Key issues in rationing and priority setting for health care services

Dr Ellie Tragakes
Dr Mikko Vienonen

WHO Regional Office for Europe
Health Care Systems
Health Services Management
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WHO/EURO
Health Services Management
Health Care Systems

Dr Ellie Tragakes
Adjunct Professor, Economics, Deree College
Consultant, Health Services

Dr Mikko Vienonen
Regional Adviser for Health Services Management
WHO Regional Office for Europe
January 1998
Abstract
Priority setting in health care involves a process of choice among alternative health care programmes and services, and patients or groups of patients who are to receive care. Priority setting is also a process by which the alternatives are ranked in accordance with normative and technical rules, leading to the definition of a minimum or basic package of health care services.

Rationing and priority setting should rest on normative valuations that have at least some degree of popular legitimacy. While rationing is a way of distributing scarce goods when there is no market to perform this task, priority setting makes a relative ranking of the goods. Both serve to allocate scarce resources among competing uses.

There are three technical approaches to priority setting, using epidemiological, economic and evidence based-medicine contributions. All three approaches are used in various European countries.

Keywords
Health Care Rationing
Delivery of Health Care
Health Priorities
Health Planning
National Health Programs – Organization and Administration
Europe
USA

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Overview

Priority setting in health care involves a process of choice among alternative health care programmes and services that can be offered, and among the patients or groups of patients who are to receive care. If undertaken in a systematic and explicit way, it is a process that ranks the alternatives in accordance with normative and technical rules. Priority setting is in effect a way of allocating scarce resources, and so is a form of rationing. In recent years, priority setting has received an increasing amount of attention in many countries, owing to the growing realization that traditional rationing practices, which have been implicit or hidden, are inadequate to solve the resource allocation problem.

The first half of this document sets the stage for the later discussion of actual country experiences with priority-setting efforts. It begins with a discussion of the relationship between rationing and priority setting. It continues with a review of the philosophical underpinnings of these twin issues, which involve the question of what is a fair distribution of health care benefits, and discusses some of the difficulties that emerge from efforts to set priorities in a way that society views as fair. One key problem is that the major theories of distribution are of limited practical use. Another problem involves the difficulty of reaching social consensus on a particular approach to distribution. Nevertheless, because rationing and priority setting have major ethical dimensions, they should rest on normative valuations that have at least some degree of popular legitimacy.

In addition, the first half of the document presents the key technical approaches that are used in actual or proposed priority-setting processes. It discussed both their potential contributions to priority setting and the difficulties associated with their use. These approaches can in principle make a major contribution to priority setting. At the present phase of their development, however, they are subject to a number of limitations that somewhat restrict their practical usefulness. Still, they are being used to varying degrees as the basis of making decisions on priority setting in countries, and they are all undergoing continuous development and refinement.

The analysis of the technical rules is followed by a discussion of the minimum or basic basket of benefits. Priority setting can be used to define the basic package of statutory health care services. Normative and technical rules can be used to provide criteria for defining the benefits package, whether narrowly (in terms of specific services included and excluded), or more flexibly (in terms of categories of services which are to receive priority).

Very few countries to date have begun to practise priority setting in a systematic and explicit way. Among those that have are the state of Oregon (in the United States), New Zealand, the United Kingdom and Sweden (in some areas). Others that have begun to think seriously about
it and have come up with some proposals include Finland, Germany, the Netherlands, Norway and Spain. Each approach differs quite broadly from the others, although some similarities appear in some cases.

The second half of this document discusses each of these cases, describing:

- what particular concept of the basic package has been adopted;
- what body or bodies have priority setting responsibilities;
- how priority setting is undertaken in relation to the normative and technical rules that are selected;
- the extent of public participation in determining the normative rules;
- some similarities and differences between the countries; and
- some of the difficulties that have emerged in the course of planning or implementation.

The country discussion is followed by a description of the procedural rights approach to priority setting, which has generated some discussion but has never been tried. Finally, the concluding section addresses the question as to whether there are alternatives to rationing and priority setting.

