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Rationing health care: moving the debate forward

Groups in Britain are encouraging the debate that the government won't lead

When governments and politicians do not act, the people may. In Britain neither the government nor the main opposition party will openly acknowledge the inevitability of rationing health care. Instead, they talk of increasing the effectiveness of health care, spending more on the health service, and setting priorities locally.

Their implication to the public is that nobody will be denied potentially beneficial treatments. But almost all of those who spend any time studying this subject recognise that people have always been denied potentially beneficial treatments, and they always will be no matter how much is spent on health services. These commentators believe that governments should come clean with the public and lead a debate on how best to ration health care. Because British political leaders will not accept this challenge, various organisations and ad hoc groups have begun to try to find ways to include the public in the debate on rationing health care. Some of these initiatives are covered in this week's and last week's *BMJ*.

Most commentators accept that rationing is inevitable, but the debate keeps returning to this point because the politicians refuse to acknowledge it. Yet many health authorities in Britain are explicitly excluding beneficial treatments.[1] Some sorts of care that were once available on the NHS—adult dental care and long term care of elderly people—are falling away. Britain's mental and geriatric health services are threadbare. Doctors' time and attention—which are effective in themselves for many conditions—always have been and always will be rationed. New and expensive treatments, like interferon beta for some sorts of multiple sclerosis, are not available to many people who might benefit from them.[2]

The British government likes to suggest that the drive for effectiveness will obviate the need for rationing. No doubt substantial sums can eventually be saved by stopping ineffective interventions, but there are increasing examples of treatments that have been proved effective but which are hugely expensive when given to certain sorts of patients. Thus statins have been proved beyond doubt to reduce deaths in patients with coronary artery disease and raised serum cholesterol concentrations. But the cost of a life year saved in women aged 45-54 years with angina and a cholesterol concentration of 5.5-6.0 mmol/l is £361 000 ($541 500).[3] The same story—of proved effectiveness but impossibly high costs for some patients—is true for treating patients with hypertension with angiotensin converting enzyme inhibitors, screening for cardiovascular disease,[4] and many other interventions. The last drops of effectiveness are available at unaffordable costs, which means that decisions must be made to deny some people effective treatments.

The debate over rationing should not be confused with debates over effectiveness and funding of the health service. Few people disagree with the need to increase effectiveness, and there is little controversy about denying ineffective treatments. Many people in the health service think that more funds should be available for health care, and many members of the public support such a proposal. But these are separate debates. More effectiveness and more money will not remove the need to deny effective treatments.

In other countries, governments or state legislatures have taken the lead in the debate on rationing health care. The well known Oregon experiment is almost a decade old,[5] and the governments in Sweden,[6] Norway,[7] New Zealand,[8] and the Netherlands[9] are all active in continuing projects to involve the public in rationing health care. In Britain several local health authorities have consulted the public on the subject,[10] various researchers have sought the public's views,[11 12] the BMA has passed motions at its annual meeting calling for a national debate on rationing,[13] the Royal College of Physicians has called for a national council for health care priorities,[14] and the media keep returning to the issue as cases of "rationing" are uncovered.

The public's role

Last week, we published an account of a fundholding practice trying to involve its patients in rationing decisions.[15] This week we publish a draft agenda for the debate we have to have on rationing (p 1593),[16] an account of using citizens' juries to consider rationing (p 1591),[17] further clarification from the Royal College of Physicians on its proposals (p 1609),[18] and a detailed analysis of how the press covered the case of child B (who was initially denied further treatment for her leukaemia by her health authority) (p 1587).[19] Some general messages seem to emerge from all this work. Firstly, many members of the British public do recognise the need for rationing. Secondly, most people seem to think that the public does have a part to play in rationing health care. Thirdly, many people are deeply uneasy about rationing happening locally without national debate and guidance.

