

Hospital and Health Care Rationing

Sub-committee on economics
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FOREWORD

During its regular meetings the Sub-Committee on Economics and Planning of the Standing Committee of the Hospitals of the European Union (HOPE) deals with the developments regarding the health care systems of the member states. As a result of this the Sub-Committee delivered reports to HOPE's Plenary Assembly on topics like planning, solidarity, trends in financing and so on. In 1998 the Sub-Committee decided to pay attention to the phenomenon of rationing in health care. Following the usual procedure, the Sub-Committee members gathered information regarding this topic from their home countries. Information which was next discussed and explained in successive meetings.

As a result a, now published, report on hospitals and health care rationing could be presented to HOPE's Plenary Assembly 2000. It deals with the problem of defining and conceptualising rationing. Next to this, three dimensions of rationing are discussed. Firstly, it stipulates the fact that socio-cultural values influence the rationing debate to a large extent. Secondly it underlines that the economic dimension is omnipresent in that same debate, whereas, thirdly, it argues that the influence of science and technology plays an important role, making patients ever more eligible for treatment, thus intensifying the rationing question. More important, however, is the fact that the report also formulates some answers concerning the question of how to cope with rationing.

Through its balanced approach, this report is a valuable contribution to the discussions concerning a health care topic that will certainly be part of the health care agenda of the European Union for many years to come. Therefore, the members of the Sub-Committee on Economics and Planning must be thanked for their efforts. My special thanks go to Douglas McKenzie, former member of the UK delegation and vice-president of the Sub-Committee who professionally took the lead in this project.

Prof. Dr. Winfried de Gooijer

President of HOPE's Sub-Committee on Economics and Planning

SECTION 1: INTRODUCTION

In 1997 HOPE published a book entitled "On Solidarity in Changing Healthcare Systems: Europe in Search of a New Balance" (de Gooijer, W J). This book addressed the roles and responsibilities of the evolving Welfare State, and its individual components, in caring for the less advantaged members of society. In so doing, it studied the interaction of altruism and self-interest, ethics and economics, with political values and systems. For HOPE, it seemed a logical next step to look at one of the most emotive topics arising from that interaction – rationing.

The presence of rationing is recognised throughout Europe, albeit more readily in some countries because, as others have found before us, it is at the very centre of healthcare policy making. By whatever method, and in whatever system, choices have to be made, implicitly or explicitly, leading to the questions how, where, when, and by whom, the decisions are made.

In preparing this paper the Sub Committee has sought to define what rationing actually is (as opposed to what individuals and pressure groups perceive it to be) and how it is applied; at the levels at which it is applied; and at the socio-cultural values which influence it. There is also a review of the economic dimension with mention of one of the best known mechanisms used to control demand – the waiting list. There is also a section on the impact of science and technology: this is important since, in many respects we have become the victims of our own success as more and more afflictions of the human body and mind can be tamed – but at a price.

Finally, there is an account of the many solutions – some controversial and some tried and tested – which we have found. We do not claim to provide all the answers for all systems but we do hope that our review will prompt further study in the search for solutions appropriate to particular circumstances, as our final quotation from the World Health Organisation suggests.

SECTION 2: A DEFINITION

In the introduction to its admirable research paper "Rationing Dilemmas in Healthcare," the UK National Association of Health Authorities and Trusts starts by using the basic definition of "what happens when demand exceeds supply," but goes on to describe the many complexities which can lie behind this deceptively simple statement¹, when it is applied to healthcare.

The World Health Organisation takes the concept further by suggesting, in its review of current healthcare reform strategies in Europe, that "the terms rationing and priority setting are used interchangeably. Both are used to describe the process by which choices in healthcare are made, particularly in circumstances where the demand for healthcare exceeds the resource available. Rationing emphasises reductions in packages of care resulting from setting priorities between competing demands."²

In this example, the definition is explained by processes used to deal with it (choices and prioritisation). This is taken to a further degree by Bill New, who identifies five types of rationing:³

- Denial
- Deflection
- Delay
- Dilution
- Deterrence

For a sound comprehensive definition of the term, which will be supported in the following sections, we turn to one supplied by the British Medical Association, also quoted in New's book, as follows:

"Rationing involves the denial of treatment on grounds other than simple clinical judgement. The treatment being denied is assumed to otherwise improve the individual's quality of life. Therefore, denial of treatment which would have no beneficial effect is not rationing. Rationing then becomes an issue of affordability versus treatments which are to varying extents beneficial."

This definition is favoured because it firmly reflects the perception that any form of denial is rationing.

