Rationing: a transatlantic perspective

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SUMMARY

Despite the differing mechanisms of health care delivery and financing in the United Kingdom and the United States many of the issues faced by the two countries are similar, most notably the increasing financial pressures. In both countries there have been recent changes in the allocation of resources and the mechanisms of decision making. Different criteria for determining resource allocation have been tried in the two health care systems. These developments change long traditions of rationing decisions at the individual patient level in the US, and of centralised government decision making in the UK.

Keywords: health services; funding; resource allocations; decision making; cost effectiveness; medical audit.

Introduction

THE fundamental tenets of health care provision are very different in the United Kingdom (UK) and the United States (US). These principles shape the rationing decisions that are made, and the mechanisms used to make these decisions. The UK has a social contract to provide health care and welfare for all, and decision making within health care is a professional and state responsibility. The US Constitution is built on the rights of the individual, and this is reflected in health care. Despite the fundamental differences in the two systems there are some who consider that they are becoming less diverse as health care reform continues in both countries.[1] Many of the issues faced by the two countries are similar, most notably the increasing financial pressures on both systems and the resulting need to review resource allocation methodology.

In the US, the libertarian argument that economic and social benefits should be allotted in proportion to the individual's contribution to those benefits supports distribution of health services according to individual ability to pay.[2] In contrast the principle of social justice on which the UK system is built is based on egalitarian theory.[3] This theory may be interpreted in two ways: in its most radical form it would support absolute equality in distribution, regardless of need. More conservatively, equitable distribution would allow access according to need.

At the provider level the medical profession in both countries has a tradition of benevolence, a moral obligation of charity or beneficence to help those in need. This benevolence has moderated the libertarianism of the US and personalised the egalitarian approach of the National Health Service (NHS).

Resource centred or patient centred?

There are a number of frameworks around which rationing can be classified; each sheds some light on the decision making process. Resource-centred rationing criteria base decisions on features of health services themselves; for example, whether to spend on acute care or preventive services. Such decisions are typically made by policy makers, legislators and government. Two types of resource-centred rationing have been defined by Jecker and Pearlman: rationing of high technology services, and rationing of non-basic services.[4] Non-basic services are those which exceed a minimum level; the question is what determines the cut off point? Basic health care services prevent, cure or compensate for deficiencies in the normal opportunities people enjoy at each stage of life. In contrast, non-basic care aims either to improve conditions unrelated to normal opportunities or to correct or compensate for deficiencies in normal opportunities, but it is ineffective in doing so. Examples include decisions by district health authorities not to fund plastic surgery, tattoo removal and, perhaps more controversially given the above definition, in vitro fertilization.[5]

One appeal of resource-centred rationing is that it removes the need to make controversial comparisons between individual patients. It could be argued that it thus ignores important moral factors. As the US health care reform debate demonstrated, it is certainly not immune from lobbying by interest groups, particularly by providers anxious to ensure that their speciality is not excluded.

Patient-centred rationing allows individual qualities and circumstances to be considered when entitlement is determined. These decisions are usually made by those directly involved with patient care and management, and may therefore be biased by the provider's beliefs and principles. One method is to ration services to those who receive the least medical benefit. This has some advantages in that it avoids making comparisons between people based on social worth, it does not discriminate against any one diagnostic group, and it allows the physician to offer care that has a high likelihood of a positive outcome. However, despite advances in the fields of quality of life and outcomes measurement, there is no universally accepted measure of medical benefit. This approach also discriminates against those who have poor health risks: for example, smokers who need coronary bypass surgery.[6]

Patient-centred methods of rationing use decision analysis to estimate outcome and assign value to outcome and health states. Two decisions are made in outcome-based health care-resource allocation: the estimation of outcome, in terms of quality of life or increased life expectancy, and the assignment of preference values to these outcomes. Both are vulnerable to discrimination against people with disabilities, who may value changes in health status differently from those who are not disabled.[7] Moreover, this is a powerful reminder to policy makers in general that the scientific approaches to decision making are not without discriminatory value.

