

and logistic support to locally owned outlets whose proprietors take the financial risks of trading.¹³ In the NHS the Department of Health acts as a franchiser, getting a network of outlets at low cost and minimal risk, with a committed and stable professional workforce with extensive knowledge of local markets. As franchisees general practitioners get protection against risk (through cost rent schemes, NHS super-annuation, and other forms of support); some element of managerial help; technical support (open access investigative services in local hospitals); local autonomy and everyday control of activity; and profits subject only to taxation under schedule D.

Franchising may be a form of organisation in which success is cloned rapidly at limited cost, and this may be one reason why the government is now seeking to shift hospitals and community services on to a franchise basis. But franchising has features that its advocates in general practice may not yet understand.¹³

To maintain a standardised product or service franchisers seek increasing control over franchisees as time passes and as the outlet network enlarges and becomes more complex in its activities. Unilateral modification of contracts by franchisers occurs, and the independence of the franchisee may be eroded by increasingly specific contractual obligations. A point may be reached where the franchisee has all the responsibilities of an employee but none of the rights—for example, paid maternity leave.

Finally, franchising may result in the rapid development of an industry that becomes too complex and too costly for local entrepreneurs to buy into and manage, so that the franchiser imposes its own management structure. The best example of this in Britain is McDonald's, which operates a franchise in the United States but mainly as a directly managed industry in Britain.

As the general practice franchise enlarges and takes on roles beyond the traditional function of gatekeeper its managerial capacity will be strained. Management skills among general practitioners are notoriously limited, and even in the extreme model of franchise, the fundholding practice, managerial skill is notable for its absence.¹⁴ Franchisers spending increasing amounts in supporting the growing franchise operation will want ever better value for money and ever greater standardisation of service. If this is not forthcoming they will be tempted

to take over completely. Elements of this may be emerging where inner city general practitioners opt to join community health trusts.¹⁵ At some future time, however, a primary care led NHS might enter a crisis of management and of service provision which will be solved through the direct control of general practice. The precedent exists in the speedy and easy conversion of the Swedish health service to one based on salaried status in 1970.¹⁶

Equally, the ability of newcomers to general practice to buy into increasingly costly outlets may fall, so that group practices become dominated by a shrinking core of established principals with a peripheral group of salaried doctors working for them on a sessional basis. The American experience of youthful doctors passing through or getting stuck in salaried posts where clinical decisions can be distorted by the commercial considerations of the practice's owners⁵ will then become relevant to us. Not only is the GMSC's decision to open debate about a salaried option less odd than it seems at first but it may indicate that general practice's negotiators are beginning to recognise necessity. The result of the ballot on *Your Choices for the Future* vindicates their decision.

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Warning signals from Oregon

The different dimensions of rationing need untangling

The Oregon experiment has become part of the folklore of the NHS. If we want to see what the future holds for the NHS, it is argued, we need only look at what is happening in Oregon now.^{1,2} The role of the purchasers in the new style NHS means that they will have to decide what services to buy—or not to buy—on behalf of their populations. The implicit rationing that characterised the NHS in the past has to be made explicit: the responsibility for allocating scarce resources, previously largely diffused among clinicians, is now concentrated in the purchasing authorities. In turn, therefore, these have to choose between competing claims on resources and devise criteria that can be publicly justified. And if this is the shape of things to come where better to look for a model than Oregon—for Oregon has been engaged in precisely such an endeavour for the past three years.

In effect, Oregon has provided a laboratory in which techniques for devising rationing formulas have been tried out. The results of the experiment are therefore of great interest. Unfortunately, they are also ambiguous and difficult to interpret. So much is clear from a report of a symposium on the Oregon plan, organised and published by the Brookings Institution, which brings together the views of both the proponents and the critics of the initiative, medical and lay.³ This suggests that Oregon holds out a warning rather than offering a model for import into Britain: a warning that there are no ready made techniques for determining choices among competing priorities in health care.

In its origins the Oregon plan was an attempt to devise an appropriate package of health care for those covered by the state's Medicaid scheme, the safety net programme for the

poor. There was a double aim in this. Firstly, the intention was to force the state's legislature to choose what health care it was prepared to finance by providing it with a ranked and costed list of procedures. Secondly, the hope was that this package would then be used as the benchmark model for designing an insurance scheme to cover the state's entire population: that it would define the basic minimum of health care protection to which everyone was entitled.

