INTERNATIONAL EXPERIENCE OF RATIONING

Chris Ham and Angela Coulter

INTRODUCTION

In an era of ever-increasing medical possibilities, publicly financed health care systems face the challenge of determining what services should be covered for the insured population. This challenge, usually referred to as health care rationing or priority setting, words we shall use interchangeably, has led governments in a number of countries to take a more systematic approach to the determination of service coverage than has usually been the case in the past. Specifically, policy makers in these countries have encouraged explicit debate about priority setting, starting in the second half of the 1980s and continuing into the 1990s. In so doing, they have built on efforts to strengthen health technology assessment and to determine coverage of pharmaceuticals in order to address priority setting in the round.

One of the earliest examples was the state of Oregon, whose work to draw up a list of priorities for Medicaid as a way of expanding population coverage has been widely studied and reported (Strosberg et al. 1992). The experience of Oregon finds echoes in countries as diverse as Denmark, Finland, Norway, Sweden, the Netherlands, New Zealand, Israel and now the United Kingdom as policy makers seek to square the circle of increasing demands and limited resources (Coulter and Ham 2000). In all of these systems, work has been undertaken to develop more explicit approaches to rationing at a macro level in the recognition that diffusing blame and muddling through may no longer be sufficient. In parallel, there have been efforts to strengthen decision making at the meso and micro levels in the recognition that responsibility for rationing is located at many different points. This work can be seen as an attempt by
policy makers to supplement political bargaining over the allocation of health care resources with efforts to puzzle more intelligently about priority setting. This chapter summarizes the results of these efforts and assesses the implications for those charged with making rationing decisions.

**RATIONING ALL AROUND THE WORLD**

Experience in states that have sought to be more systematic in their approach to determining what services should be covered for the insured population demonstrates the menu of possibilities available to health policy makers in setting priorities at a macro level. Despite the attention given in health policy debates to the development of a basic benefits package or a set of core services, only in Oregon’s Medicaid programme has the priority setting dilemma been addressed mainly by excluding certain categories of treatments from funding. In Oregon this was done by drawing up a list of condition–treatment pairs and ranking these in order of priority.

When it was implemented in 1994, the Oregon Health Plan funded 565 out of 696 treatments, the main exclusions being treatments for minor medical conditions or those where evidence of effectiveness was lacking. In taking this approach, policy makers in Oregon were seeking to increase population coverage by limiting service coverage, although even the original Oregon Plan included some services that had previously been outside Medicaid, such as dental care. Subsequent revisions have tended to increase the scope of service coverage to the extent that most treatments are now covered (Bodenheimer 1997; Ham 1998; Jacobs et al. 1999). An example is cochlear implants, which were added to the list of funded services when new evidence on the benefits offered by implants became available.

Oregon aside, those responsible for rationing have adopted an approach centred on the development of national frameworks to guide priority setting rather than defined lists of treatments or services to be covered. The Netherlands and New Zealand exemplify this approach. In the Netherlands, politicians have shied away from the exclusion of services from funding, after flirting with this strategy. One of the reasons for their reluctance to go down the road of exclusions was criticism from groups opposed to the removal of services from funding. An example was the proposal to exclude funding of contraceptive pills from coverage, a proposal that
was withdrawn after opposition from women’s groups and family planning organizations. Similarly, in New Zealand the government-appointed Core Services Committee declined to draw up a list of services to be publicly funded, even though it was charged with this task. The view of the Committee was that priority setting was best approached not by limiting service coverage but by determining how services could be targeted on those patients most likely to benefit. In both the Netherlands and New Zealand, effort has focused on the development of evidence based guidelines intended to ensure that services are provided appropriately.

Research into explicit rationing at a macro level demonstrates that there are no simple or technical solutions that can resolve the dilemmas facing decision makers. As Oregon discovered, techniques drawn from economics designed to compare the costs and outcomes of health technologies are not sufficiently developed to provide a reliable basis for decision making (Hadhorn 1991). This was starkly illustrated by the ranking of tooth capping above appendectomy in the original Oregon list. Anomalous results of this kind show the difficulties of applying economic analysis in practice and also reveal gaps in the availability of information on costs and benefits.

