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ASSOCIATION OF
COMMUNITY HEALTH COUNCILS
FOR ENGLAND & WALES

HEALTH NEWS BRIEFING

RATIONING HEALTH CARE -

Should Community Health Councils Help?

Summary

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SUMMARY

Introduction

The National Health Service has always rationed health care in the sense that there has always been unmet need. However, there is now great interest in how health care rationing is done and ought to be done. This can be put down to:

1. Concern that there is a growing gap between what is technically possible and what is affordable.

2. The Government's commitments to reduce public borrowing and hold down taxation.

3. Enthusiasm for opening up decision-making in public services and challenging doctors' authority.

4. Improved information gathering in the NHS.

5. Interest in attempts to ration health care in the USA state of Oregon.

6. Government policy initiatives:
   (a) the maximum waiting times set out in the Patient's Charter.
   (b) the health targets set out in The Health of the Nation.
   (c) the purchaser-provider split.

Rationing in Theory

It is possible to distinguish two main theories about how best to set priorities for health care services.

The first is the 'health gain' approach. The argument here is that planners should assess the causes of ill-health in the district for which they are responsible and provide services accordingly. In particular, it is possible to calculate the number of years of life which are lost because of particular illnesses. For example, if you assume that a 'normal' life lasts 85 years, then you can say that someone who dies at 60 from Ischaemic Heart Disease has lost 25 'life years'. In England and Wales, 1,800,000 life-years are lost pa from this cause, compared to 170,000 lives lost in traffic accidents.

However, this does not tell health care planners how to spend NHS money. Should they spend all the money on heart disease? Or divide up the money proportionately and give to heart disease treatment slightly more than ten times what they give to traffic accident victims? The 'health gain' approach takes no account of the effectiveness or the cost of the various health care procedures which could be funded.

The second theoretical approach is based on QALYs or Quality Adjusted Life Years. This starts from the position that resources should be spend on the services which save most years of life. However, it also recognises that a life year in full health is better than a life year in poor health. Taking this into account means that the important thing is the number of

Quality-Adjusted Life Years a procedure brings about. However, NHS planners also need to consider the cost of procedures. League Tables can be created to show how much you need to spend to buy a QALY if you buy one service compared to another. According to one study, it costs £16,000 to buy a QALY if the money is spent on haemodialysis in hospital but just £200 to buy a QALY if the money is spent on chiropody at home.

However, a number of important points should be noted about QALY-rationing.

1. It is inherently all-or-nothing. The argument is that the most cost-effective way of using limited resources is to meet the need for the procedure which costs least per QALY. Once you have met that need you can spend money on the next most cost-effective service - and so on, until you run out of money. Services are provided to meet all the needs or they are not provided at all - people who need unfunded services must go private or go without.

2. The information used in QALY League Tables is dodgy given the lack of research into the real costs and effectiveness of medical procedures. Bringing in the subjective notion of Quality of Life makes the calculations especially suspect.

3. The upshot of QALY-rationing is that less would be spent on expensive services designed to keep people alive. A more common-sense view is that few things matter more than saving lives.

The Government's view is that Health Authorities can draw from the best points of the 'health gain' and QALY theories by conducting Health Needs Assessment. The official view is that HNA consists of:

1. epidemiological assessments based on the ability to benefit from health care;

2. comparative assessments by which DHAs look at performance and price elsewhere;

3. a "corporate" view which reflects the interests of other agencies.

However, Health Needs Assessment is as good as the NHS planners doing it. There is a danger that it will draw on the faults with the 'health gain' and QALY approaches as much as on their positive aspects. Community Health Councils, local people and patients may not be able to influence what is planned on their behalf.

There has also been great interest in the Oregon experiment. Health care planners in Oregon have been trying to restrict the range of treatments available on Medicaid, the public health insurance programme for people on low incomes. The plans have drawn upon QALY-type calculations as well as information about community values derived from a series of public meetings. 29 panels of doctors and other health care providers reviewed the

conclusions and a ranking of procedures was finally published in February 1991. This gave top ranking to medical treatment for pneumonia. It was proposed to draw a line at the service ranked 587th - ruling out, for example, life support for extremely low birth-weight babies and stripping of varicose veins. The Bush administration refused to endorse the proposal and returned it to the Oregon health planners "for further work". It is reported that Bill Clinton has approved their latest plan.

Rationing in Practice

Traditionally, NHS rationing has largely consisted of new priorities being established at a national level and spread through the Health Service in an incremental manner. Resource constraints have resulted in restrictions in lower priority areas as well as hospital waiting lists. 'Modern' rationing, by contrast, consists of:

1. the withdrawal of the NHS from a particular type of service or treatment, whether on a national, regional or district basis.

2. explicit and regular attempts to define how much of which services should be provided, including the explicit identification of low-priority services.

3. balancing the needs of categories of patient rather than categories of service, including the imposition of more explicit age restrictions on access to NHS treatment.

