus on the biochemistry and molecular genetics of plant viruses, and defense mechanisms against viruses.
Robert Ruck, Distinguished Professor Emeritus, Department of Nutrition, School of Medicine, for his research on the role of nutrients in early growth and development and the physiological roles of quinone cofactors. The award names his work on “The Chemical Properties of a Novel Dietary Biofactor: Pyrroloquinoline Quinone.”

James Seiber, Professor Emeritus, Food Science and Technology, for his research “Reducing the Risk from Toxic Compounds in Foods.”

Yin Yeh, Professor Emeritus of Applied Science, is credited as cofounder of the NSF Center for Biophotonics Science and Technology at UC Davis. The Dickson award is in recognition of his “initiating research toward understanding the molecular mechanism of the onset of Alzheimer’s disease.”

UC RIVERSIDE

Uta Barth, Professor Emerita of Art, who is known for her photographic work in visual perception, was awarded a MacArthur Fellowship for 2012. The MacArthur Foundation described Barth as “an artist whose evocative, abstract photographs explore the nature of vision and the difference between how a human sees reality and how a camera records it.”

Anthony W. Norman, Distinguished Professor Emeritus of Biochemistry and Biomedical Sciences, is the recipient of the UCR Distinguished Campus Service Award for 2011-2012.

UC LOS ANGELES

Lloyd Shapley, Professor Emeritus, Economics and Mathematics, received the 2012 Nobel Prize in Economics, shared with Alvin Roth (Harvard).

Daniel Mitchell, Professor Emeritus, Anderson School of Management and the School of Public Affairs, received the UCLA Emeriti Association Emeritus of the Year Award for 2012.

The recipient of the association’s Distinguished Service Award was Barbara Rappaport who has served as Secretary of the association’s Executive Board for many years.

(Awards announced too late to include in this issue of the newsletter will be listed in the October 2013 issue.)

Jumpstart Your Volunteer Program

By Sue Barnes, Director UC Davis Retiree Center

“if you want to build a ship, don’t just gather people and assign tasks; find those who long for the endless immensity of the sea.” Antoine de Saint-Exupery

One of the most common challenges facing emeriti and retiree associations is the recruitment and engagement of volunteers and board members. Associations that are struggling to find and keep volunteers should ask themselves whether they are meeting the needs of their volunteers. Every volunteer has basic needs:

- Understanding the organization
- Tasks that match skills or interests
- Adequate training/instruction
- Space and resources to complete tasks
- Follow-up/communication
- Acceptance within the organization
- Opportunity to provide feedback
- Appreciation, recognition, rewards

If associations fall short of meeting these needs, how can they make adjustments? Developing a planned and purposeful approach should yield an increase in both the number and level of engagement of volunteers and board members. Here are some ideas on steps to take to develop and improve a volunteer program:

Planning—we all know the old adage, "If you fail to plan, you plan to fail." So plan these steps first:

Define the mission and goals. Determine if the organization has developed a mission statement and goals and, if so, whether the board members and volunteers know what they are? An organization must be able to articulate the bigger picture for its volunteers.

Determine the number of volunteers needed. While it can be challenging to find an adequate number of volunteers, it is also problematic when too many volunteers show up and there is nothing for them to do.

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Identify volunteer task/skill sets. Job descriptions for volunteer, committee members, and board members, should be developed. They should be short and concise, and include job title, purpose, key responsibilities, time commitment, length of appointment, and skills needed.

Recruiting

Develop a recruitment message. Excerpted from the position description, these are brief announcements that include the needs of the organization, the benefits to the volunteer, a description of the duties and skills required, time commitment involved, and contact information. An example follows:

UCDEA Video Records Project—Volunteers Needed

The UC Davis Emeriti Association (UCDEA)’s Video Records Project creates an oral history of UC Davis by interviewing campus faculty and administrators who created the history. Become a part of this legacy project by volunteering for the following tasks:

- Videographers (set up equipment, record interviews)—2-3 hrs per week
- Video Editors (edit video and audio)—4-5 hrs per week
- Reviewers (review videos, suggest improvements)—2-4 hrs per week
- Recruiters (contact interviewers, schedule interviews)—hrs per week

For more information, or to volunteer, contact _____ at ___.

Decide where and how to recruit. There are many avenues to recruiting volunteers and board members—through newsletters, e-mails, etc. But the best way to recruit is by personal contact by current volunteers. Everyone in the organization should play a role in recruiting. Start with the people who attend events regularly. Those who are already involved at some level are more likely to be interested in a higher level of service.

Follow up with interested people. Follow up with anyone who expresses interest, as this is vital to turn a casual interest into a committed volunteer or board member.

Develop a “pipeline.” Provide opportunities for people to be involved at lower levels such as serving occasionally at events or helping with special projects. This develops a familiarity with the organization and increases the volunteer’s commitment level if they later step up to a committee or board assignment.

