LETTERS

Rationing health care

Politicians do not want to duck the issues

EDITOR,—Richard Smith's view that British political leaders will not accept the challenge of leading the debate on health care rationing is, I suspect, widely held.[1] However, like many widely held views, it is not wholly accurate. The rationing of health services was the focus of the most wide ranging inquiry by the House of Commons Select Committee on Health in this parliament. In 1994, we spent 10 weeks taking evidence on priority setting in the NHS from a variety of bodies, including health authorities, fundholding general practitioners, academics, royal colleges, and, of course, the BMA.[2]

Our subsequent report was an attempt to stimulate public debate on the subject.[3] Central to our conclusions were that the availability of NHS services should always be founded on the principles of equity, public choice, and the effective use of resources. It was also central that purchasers' decision making processes should be systematic; be transparent; take full account of the views of the public, health professionals, and other interested parties; be based on a firm assessment of need; and make full use of effectiveness and cost effectiveness data. We did indeed talk of increasing the effectiveness of health care, but we also recognised that the need to set priorities in the NHS has been, and will be, always with us.

Any attempt to examine the question of NHS rationing in a serious and systematic manner, by health professionals, academics, and the public at large is to be welcomed. However, it is politicians who will be called on to oversee the rationing process, and politicians should not, as you rightly suggest, attempt to duck the issue. I believe that our report will provide a useful starting point for anybody who wants to move the debate on health care rationing forward.

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1 Smith R. Rationing health care: moving the debate forward. *BMJ* 1996:312;1553-4. (22 June.)
2 Health Committee. *Priority setting in the NHS: purchasing—minutes of evidence.* London: HMSO, 1995. (HC (1993-94) 227 and 288-1 and HC (1994-95) 134-11.)
3 Health Committee. *Priority setting in the NHS: purchasing.* London: HMSO, 1995. (HC (1994-95) 134-1.)

Britain could still have a comprehensive NHS without rationing

EDITOR,—I find it difficult to agree with Richard Smith in his editorial on rationing health care.[1] To assert that some form of rationing or "denial of potentially beneficial treatment" has always been present in the NHS is surely not a justification for its existence.

There is a quantitative and qualitative difference between having to wait 4-6 months for a hernia repair and waiting 12-24 months. When it becomes impossible to find a bed for an emergency admission and patients are being discharged before they are ready, I think we have to ask ourselves a more fundamental question—namely, do we as a country want to provide publicly funded health care?

There is no shortage of money in Britain, but we have become the victims of political rhetoric and are beginning to believe the politicians' assertions that we cannot afford a national health service, that as tax payers we are not prepared to pay for a comprehensive service, and that such a service would require endless amounts of money. How do we know that these assertions are true? Where is the evidence to back them?

The royal colleges highlighted the crisis in the NHS in 1988 and costed the extra resources required to maintain the service. The government responded by inventing the internal market and did not consider the option of investing more public money into health care.

Do we know if we can afford a national health service? As in Smith's editorial, figures are quoted on the cost of new treatments. On their own, these figures are meaningless. It is only recently that we have costed individual services within the NHS. Apart from the obvious question on the accuracy of these prices, how should we interpret them? How do we compare the cost of treatments for life with the annual NHS budget, and can we really estimate the price of drugs for the next 20-30 years? We chose to introduce new treatments in the past which must have been expensive—for example, antibiotic treatment for tuberculosis and blood transfusion techniques.

The question we should ask is not how do we ration but should we be rationing at all. We have no evidence for assuming that a comprehensive national health service is impossible in Britain today. Indeed, evidence suggests that it is a good investment for any country to put money into effective health care. Can we please start by debating the real issue?

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1 Smith R. Rationing health care: moving the debate forward. *BMJ* 1996; 312:1553-4. (22 June.)

Anti-Rationing Group also wants to contribute to the debate

EDITOR,—The Rationing Agenda Group [1 2] seems to be a counterpart to the Anti-Rationing Group, which was founded more than 18 months ago and has published a series of articles in the *Health Service Journal*.[3-5]

The Anti-Rationing Group is multidisciplinary, currently some 30 people strong, with over 500 person years of experience in the delivery, management, and evaluation of clinical services. It began as a think tank promoting and publishing views about clinical resource management in the NHS and has now evolved into a research and development group spread throughout England and Wales. Its principle aim is to help strengthen both the contracting and management of clinical resources so that the delivery of health care from existing funds becomes more effective and efficient.

Like the Rationing Agenda Group, the Anti-Rationing Group comprises people from all parts of the NHS who share common views. These include the belief that the rationing of effective health care is unnecessary and if allowed to occur would lead to the destruction of the NHS; that denying treatment known to be effective while, at the same time, overbuying some services and overpricing others is unacceptable, if not immoral; and that an endorsement of rationing would, de facto, be a mandate to hold most health care prices at their present level.