Yet even if information were more complete, the results of economic analysis would still have to be interpreted by policy makers in the process of determining priorities, given that the aim of health policy is not simply to maximize health gain for the resources available. As an example, the pursuit of equity may result in resources being allocated to services where the cost of achieving a certain quantum of benefit is greater than in relation to alternatives. Trade-offs of this kind are made all the time in health policy and indicate the potential incompatibility of efficiency and equity objectives.

Those responsible for priority setting therefore have to confront the need to make decisions in conditions of incomplete information and likely conflicts between objectives. While one response has been to seek to fill the gaps in information and to refine the tools to support decision making, for example through an investment in health technology assessment and evidence based medicine, another approach has been to widen the debate beyond the experts (whether physicians or economists) to include other stakeholders. An important motivation in this context is that choices in health care involve making judgements about the relative priority to be attached to different objectives and services. It follows that these choices need to be informed by an understanding of community preferences, if they are to gain acceptance among those affected.
It was for this reason that decision makers in Oregon, for example, sought to strengthen their approach by drawing on public consultation and evidence of community values in determining priorities for Medicaid. Other systems have also endeavoured to engage the public in debate about rationing, and a wide range of methods have been used for this purpose. In part this has been stimulated by a concern to inform the public about the inevitability of rationing, and in part it has been designed to use the public’s views to inform decision making.

The need to make trade-offs in health care rationing has also led to an interest in clarifying the values that should guide decision making. In some systems, such as the Netherlands, Oregon and Sweden, values have been defined explicitly, while in others they have emerged implicitly. The work done on values has been used to aid the process of rationing by identifying criteria for making choices and in some cases for ordering priorities. A distinctive feature of the Swedish approach is the attempt to rank values, the highest priority being attached to respect for human dignity followed by solidarity or equity and then by efficiency (Swedish Parliamentary Priorities Commission 1995). The experience of Sweden reinforces our earlier observation on the potential conflict between objectives.

With few exceptions, the articulation of values has remained a high-level activity, and little effort has been put into the use of values in decision making or in day-to-day clinical practice. As a consequence, there is often a gap between the proposals put forward by government committees and expert groups in relation to rationing and what happens at the meso and micro levels. This is most apparent in the case of countries such as Norway and Sweden where the emphasis has been placed on the promulgation of ethical frameworks at a macro level to guide decision making. The impact of such frameworks, based on the identification of core values rather than core services, is difficult to determine precisely because they are expressed in general terms and their effects have not been fully evaluated.

Set against this, explicit rationing may result in more resources being allocated to the health care budget if the approaches adopted are sufficiently specific to expose areas of underfunding and unmet need. This was one of the effects of the Oregon Health Plan, in that the legislature voted more resources for Medicaid to enable the cut-off point for funding to be lowered when the effects of maintaining previous funding levels became transparent. Similarly, in New Zealand the government provided extra funds to reduce waiting
lists for surgery when it was possible to identify patients who would benefit from treatment but were not receiving it because of financial constraints. Experience in Israel reinforces this point, with the government there increasing the health care budget to enable new and relatively expensive drugs for cancer care to be included in the benefits package following publicity demonstrating the denial of treatment to patients (including children) in need (Chinitz et al. 1998).

**THE POLITICS OF RATIONING**

One clear conclusion from experience so far is the sheer messiness of health care decision making and the inherently political nature of priority setting. The allocation of scarce resources between competing demands is at once an economic challenge and a political puzzle. Giving higher priority to one service means giving low priority to another when budgets are fixed, and the evidence indicates that this is likely to stimulate lobbying among those groups affected. One of the reasons why political leaders have been reluctant to engage in explicit rationing at a macro level in the past is that in determining priorities they are also accepting responsibility for what may be unpopular choices. This helps to explain why politicians in most countries have declined to ration by excluding treatments or services from funding even though priority setting has become more explicit.

In these circumstances, there is a tendency for policy makers to seek to avoid blame either by ducking tough choices or by devolving responsibility to others. Rationing by guidelines rather than exclusions is one manifestation of this, in that it leaves ultimate responsibility for deciding who should be given access to health care resources to agencies such as sickness funds and health authorities at the meso level and to physicians at the micro level. The tendency of political leaders to avoid blame for rationing is consistent with research into the motivations of politicians (Weaver 1986). It is also congruent with the findings of research into comparative social policy demonstrating that retrenchment strategies are more likely to take the form of relatively incremental and invisible initiatives than direct cut-backs (Pierson 1994).