Orienting and Training—All new committee members, volunteers, and board members should be given training or an orientation appropriate to their position. It is important to provide an overview of the organization, it’s mission, goals, programs, and services. A binder for new board members should include information on the organization’s history, mission, and culture, including a listing of the current board and committees, bylaws, policies and procedures, and position or committee descriptions. Also, be prepared to train members for specific tasks and responsibilities or assign a mentor. If possible, ask outgoing committee members or board members to train or overlap service where applicable.

Retaining—It can take many years to find a good volunteer and only seconds to lose one. The most successful recruitment method for any organization is to retain happy and engaged volunteers and board members who will spread the good word about the organization.

What makes volunteers stay? Surveys validate that volunteers stay because they have opportunities for skill development, personal growth, challenge, contact with people, recognition and rewards.

What makes volunteers leave? The primary reasons volunteers leave are lack of orientation/training, lack of communication, lack of organization, interpersonal relationships and working conditions. Every time a board member, committee member, or volunteer leaves, they should be asked about their experience with the organization. This will help identify problem areas that need to be changed.

Recognition—Remember that every volunteer has a basic need for appreciation, recognition, and reward. Every organization needs to build a culture that celebrates volunteers on an ongoing basis. Their contributions should be recognized informally as well as formally. A simple word of thanks at the conclusion of a task is very powerful, but there are many other ways to recognize volunteers such as:

- Personal thank you notes
- Formal thank you letters
- Asking for volunteer’s ideas
- Name listing in event programs
- Thank you article in newsletters
- Announce/recognize at events;
- Special nametags at event;
- Appreciation luncheon/events

A successful volunteer program doesn’t just happen. It takes work and organization on the front end and ongoing attention to reap benefits down the line. Meet the needs of
the volunteers and they will meet the needs of the organization.

In addition to her responsibilities as Director of the UC Davis Retiree Center, Sue Barnes is currently serving a two-year term as the president of AROHE (Association of Retirement Organizations in Higher Education). AROHE educates, advocates for and serves campus-based retirement organizations. At the AROHE national conference in October 2012, retiree organizations, leaders and college administrators gathered in Chapel Hill, North Carolina, to network and share innovative ideas and successful programs. At the conference Sue presented “Jumpstart Your Volunteer Program,” an overview of best practices for volunteer and board recruitment and engagement. UC emeriti associations are encouraged to join AROHE. For more information, visit http://arohe.org.

On The Lighter Side

Quotes from Notables

“Having more money doesn’t make you happier. I have 50 million dollars but I’m just as happy as when I had 48 million.” Arnold Schwarzenegger

“We are here on earth to do good unto others. What the others are here for I have no idea.” W.H. Auden

“As I hurtled through space, one thought kept crossing my mind – every part of this rocket was supplied by the lowest bidder.” John Glenn

“When the white missionaries came to Africa, they had the Bible and we had the land. They said, ‘Let us pray.’ We closed our eyes. When we opened them, we had the Bible and they had the land.” Desmond Tutu

Other Nonsense

A senior citizen phoned her doctor to ask about a medication he prescribed for her. “Is it true” she asked “that I have to take this medication for the rest of my life?” “Yes, I’m afraid so” the doctor told her. After a brief silence, she replied “I’m wondering, then, just how serious my condition is because this prescription is marked “NO REFILLS.”

The children were lined up for lunch in the cafeteria. At the head of the table was a large pile of apples and a note that read:

“Take only ONE. God is watching.”

At the end of the lunch line was a large pile of chocolate chip cookies. A child had written a note:

“Take all you want. God is watching the apples.”

The little girl noticed that her mother’s hair had some grey strands. She asked “Mummy, why are some of your hairs white?” Her mother replied “Well, when you do something wrong and make me unhappy, one of my hairs turns white.” The little girl thought about this and then said “Mummy, how come ALL of grandma’s hairs are white?”
### CUCEA Officers 2012-13

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<tr>
<th>Name</th>
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<tr>
<td>Douglas Morgan (SB)</td>
<td>Chair (2012-14)</td>
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<tr>
<td>John Marcum (SC)</td>
<td>Chair Elect (2012-14)</td>
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<td>Ernest Newbrun (SF)</td>
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<td>Charley Hess (D)</td>
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<td>Charles Berst (LA)</td>
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<td>Lyman W. Porter (I)</td>
<td>Treasurer</td>
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<td>Louise Taylor (B)</td>
<td>Information Officer</td>
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<td>Marjorie Caserio (SD)</td>
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<td>William Ashby (SB)</td>
<td>Secretary</td>
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<td>Ralph Johnson (LA)</td>
<td>Archivist, Historian</td>
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<td>Charles Berst (LA)</td>
<td>Chair, Biobibliographic Survey; CUCEA Honorary Member</td>
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<td>Adrian Harris (LA)</td>
<td>Chair Joint Benefits Committee</td>
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