**Defining the problem**

**Priority setting and rationing for health care services: are they different sides of the same coin or are they different currencies?**

At first sight, rationing and priority setting in health care might appear to be two somewhat different concepts. As an economic term, rationing refers to distribution under conditions where a supply that is limited by considerations of cost confronts a demand that is not constrained by considerations of price. The rationing of health care services, therefore, is simply what results when there is no market price to distribute excess demand for services to their would-be users. Priority setting in health care, by contrast, refers to a process whereby governments or public authorities or clinicians make decisions about the relative ranking (priorities) to be attached to different programmes, services or types of patients.

Closer examination shows that rationing and priority setting can be seen as two ways of achieving the same objective: allocating scarce health care resources among competing uses. With rationing, this is obvious, since by definition rationing is simply a substitute for the price mechanism in the process of resource allocation. Priority setting has the same result, since the assignment of relative priorities to different
activities necessarily results in a corresponding allocation of resources among the competing activities; moreover, whatever is deemed to be of relatively low priority absorbs a lower level of resources, thereby helping to solve the allocation problem.

Thus, the terms rationing and priority setting are sometimes used interchangeably. Nevertheless, they are not always one and the same thing. While priority setting ultimately achieves rationing, rationing itself may or may not be achieved through priority setting. Rationing can take place in many different ways, of which priority setting is only one.

There is, therefore, a clear conceptual distinction between the two. In practice, however, the two terms often become muddled because of the ambiguous ways in which priority setting is defined. On the other hand, priority setting may be defined as a conscious and organized process, undertaken, for example, by a government or health authority allocating resources among competing uses, and based on well formulated rules and criteria. In this case, priority setting is one way of achieving rationing. On the other hand, priority setting is sometimes thought of as a process that takes place at all levels of decision-making, including that of the individual clinician, who makes decisions about which patient should be treated for what type of condition. In this case, priority setting is interpreted to involve a process that is virtually indistinguishable from rationing. Thus, whether rationing and priority setting are regarded as different terms for the same thing or as two similar but different things depends on how one chooses to define them.

Despite their similarities in resource allocation function, rationing and priority setting have very different emotive connotations. Rationing is regarded in a negative way, as it is imbued with an aura of scarcity, deprivation and forced choice, which cannot be in society’s best interests. In contrast, Priority setting has a positive connotation, indicating a situation of being in control, knowing the alternatives, and making informed choices between them that will be in the best interests of society. These different emotive connotations follow from the distinction between having to choose (forced choice) in the case of rationing, and being able to choose, (the privilege of choice) in the case of priority setting. This distinction arises because priority setting appears to be prompted in the first instance by the desire to make choices that will use society’s resources more effectively, and thus promote society’s welfare. In this sense, the rationing function of priority setting seems to arise by default. Rationing, in contrast, has no connotation of effective resource use. In the practice of rationing and priority setting, however, this distinction has been of more theoretical than practical interest, as priority setting has more often than not been used as a camouflage for what is in effect implicit rationing.
Priority setting and rationing: are the rules transparent?

The rationing of health care services has always been practiced in some form virtually everywhere. No country has ever allocated enough resources to statutory health care provision to provide comprehensive and universal coverage of every possible health care need. Until recently, however, rationing has been largely implicit and largely. While rationing has been taking place, the rules have not been transparent; users of health services have been unaware of it, and have not perceived it for what it is.

Thus, rationing has only in recent years gained prominence as a political issue and increasingly generates public debate. What are the factors behind this development? One is the growing debate about the future of the welfare state and the position of publicly funded health care services within it. While no country to date has retreated from its commitment to play a major role in the provision and regulation of health services, many countries are reviewing their health care systems to manage their resources more effectively. Hence, rationing and priority setting are coming under investigation for their potential contribution to solving the problems of resource allocation and management. An equally important factor behind the growing interest in rationing and priority setting is the general public’s changing expectations for health care services. Rapidly growing public expectations of what the health care system can or should provide increase public awareness of the system’s deficiencies. In so doing, they also translate into dissatisfaction with the system’s lack of transparency and implicit forms of rationing and priority setting, which tend to become increasingly visible as users of health services come to perceive them for what they are.