SECTION 3: THE CONCEPT OF RATIONING

There is no doubt that the developed nations of the western world aspire to provide quality health care for their citizens. The very language of their various, and differing, official policies illustrates this approach.⁴ It is equally clear that these aspirations now exist in an increasingly difficult economic climate in which those same governments have to balance the potential for health services to consume even larger proportions of their resources in competition with other pressing priorities.

These two fundamental forces form the basis of this examination of the rationing phenomenon because we start from the premise that there is, indeed, an intention of equal opportunity between citizens to have access to a certain commodity, product or service to satisfy a certain need or demand. Another essential element of the rationing phenomenon is that there is a shortage of the commodity, however that may be caused.

Whatever the national characteristic of the health care system, be it based on general taxation or insurance principles, governments will invest much time, money and political energy in attempting to control health care expenditures while seeking to maintain solidarity with their citizens – in theory at least if not entirely in practice.

Because of the sensitivity of the issues, the language of rationing tends to be softened by euphemism. Terms such as “prioritisation”, “competing demands”, and “finite resources” are commonplace. Behind this language, as we will see, “rationing” takes on many different forms. It can happen at the macro level as, for example, a matter a policy in seeking to reduce morbidity and mortality in regard to a particular disease; or it can happen at the micro level in, for example, a clinician’s decision in a particular hospital to place a patient on a waiting list. It can be explicit, on a declared national policy decision, or it can be implicit, where the reasons for a decision (which may be multiple) may not be immediately evident. Is a health authority culpable, for example, if there is a national shortage of specialist anesthetists and, because it is unable to recruit, has to reduce its surgeons’ operating commitments? One thing that can be said for certain is that there are pressures to make the rationing issues more explicit and to enter into public discussion about them. It is therefore useful to explore some aspects of the rationing debate.

Firstly, in the words of Bill New, “we consider that health care services that are not regarded by anyone as beneficial under any circumstances are not relevant to this topic. In short, the empirical quest to establish which medical interventions have no benefit is not a question of rationing”.⁵ While this can be understood, and perhaps accepted, as a principle the issue becomes much more contentious when the ethical issues concerning the words “beneficial” and “circumstances” are discussed.

Secondly, it is important to put the issue into perspective. When we restrict access to health care we are, in the majority of cases, speaking about non-

urgent, or elective, activity. Therefore urgent or emergency treatment is given immediately.⁶ So, for substantial proportions of hospital patients the problem does not exist. In Spain, for example, 65% of hospital admissions in 1997 were urgent, with variations between hospitals and specialties. In Sweden the figure was around 80-90%, in Ireland, it was 62% and in the UK it was 70-80% for the medical specialties and 50% for surgery and trauma. Thirdly it would be important to distinguish between need and demand. Demand will often be used as a proxy for need because the latter term is much more difficult to quantify, entering as it frequently does into the realms of subjectivity and, particularly in health care, emotion. For example, the Irish, like some other European Union countries, have tried to limit demands on hospital accident and emergency departments by those who really do not need these sophisticated hospital resources⁷, referring them back to their family doctors. The fact that a patient who needs an aspirin is sent back to the family doctor is not a denial of treatment, but a referral to a different, hopefully more appropriate, response. In the frenetic atmosphere of a hospital accident and emergency department, after a serious accident, triage is not a denial of treatment, but a necessary identification of those who are in most need of immediate attention. The family doctor who decides against requesting admission of a patient to hospital, in favour of care at home or as an outpatient, is not necessarily rationing care: he/she may be making a more appropriate response based on clinical judgement. There is the added factor here that the mode of treatment chosen in this particular case may not only be more effective, but it may also be more convenient for the patient and family, even if the patient himself/herself may not perceive it that way. Fourthly, the "entitlement culture" which has developed over the years is responsible for eliciting, even encouraging, a response which later experience has shown to be outmoded. For example, campaigners have been working for years to return to the concept of home birth in all but potentially problematic deliveries. In that time, patients have become reliant upon the reassurance they receive from inpatient hospital care⁸, with the result that there can be resistance to alternatives of care, such as day case surgery, outpatient care or home care.

Fifthly, it must not be assumed that "rationing" is always the result of a deliberate, planned, process. It often is, but the number of players involved, and the number of influences which can affect decisions, may make the whole process difficult to understand. The reasons for restriction of supply and demand may be implicit rather than explicit and they may be taken at different levels:

- at national level, where the first, fundamental, decision has to be made about the very nature of the health service – whether it will be essentially tax based, or insurance based (or any of the many blends of these systems). The next decisions are those about what to spend on health as opposed to other national programmes (e.g., defence, education, transport, etc.)

