CORRESPONDENCE

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Rationing

SIR,—Richard Smith's editorial on rationing implies that I expressed paternalistic, indeed undemocratic, views in my Harveian oration.[1] I should like to try to explain myself.

Like others with whom I've debated the issue Smith fails to distinguish between rationing and determining priorities. In determining priorities, I agree, everyone should be involved—doctors, nurses, other health professionals, managers, and the general public—and I made this point in my oration. This is what happened in Oregon. As Smith says, the process was not easy and some rather bizarre proposals emerged first time round; the latest, much improved set of priorities was arrived at with the help of medical advice and guidance. This professional role is neither paternalistic nor improper: I would not feel competent to vote on the best way to provide our energy needs over the next few decades without the advice of physicists.

Rationing is something different. It is the deliberate withholding of certain services because of costs or lack of facilities or staff. It is a policy decision, one that is taken by the government or a health authority, not by the public. An example of successful rationing was the government's prohibition of heart transplantation in 1973. It was accepted because the public at the time had strong ethical reservations about the operation anyway; I suspect that it would not be accepted today. An example of unsuccessful rationing was the attempt some years ago by West Midlands Regional Health Authority to impose a limit on the number of patients admitted to a renal dialysis programme because the budget was overspent. The doctors in charge of the programme objected furiously and publicised the issue, and as a result the restriction was withdrawn. My sympathies were with the doctors: they were the ones who had to tell patient number x+1 that, although he was an otherwise fit young man ideally suitable for dialysis, he would have to go home to die because they had used up their quota of x places on the programme. This sort of explicit rationing by authority forces doctors to make unpalatable, indeed unacceptable, decisions at the bedside or in the clinic. Of course, they object. Why should they function as the authority's hatchet men?

If rationing is to be explicit I believe that it will work only if a defined block of services is withdrawn or withheld, such as bone marrow transplantation or in vitro fertilisation. The public—and the doctors—then know that these services are not available; like it or not, there is no choice. In deciding which whole service to exclude a wise government or authority would take account of the public's view of priorities and delete those placed at the bottom of the public's list or face the electoral consequences.

Anything less than an absolute embargo on specific services places clinicians in an extraordinarily difficult position. Which patients should they select for their annual quota of coronary bypass operations? Should they reserve judgment on a particular patient in case a more deserving one comes along to take up the last quota place? Such decisions are being made today by individual doctors dealing with individual patients, most starkly by those with tight budgets. It is this sort of rationing that I would prefer to see implicit rather than explicit, not through a belief in medical imperialism or paternalism but through a concern about the anguish that patients and their relatives might feel if they knew that they were being denied services that other patients had received explicitly because of cost.

Smith might wish to argue—and I might be persuaded to agree—that this sort of explicitness is precisely what is needed to open people's eyes to the present government's parsimonious attitude to our NHS. In my Harveian oration I made the point that if we spent as much on our health service as the average for countries in the Organisation for Economic Cooperation and Development we could probably meet all reasonable clinical demands now and for some time to come at a level inferior to none—that is, serious rationing could be deferred almost indefinitely.

Sadly, I suspect that our NHS will remain underfunded. I strongly support Smith's plea for more public debate about medical priorities and rationing. This is what I intended my Harveian oration to stimulate.

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1 Smith R. Rationing: the search for sunlight. *BMJ* 1991;**303**: 1561-2. (21-28 December.)

SIR,—Murray Cochrane and colleagues report that Southampton and South West Hampshire Health Authority would not shy away from setting priorities, even though it was hard.[1] But health authorities should do this with caution and recognise that in shifting implicit rationing away from doctors and making it explicit they assume a heavy burden and the rationing must be carried out fairly. One of the greatest strengths of the NHS is its foundation on social ideals. It aspires to social justice, equity in health care, and providing an effective and efficient service. It is essential that the new reforms reinforce these basic principles.

Cochrane and colleagues point out some of the inherent difficulties and dilemmas in setting priorities, not least the dearth of information on the effectiveness of different treatments. There is a more basic difficulty: health is a concept shaped by value as well as fact. Fact is objectively verifiable, whereas value is not. Many people have tried and failed to derive value from facts, and if factual knowledge about diseases, their causes, and their treatments is used alone to define health needs and set priorities they will be wrong.

The call to follow Oregon and make rationing decisions explicit and rational is therefore only part of the solution.[2] The general public would have some involvement, but what is crucial is that any universal system must try to allow for variation in individual perceptions of need because individual people will place different values on each disability or condition. This flexibility is potentially lost when clinicians are no longer responsible for rationing.

Health authorities must accept that there is no universally right answer, but this should not deter them from attempting their difficult task: decisions must be made. Explicit rationing must be seen to be built on the common ground of fact and to accommodate variation in individual values to provide a service that is sensitive to individuals.

Doctors undoubtedly have a role in setting priorities by advising on the technical grounds and the range of services that they think should be provided. In addition, the health authority should consider itself to be accountable to its resident population and explain its range of services and how it determines priorities and, most importantly, how patients can appeal against particular decisions.

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1 Cochrane M, Ham C, Heginbotham C, Smith R. Rationing: at the cutting edge. *BMJ* 1991;**303**:1039-42. (26 October.)
2 Smith R. Rationing: the search for sunlight. *BMJ* 1991;**303**: 1561-2. (21-28 December.)

Economic approach to priority setting

SIR,—Cam Donaldson and Gavin Mooney suggest that purchasing authorities should maximise health gain by shifting the balance of services towards those with a lower marginal cost per quality adjusted life year (QALY), making epidemiological needs assessment unnecessary.[1] Their argument seems uninformed by knowledge of the methods of needs assessment and takes inadequate account of current views on the limitations of using QALYs.

Firstly, needs assessment is not a simple summation of morbidity or of loss of life years. Need is defined as the population's ability to benefit from health services.[2,3] This depends on both the occurrence of health problems and the effectiveness of services. Needs assessment has much in common with the authors' economic approach—indeed, it incorporates it. But, unlike their pure QALY approach, it does not conflate morbidity and service effectiveness until morbidity has been analysed. This is important because of the range of