Partly because of this, but also because of the obstacles to developing more systematic approaches, some writers argue that muddling through is a virtue rather than a sin and, whatever its
weaknesses, is to be preferred to the fruitless quest for a technical ‘fix’. In other words, disillusion with the results of systematic attempts to set priorities is used to justify the *status quo ante* and to caution against the pursuit of more ‘rational’ solutions. This is the contention of, among others, Mechanic (1997), who argues that implicit decision making offers greater flexibility in circumstances in which judgements about treatments are surrounded by uncertainty and the needs of patients are diverse. Mechanic acknowledges that explicit approaches have a part to play at the macro and meso levels but, even so, he maintains that these approaches are liable to political manipulation and are not sufficiently responsive to change. Mechanic’s view is endorsed by Hunter (1993), who contends that ‘muddling through elegantly’ is the most that can be expected and who is even more sceptical than Mechanic about the desirability of explicitness.

A related argument is advanced by Klein (1998), who is sympathetic to the case for muddling through but places greater emphasis on the need to strengthen the institutional basis of decision making. Writing as a policy analyst, Klein sees priority setting as ‘inescapably a political process’ in which debate and discussion between different interests are inevitable. It follows from this that the challenge is to devise mechanisms for addressing the intractable questions involved, while being cautious about the likelihood of finding answers. Klein is here echoing Holm’s (1998) analysis of experience in the Nordic countries which points to the increasing interest in transparent and accountable decision making processes at a macro level rather than the pursuit of technical solutions.

As Holm (1998) shows, policy makers in these countries have turned their attention to ways of strengthening decision making processes to generate legitimacy for rationing as the limits of technical approaches have been exposed. Specifically, expert committees in both Denmark and Norway have made proposals for widening the debate about priority setting and involving a range of stakeholders. The importance of transparent and accountable decision making processes is reinforced by Daniels and Sabin’s analysis of limit setting decisions in managed care organizations. On the basis of their analysis, Daniels and Sabin (1998) set out the four conditions presented in Chapter 1 that have to be met to demonstrate ‘accountability for reasonableness’.

The relevance of these conditions has been demonstrated in studies of priority setting decisions in the United Kingdom as well as the United States, suggesting that the characteristics of defensible
decision making apply regardless of differences in the funding and provision of health care. This was clearly illustrated by the case of Child B in which an English health authority that declined to fund further intensive treatment for a girl with end-stage leukaemia found itself vulnerable because of weaknesses in the decision making process (Ham and Pickard 1998). The common thread in both north American and European experience is the need to show that the way in which priorities are set is fair and reasonable even if agreement on the outcome is not possible. A similar motivation can be detected in New Zealand, where the work of the Core Services Committee (since renamed the National Health Committee) has given particular emphasis to raising public awareness of priority setting in health care and bringing choices out into the open (Edgar 2000). Having made this point, those involved in this work recognize that much remains to be done to promote public involvement in and understanding of priority setting. In other words, just as techniques drawn from economics and other disciplines are still in the process of development, so too methods of public participation and stakeholder debate need to be refined.

A NEW SYNTHESIS

To articulate these arguments is to illustrate that approaches to priority setting do not simply involve a choice between muddling through implicitly and pursuing systematic, explicit alternatives. Our reading of the international evidence is that these and related dichotomies fail to capture the complexity of rationing in practice. Put another way, the policy learning that has occurred in the decade or so since political leaders in Oregon and elsewhere grasped the nettle of explicit priority setting has highlighted not only the absence of technical solutions but also the need to join together approaches that have often been presented as alternatives (Martin and Singer 2000).

The argument can be taken a stage further by invoking the debate between Klein and Williams (2000) that formed the centrepiece of the Second International Conference on Priorities in Health Care. Writing as an economist, Williams challenged Klein’s contention (see above) that strengthening the institutional basis of rationing was the issue that needed most urgent attention. Williams maintained that effective priority setting required clarity about objectives, information about costs and outcomes, and the ability to measure
performance. In other words, Williams reasserted the case for technical solutions. For his part, Klein responded that the key task was less to refine the technical basis of decision making than to construct a process that enabled a proper discussion to occur given that questions of rationing 'cannot be resolved by an appeal to science'.