Information is available on rationing initiatives by 16 Health Districts in England. So far, restrictions have been largely in the areas of cosmetic surgery and infertility treatment. While most media interest has been focussed on withdrawn services (No. 1 above), it may be that in future more people will be denied treatment through the development of 'protocols' or 'clinical guidelines' (under No. 3).

The Government wishes Community Health Councils to be closely involved in rationing: "If CHCs are to make their full contribution to the purchasing process, they must be in a position to assess competing claims and to express an opinion about the relative, as well as the absolute, value of a particular proposal". Some CHCs have been reluctant to be associated with rationing decisions. However, some have been participating to varying degrees:

1. Discussing issues with purchasers, sometimes in working groups.

2. Taking part in prioritising exercises initiated by the Health Authority.

3. Helping to develop participation by local people so that Health Authorities can gain some sense of community values and priorities.

Rationing: The Debate

Advocates of 'modern' rationing argue that some form of health care rationing is inevitable. Rationing should be done in a systematic way, drawing on available information about cost-effectiveness and with full input from local communities. It is not right that major decisions on rationing should be hidden from view by the professional status of doctors.

Opponents of 'modern' rationing can make a number of sound objections to the 'health gain' perspective, to QALYs, to Health Needs Assessment and to rationing in practice. Three main lines of argument can be distinguished.

1. Health care rationing is unnecessary.

The most fundamentalist line is to argue that all forms of health care rationing, traditional or modern, are unnecessary and wrong. This would reject the common assumption that the demand or need for health care is infinite. On the contrary, a major input of additional resources - for example, bringing UK spending up to levels in comparable countries - would dramatically reduce the length of waiting lists and the amount of unmet need.

However, the Advocates of rationing would insist that one way or another it happens in all health care systems. It is a fact of life.

2. 'Traditional' NHS rationing is the way to do it.

If Opponents of 'modern' rationing accept that there is never enough money to meet all health care needs, they may nevertheless feel that the NHS has rationed care effectively for 45 years: "If it ain't broke, don't fix it". The NHS, after all, enjoys overwhelming support, despite underfunding. Opponents of 'modern' rationing may feel that it is reasonable to postpone treatment by asking people to wait but that it is not tolerable to deny treatment altogether. That would force whole categories of people to go private or go without, depending on their means. Also, the NHS has been comparatively successful at distributing resources fairly and its priorities can be changed. Narrowing the range of treatments would whittle away the comprehensiveness of the Health Service which is one of its most admired characteristics.

However, Advocates of 'modern' rationing would argue that 'doctor knows best' attitudes, and long hospital waiting lists, are no longer acceptable.

3. 'Modern' rationing is a myth.

Lastly, Opponents could argue that 'modern' rationing is a mythical beast. In practice all that has happened is that a few Health Authorities have cut highly marginal services and others are continuing to develop protocols. There has been no dramatic change in NHS priorities as a result of the purchaser-provider split. In any case, the attempts of commissioning agencies will be increasingly undermined by the development of fund-holding general practices. The information available on 'health gain', health care need and health care costs is so poor that any

rationing system relying on existing data would be a castle built on sand.

Advocates would argue that 'modern' rationing is already happening and fundholders will have to do it too.

Even if rationing is desirable or inevitable, that leaves open the question of who should be making the decisions. Some say decisions should be made at a local level while others feel they should apply across the National Health Service. Some feel Government Ministers (of whatever colour) should be required to decide if services are to be withdrawn due to the under-funding of the NHS; others feel the issues are too important to be left to politicians.

CHCs often argue for more local, lay involvement in NHS purchasing decisions although the public's priorities can be different from those identified with the Health Service. CHCs were established to represent the interests in the Health Service of the public in their districts. That does not mean that CHCs should support the distortion of NHS priorities by public prejudice or ignorance, let alone the use of 'community participation' to legitimate 'cuts' or forms of health care rationing which are abhorrent to the public.

Even CHCs which support 'modern' rationing may feel that they should not be involved in the process. They may argue that it is the job of CHCs to campaign for more resources and not to help NHS managers cope with what is available. They may also believe that local campaigning and voluntary organisations could become hostile to the CHC or that the CHC's credibility with the public is more important that its credibility with the Health Authority.

The alternative view is that CHCs should ensure that the rationing decisions are the best possible in the circumstances. With the development of the internal market, CHCs' traditional role of being consulted on substantial service changes is being whittled away. Their job is now to influence purchasers and that involves talking about priorities.

However CHCs approach this dilemma, they should ensure that decisions are made in public. CHCs can act as information brokers, informing the community and enabling groups and individuals to express views if they wish to do so. Consulting on choices does not mean that the blame for decisions is spread around. The health authorities will be deciding priorities within budgets set ultimately by the Government. The health authorities and the Government will be held responsible for the rationing decisions they make.