These factors have led to a growing demand for explicit rationing and transparency in setting the rules of resource allocation. They carry their own set of difficulties, however, as they lead the way into new, unexplored, and highly controversial territory. Despite the broad agreement on the need for such rules, few if any countries have yet succeeded in devising a system that meets this need. For the most part, rationing continues to be implicit, camouflaged by rhetoric on the importance of explicitness and transparency. This is due partly to a lack of knowledge on how to proceed, partly to the inherent difficulties and complexity of the issues involved, and partly to the avoidance of responsibility by the key actors involved.

Ethical and moral foundations of rationing and priority setting: is the pursuit of justice utopian?

Virtually every publicly funded health care system in the world is based on some theory of justice, no matter how vaguely formulated. Theories of justice abound, but those that most commonly lay the groundwork for the public funding, provision or regulation of health care systems in Europe rest on some concept of equity (equality). In recent years,
perceptions of a growing gap between needs and the material resources necessary to satisfy them have given rise to a policy debate on the future of the welfare state and to new policy orientations in many countries that focus increasingly on individual responsibility. This gradual but perceptible move towards a more libertarian foundation for the welfare state may have implications for the equity principle on which the concept of universal and comprehensive health care in Europe has rested during the past 40 or so years. While there has been no major retreat from the concept of equity as a justification for public involvement in health care, the ethical and moral foundations of rationing and priority setting must be considered within the context of this shifting ideological orientation.

In addition, theories of justice have practical implications for the pursuit of rationing and priority setting. The problems of explicit and transparent choice underlying rationing and priority setting are inherently complex. Theories of justice thus attempt to provide not only an ethical foundation for rationing and priority setting, but also, and very importantly, practical guidance on how these should be carried out.

The Ljubljana Charter on Reforming Health Care in Europe (1996) reaffirms the commitment of WHO European Member States to equity, solidarity and human dignity, and stresses that health care reforms should be driven by values. The issue here is that interest in the technical issues of health care reform, such as resource allocation, rationing, priority setting and cost-containment, should not obscure the guiding moral principles, but rather should be pursued in ways that are consistent with them.

Why do we have an ethical problem in the first place? What prompts us to look for moral guidelines for rationing and priority setting, as opposed to purely technical ones? The answer is that the choices that must be made necessarily involve moral judgements, and not purely technical ones. The technical choices on how to conduct rationing and priority setting are embedded in moral decisions about who is to receive benefits and who is to be excluded from receiving them. This is the essence of the rationing problem. The question of rationing arises in the first place because of the competition for scarce goods (benefits) between people who press claims for them. The problem of distribution means overriding some claims and treating some people or groups of people more harshly (or favourably) than others.

We are therefore in the domain of distributive justice. On the most general level, the concept of justice is closely linked to the notion of "fairness". Distributive justice, therefore, is concerned with the question of the fair allocation of benefits. Fairness can only be determined by using a set of rules, standards or principles contained in various approaches to justice, which provide the basis for making decisions on the allocation of resources and benefits. There are a number of such
principles of distribution; three of the most important are briefly considered.

One of the most commonly found principles of distribution for rationing and priority-setting purposes, which is invoked as the rationale for many actual rationing practices, is allocation according to need. This is perhaps the most egalitarian approach to rationing, and is based on Aristotle’s view of distributive justice, which can be briefly stated as follows: justice involves treating equals equally and unequals unequally, but in proportion to their relative differences. The needs-based approach thus argues that people with equal needs should be treated equally, and those with greater or lesser needs should receive treatment that is in proportion to the magnitude of their needs.