The use of cost-effectiveness data in medical decision making is also controversial, and many clinicians believe it to be unethical. Health economists argue that clinicians are mistaken in this belief, because it cannot be ethical for health professionals, or policy makers, to ignore the adverse implicit consequences of the decisions they make.[8]

Explicit and implicit rationing

The way in which rationing decisions are made shapes public reaction to resource allocation. Explicit rationing appears intuitively appealing if the criteria for decision making are in the public domain, and are subject to evaluation and criticism. The health reforms implemented by the State of Oregon resulted from an explicit decision making process.[9] The Oregon plan was

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intended to provide universal coverage for the low income people of the State; it was a response to the rapidly growing national problem of provision of health care for this group.[10] The redesign of the Medicaid benefits, the health care available to eligible low-income people, produced the most comment and controversy.

A health services commission of lay and professional members ranked health services from the most important to the least important, in terms of health produced, as a function of clinical effectiveness and social values. The views of the public were solicited, and were incorporated in the commission's decisions. Services most valued were for acute fatal conditions and preventive care. Minor conditions and futile care were given low priority. Actuarial costs were then attached to the services, and the legislature determined how much could be funded. The resulting package covered the majority of existing Medicaid benefits, plus additional services.[9]

There was a considerable response from the public and private health care sectors to this innovate and bold approach. Criticisms included Oregon's rationing of services to poor mothers and children, who represent about 70% of Medicaid recipients but consume only 30% of the budget. The disabled and chronically sick, who consume more resources, were virtually exempt from the process because long-term care, social services and mental health services were excluded.[10] There were criticisms of the cost-effectiveness data used, and of the way in which diseases were grouped in the decision making process.[4] It was also argued that few of the people who attended the public feedback sessions were Medicaid recipients.[11]

In the UK there is a tradition of implicit rationing which results from fixed budgets and physicians balancing their roles as the patient's advocate and the guardian of society's resources. Mechanic suggests that rationing decisions in the UK are becoming more explicit as the result of health care reform.[12] He criticises this move: 'Implicit rationing reduces tensions arising from scarcity by taking into account the determination of people to receive a particular procedure.' He argues that explicit rationing excludes some people who care deeply about treatment, yet includes others who do not. Explicit rationing is therefore detrimental to social relations and results in conflict, confrontation with government and pressure for budget increases. However, it could be argued that implicit rationing excludes treatment for people with unequal access to information, and favours those who are more able to influence the decision making process.

Rationing in the USA

In the past the focus of the US health system on the individual, as a consumer who has rights to the health care that he or she can afford, had implicit effects on the access of individuals to health care. While it is not explicitly stated that the poor should not have access, health care is a commodity that is bought as a consumer good, and is an economic rather than a social entitlement. Increased utilization of health services and rapidly rising costs have raised insurance premiums so that not only the poor, but also the self-employed — and others outside the safety nets of federal, state or large employer programmes — struggle to afford them.

The libertarian principles have not changed, but the financial crisis now faced by society has introduced the potential of health care rationing for all Americans. During the 1994 health reform debate Eddy suggested that cuts in services will be deep, will not be achieved by controlling waste and administrative efficiencies alone, and will result in the rationing of effective practices.[13]

It is extremely difficult to ration care that is purchased in the free market on a fee-for-service basis — especially when a third party payer insulates the individual from the majority of the cost. One response to the health care crisis is the growth in managed care. Managed care plans provide primary and specialist services on a capitated basis. In some cases primary care physicians are capitated; in most cases the plan is at risk. Managed care has been blamed for introducing cost-based denial and rationing into health care. However, given the financial crisis faced by the US health care system, managed care seems to be a scapegoat. Capitated care is also criticised for the ethical dilemma it presents to physicians. The American Medical Association has raised concerns about bedside rationing by primary care physicians who act as gatekeepers to resources.[14] Other critics raise concerns about rationing decisions made by physicians who stand to profit financially if they restrict access to care: for example, requiring pre-authorisation review for all admissions to hospital, and limiting lengths of stay.[15]