- what to spend within the now determined health care “vote” (e.g., mental health, acute hospital care, community care, etc.)
- at regional level where, depending on the system, the same factors as those described above may also apply. In some countries, for example, France, Spain, Ireland, regional organisation may be dedicated to health care only; in others, such as Austria, Finland and Sweden, regional governments may be determining other priorities within their local budgets, but usually within framework legislation set at national level.
- at local level – by now we are looking at health care organisations which may be a grouping of institutions or services, or a single institution. Here the choices may be between specialties or models of care, and they are usually made within a broader framework of health strategy which may be set nationally and/or regio-nally.
- at clinician level – where decisions will impact directly on individuals, or groups of patients.

With so many players involved it is inevitable that responsibility for any controversial or unpopular actions will be passed from one to another. Governments may claim, for example, that they should not proscribe at national level what should be done at local level⁹. Others believe that there is a case for specifying at national level the range of services which health care organisations are in the business of providing¹⁰.

Last, but by no means least, is the extent to which the public is aware of, and able to influence, the decisions being made on its behalf about the allocation of health care resources. Consumerism and “patient power” are on the increase and there are pressures to make the rationing issues more explicit and enter into public discussion about them. For example, in now famous cases, two Luxembourg citizens Decker and Kohll, have asserted their right to access healthcare services where they choose, at their insurers’ expense, and without prior authorisation, even if the service is provided outwith their own country’s health system. The consequences of this landmark ruling by the European Court of Justice can be expected to be far-reaching. Public discussion is, of course, an area in which the media have enormous influence. Potentially this could be a benign influence, in helping to open out a rational debate on the real issues so that they can be understood and a balanced and competent reaction expressed.¹¹ It is important, if this welcome movement is to prosper, that the media also adopt a balanced and responsible approach to reporting on it.

SECTION 4: SOCIO-CULTURAL VALUES

"Equity" or "equality of access" would be the overwhelming response if European legislators and businessmen were to be asked for their characterisation of the important values of the health care system¹². This is an approach which can readily be identified in government policy statements across Europe, whether the system is inherently based on general taxation or insurance. In any of these systems, and the many variations of them, there will also be voluntary, additional, insurance or out-of-pocket payments to supplement the established care package (the components of which will be also vary). The important issue, however, is that there is a principle that the poor, disadvantaged and chronically sick should not be financially ruined or socially excluded from health care because of their life circumstances, and that this is accepted by society¹³. As always, there are differences between principle and practice as evidenced by the increasing recognition of western governments that they have to tackle the issues of widening inequalities in health care. In their own ways, for example, the French, German, and UK governments speak about the unwelcome risks of "two tier" or "two speed" health systems developing in a health market. Latest studies in France have shown interesting differences in the use of, or access to, medical structures, given their almost unrestricted availability. For example, it has been found that the upper classes, on average use fewer emergency services than elective, and visit general practitioners less than specialists. This is a clear manifestation of the factors which must be taken into account by those who seek to put into practice their concepts of equity.

At the opposite extreme to the view that health care is a social good, there is the opinion that it is essentially a private consumption good for which the individual is responsible, as Reinhardt says "... often ... reinforced by the clinical theory that many if not most modern diseases are rooted somehow in the individual's behaviour ... an integral part of the individual's lifestyle consumption choices."¹⁴ The doctrine of personal responsibility for one's own health has always been present¹⁵, but it has taken a higher profile in recent years as the pressure on health care resources has increased and attention has been focused much more on prevention as a more effective and less costly approach, than cure. This is now stated clearly and specifically in government publications on health strategy and public health across Europe, for example, in Austria, Finland, Ireland, Spain and the UK. Moreover, the person requiring treatment is nowadays much more likely than before to be told that treatment will be withheld (particularly for Reinhardt's "modern diseases") unless he/she loses weight, stops drinking or stops smoking. Whether "the public" is yet ready to be more tolerant of such sanctions remains to be seen.

This last point brings us to the huge and complex area of medical ethics and the determination of what is morally and/or legally acceptable¹⁶. This may have nothing to do with whether or not the patient has done something wrong

(the issues encountered in discussion on diseases associated with smoking, drinking, substance abuse and the contraction of AIDS are themselves enormous) or has contributed to his or her own illness. Consider, for instance, the significant debate conducted in the British Medical Journal in which two respected physicians argued persuasively for and against the proposition that, in a situation where resources were limited, treatment might be withheld on grounds of the age of the patient¹⁷.

Consider the case of Denmark, where doctors and nurses have the right to refuse to participate in abortions if these procedures are against their beliefs (patients can be referred to other hospitals in such circumstances). This also happens in Ireland, Spain, Sweden and the UK, while in France there is a law on bio-ethics and in Finland there are established ethical guidelines.

Consider also the health authority which refuses expensive drug therapy for, for example, cancer when the clinical prognosis is not favourable, and which exposes itself to public condemnation, as recently illustrated in the "child B" case in England. The fact that the subsequently-provided private treatment (donated by a benefactor and welcomed with acclaim by a press hostile to a "heartless" health authority) was unsuccessful, as predicted, did not, of course, attract the same level of media interest.