A second approach to distribution is somewhat removed from egalitarian principles, and focuses on the notion of merit (or desert). This is based on recognizing particular characteristics of individuals that earn them special consideration and hence increased health services. This is particularly typical in eastern Europe, where all types of favourable treatment have flourished. Being classified as an invalid, veteran, pensioner, member of a political party, etc. guaranteed a plethora of privileges, especially in the health care field. In some cases, however, preferential treatment is well justified, as with children or elderly people. Alternatively, other characteristics of individuals may be used to justify their exclusion from or decreased access to services. For instance, in some countries rich people are excluded from being eligible for social health insurance and hence statutory benefits. At first sight this might seem unfair treatment, but it actually means letting them escape from the solidaric burden of sharing the expenses for poor population groups.

The third approach is similarly removed from the principle of equality and can be broadly termed the utilitarian view. Briefly stated, utilitarianism involves the principle that the rightness of any action is determined by a single criterion: namely, that it contributes to the greatest happiness of the greatest number. For the purposes of resource allocation in health care, this translates into allocation that maximizes the overall gain in utility (or satisfaction) that results from health care expenditure. In this view, collective (societal) gains have priority over individual gains. This means that a certain level of misery (or ill health) for some people would be acceptable if it permitted the achievement of a greater level of happiness (or good health) for some other people. The question then is how to utilize resources in the best way (with respect to maximizing health benefits). Specifically, this involves allocating resources so that the marginal cost-effectiveness ratios obtainable for every possible activity are equal (the ratio between additional or incremental benefits arising from additional or incremental resource allocations to the additional allocations). This equality ensures that resources could not be used more effectively.
While the needs-based approach makes its way most frequently into the actual practice of rationing and priority setting, the other two approaches are sometimes invoked as the rationale for certain rationing activities. Yet while each of these is used to varying degrees as a guideline or justification for particular practices, all are subject to pitfalls that render their usefulness questionable.

Specifically, all three suffer from operationalization difficulties. In the case of the needs-based approach, a key issue is whether a measure of need can be developed that will be comparable across individuals and groups of individuals. In the absence of such a measure, there can be no objective assessment and ranking of needs. As to allocation on the basis of merit, the question is what criteria can be devised to rank relative merits. Who determines what social groups are particularly deserving (or undeserving), and how is such an assessment to take place? The difficulties of using the utilitarian approach are even more intractable. For the utilitarian approach to be practically useful, it would be necessary to calculate cost-effectiveness ratios for every conceivable health care activity, which is a virtually impossible task.

One might argue that the practical limitations of the approaches to distributive justice need not prevent them from being used as very rough or approximate guides to rationing and priority-setting activities. Each one has rough-and-ready implications that suggest rules. Hence it is hardly surprising that these approaches have found their way into the practice of rationing and priority setting. Nevertheless, using theoretical approaches with limited practical usefulness may be dangerous. Since they have limited practical recommendations that can be followed with any degree of precision, the relevant decision-makers may easily engage in practices of all kinds, which they may then justify by recourse to a theoretical approach that has no bearing on their actions. Presenting rationing practices in the language of principles of justice may only obscure the real issues and prevent the achievement of transparency. In such a situation, implicit rationing as traditionally practised may be presented in the form of explicitness: in effect, a double deception of society.

Moreover, the above principles of fair distribution clearly conflict with each other. Each one is meaningful as a guide to distribution only with respect to its own logic and set of rules, which should be applied across the full range of health services within a given society. When these principles are applied selectively to particular health services, at different times or in combinations, their internal consistency with respect to their distributive implications collapses, and the rationing or priority setting actually taking place may end up looking like a collection of random activities bearing no relation to any underlying theory of distributive justice.
This suggests that a society should achieve consensus on the particular approach or approaches to distribution adopted as a basis for its policies. Quite clearly, pluralism in theories of justice reflects the moral pluralism of societies. A notion of fairness in distribution that may be appropriate for one society or one group within a society may be inappropriate for others. The overriding consideration here is the acceptability to society of the particular notion of fairness to be selected.

