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Priorities and rationing: pragmatism or principles?

See p 767

Time for Britain to follow the Netherlands, New Zealand, and Sweden's lead and get serious

There is always the danger of assuming that the NHS's problems are unique: that they reflect either the special characteristics of Britain's health care system or the government's niggardliness in funding it. The issue of priority setting—or, more emotively, rationing—is a case in point. This is not some peculiar British obsession. All health care systems have to grapple with the problem of how best to allocate scarce resources. The real difference is between how different health care systems have tried to address this issue: between those countries that, like Britain, tend to diffuse responsibility and those that have sought to develop a national framework for the decisions of health authorities and clinicians.

Britain's Department of Health issues an annual set of priorities, but these are largely a shopping list reflecting the department's current concerns. In contrast, other countries have sought to develop explicit criteria for guiding decisions about allocating resources. While Britain relies (as usual) on pragmatic incrementalism, with policy emerging almost as a byproduct of individual decisions, others have sought to devise a set of principles designed to shape those individual decisions. So which is the right way forward? Should policy be guided by pragmatism or principle? And, in making this choice, what can be learnt from other countries?

In trying to answer these questions we can now draw on the experience of three attempts by governments to devise national criteria for priority setting. In 1992 the Dutch government's Committee on Choices in Health Care produced what has since become known as the Dunning report, named after its chairman.[1] The same year New Zealand established the National Advisory Committee on Core Health and Disability Support Services, which has since produced a stream of reports.[2] And most recently the Swedish Parliamentary Priorities Commission issued its final report.[3]

One very simple conclusion emerges from a comparison of these exercises: no readymade formula exists for deciding on priorities. The one common element in the three attempts to determine priorities is their rejection of an economic approach —that is, ranking services according to the ratio between costs and benefits. The Swedish report is most explicit in taking this view: "The Commission does not accept a benefit principle basically implying that the choice must fall on that which confers the greatest benefit on the greatest number. Thus the Commission reject the idea of deploying resources to help many people with mild disorders instead of a few with severe injuries or giving priority to the patients who are most profitable to society." Considerations of efficiency—that is, least cost for the greatest benefit—should be limited, the commission believes, to choices between different kinds of treatment for the same condition and should not be invoked in choices between the claims of different services or specialties.

The conclusion of the Swedish commission follows from its definition of the principles that should guide all choices. They are the principle of human dignity (which emphasises that all people have the same rights irrespective of their personal characteristics), of need (which emphasises that resources should be devoted to those in greatest need), and of social solidarity (which emphasises that the most vulnerable groups should be given special consideration). Building on these principles, the commission then develops a hierarchy of priorities. Top of the list come acute conditions, in which failure to treat would lead to disability or death, and severe chronic disease, such as rheumatic disease and prolonged mental disorders. Then come prevention and rehabilitation, followed by the treatment of less severe acute and chronic conditions such as varicose veins, gastritis, and prostatic disorders. Bottom of the list comes care for reasons other than disease or injury. Greater needs are always to have precedence over lesser ones. But, the commission acknowledges, managers and doctors will interpret these priorities somewhat differently. The managers will be guided by the needs of the population as a whole; the doctors will be guided by the needs of individual patients.

The approach of the Dutch and New Zealand bodies was somewhat different from that of the Swedish commission. This, in turn, reflected differences in their remit. They were charged with advising their governments on a basic package of health care to which all members of the population would be entitled. Significantly, however, their conclusion was not so very different from that of the Swedish commission—instead of coming up with a defined package of core services they developed criteria for assessing competing claims on resources. In the case of the Dunning committee, the recommendation was that all such claims should have to pass four tests. Firstly, is intervention necessary to allow individuals to function in society? Secondly, is the treatment effective? Thirdly, is it efficient? Fourthly, could it be considered a matter of individual responsibility? So, for example, it argued that in vitro fertilisation could be left out of any basic package on the ground that no one has a right to have children, and adult dental care could similarly be omitted because it was a matter of individual responsibility.

The New Zealand case is somewhat different again. The committee there has decided that "excluding whole treatments, services or diagnostic categories is arbitrary and does not have the capacity to tailor services according to the needs of individuals."[4] It has developed a four point framework, however, for making decisions about allocating resources. The four criteria are that treatment or service should provide benefit and value for money, that it should represent a fair use of resources, and that it should be consistent with community values. The committee's main work, however, has consisted in developing consensus among the medical profession about the desirability of particular forms of treatment and generating public debate about such issues as whether social factors should play any part in deciding priorities in the treatment of individual patients. Like the Dunning committee it has proposed that there should be explicit national criteria for determining the need for non-urgent surgery and diagnostic procedures—replacing waiting lists by "booked admissions." Unlike the Dunning committee, whose life ended with the publication of its report, the New Zealand body is implementing its own recommendation in cooperation with the medical profession.