This, last mentioned, case (child 'B') demonstrates an important aspect of the ethical dimension – that of efficacy or, as stated earlier, whether a proposed course of action could be regarded as beneficial, and whose opinion should count, because there will clearly be differences between patients, doctors, managers, politicians and journalists, according to their own perspectives. As we have said earlier, the exclusion of an intervention which has no benefit should not be described as "rationing" but the issues are rarely simple. To one person a minor, even trivial "aesthetic" procedure may, in fact, have enormous significance for the personal well-being, self-esteem (even mental health) not only of the patient, but also the immediate family – and could prevent much more serious problems in the future. We are on similar ground when we hear arguments that in-vitro fertilisation should be available free of charge as part of the (publicly funded) health package, since the health consequences, in the broadest sense, can go potentially far beyond the couple's inability to conceive a child.

SECTION 5: THE ECONOMIC DIMENSION

Money, or rather the lack of it, is present in the rationing debate from top to bottom. As we have seen, decisions start to be made at the macro or national level where government departments compete with each other for the funding of their expenditure plans. They are also being made at the micro level (individual clinicians and patients). We are all familiar with the regularly, and widely, published league tables of what the various economies of the world spend on health, expressed as a proportion of Gross Domestic Product, so there is no need to review them again in this paper. All the more so, because these figures do not give any indication of whether that level of expenditure gives value for money or provides for an effective health care system (i.e. how comprehensive the health care package is, and the level of satisfaction with the service provided).

Rationing at the National Level

Let us look now more closely at what happens once the national government has determined its limits for health care expenditure. For example, the UK Government White Paper on the NHS acknowledged, in 1996, that rationing was part of the system. It also stated a belief that “the pressures which have played a large part in influencing health care spending in the recent past – population characteristics, public expectations, and medical advances – are likely to continue as the major driving forces into the 21st century” and that “these pressures are manageable 18,19. In stating that belief it pointed to the evidence of greater productivity in recent years and stated, furthermore, that “there should be no clinically effective treatments which a health authority decides as a matter of principle should never be provided”. 20

On the other hand the British Medical Association’s 1996 policy on rationing stated “that this meeting believed that future decisions to disinvest or ration services within the NHS should be made by government and be based on a national consensus generated by the widest possible public consultation, informed by the entire profession.21 In September 1995 the Royal College of Physicians suggested that a national council for health care priorities should be established “to carry out a continuing review of the methods employed in determining priorities, monitor how they are set, and evaluate the implications that follow when allocations are made.22

The Institute for Public Policy and Research put the case for national guidelines in the form of a code of practice setting out procedures for rationing decisions in health care, drawn up on advice from a National Health Commission.23 In the same year the King’s Fund concluded that there was a case “for specifying at national level the range of services which the NHS is in the business of providing”.24

In certain areas of health care this has always been the case. Successive UK governments, for example, raised prescription charges (while maintaining exemptions for the less privileged in society and for such categories as

pregnant mothers, the elderly and the young) and introduced fees for NHS dental care and eye tests. The Dutch 25 have also been tinkering with the compulsory insurance care package. In 1996 the French had to initiate a wide-ranging overhaul of their health system in the face of an escalating social security deficit. In Austria ceilings placed on regional hospital funds since 1997, and a coordinated "Austrian Health Plan" have also helped to reduce costs, while co-payments for treatment remain relatively low.

Rationing at Local Level

(For the purpose of this paper "local" is defined as a stage between the national level and individual institutions. This may be recognised by the term departmental, regional, district, county or municipality).

The last UK government's approach was to express its clear expectation that priorities should be "informed by proper consultation with the public"²⁶ setting out clearly defined values of equity, efficiency and responsiveness as a guide to local decision-making. Its unwillingness to specify in any greater detail at national level was regarded by some commentators as an "opt-out". Local health managers did not escape criticism either. In a survey of health purchasing plans between 1992 and 1996 the University of Bath in Southern England looked at the type of services which authorities were excluding.

Those who conducted the survey concluded "the story revealed ... a retreat to the NHS's traditional reliance on clinicians to decide who gets what ... with an increasing number of health authorities announcing restrictions on what they proposed to purchase on behalf of their populations, but usually qualifying their decisions with escape clauses designed to put the ultimate responsibility for determining the selection of treatment of individual patients on doctors".²⁷

Individual Clinicians

Though governments may make pronouncements about the principles of equity of access to necessarily limited resources (as in, for example, the UK Patient's Charters and their targets for waiting lists and waiting times, the Swedish Priorities Commission, and the attempts in the Netherlands and Spain to define entitlements to healthcare) it is ultimately individual clinicians, and clinicians acting together with colleagues in clinical directorates and similar groupings at institutional level, who actually manage the process.