An approach has been developed in recent years to attempt to deal with the problem of the social acceptability of resource allocation in health care: the community-oriented approach of philosopher Daniel Callahan. This approach argues that societies cannot manage their problems of resource allocation in health care if they do not attempt to answer normative questions such as: “What makes a good and fulfilled life?”; “What is the place of illness and old age in our lives?” and “How may health care contribute to the good life?”. In the community approach, the good life is considered from a community perspective, as opposed to the liberal or individual perspective. This means that the individual is considered first and foremost as a member of a moral community within which he or she has a moral identity, rather than as an individual with individual needs and wants.¹

The community approach is intuitively appealing, but its practical usefulness is questionable. It brings to the fore the difficulty of achieving consensus within a society on the values that will determine inclusion and exclusion principles. The community approach demands a social consensus on fairly specific normative issues. While reaching consensus on very broad normative principles, such as equity and solidarity, may not be difficult, the more specific and detailed the principles become, the more difficult will be the achievement of consensus.

Do all these difficulties suggest that it is futile to couch the problems of rationing and priority setting in terms of principles of justice? Not at all. In fact, discussions of rationing and priority setting focus too little on the ethical and moral implications of the practices used. Greater emphasis on these should be welcomed, as it raises awareness of the moral dilemmas involved and the practical difficulties finding socially acceptable solutions. Moreover, such a discussion engages governments, professionals and the broader public in a debate of vital interest to most members of a society. It highlights the overriding importance of openness in the discussion, explicitness and transparency in rule setting and accountability in decision-making. It also opens the way for searches for more pragmatic solutions to the problems.

¹ The community approach is not utilitarian; in fact it is not a theory of distributive justice at all. It does not specify what is “good” and “just” for society, as this is left open for members of society to decide upon. What is stressed is that in making such normative valuations, which are essential to resource allocation decisions, individuals should regard themselves primarily as members of society.
Implicit rationing in practice: moving towards explicit rationing

Techniques of implicit rationing

As mentioned, rationing has always taken place, as no society can ever provide enough resources to satisfy every health care need through statutory funds (tax funds or social insurance funds). Such rationing, however, has for the most part been implicit: it has not involved the use of explicit techniques or rules of distribution defining how rationing is supposed to take place. Implicit rationing has continued to take many practices:

- rationing by denial, in which care providers turn away would-be patients on the grounds that their needs are not urgent enough;
- rationing by selection, in which service providers accept only the patients with the greatest likelihood of benefiting from an intervention;
- rationing by deflection, in which would-be patients are directed to other programmes or services;
- rationing by deterrence, which, instead of flat denial, makes access to a service more difficult, (by, for example, long queues, lack of information on the service, incomprehensible forms, etc.) thus discouraging its use;
- rationing by delay, which discourages demand through the imposition of long waiting periods (through, for example, the waiting list);
- rationing by dilution, in which services continue to be offered but their scale or depth is reduced, so no one is excluded but everyone gets less; and
- rationing by termination, in which a treatment or intervention is terminated earlier than in the past (for example, early discharge from a hospital or termination of treatment for a condition).

These techniques of implicit rationing may be used in isolation or in combinations, and very likely involve different practices or combinations of practices by different services of a health care system. Moreover, they may not represent conscious or deliberate rationing, but may rather be undertaken as a way to make life easier for all those involved under constraints of funding, time or other resources.

2 The following section is based Klein, R. et al., Managing Scarcity: priority setting and rationing in the National Health Service, Buckingham, Open University Press, 1996.
Micro level and macro level rationing and priority setting

The above list of techniques shows that implicit rationing takes place at the clinical or micro level. This refers to the process of resource allocation among individuals or at the point of service delivery, and involves mainly doctors but also social workers or other professionals as the rationing agents who can decide whether and to what extent a patient can get a particular service.