The Anti-Rationing Group is committed to avoiding the rationing of effective health care through the implementation of practical measures targeted at the rationalisation of price. Its guiding principle for the delivery of publicly funded health care systems faced with the threat of rationing is the need to control price before rationing supply, for overpricing offends the principles of equity and of natural justice. It believes that there are considerable opportunities for price control in the NHS which, if implemented, would release resources for redeployment elsewhere, sufficient to eliminate any need to ration effective health care in the short or medium term future.

The resolution of these issues is clearly of the utmost importance, and the Anti-Rationing Group is eager to contribute to this debate. Indeed, in this regard the Rationing Advisory Group and the Anti-Rationing Group share the belief that there is a need for public discussion and education. The Anti-Rationing Group therefore looks forward to developing the arguments (perhaps in the *BMJ*) with the support of abundant evidence that has so far been unrefuted, if not largely ignored.

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1 Smith R. Rationing health care: moving the debate forward. *BMJ* 1996;312:1553-4. (22 June.)
2 New B on behalf of the Rationing Agenda Group. The rationing agenda in the NHS. *BMJ* 1996;312:1593-601. (22 June.)
3 Roberts CJ, Crosby DL, Dunn R, Evans K, Grundy P, *et al.* Rationing is a desperate measure. *Health Service Journal* 1995;105(5435):15.
4 Crosby DL, Roberts CJ, Hopkins R, Jones JH, Lewis PA, *et al.* According to the evidence. *Health Service Journal* 1995;105(5442):23.
5 Dunn R, Vetter NJ, Harvey L, Lewis PA, Crosby DL, *et al.* What do we mean by "case"? *Health Service Journal* 1995;105(5446):21.

Patients have strong input into purchasing decisions in Droitwich

EDITOR,—We were interested in Richard Smith's editorial on rationing health care and in how fundholding practices are trying to involve patients in their rationing decisions.[1 2] We report developments in the Droitwich Locality Project, which has sought the involvement of patients in all of the decisions of the commissioning group since its inception in 1995.

The Droitwich Locality Project is a commissioning group consisting of two fundholding and one non-fundholding practice which cover a population of 28 000 people. A patient panel is integral to the decision making of the locality steering group.

The panel was formed after discussions with the local community council and the Droitwich

Community Health Forum. This was a group who represented over 60 voluntary organisations in the locality. The panel has eight members, six being core members nominated from the health forum and two being roving members who represent other groups that are coopted on to the panel when discussions involving their particular interest group are taking place. There is a close relationship with the Community Health Council, which has secured research and development monies to pay for the training of panel members in certain skills.

The patient panel participate in project work and in the purchasing decision making of the steering group. This group will be involved in "rationing" decisions, which are really just part of the purchasing intentions of the group.

Reference has been made to previous work done in this field in Oregon and the Netherlands, and information and support has been obtained from the Worcester Public Health Department. There is also a public health consultant also on the steering group.

With all the hard work that has been put into the formation of the group, the purchasing decisions now reflect the wider view of the population of the Droitwich area, and we believe that this integrated response is a leader in its field. We plan to fully evaluate the process and publish in the future but thought that it would be of benefit to share our developments with readers of the *BMJ*; we also hope that other locality commissioning projects are working as closely in partnership with the patients that they serve as we are.

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1 Smith R. Rationing health care: moving the debate forward. *BMJ* 1996;**312**:1553-4. (22 June.)
2 Crisp R, Hope T, Hobbs D. The Asbury draft policy on ethical use of resources. *BMJ* 1996;**312**:1528-31. (15 June.)

US judicial guidelines on sentencing could show way forward for NHS

EDITOR,—Allocation of scarce medical resources presents problems that have striking similarities to judicial sentencing or the decisions of parole boards. Both the medical and judicial decisions involve ethical and technical constraints. Both must avoid disparity. Both must in principle be accountable to the public, and both must be seen to be fair.

In some states of the United States, notably Minnesota, judicial sentencing guidelines have been developed by the Sentencing Commission to ensure that the punishment allocated both fits the crime and avoids disparity between individual judges. For a crime of a particular degree of seriousness and an offender with a particular record, the judge refers to the guideline sentence. He or she can give any sentence that fails within the limits of the guidelines (such limits being originally defined as a given departure from the mean sentence for the particular combination of seriousness and record). If there are exceptional circumstances and the judge wishes to give a sentence that lies outside these limits, he or she must give reasons for departing from the presumptive disposition. The guidelines are published and reviewed periodically.[1]

Initially the guidelines for the fair allocation of prison terms were derived from research projects funded by the US Federal Parole Commissioners, who had been criticised for disparities in their decisions and were under political pressure to curtail their discretion. In much the same way, the allocation decisions being made by providers of medical care are now under criticism for disparity. Proposals for change have been made, but on the basis only of general principles, not of current best practice.[2] Before we can move towards a more rational rationing, we need to model rationing decisions as they now exist and attempt to quantify the current practice in probabilistic terms. The mathematical description of decisions could have at least three important benefits: (*a*) it would be possible to allocate resources more evenly and equitably, (*b*) the allocation could be more efficient, and (*c*) the moral principles underlying the decisions would be available for scrutiny. The modelling could facilitate the creation of a codified general policy, formulated as guidelines, which would allow discretion for truly exceptional cases with elements that are not covered by the general policy. Public debate on the principles that underlie the guidelines would draw attention away from the dramatic cases that so often prejudice both the ethics and the effectiveness of decisions.

