Rationing of health care in medicine

A conference on ‘Rationing of health care in medicine’ was organised by the Royal College of Physicians and the Institute of Health Services Management on 11 November 1992. In his opening remarks the President, Professor Leslie Turnberg, declared it an opportune time to be hosting a conference on such a topical subject. Rationing of health services exists; the challenge is to find how to do it rationally.

A rational approach to rationing

Professor Maynard (University of York) outlined his idea of a rational approach to rationing. He defined it as the process of deciding how to allocate scarce resources. We do not make the best choices because of ritual, ignorance, and haste, he said. What we need is more information relating to effectiveness, cost, and outcomes of medical interventions. The move towards such studies is welcome. Existing modes of rationing are indefensible and most medical practice is essentially experimental. What is needed is honesty and modesty on our part in acknowledging that.

Professor Kirk (University of Oregon, USA) then described one example of a rational approach. In the US State of Oregon the public had been involved in attempts to rank medical services in order based on effectiveness as well as importance, to help the State authorities to determine a cut-off point for interventions that would be funded (and those that would not). By rationalising the choice of which particular services would be provided, it was intended that Medicaid should be available to a wider section of the population. This experiment has engendered much ethical and political argument, and though in the end the Federal Government has refused to allow the State to implement it, the discussion has had far-reaching implications. Ironically, the Federal Government has refused to permit the scheme to be implemented because it violates the Americans with Disabilities Act by involving the public in making decisions about treatment of disabled people. So much for explicit rationing and democratic decision-making.

Outcomes and choice

The Chief Medical Officer, Dr Calman (Department of Health, London), talked about outcomes and choice, and began to bring the discussion round to the realm of the individual practitioner. Knowledge of the outcomes of procedures is central to making decisions about resource allocation, and this can be pursued by evaluating the effectiveness of interventions through an outcomes clearing house, through clinical audit and through the work of the Research and Development Directorate. New technologies and procedures must be evaluated. Purchasing must be based on outcomes.

A member of the audience, however, identified what many seemed to think was the crux of the problem—how can individual doctors accommodate rationing within the overriding ethic of being required to do everything possible for their patients? Dr Calman replied that rationing is not new. Doctors have always had to decide whom to treat and whom not to treat. What is new is the need to make the basis for these decisions explicit.

Medical NIMBY-ism

Acute medicine

The difficulties facing practising doctors were then described and enlarged upon by the next four speakers, all physicians practising in the acute sector of hospital medicine. A cynic might have seen it as an example, or examples, of medical NIMBY-ism—rationing is acceptable, essential even, but Not In My Back Yard. Each speaker made a persuasive case. Dr Tunbridge (General Hospital, Newcastle upon Tyne) described the difficulties facing acute general medicine, a service almost entirely demand-led, unable to control the level of workload, but operating within severe resource constraints. Using facilities to maximal capacity, he pleaded, does not necessarily mean the same as using them optimally, and if resources are to be cut back, it must remain possible when necessary to respond rapidly to an increase in workload.

Ageism

Professor Grimley Evans (Radcliffe Infirmary, Oxford) disputed the overall level of funding available to the Health Service: rationing occurs at the service level as well as in health authorities and hospitals. Once the budget is set, equity must remain a central determinant of allocation. The elderly are already discriminated against by being denied treatment which is available to younger people, a discrimination justified on the basis that intervention is less effective in the elderly. This is just not so, he said, taking thrombolysis as an example. Moreover, to use the average response of a group of patients as a guide to determining the treatment of individuals is neither scientific nor ethi-
cal. He concluded by arguing that QUALYs are inevitably ‘ageist’, as they discriminate in favour of providing services to the young (who have more potential life years to gain).

**End-stage renal failure**

Dr Mallick (Royal Infirmary, Manchester) then argued his corner, pointing out the gross underprovision of services for the treatment of end-stage renal failure in the UK in comparison with Western Europe. Poor planning has been responsible for rationing, with the result that many thousands had died prematurely. Further, if resources are inadequate in the early stages of chronic renal disease, this results in greater morbidity. He too was sceptical of the use of QUALYs—a concept which he said must be viewed with extreme caution.

**The drug budget**

Professor Rawlins (University of Newcastle upon Tyne) looked at rationing in the context of the drug budget. All regions face an overspend on their drug budgets in the current financial year, due partly to the increased use of established drugs and partly to the introduction of new therapies. Some individual drugs are enormously expensive—for example, in Northern Region one patient is being treated with epoprostenol at a cost of £1 million per year. He then outlined a strategy used in that region to deal with high-cost/low-volume items, and emphasised that physicians must be proactive and cooperate with managers. In response to questions, he acknowledged that often full information on cost and effectiveness is not available, but also pointed out that the strategy of examining each case of need sometimes brings to light a great disparity in service provision.

**Rationing and decision-making**

Professor Klein (University of Bath) took the discussion away from the individual case and back onto a theoretical plane. He, too, emphasised the paucity of information and justification for backing up decisions on the allocation of resources. This was shown in his study of the purchasing plans of health authorities: authorities apparently have many concurrent priorities, their overall strategy appearing to be one of ‘trying to keep everyone happy’. Is this a shambles; or a reflection of unfamiliarity with the ways contracting may be used; or are authorities being more rational than they are given credit for? Rather than seeing rationing as decision-making on the basis of hard information, it is perhaps better to view it as akin to clinical decision-making, balancing probabilities in the context of imperfect knowledge. It is inevitable, he thought, that the finer aspects of rationing are done by physicians. But it is important is that they should be publicly accountable for those decisions. This may even give them added clout in arguing for more resources from the government.

Professor Howell (University of Southampton) then spoke from the perspective of the district health authority. The recent NHS reforms were intended to improve efficiency, but have altered the way the service can respond to a shortfall in resources. Provider units can no longer reduce their expenditure by reducing the levels of services as these are defined in the contracts. Further, the Department of Health has removed the option of allowing waiting lists to accumulate. In his view, purchasers and providers must now meet to discuss ways in which health gains can be achieved—it is only when the time comes to write contracts that their interests differ. Explicit rationing should be avoided for as long as possible, because of the threat to the doctor–patient relationship.

**Setting priorities**

The final speaker, Mr Nicholls (Chief Executive of Oxford RHA), said regional health authorities have a clear role in setting priorities, determining a financial strategy, and promoting value for money. They must do this in the context of providing population equity. But the key need is for explicit decision-making, based on a sound knowledge of what is effective. He welcomed the establishment of the Cochrane Centre (see page 000 of this issue of the Journal) in Oxford as a step towards identifying and disseminating such knowledge. The debate over rationing, he thought, was not a question of whether, but of how.

At the end of the day, the President commented that many of the right questions had been asked, and many issues highlighted, but not all the answers had been provided!

*The full proceedings of this conference will be published by the Royal College of Physicians in June 1993.*