Micro-level rationing can be distinguished from macro-level rationing and priority setting, which refer to activities taking place at the level of national, regional and/or local government, depending on the administrative structure of the health care system of a country. Governments are almost invariably involved with resource allocation through such activities as setting budgets for specific services and programmes, and sometimes determining the distribution of resources within particular services and programmes. Decisions on their rationing and priority setting tend to be explicit in that they are visible and may also be transparent, although they are not usually undertaken in accordance with consistent normative rules of distribution. In addition, macro-level rationing or priority setting may be pursued by health authorities in countries where they have developed a purchaser function (for example, Sweden, New Zealand and the United Kingdom) and by social insurance funds in countries whose health care is predominantly financed by social insurance and where the funds have freedom to influence reimbursement rates and coverage of services (for example, Germany and the Netherlands).

Efforts to introduce explicitness into rationing and priority setting have therefore usually attempted to shift some of the responsibility away from clinicians, who have made implicit rationing decisions, and towards other, mainly government bodies. The effort to introduce explicitness has focused on the development of institutions or normative guiding principles, as well as technical criteria on the basis of which this shift can take place.

Specifically, the intention has been to use normative and technical principles as the basis for the development of explicit criteria that can be used to include or exclude patients or groups of patients from service provision, or include or exclude services from statutory provision. These criteria (presumably embodying society’s normative valuations) would replace clinicians’ subjective and implicit rationing practices and progressively limit their freedom to make decisions.

Nevertheless, there are limits to the extent to which restrictions to clinical freedom can or should be imposed. Not only the medical profession oppose these restrictions, but also the practice of medicine, and the high degree of heterogeneity of patients require a certain degree of discretion for doctors to decide who should be treated for what
conditions. Completely replacing clinical freedom with macro-level rules would be equivalent to treating all individuals as if they were identical, and to allowing no room for individual differences.

**Technical approaches to priority setting**

Efforts to achieve explicitness in priority setting involve the development and use of technical criteria as basis for choices among competing uses of resources. These technical approaches are grouped here under three broad headings: the epidemiological, the economic and the evidence-based-medicine contributions.

**The epidemiological contribution**

Epidemiological studies are undertaken in conjunction with the needs-based approach to priority setting. Epidemiological findings constitute the key measures of need that are used as a basis for the application of the equity principle in resource allocation. Epidemiology analyzes patterns of morbidity and mortality across geographical areas, age groups and social groups, and accumulates information on the main causes of death and disability, and on relative burdens of disease. This information can then be used to determine relative health care needs (needs assessment), prioritizing them on the basis of their relative importance to society and subsequently allocating resources in accordance with their relative ranking.

This approach presents difficulties because there are many ways of measuring needs and burdens of disease. A key difficulty is that each way gives different answers, and hence a different relative ranking of priorities. The questions are how to choose the way of measuring needs and who should make the choice.

Several criteria are used to define needs and burdens of disease as the basis for developing priorities. One that is frequently used is the impact of disease on mortality. This involves use of the concept of premature death, and hence the calculation of numbers of years of life lost or numbers of deaths before a certain age that are due to specific diseases. This method identifies key problem areas and hence priorities for preventive and/or curative action. Other criteria include the impact of disease on morbidity, measured as days or years of poor health. In addition, the morbidity and mortality criteria have been combined to produce a further criterion, the disability-adjusted life-year (DALY). Further, priorities may be determined on the basis of a disease’s potential to develop into a major cause of morbidity or mortality in the absence of appropriate preventive action (for example, infectious diseases and AIDS).
Quite clearly, the choice of any one of the above criteria leads to a set of priorities that differ widely from any other. An additional limitation of the needs-based approach is that it fails to consider the costs of alternative courses of action. Since rationing and priority setting result from the need to conserve resources, the economic costs of alternatives may become an important consideration.

The economic contribution

On the most general level, the economic contribution rests on rational economic analysis of the problem of how resources are to be allocated among competing claims. Economic analysis examines the problem from the perspective of the economic costs and benefits of alternative interventions or programmes. The approaches to this problem vary mainly in the ways that costs and benefits are defined and operationalized.

Cost-effectiveness analysis compares incremental health benefits associated with additional resource expenditures. A particular activity is worth undertaking if the benefits arising from its implementation exceed the costs. Cost-effectiveness analysis is alternatively termed cost-benefit analysis (when the benefits are expressed in monetary terms) or cost-utility analysis (when the benefits are expressed in terms of utility).