Our view is that the debate between Williams and Klein is a defining example of the false antitheses that have been so much in evidence in discussions in this field, even accepting that their respective positions may have been artificially polarized for the purpose of debate. The choice available to policy makers is not between more information and stronger institutions, rather it is a matter of how the work of institutions can be enhanced through the provision of better information and other mechanisms. Expressed in the language used earlier in this chapter, the challenge is to improve both technical approaches and decision making processes to enable the judgements that lie behind rationing to be as soundly based as possible. In relation to techniques, this means developing further the work of economists and others to inform decisions on priorities. And in relation to decision making processes, it entails developing institutions capable of using these techniques and also of involving the public and other stakeholders in debating priorities and making choices.

To make this point is to suggest that strengthening information and institutions also involves transcending another dichotomy, namely that concerning the role of experts and lay people in rationing. The challenge here is to find ways of enhancing the contribution of the public in its many different guises alongside that of experts. International experience testifies to the efforts that have been made to consult the public and to promote democratic deliberation in health care through the use of surveys, focus groups, consensus conferences and other methods. In parallel, the advice of experts has been drawn on through membership of government committees set up to advise on priority setting and use of the findings of evaluative research. A new synthesis requires that the input of both experts and lay people is seen as legitimate and relevant to decision making on priorities and that continuing efforts are made to find the most appropriate mechanisms for securing this input. This has recently been recognized in the United Kingdom with a proposal to set up a Citizens Council to advise the national agency charged with advising government on priority setting.

Similar considerations apply to the debate about the comparative
advantages of explicit and implicit decision making. As experience shows, the choice between explicit and implicit rationing hinges on how political leaders deal with controversial choices when they arise. In the case of Israel, for example, an explicit approach to the determination of additions to the services that should be covered was combined with the imposition of limits on an implicit basis. Confirming our reading of international experience, analysts of this approach have concluded that ‘The Israeli case suggests that explicit and implicit approaches to rationing and priority setting are not exclusive alternatives but rather complementary tools which support each other’ (Chinitz et al. 1998).

Much the same applies in the United Kingdom, which is belatedly following the example of the other countries reviewed here through the establishment of the National Institute for Clinical Excellence (NICE) to advise politicians on priority setting. The modus operandi of NICE follows (unconsciously) the precepts of Daniels and Sabin, with a commitment to transparency and accountability in decision making on the funding of new technologies. This explicit approach goes hand in hand with a continuation of implicit decision making in many other aspects of rationing within the National Health Service (NHS), including the decisions that physicians make on the implementation of NICE guidelines and advice. Explicit rationing at a macro level is in this way combined with implicit rationing at a micro level. And at the meso level, health authorities have adopted both explicit and implicit approaches in discharging their responsibilities (Ham 1993; Klein et al. 1996; Hope et al. 1998).

The other element of the new synthesis is the use of exclusions as well as guidelines in addressing the priority setting dilemma. We have emphasized the political obstacles to rationing by exclusion, but in addition it has to be acknowledged that there are other reasons for avoiding this approach to priority setting. The weight of evidence suggests that there are few treatments that are wholly good or entirely bad, and the challenge for decision makers is to ensure that services are funded and provided to those patients who stand to benefit. This was expressed clearly by the chairman of the New Zealand Core Services Committee:

The approach we decided to take was one that has flexibility to take account of an individual’s circumstances when deciding if a service or treatment should be publicly funded. For example . . . instead of a decision that says hormone replacement therapy (HRT) is either core or non-core . . . the committee has decided
that in certain circumstances HRT will be a core service and in others it won’t be. The committee has recommended that HRT be a core service where there is clinical and research-based agreement that it constitutes an appropriate and effective treatment. (Jones 1993)

It is this that provides the rationale for the development of guidelines designed to target services and resources to achieve the most health gain for the population served. In reality, guidelines can be used alongside exclusions, as in the approach taken in the Netherlands which combines the exclusion of a limited number of services – examples being cosmetic surgery, adult dental care and homeopathic medicines – with the use of guidelines for the majority of services in a manner that is also finding favour elsewhere. Another example is the United Kingdom, where the exclusion of new drugs like Relenza from NHS funding is occurring at the margins, with the main emphasis being placed on the use of guidelines intended to ensure that those services that are funded are used appropriately and effectively. Indeed, in the United Kingdom, NICE has since reversed its original decision on Relenza and the drug can now be prescribed within defined guidelines. A further example is Oregon, where the inclusion of services on the list of funded treatments is accompanied by the use of guidelines to ensure that these services are provided appropriately. It might be added that setting priorities through guidelines preserves the degree of discretion in the treatment of individual patients that for Mechanic (1997) provides the basis for implicit rationing in health care.