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1 Wilkins LT. *Consumerist criminology*. Heinemann: London, 1984:130-7.
2 Smith R, ed. *Rationing in action*. London: BMJ Publishing Group, 1993.

Degree of rationing in Zaire would be unacceptable in Britain

EDITOR,—The paper by the Rationing Agenda Group and the accompanying editorial by Richard Smith are encouraging a serious and more public review of rationing within the NHS.[1 2] While working as a junior doctor within the NHS I was rarely bothered by the issue, but it is unavoidable here in north east Zaire, and it is occurring at a level of health care that would be unacceptable in Britain. For example, we have decided not to obtain a supply of third generation intravenous cephalosporins to treat meningitis, despite having experienced a number of treatment failures with benzylpenicillin and chloramphenicol. The hospital does not pay for postexposure rabies vaccination, and until recently diabetic patients needing insulin were discharged home if they could not pay for their treatment.[3] These decisions have been made on the basis of cost effectiveness; if we subsidised these conditions then other hospital activities would suffer—activities considered to be more important.

"Health for all" is a much used phrase that has an ambiguous meaning. If by it we mean perfect healthcare provision for everybody then we are living in a fantasy world. Reality tells us that many people have little or no access to affordable health care. Rationing is difficult, especially so when it impacts on your daily work, but by admitting the need for rationing we can escape from the fantasy world of perfect healthcare provision and rationing then becomes a useful tool. It can even become a positive experience, albeit a difficult one. Done well and reviewed frequently it may combat the sense of frustration encountered by those working in a situation with grossly inadequate resources, for by wielding this tool effectively and bravely it can help us achieve the best possible healthcare provision for the greatest number of people in any given situation.

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1 New B on behalf of the Rationing Agenda Group. The rationing agenda in the NHS. *BMJ* 1996;**312**:1593-601. (22 June.)
2 Smith R. Rationing health care: moving the debate forward. *BMJ* 1996;**312**:1553-4. (22 June.)
3 Burdon J. Another deadly Zairian disease. *BMJ* 1996;**313**:58. (6 July.)

Responsibility for social care needs to be considered

EDITOR,—The article by the Rationing Agenda Group was well thought out and comprehensive.[1] I would like to comment on what should be health and what should be "other" forms of care responsibility—that is, social, etc. Although I agree that, ideally, social care should be the responsibility of agencies other than the NHS, in practice this is not the case. Because of funding problems the NHS is often "forced" into paying for social care as a form of insurance against the greater health consequences of not doing so.

I have responsibility for purchasing for mental health, learning disability, and substance misuse locally, and this is a definite and worsening problem. For instance, if we do not spend money on social care in the form of partnership homes or day care or as intensive social support for some ex-users of NHS beds for any of the above three reasons we risk being forced into purchasing far more expensive care—for example, for inpatients, as extracontractual referrals, or privately. We therefore pay for such services knowing that they are predominantly social but being aware that we cannot unilaterally extract the NHS from doing so either on moral or ethical grounds (casting the patients out) or on legal grounds (against government guidance on joint working).

I accept that an ideal position may need to be stated, but to help in reality I think that such practical problems must be faced by any group trying to shed light on the subject. This interface is a huge area of spend (up to 20% of the NHS budget for some of these client groups).

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1 New B on behalf of the Rationing Agenda Group. The rationing agenda in the NHS. *BMJ* 1996;**312**:1593-601. (22 June.)

Elective waiting lists are becoming explicitly rationed

EDITOR,—The move from implicit to explicit rationing is already under way in the management of elective waiting lists, giving immediacy to the philosophical and practical questions raised by the Rationing Agenda Group.[1]

Conflicts have emerged between NHS managerial performance measures and clinical priorities for the management of waiting lists.[2] The need for the explicit, transparent, and accountable prioritisation of elective waiting lists, perhaps through points schemes, is becoming more evident. Although consultants distinguish between urgent and routine cases on their waiting lists, centralised administrative booking systems in hospitals make further prioritisation within urgency categories difficult. This results in a largely first come first served system. NHS waiting time targets have, until recently, focused debate on achieving waiting times in line with guarantees in the patient's charter. This has served to deflect attention away from the role of waiting lists as a rationing mechanism. Purchasers facing financial constraints are beginning to look at waiting lists as rationing mechanisms.

To avoid further conflicts between clinical and managerial goals for waiting list management, explicit criteria for their prioritisation will be