The introduction of benefit packages, or limitations of covered services, is not restricted to managed care. The decisions about included services are made explicitly by insurers, sometimes in collaboration with large private or public sector purchasers. Benefit packages specify covered services, items, providers and settings. Other services are excluded implicitly. The small print does not cover all eventualities, and decisions are made about unusual or extenuating circumstances by reviewers within the provider organisation, or by independent outside experts.

The limitations of current benefit package design were highlighted by the case of a patient in California (Fox versus Health Net) who was denied autologous bone marrow transplant (ABMT) for breast cancer, a treatment that was regarded as experimental. The decision not to cover ABMT in breast cancer was made explicitly, on the basis of medical evidence. The case went against the insurance company, resulting in a change in the benefit packages of other insurers. For example, the Federal Employees Health Benefits Package was extended to include ABMT for breast cancer. As a result of the court case and its effect on public opinion, the standard of care was changed and a rationing decision was made in the face of conflicting medical evidence.

Resource allocation in the US was traditionally based on individual needs and rights, and decisions were contested in the courts. The infrastructure of managed care allows for more effective management of resources, a necessity that may not prevent cutting of care in the future. However, determinations are still subject to legal challenge and decisions are not consistently based on evidence of effectiveness.

Rationing in the UK

Rationing in the UK has traditionally been associated with queuing, an implicit form of resource allocation that would be unlikely to succeed in the US. Queuing results when fixed medical resources do not meet demand, and delay is considered preferable to explicit restricted areas. When medical utility and the probability of successful treatment are equal among patients, queuing can be seen as the fairest way to distribute care.[3] As patients are rarely similar in their need or their probable response to treatment, it could be argued that providing therapy on a 'first come first served basis' is unfair. However, queuing in the UK is on a managed delay basis; those with serious conditions are given precedence over those with inconvenient but not life-threatening conditions.

The UK also has explicit rationing; an example is the recent case of child B in Cambridge. There are obvious parallels to be drawn between the American ABMT example and this case.

However, the courts upheld Cambridge Health Authority's right to make a decision.[16] Explicit rationing also occurs through other mechanisms. For example, charges paid for prescription drugs and eye test, the Resources Allocation Working Party changes in the allocation of the health care financing budget, and changes to the provision of long-term care for the elderly.

The health care reforms in the UK have introduced new resource allocation decisions, and new players in the field. The new system and the need for informed purchasing decisions have increased activity in the fields of needs assessment, clinical effectiveness and guideline development. Purchasers are also beginning to engage in shared decision making, consulting with patient groups and surveying practice and district populations about resource allocation decisions.[17,18,19] There are parallels here with Oregon, and it will be interesting to see whether the process will be subject to the same criticisms.

The government has advocated the growth of clinical audit and a knowledge-based health service as the basis on which decisions about priorities should be made. In introducing budgets for GP fundholders and local district health authorities it has brought rationing decisions closer to the service provider, and variations in the implementation of decisions will result. The emphasis is on trimming services through improved knowledge and effectiveness, rather than on rationing core services.[20,21] However, as Eddy has argued, practice patterns often do not correspond well with know effectiveness data.[22]

Conclusion

In the US and the UK there have been recent changes in resource allocation decisions, and revisions in the mechanism or process of decision making. There is a new distribution of shared decision making in the local and central levels of the two health care systems. In the US managed care companies devise benefits packages that are subject to utilisation review and case management. In the UK recommendations filter down from the central NHS executive, for interpretation by district health authorities and individual GP practices. These developments change long traditions of individual rationing decisions at the patient level in the US, and of centralised government decision making in the UK.

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