Increasingly, they are being supported in this task by such aids as prescribing formularies and best practice guidelines as part of the development of evidence-based medicine which identifies the most effective course of action, and the best use of resources to benefit both the individual patient and the clinician's wider practice. Such aids do not, however, help the clinicians faced with, for example, two equally deserving cases and only one organ suitable for transplant. The argument here is of course, that such rationing is unacceptable, that systems should be improved to lessen the risks of such a dilemma occurring. For many, the answers to resource shortage may be found within the existing systems which are inefficient. The anti rationing lobby claims, for example, that rationing is immoral in the face of large

variations in the costs and volumes (and quality) of services purchased in the UK.²⁸

Waiting Lists

Of all the features of a system subject to prioritisation rationing the terms “waiting list” or “waiting time” are perhaps²⁹ the most well known to the public, and the most emotive. It is therefore worth looking closely at what is meant by a waiting list.

A waiting list for hospital admission (or waiting time for a first hospital outpatient appointment) is an instrument which seeks to square the circle of supply and demand. It is tempting to describe it as a valve by which pressure is dissipated. It comprises people whose cases are not urgent and life threatening so that those who need immediate treatment can receive it. So we are talking of rationing a proportion of the total demand (see the second point in Section 3).

Some patients may be waiting because they choose to delay admission because of non-health care reasons, or because they may not be ready for a planned intervention or course of treatment. Such patients will not therefore be included in a “true” waiting list, being regarded as planned or deferred admissions. Separate account will also be taken of those awaiting an organ for transplant, so that a true waiting list will comprise:

patients who have to wait because of hospital resource constraints

patients given an advance date of admission, except those appearing on a planned repeat admission list or deferred admission list

patients sent home at the time of admission because of lack of beds or other resources

patients offered admission who could not attend

patients awaiting transfer to another specialty (except in an emergency)

It should be emphasised that, if a case became urgent at any time, emergency admission would be arranged.³⁰

SECTION 6: SCIENCE AND TECHNOLOGY

Health systems are characterised by their reliance on a skilled, trained, workforce. Hospital budgets across Europe will, typically, show that some 70% of their revenue expenditure is on employment costs. As science and technology advance in general, so also does medical technology develop. More and more sophisticated – and expensive – equipment, techniques and drugs become available. We tend to forget the enormous beneficial impact of such developments as vaccines for disorders like smallpox, rubella, tuberculosis, etc. which have very low direct costs. 31 The result is, of course, to create demand where it did not exist before. The strong desire to push back the boundaries of knowledge is fuelled by the equally strong desire to find solutions to clinical problems that even a decade ago would have been beyond the reach of the critically and chronically ill. A terminally ill patient who will see hope in a new “superdrug” or a new transplant technique, and the attending doctor, will naturally seek that treatment. Furthermore, “innovations that make things better for the patient often have the effect of putting those who are on the borderline (for treatment) into the “should-get-it” category.32

New technology is frequently rationed for three main reasons:

The technique, equipment or drug may be so new that the supply is as yet scarce. It may also be going through a developmental stage.

There may not have been developed in the relevant professions the necessary local expertise to provide the service, which may only be available in a regional “centre of excellence”.

In its early days the treatment may be extremely expensive.

It is the latter of these three factors which is often quoted as the reason for the rationing of the treatment or technique. It is sufficient to illustrate the impact of the cost of new technology by offering a small sample of cases under the broad headings of diagnostics and therapy, with the latter being subdivided into the categories of equipment, techniques and drugs.

Diagnosis

The point to remember about decisions to implement a new medical diagnostic technique is that “it has to be both effective and efficient – that it increases survival and/or quality of life and that it makes sense financially. The unique feature of the assessment of diagnostic tests is that the results of such tests are intermediate outcomes. This implies that the effectiveness gained, and the potential cost savings, are largely the effect of the management strategy chosen on the basis of the test results and not a direct effect of the diagnostic test itself”.33 This also means that the results of trials held to assess the new equipment or process “may be confounded by the effects of further work-up and treatment”.34

Our diagnostic example, magnetic resonance imaging (MRI), is typical of the new technology phenomenon. It made a huge impact on the radiology world

when it was introduced in the early 1980's. But the distribution of this expensive equipment (a machine could cost as much as \$1.5 million – 1998 prices) has been patchy. Industry estimates quoted in Modern Healthcare Magazine 35 claim wide variations in the availability of MRI scanners across Europe – from 14 per million people in Switzerland, to 10 in Germany, 9 in Sweden, and between 4 and 6 in Italy, Spain, France and the UK. The same article claims, significantly, "The share of healthcare spending outside of governments' direct control usually predicts where MRI (scanners) can be found. In general, it is fair to say that the density of MRI scanners tends to correlate with the size of the private market in countries".³⁶

