

Out of Hours

It's time for rational rationing

'Ask me my three main priorities for the NHS, and I tell you: efficiency, efficiency, efficiency.'

No government minister said this, at least not yet. Of course, the government wants quality too, but its war is on spending, and efficiency is its weapon. NHS spending power is set to remain stable at best for the foreseeable future. Unprecedented 4% productivity gains for at least 5 years are now demanded by the government.¹

And this is in the face of a relentless increase in the demand for health care, throughout modern history, and across the world.² December brought news of a rising UK population, and that across the globe we live longer but are sicker, so increasing demand for NHS care seems certain to continue.³

December's National Audit Office (NAO) report told us that the NHS in England met its first year target mainly by plucking the low-hanging fruit. The NAO is doubtful about prospects for large year-on-year efficiency savings until 2015, let alone beyond. It also examined the government's only alternative to efficiency savings, 'demand management':⁴

*'The aim is to control demand without inappropriately restricting patients' access to care, but the Department has no way of routinely gaining assurance that this is being achieved.'*⁴

The NAO is drawing a distinction between appropriate and inappropriate demand management. However, like the government, it offers no indication of how to distinguish between the two. This comes as no surprise as neither the government nor the NAO has explained how to judge what health care should, and what should not, be provided by the NHS.

Demand management is a euphemism for what may more honestly be called healthcare rationing. Almost all academic

writers recognise that rationing is inevitable, even in private healthcare systems where treatments are either included or excluded from insurance policies. However, 'rationing' is not a word the public likes to hear. In a society where maximising consumer choice and spending are ideals, it should be no surprise that the word rationing has been expunged from politicians' vocabulary. English courts have placed significant demands on primary care trusts to ensure that they follow processes to justify refusing treatment to individuals, but courts too are wary of getting involved in rationing decisions.⁵

This culture has prevented the creation of what the *BMJ* proposed 12 years ago: a committee for honest and open rationing.⁶ But now its time has come.

Rationing is not a bad thing, as some have suggested.⁷ The roots of the word are reasonable and ratio. Our reasoning allows us to allocate good and fair ratios of health care. It lets us choose the health care that will do the most good, and distribute it fairly.

Currently, we have no idea whether we are choosing the health care that does the most good with the money available. We have some idea how much different treatments cost. But other than NICE assessments of new medicines and other technology, and the occasional assessment done by commissioners of specific cases like *in vitro* fertilisation, the NHS does not attempt to assess, and take into account, the relative good done by the thousands of different types of things it does, from hip operations to health checks.⁸ The NHS attempts to monitor outcomes by healthcare organisations, but not assess the good done by different types of treatment. Collecting that information is a big task, to be done systematically, and for efficiency, to be done once centrally.

However, first there needs to be some measure of the good of health care. NICE uses the quality-adjusted life year (QALY), seeking to maximise the years of good quality health from available resources. An

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important criticism of QALY maximisation is that it is unfair to older people and others with short life expectancy.⁹ When resources are limited and we cannot do everything, fairness is relative. Fairness means some health care for everyone, and more to those with the strongest claims. The QALY was not designed to be fair but to measure the good of health care.

The NHS budget should be used to do as much good as possible, while being fair. This is easier said than done. The writing of economist and philosopher John Broome explains how good and fairness can be balanced, as outlined in the RCGP's Ethical Commissioning Guidance.^{10,11} However, our values differ on what is good and fair, and so the government needs to engage the public openly and honestly in the difficult choices that face us, as done in some other countries.¹²

The government cannot continue to pretend that the only thing that the NHS needs is a good dose of efficiency. Efficiency gains are not inexhaustible. As more people seek more, and more expensive, health care, we must also decide what health care the NHS should provide, and not provide, and to whom. That requires much better information, and more systematic analysis, of the relative good done by health care. We should aim to do as much good as possible, while being fair. We won't all agree on what is good and fair, so honest and open consultation is needed. You may call that rational rationing.

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