Cost-effectiveness analysis should be distinguished from the utilitarian approach to distributive justice discussed earlier. Utilitarianism uses cost-effectiveness calculations, but takes them a step further by making a leap from positive to normative thinking. Utilitarianism asserts that cost-effectiveness calculations can be used to determine what is good and just for society, by specifying that the good and the just consist of the greatest achievable health benefit given society’s resources. Cost-effectiveness calculations by themselves do not make this normative leap. They only show which interventions can yield the greatest health benefits for a given cost. They do not state that achievement of the greatest health benefits is good and just for society. This may appear to be a truism, but it is not, because cost-effectiveness analysis is in fact consistent with any principle of distributive justice. It does not necessarily conflict with the equity (or needs-based) approach to distributive justice, for example, whereas utilitarianism as a theory of justice is in conflict with other theories of justice.

Cost-effectiveness analysis undertaken in terms of monetary units (cost–benefit analysis) was used in the early years of economic valuations and attaches monetary values to costs and benefits. Costs may be interpreted to include the costs of treatment, of travel and to the patient during

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3 See the section on the combination of approaches and their normative implications for a discussion of this point.

4 There is a great deal of confusion on this point in the literature, as cost-effectiveness is often assumed to be virtually synonymous with utilitarianism.
treatment time. Benefits are defined as the future earnings of the patient (discounted to present values). The costs can be calculated as costs to the patient, the government or society.\textsuperscript{5} This approach suffered seriously from the subjective judgements necessarily involved in attaching monetary values to costs and gains of alternative treatments, which are multi-dimensional and do not easily lend themselves to quantification. In addition, this approach was severely limited by its socially unacceptable value judgements. An individual’s life and health are valued by the level of earnings that he or she can secure. If the individual can be replaced by an unemployed person, the amount of future earnings that he or she is worth is lessened. In this view, the life and health of the retired, the unemployed, and the disabled have little or no value.

Efforts to overcome these difficulties have led to more sophisticated versions of cost-effectiveness analysis. One of these is programme budgeting in conjunction with marginal analysis (PBMA). Programme budgeting attempts to analyze the expenditures involved in different programmes, and makes judgements about alternatives based on this information, including not only existing programmes but also proposals for new ones. When combined with marginal analysis, this approach attempts to evaluate the desirability of alternative choices within programme areas.

A second example of an effort designed to improve the traditional and problematic cost-benefit analysis is cost-utility analysis in conjunction with quality adjusted life years (QALYs) and disability adjusted life years (DALYs). Cost-utility analysis differs from cost-benefit analysis in that the benefits are redefined to involve years of life gained. QALYs are one of the most widely known and discussed methods of cost-effectiveness (or cost-utility) analysis. They constitute an attempt to reach a more precise value or measure for the gains arising from alternative interventions. They measure the benefits of health care services in terms of additions of healthy life years made possible by the particular service. If certain periods of life are believed to be more valuable than others, weights can be attached to compute the final value of gain. If less than full health is to be gained, then a corresponding proportion of a healthy year is considered. This information, in combination with information on the costs of interventions, is used to produce a scale of the cost per QALY of different interventions. The World Bank used an alternative approach, involving DALYs to assess the impact of a large variety of diseases around the world.\textsuperscript{6}

Similarly, calculations of DALYs arising from particular interventions can be similarly combined with information on the costs of the

\textsuperscript{5} If calculated in terms of social costs, these would include expenditure on social welfare and social insurance payments, reductions in income tax and the cost of publicly financed health care.

interventions to produce a scale of cost per DALY of different interventions.