Another element of the cost/scarcity factor is given by Hensley, who reports that the cost of a scan has fallen in the United States from around \$1,200 in the late 1980's to about \$500 or less today.³⁷

Therapy

One of the best known therapeutic interventions developed in recent years has been the treatment of renal failure using the technique of transplantation, and dialysis equipment. The dispersal/availability of transplantation, haemodialysis and peritoneal dialysis shows wide variations. In the former case, the availability of donor organs is the main limiting factor although Spain, unique in the European Union, has succeeded in achieving a high rate of donation through the creation of a nation-wide network of co-ordinators backed up by an efficient and professional transplantation service. As far as dialysis is concerned, the choice between the two techniques may not be wholly a clinical one. It is claimed, for example, that in Belgium the payment system discriminates against peritoneal dialysis, while in the UK the government-controlled budgets and nephrologists' support of peritoneal dialysis have helped to shift the emphasis away from haemodialysis.³⁸

The marriage of computerised communications with computerised diagnostic and other equipment has enormous benefits for patients and health professionals – and governments interested in securing value for money and enhancing quality and outcomes. The real-time linkage between, say, a general practitioner in a small hospital or clinic with a specialist colleague in a university teaching centre for advice on a difficult case is now commonplace, and presages the "virtual reality" of a surgeon operating from a remote site with the assistance of computerised imaging and robotics. For the meantime, however, we content ourselves with the benefits of "direct health services", telephone triage³⁹ and televideo conferencing.⁴⁰

When we look at new drug therapies we encounter some of the more well known "causes célèbres" of the health industry. For example, clozapine and its derivatives are widely believed to be capable of reducing the suicide rate amongst people suffering from schizophrenia by four fifths⁴¹ – but the drug is twenty times more expensive than other treatments.

Inconsistencies in prescribing practice which have become known as "postcode prescribing" are a phenomenon present in a second example – that of beta

interferon. It can significantly delay deterioration in secondary progressive multiple sclerosis but it was the initial findings of benefits in treating relapse-remitting sclerosis – the earlier and less severe phase of the disease – which started the major discussions about its funding in the UK.⁴² Mayor says that “multiple sclerosis and public health experts are calling for a more rational approach to the funding of beta interferon than just looking at the direct cost of the drug”. This leads to another facet of the rationing issue. Quoting research published in “The Lancet”.⁴³ Major points out that the other, indirect, costs should be considered also, such as loss of earnings, and other more intangible costs such as loss of status and self esteem. But the “more rational approach” sought should be on the basis of good clinical reasons for explaining why only certain patients can be treated.

SECTION 7: SOME ANSWERS

The solution (or the problem) starts with decisions taken at national level. These involve the values placed on competing programmes and will therefore reflect the complexion of the government of the day. The resultant health policies may not, however, directly reflect the democratic will of the people because, of course, governments are not elected purely in terms of their health policies but on a broad manifesto of political, economic and social objectives. "The people", then, may have less influence than, say, politicians and their many advisers. This situation is at the very centre of the search in many countries for mechanisms which can somehow involve the public in these high level decisions. A fundamental issue for the healthcare rationing debate is whether rationing is to be accepted as inevitable, and ways found to reduce its impact, or whether it should be rejected out of hand as a matter of principle. These two diametrically opposed views are actually not so different in their desired aim, which is an equitable comprehensive and effective health care system which provides the citizen with confidence that health needs will be met in a crisis without resulting in financial ruin, and which provides the government with value for money.

The next question is, as we have seen, whether national bodies have a legitimate role in rationing. Jo Lenaghan argues that they do, for "if rationing issues are too difficult to resolve on a national level, involving all the expert and interest groups, then what chance do hard pushed local health authorities have?".⁴⁴ Many believe in fact that the logical way to tackle the problem is to establish some national standards and guidelines which should inform the criteria used in decisions taken at the clinic, GP office or hospital ward – and it is important that these standards are seen to be consensual, legitimate and consistently applied.⁴⁵ It therefore seems that governments should:

- take a strategic approach which prompts action at the different levels of decision making;
- build a sound explicit ethical platform based on a hierarchy of human dignity, need and solidarity and cost effectiveness;
- lead on making rationing or prioritisation more explicit by protocols or guidelines – promoting clinical governance;
- incentivise alternatives to expensive hospital care – e.g. prevention policies, care in the community;
- identify more cost effective patterns of resource allocation and delivery through guidance on planning and priorities, funding only those interventions that are appropriate;
- consider where co-payments/cost sharing will be appropriate (including review of exemptions from charges);
- campaign against excessive referrals and over prescribing;
- develop national centres of excellence and advice on, for example, the introduction of new technologies and techniques;

- implement effective manpower planning which ensures that there is neither costly and unnecessary over production nor waste of facilities because of a scarcity of the necessary expertise

At this level many of the policies are as much about economics as they are about health, because they will find expression in such instruments as cash limited budgets and promoting competition amongst health insurers and providers.