What conclusions can be drawn from this international experience? Firstly, drawing up a set of principles is extraordinarily difficult. There is little cross national consensus: contrast Sweden's rejection of a cost-benefit approach with New Zealand's use of the value for money criterion. Secondly, where agreement exists it tends to be about the easy options: thus everyone is agreed that ineffective treatment should not be offered. Thirdly, the devil lies in translating general principles into practice, particularly when it comes to the treatment of individual patients. There is a case, therefore, for pragmatism—that is, for distilling general rules from practice rather than imposing a set of principles on practice.

Accepting such a conclusion does not, however, imply grounds for self congratulatory complacency in Britain, for Britain's pragmatism is half baked. There has been no systematic attempt to draw out, let alone codify, the implications of practice in the setting of priorities: to examine, for example, the assumptions about the allocation of resources implicit in clinical guidelines. Here the example of New Zealand is instructive. The Swedish parliamentary commission and the Dunning committee were one off exercises. Once the tablets of stone were delivered, work stopped. In contrast, the New Zealand core services committee is engaged in a continuing process of dialogue with doctors and the public. Priorities and criteria for rationing emerge from this process.

It is difficult to know just how effective the New Zealand committee has been in influencing public policy or medical practice and whether such a model would survive transplantation into the very different environment of the NHS. Nevertheless, the New Zealand experience strongly supports the recommendations of the Royal College of Physicians that a National Council for Health Care Priorities be established "to identify all the relevant issues, analyse them publicly and comprehensively, and satisfy all interested parties that their views are being considered" (p 767).[5,6] Precisely because there is no way of resolving this question once and for all—because changing medical technology and shifting social attitudes will always create new dilemmas of choice—there is all the more reason for institutionalising what is bound to be a continuing debate.

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2 Cumming J. Core services and priority-setting: the New Zealand experience. *Health Policy* 1994;29:41-60.
3 Swedish Parliamentary Priorities Commission. *Priorities in health care.* Stockholm: Ministry of Health and Social Affairs, 1995.
4 National Advisory Committee on Core Health and Disability Support Services. *Third report: core services for 1995/96.* Wellington: Core Services Committee, 1994.
5 *Setting priorities in the NHS: a framework for decision-making.* London: Royal College of Physicians, 1995.
6 Smith J. Royal college calls for national priority setting. *BMJ* 1995;311:767.

Emergency contraception

Time to loosen medical controls over its availability

See p 806, 807

Emergency hormonal contraception is well established in the form of the Yuzpe regimen.[1] This comprises 100 μg ethinyloestradiol and 1 mg levonorgestrel given in two doses 12 hours apart. The first dose must be given within 72 hours of the unprotected intercourse or failure of contraception. At present only one medicinal product (PC4) is licensed for the purpose (although an alternative is four tablets of the combined oral contraceptive ethinyloestradiol 50 μg and levonorgestrel 250 μg (Ovran)), and may be obtained only on prescription from general practitioners, family planning clinics, and some accident and emergency departments. But a growing number of doctors would like emergency contraception to be made more widely available, recognising that it could do much to reduce the abortion rate among teenagers.[2] Acting before implantation, the method does not constitute abortion under the terms of present legislation.

Studies suggest that three out of four potential pregnancies are prevented by emergency hormonal contraception.[3] A strong belief persists, not only among potential users but also among doctors,[4] that such contraception is medically unsafe and should be prescribed with great care. One hundred micrograms of ethinyloestradiol is perceived as a high dose of oestrogen, with all its expected risks—but only five adverse vascular reactions in association with the Yuzpe regimen have been reported to the Medicines Control Agency over the past 10 years.[5] When drawing up guidelines, the clinical and scientific committee of the Faculty of Family Planning found few contraindications to its use.[6] Suspected pregnancy is an absolute contraindication, as is migraine at the time of presentation in a woman with a history of focal migraine.

Patients who are immobile, have known abnormalities of clotting factors, or have a history of thromboembolic disease have a theoretically increased risk, but this should be weighed against the known risks of pregnancy. When the Yuzpe regimen was introduced an increased risk of ectopic pregnancy was feared but only one case has been reported, in a woman with tubal disease.[7] Breast feeding is a relative contraindication until feeding is established.

Should we be anxious about repeated use of emergency hormonal contraception? Three episodes of use in a single cycle would still be equivalent only to a packet of a modern low dose combined pill. Nausea is common, and it seems