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