As one might expect, the solutions at local level are more about management and operational conditions and the ethical considerations narrow from population level to individuals or groups of individuals. We therefore see systems for:

- planning the admission of patients, and better management of emergency admissions and elective caseloads;
- better management of seasonal variations in demand;
- shorter inpatient stays (with reduction of unnecessary occupation of an acute bed by a patient who no longer needs it – i.e. “bed blocking”) and more use of alternatives to inpatient treatment such as day and outpatient treatment;
- passing more routine elective work to nurses;
- improving the training and assessment of general practitioners and extending the range of services they can both access and provide;
- using hospital referral systems which refer to a given hospital and not to a named specialist;
- redefinition of the local health care package
- the development, and controlled introduction, of new techniques and technology.

Many of these solutions come under the heading of better, closer management of hospital specialists, which is easier said than done. This may be because of a history of strong professional and political power base aligned against weak local management. More importantly though, attempts at controlling specialists will attract the justified criticism that clinical freedoms are being undermined.

Turning the focus to patients and carers we also find solutions in:

- better information to patients about available choices;
- involvement in the decisions about priorities (also at national and local level);
- involvement of patients in the planning and delivery of their own care;
- greater responsibility for personal health and wellbeing;
- more responsible use of the health care resource.

CONCLUSION

Perhaps a fitting conclusion to this paper would be to quote the World Health Organisation's analysis of current strategies from its publication "European Health Care Reforms" (Copenhagen 1997) which states:

"Ultimately it is the responsibility of elected public officials to use their best judgement in determining priorities. Their decisions will be shaped by the availability of resources, information on the health needs of the population, evidence on the cost and effectiveness of available interventions, population preferences, an assessment of what is politically feasible and, of course, the values they bring to bear. The one clear message from international experience is that health care rationing cannot be divorced from values».

Notes / References

1. NAHAT (now NHS Confederation) Research Paper No. 8 (Birmingham, 1993).
2. "European Healthcare Reform – Analysis of Current Strategies" Saltman, R and Figueras, J. WHO Regional Office for Europe (Copenhagen 1997).
3. New W (Ed) "Rationing - Talk and Action in Healthcare" BMJ Publishing and King's Fund (London, 1997).
4. Examples from the UK: "A Service with Ambitions" (Stationery Office, London, December, 1997, C.M. 3807), "Designed to Care" (Stationery Report, Edinburgh, December, 1997, C.M. 3811)
5. New W (Ed) "Rationing - Talk and Action in Healthcare" BMJ Publishing and King's Fund (London, 1997).
6. Most countries will be able to find some highly publicised exceptions to this statement, but it generally holds good.
7. The campaign, which asked people if their visit was really necessary, worked while it had media coverage, but attendances rose again afterwards.
8. Not long ago it was common practice for a woman to remain in hospital several days after childbirth. Now, short stays of 48 hours or less are commonplace, except in high risk cases.
9. The UK Government White Paper on the NHS "A Service with Ambitions" took this line on the grounds that no national list of priorities could hope to take into account all the factors encountered by clinicians in individual cases.

10. As suggested in the British Medical Association's Briefing Note No 7 (April 1997) produced by its Health Policy and Economic Research Unit.
11. This is beginning to happen in "citizens' juries" and "contact groups". In the UK the King Edward's Hospital Fund for London (The "King's Fund") has made grants to health authorities to develop such groupings to ask people about local health care priorities. See KF "Newsline" newspaper June 1997.
12. Reinhardt, UE "A Special Contract for 21st Century Health Care : 3-Tier Health Care Without Bounty-Hunting". Health Economics magazine Vol 5 (1996).
13. de Gooijer, WJ, in "On Solidarity in Changing Health Care Systems" (SCHEU 1997).
14. Reinhardt, UE : op.cit. Reality, of course, lies somewhere between these two extremes. In France, as in other countries in recent decades, the policy has been to ask the patient to pay more and more - for a number of more or less "scientific" reasons – but mostly to do with transferring health costs to the household budget.
15. We might add "responsibility for other peoples' health" also, with the growing intensity of road safety campaigns and the wide publicity being given to the dangers of "secondary smoking" and measures being taken to restrict smoking in public places.
16. The concept of rationing is uncomfortable – "synonymous with costs, with reductions, with insufficient amounts of care ... linked to the need for tough decisions, but rationing is also an ethical word. Rationing implies fair shares for all or, in healthcare at least, equal treatment for equal need" see New, B (Ed.) and footnote 2.
17. "The Rationing Debate : Rationing Healthcare by Age" Williams, A, and Grimley Evans, J, in the British Medical Journal, 15 March 1997.
18. The 1996 UK White Paper "A Service with Ambitions" (see also note 5).
19. In 1993 a BMJ paper "Funding the NHS : is the NHS Sustainable?" Harrison, A, et al, concluded "there is no convincing evidence that the NHS will not be able to cope if funding continues to keep pace with current levels".
20. The 1996 UK White Paper again, in Chapter 3.
21. Quoted in BMA Briefing Note No. 7 (see also note 6).