The procedures for determining the basic minimum set were both elaborate and sophisticated. They involved collecting data about outcomes from expert panels, devising quality of wellbeing scores for specific outcomes on the basis of telephone interviews with the public, and holding community meetings to elicit the value attached to broad categories of services. Nevertheless, the first ranking list produced by the Oregon Health Service Commission, more than half of whose members were health professionals, provoked much criticism and sent the commissioners back to the drawing board. The second list, ranking 709 items, was published in 1991. The Oregon legislature has since agreed to fund the first 587 items and to extend coverage to the poor excluded from the Medicaid scheme. Implementation of the Oregon plan still awaits approval from Washington.

Much of the debate in the report of the Brookings symposium is, inevitably, concerned with specific American concerns. In particular, there is much argument about the ethics of devising a rationing system specifically for the poor. However, the analysis of the way in which the priorities were determined—the mechanics of making rationing decisions—have implications for Britain. Here the differences between the first and second ranking lists are central. The first list was, essentially, a crude exercise in number crunching: the ranking of the different procedures followed automatically from the relative costs of producing given quality of wellbeing outcomes. In contrast, the second list was the product of a more complex process. The attempt to use cost-benefit or cost-effectiveness criteria was, in effect, abandoned because of lack of adequate data. Instead, the commissioners put more emphasis on community values and their own judgments about what was reasonable.

The second exercise produced a very different and more acceptable list. But the price paid for doing so, as many of the contributors to the Brookings symposium point out, was heavy. The decision making process was opaque. It is not clear what weight the commissioners gave to their own intuitions as distinct from the evidence about outcomes and benefits or community values. What started as an exercise in participatory democracy seems to have ended up, in the absence of popular interest, as a debate among experts.⁴ There were other oddities about the exercise. As Robert Veitch, director of the Kennedy School of Ethics at Georgetown University, argues, moral judgments seem to have crept into the rankings: thus liver transplantation for alcoholic cirrhosis was ranked 690 whereas liver transplantation for cirrhosis not involving alcohol was ranked 366, even though the outcome for the first is as good or even better.

The problems do not stop there. Most fundamentally, the Oregon exercise conflates the various dimensions of rationing. It focuses exclusively on specific conditions and procedures.

Thus it ignores, on the one hand, rationing in the process of intervention—that is, as Veitch once again points out, deciding that appendicitis should be treated is easy, but laying down what resources should be used during treatment (the numbers of tests, nurses, operating room staff, and so on) is difficult. In other words, the most important rationing decision in terms of resources may be not what to treat but how to treat—the investment in avoiding risk. On the other hand, the Oregon approach ignores the sheer heterogeneity of patients: within any broad category there will be some patients who will benefit greatly from treatment while others will not. So excluding any particular form of intervention on the grounds that outcomes are generally poor may also exclude individual patients with a good prognosis.

The main conclusion to be drawn from the Oregon experience is therefore that the notion of rationing needs to be disentangled. There are at least four different dimensions to rationing. Firstly, there are decisions about the allocation of resources to broad sectors or client groups. Secondly, there are decisions about the allocation of resources to specific forms of treatment (particularly those which require investment in new facilities) within those broad sectors or groups. Thirdly, there are decisions about how to prioritise access to treatment between different patients. Fourthly, there are decisions about how much to invest in individual patients—by way of diagnostic procedures and so on—once access has been achieved. The first two dimensions are clearly the responsibility of purchasers; the second two are the responsibility, primarily, of doctors.⁵

In none of these four dimensions of rationing is there a simple technical fix that will give the required answers. If the Oregon experiment has shown anything it is that there is no such formula, be it an appeal to cost effectiveness analysis or an appeal to public opinion. In all of them, however, there is a need to engage in dialogue about how to devise the criteria for decision making. And the means chosen to promote such a dialogue, as well as the participants involved, are likely to be very different in each of the various dimensions of rationing.

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Correction

Accreditation after Goldstein

We regret that we made an error in the editorial by Mr Stephen Brearley (29 February, p 518). The statement that the certificate of specialist training has "no legal standing" in the United Kingdom is incorrect. As part of European Community law such certificates do have legal standing and are registerable by the GMC. This sentence should have read that they have "little effect in the United Kingdom," unlike in some other EC countries, where they are the basis of reimbursement from state sponsored health insurance schemes.