in psychiatry and other areas of medicine.[8] Will those who practise cardiac rehabilitation be able to see this as a useful conclusion?

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Rationing health care

What use citizens' juries and priority committees if principles of rationing remain implicit and confused?

After a "spring offensive" on healthcare rationing,[1-4] new work is falling on the NHS like autumn leaves. Three recent books examine the hard choices of resource allocation.[5-7] They offer insights into the processes of rationing and how these processes might be developed, for example, by greater citizen involvement and national mechanisms of priority setting. But does all this academic effort help or hinder policy making?

There seems to be a consensus that rationing is ubiquitous in all healthcare systems, yet in no country is there a clear and publicly accepted set of principles that can determine who gets what health care and when. The NHS has a limited budget of over £40bn, and clinicians, purchasers, general practitioners, and providers are given discretion to "do their own thing," rationing care by rules that differ and are incoherent and implicit.

This leads to both inefficiency and inequity. The discussion of the handling of the case of Child B[8] raises questions about the media's capacity to deal with life and death situations when competition for circulation encourages sensationalism. There is also an absence of critical review among complacent politicians and policy makers who condone waste and enhance inequality. While Cambridge and Huntingdon health authority chose not to finance Child B's "experimental" care, other purchasers indicated that they would have treated her. The Department of Health condones such practices by encouraging local discretion. The result is that in a national health service patients get unequal access to care.

They also get unequal access to inefficient care. Can Cambridge and Huntingdon health authority show that it provided no other treatments of dubious effectiveness or cost effectiveness at the time that it refused to treat Jaymee Bowen? Did it or other purchasers fund care, for example, of HIV positive children who were haemophiliacs or of adults with terminal AIDS? Why make a special case of this child if other people were being treated at high cost and with little evidence of benefit in terms of length and quality of life? Should experimental treatments of unproved cost effectiveness be provided by NHS purchasers when it would be more sensible to control the diffusion of new technologies until research has shown their effectiveness and cost effectiveness?[7]

Such issues are glossed over all too often in the 1996 crop of literature on rationing. This partial analysis is facilitated by a reluctance of authors to articulate the principles of rationing and to examine the consequences for policy.

Let us assume that the purpose of the NHS is to improve the health of the population, and that health is defined as length and quality of life. Thus clinicians and managers in the NHS are seeking to allocate the NHS budget using the benefit principle: patients will be prioritised in relation to their capacity to benefit from care (improve their length and quality of life) per unit of cost. If patients' needs for health care—the scope for them to benefit from care in terms of "well-years"—are provided by imposing the least sacrifice (or cost) on others, the NHS will use resources efficiently. Such an outcome is ethically desirable. If care was provided inefficiently potential patients would be deprived of care from which they could benefit. Such inefficiency is unethical.

The efficient use of scarce healthcare resources might not be the only objective of society. Society may be prepared to forego efficient health gains in order to behave "fairly." If health gains are to be sacrificed to achieve fairness, it is necessary both to define this concept and to monitor the transfer of health gains derived from efficient behaviour to achieve goals in equity.[9] One possible definition of "fairness" in health care is that decision makers will use the NHS to reduce inequalities in people's lifetime experience of health. Such an approach reflects the idea of a "fair innings" and could support the transfer of health gains from elderly people—who have had their "seven score years and ten" (or, hopefully, more)—to young people. Thus, the NHS might deny efficient treatments—such as hip replacements or coronary artery bypass grafting—to those who have had a fair innings in order to redistribute resources and inefficiently treat young, chronically ill patients.

Evidence based rationing requires the careful measurement of costs and health outcomes, and the redistribution of health to inform decision makers about the performance of the NHS in relation to agreed public criteria for rationing. Evidence based medicine, with its primary focus of clinical effectiveness, is not enough. Until principles of rationing are established and measurement is improved, allocation of NHS resources will continue to be inequitable and inefficient.

The autumn crop of literature on rationing includes interesting reading, but some of it is inconclusive and diffuse. What is the use of "rights," citizens' juries, and a national priority committee if the principles of rationing remain implicit and confused? Such mechanisms would be of much greater benefit if NHS practices could be appraised in relation to socially agreed criteria that determine access to limited NHS care.

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