All this amounts to Britain "muddling through" in a way that is very British. But we need to do better. Rudolf Klein, one of Britain's best informed and most acute observers of the health service, has called this British pragmatism "half baked."[20] We need, in the words of the Royal College of Physicians, "to identify all the relevant issues, analyse them publicly and comprehensively, and satisfy all interested parties that their views are being considered."[14] The Rationing Agenda

Group has made a first stab at identifying all the issues to be considered (p 1593).[16] But government needs to take the lead and to institutionalise what will have to be a continuing debate.[20] The major parties are not likely to acknowledge this before the general election, but sanity will return once the votes have been counted: Britain's next government must take a lead on health care rationing.

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Clinical guidelines in the independent health care sector

An opportunity for the NHS to observe managed care in action

Ever since Aneurin Bevan "stuffed the consultants' mouths with gold" the place of private medicine in the provision of health care in the United Kingdom has been much debated. With over six million lives insured—over 10% of the population—and with numbers forecast to rise,[1] the independent sector is an increasingly important provider of health care. The activities of the private sector have the potential to influence the NHS and cannot be ignored. Indeed, the private sector might act as a test bed for measures, such as clinical guidelines, that the NHS would like to see widely implemented.

Eighty per cent of private health care bought in Britain is funded by insurance. To keep premiums low, insurers must contain costs, and one perceived mechanism is evidence based medicine. Some of the larger insurers are therefore introducing clinical practice guidelines into their business. BUPA, for example, has set up clinical consensus panels to develop professionally led guidelines that will "encourage the delivery of the very best health care...both in terms of appropriateness and quality of outcome."[2] The clinical guidelines being developed or in use cover mainly high cost, high volume elective surgery, which constitutes the bulk of private medical insurers' business, but psychiatric and medical guidelines are also being developed.

Implicit in this activity is the belief that guidelines will eliminate inappropriate treatments, improve quality, reduce costs, free up resources, and avoid the need for rationing—a concept not usually associated with private medicine. Insurers see quality and long term cost control as closely linked. Thus the agendas of the private sector and the NHS are not so different. What is different is the approach to the implementation of guidelines. Whereas the NHS encourages the use of evidence based medicine in general and guidelines in particular to promote best practice, the independent sector will increasingly be using guidelines to authorise care before it is given or to contract with preferred providers. This guideline activity is thus a springboard for the introduction of the American concept of managed care.

Defined as "a variety of methods of financing and organising the delivery of comprehensive health care in which an attempt is made to control costs by controlling the provision of services,"[3] managed care is increasingly being discussed as a possible part of future British health policy. Yet there has been little real debate on how, or indeed whether, the concept of managed care might be applied in the NHS. Its introduction and evolution in the private sector may well have lessons for the NHS.

Influencing doctors' practice towards high quality, cost effective care is critical to the success of evidence based medicine but not always easy to achieve. The contracting process has been suggested as having the potential to support the implementation of guidelines,[4 5] though doubts have been expressed about this approach.[6] By contracting with preferred providers to work within guidelines through managed care, private insurers could be "purchasing guidelines" to a greater extent than is currently the practice in the NHS. Will this achieve, firstly, a change in practice and, secondly, better clinical and financial outcomes?

Managed care works by modifying the practice of doctors by using clinical guidelines, by financial incentives, by restricting access to specific doctors (preferred providers), or by a combination of all three measures. If insurers are successful in using managed care to change practice nationally, in volume and across specialties, then the NHS must take note. On the other hand, if the private sector, with its strong financial levers, is unsuccessful what chance has the NHS? Just as doctors value their clinical freedom, insured patients value freedom of choice and expect a luxury product at a competitive price. They will not pay to be rationed when they can be rationed on the NHS for free. Therefore, how insurers market guidelines and managed care to both clinicians and their subscribers will be central to their success—and of great interest to the NHS.

Although a claims driven system allows insurers to evaluate use and cost, long term clinical outcome data are presently lacking. Insurers are developing increasingly sophisticated information systems which may help to overcome this problem. In addition BUPA has recently announced that it will provide some primary care services. An extension of this and other possible initiatives by some insurers, such as the establishment of health maintenance organisations, may also help to provide long term outcome data.

In the short term, cooperation with the NHS to provide data is one possibility. Some insurers are willing to cooperate with the NHS by sharing skills and information or by contributing