Having made this point, it is important to recognize the force of Norheim’s argument that guidelines themselves need to be developed through fair and open procedures. That is, the increasing reliance on guidelines in rationing requires the same rigour in relation to how guidelines are determined as decisions on whether or not to exclude services entirely from funding. Only in this way, Norheim argues, will it be possible to demonstrate that guidelines are acceptable and the decisions on which they are based defensible (Norheim 1999).

**CONCLUSION**

In conclusion, we return to address the other dichotomy that has run through this chapter, and that was identified by Heclo (1974) in a
study of comparative social policy published over twenty years ago, namely the conception of policy making as a process of bargaining between interests on the one hand, and an exercise in puzzling and learning on the other. It is not necessary to subscribe to a view of policy making as red in tooth and claw to recognize the way in which debates about priority setting illustrate the quest for power and influence in the health sector. This is evident in the role of pressure groups in lobbying for additional resources for their priorities and the strategies used by political leaders to evade responsibility for unpopular choices. One of the conundrums in this context is the willingness of politicians to be brave (or foolish, depending on your point of view) in some systems, but not in others, by encouraging explicit rationing at the macro level. The point here, to reiterate our earlier argument, is that explicitness tends to enhance accountability by making transparent the location of decisions and runs counter to the blame avoidance strategies that often motivate politicians.

Having made this point, there is evidence of learning in the policy process, exemplified by the retreat from purely technical solutions and the efforts made to involve the public in debates on rationing. There is also an increasing focus, in what Holm (1998) describes as the second phase of priority setting, on the process of determining priorities. The interest in decision making processes is at once a response to the shortcomings of technical solutions and an attempt to earn legitimacy for what will often be difficult choices. Furthermore, by widening the circle of participants in decision making and demonstrating that the way in which decisions are made is rigorous and fair, those responsible for rationing are, consciously or unconsciously, striving to achieve accountability for reasonableness in the rationing process.

There is also evidence of learning in the partial retreat from explicitness in some countries. The renewed (in some cases, continuing) focus on the meso and micro levels of rationing can be interpreted as a return to blame avoidance as decision makers respond to the costs of being explicit about priorities at the macro level by shifting the emphasis and responsibility to agencies such as sickness funds and health authorities and to physicians. If this interpretation is correct, then the recent interest in explicit rationing may be a temporary aberration in a much longer history of muddling through and evading responsibility. In other words, the political costs of explicitness may outweigh the benefits, and this could result in a return to previous decision making processes.
The force of this observation is underlined by experience in those countries like the United States that (with limited exceptions such as Oregon) have chosen not to ration explicitly. As the US experience suggests, there remain fundamental political obstacles to adopting a different approach, not least because ‘the American way of rationing is to decentralize (in political terms hide) the choices; the result is rationing through an accumulation of narrow public policies, private decisions and luck’ (Morone 1992). This is because in the US ‘attempts to ration health care explicitly are political dynamite’ (Morone 1992). Nevertheless, decisions about limits to coverage and whether to fund new technologies have to be taken. In the US these decisions fall to public agencies, insurers and managed care organizations. Whether they like it or not, these agencies are involved in rationing (Daniels 2000; Rodwin 2000).

In both the US and elsewhere, the release of the rationing genie from the bottle has had the effect of initiating a debate that will be difficult to halt. At a time when there is increasing public awareness of the possibilities created by medical advances and the denial of access to treatment, the challenge is not how to avoid discussion of rationing at the macro level, but rather how to develop an informed democratic consensus model in which through broad mechanisms of public deliberation there is debate about how limited health care resources can be distributed. The rationale for encouraging democratic deliberation is that choices in health care involve moral issues that should be neither hidden nor fudged (Fleck 1992). If those responsible for rationing continue to obfuscate and fail to confront the dilemmas directly, then public confidence in the legitimacy of decisions and those charged with making them will be further undermined. In this sense, the case for a systematic approach is at root an argument to maintain and in some cases restore faith in the political system and to strengthen democratic practices. It is also an argument for finding a way of increasing the resources available for health care in the light of evidence that explicitness makes it more difficult for policy makers to evade responsibility for difficult choices.

NOTE