22. "Setting Priorities in the NHS: a Framework to Decision-Making". See BMA Briefing Note No. 7.

23. "Lenaghan, JM "Rationing and Rights in Health Care" quoted in BMA Briefing Note No 7.

24. "Rationing in the NHS : Principles and Pragmatism" (King's Fund, London).

25. The Dunning Committee was appointed in 1990 to look at rationing issues, and came up with a framework of criteria for an explicit decision as to whether an intervention should feature in the basic healthcare package. These were necessity, effectiveness, efficiency and individual responsibility.

26. The 1996 UK White Paper, Chapter 3.

27. Klein, R; Day, P; Redmayne "Managing Scarcity and Priority Setting and Rationing in the NHS" Open University Press (Buckingham 1997).

28. Roberts, C "The Wasted Millions" Health Service Journal Vol 106 No 5524.

29. Maybe not in France, where opinion is divided on whether or not waiting lists exist. See Piganeau, K, in "Le Quotidien du Médecin" 8 December, 1998. In Austria, for example, they are facts of life, but not officially recognised.

30. For a review of surgical waiting lists and their management, in three European countries, see SCHEU's Co-ordination Sub-Committee report "Measures to Reduce Surgical Waiting Lists" (Leuven, March 1998).

31. Take smallpox, for example. In 1997 the World Health Organisation estimated that vaccination had spared 350 million people and 40 million deaths had been prevented.

32. Chernow, M, quoted in "The Price of Technology" by Hensley, S, in Modern Healthcare Magazine, November, 1998. This gives rise to the so-called "woodwork" effect by bringing new patients into the health care system – an effect which has come to prominence lately in the debate on the drug sildenafil (otherwise known as viagra!).

33. Hunink, MGM, in "Outcomes Research and Cost Effectiveness Analysis in Radiology". European Radiology (1996) pp. 615-620.

34. Hunink, MGM, op.cit. Notes 33 and 34, give only brief flavour of a very detailed analysis.
35. Hensley, S, "A World of Difference" in the November, 1998 issue of Modern Healthcare Magazine pp. 25, 26. This interesting article is sub-titled "Access to care dependent on payment systems, wealth, cultural traditions".
36. Hensley, S, op.cit. (see note 35).
37. Hensley, S, op.cit. (see note 35).
38. Hensley, S, op.cit. (see note 35).
39. See European Hospital Management Journal vol 5 issue 4, 1998, pp. 50-51. "The Cost-saving Potential of Direct Health Services" – an article based on a report by Coopers, Lybrand and Dr. Graham Lister. The same article notes that telephone triage is not infallible, as found in a survey conducted in Sweden.
40. Schwing, C, in "The Future for Imaging" – Diagnostic Imaging: Hospital Healthcare Europe 1998/99 (Hope-Campden Publishing). In this article it is reported that "An analysis carried out by a telemedicine association has shown that 80% of emergency referrals to neurosurgery are unnecessary. Two thirds of neurology cases discussed in video conferences can be turned away. Only 14 out 100 allegedly acute cases in fact required an immediate or subsequent neurosurgical intervention".
41. According to the National Schizophrenia Fellowship and the Maudsley NHS Trust (UK) it could save 1,000 lives in ten years if prescribed to all the 50,000 sufferers in the UK. See "Cost Denies Patients Best Anti-Psychotics" in Health Manager Today magazine Dec 1998/Jan 1999.
42. Major, S "Beta Interferon Demand Can Be Managed Cost Efficiently" in Health Manager Today Dec 1998/Jan 1999. Major reveals varying patterns of prescription across the country : the cost is about £10,000 per patient per annum.
43. See Thompson, A, The Lancet 1998 352 pp. 1491 – 1497.
44. Lenaghan, J, "Rationing : Talk and Action in Health Care" King's Fund/BMJ. Editor new W (BMJ Publishing Group 1997).
45. Lenaghan, J, from the same chapter in "Rationing: Talk and Action in Health Care".