The advantage of the cost-utility approaches is that they link the costs of alternative interventions with benefits defined in concrete terms of health gain. Yet all these approaches suffer from similar limitations associated with the difficulties of measuring and comparing health outcomes and gains. A danger is that, given these limitations, whatever measures are developed in the present state of our knowledge are likely to be inaccurate and misleading. In the case of QALYs and DALYs, the relative valuations of quality of life-years depends on the particular group of people selected for study and differing levels of aggregation. The numerous technical difficulties include:

- the problems of valuing future levels of benefits;
- the fact that QALYs and DALYs are estimates and averages from which individuals or even groups of individuals depart (such as the elderly who have fewer life years following an intervention, and hence could be discriminated against);
- the fact that different people have different abilities to respond to the same treatment; and
- the absence of full knowledge on the effectiveness of different treatments; and others.

Moreover, key questions arise in connection with how conditions of disability or ill health are to be assessed and measured, and who is to do the assessment.

It could be argued that at least some of the limitations of QALYs and DALYs are due to their relatively recent development, and that further refinements would at least mitigate some of their present shortcomings. This may well be the case. At the present phase of their development, however, QALYs and other cost-effectiveness approaches are more useful in pointing out the dilemmas of rationing and priority setting than in providing answers to the difficult questions of choice.

At any rate, cost–effectiveness analysis is or should be only a tool in the service of the broader normative choices on the distribution of benefits that society must make.

It would be very dangerous to consider cost–effectiveness analysis capable of resolving the moral and ethical dilemmas posed by rationing and priority setting. (This would be tantamount to equating cost-effectiveness with utilitarianism.) At best, and assuming that all the technical difficulties have been satisfactorily resolved, cost–effectiveness analysis could only tell us which interventions can give rise to greater health benefits for a given level of cost. It cannot tell us anything about the distribution of health benefits that society deems to be the most desirable.
Cost–effectiveness analysis can therefore be an invaluable aid to decision-making, if we see it only as an aid and not the normative rule by which health benefits are to be distributed. For example, society may decide on distributive rules and criteria that favor particular social groups, such as children and/or the elderly. Cost–effectiveness analysis applied to interventions across these social groups, or between these social groups and others would then become irrelevant, and would not or should not be undertaken.

The evidence-based-medicine contribution

The appeal to science or new medical knowledge that can reveal the relative effectiveness or ineffectiveness of different interventions is an additional tool to use on rationing and allocation problems. Such new knowledge can help in two different ways.

First, if certain interventions are identified as ineffective or less effective than others in treating a particular condition, they can be removed from the range of admissible interventions in the health care system. This eliminates a certain degree of waste, and frees resources for use on other activities of known effectiveness. This process in effect increases the amount of resources available for health care, thus lessening the severity of the rationing problem. Perhaps even more important, new treatments would not come into general use before evidence has demonstrated their impact.

Second, medical knowledge is an essential ingredient of cost–effectiveness analysis. Cost-effectiveness calculations, as we have seen, require the measurement of effectiveness in terms of the health benefits of different interventions. One of the limitations of cost-effectiveness analysis involves the difficulties of accurately measuring benefits. Hence new medical knowledge to assist the assessment and measurement of benefits is essential for the improvement of the cost-effectiveness method. In this way, new medical knowledge is a tool for priority setting.

The issue at hand involves not only the production of knowledge on outcomes of new interventions but also the use of old or existing knowledge. The latter is not always used effectively, or may be ignored in medical practice, owing to doctors’ refusal to change habitual practices, regardless of the evidence. Thus, questions for the evidence-based contribution are:

- whether the process of new knowledge production can be speeded up; and
how to ensure that new or existing knowledge is actually incorporated into the practice of medicine (that doctors use this new knowledge).

At this point, certain limitations of this approach appear. The difficulties arise mainly from the time taken to generate new knowledge and certain complications in the process of putting this new knowledge to use. Here, new knowledge refers both to innovations in interventions and to outcomes in terms of health benefits. A great deal of uncertainty about medical intervention processes is associated with diagnosis, treatment, responses to treatment and the likely outcome. It has been estimated that only about 15% of clinical interventions can be supported with solid scientific evidence. Innovation, or the production of new medical knowledge, is a step-wise process that as a rule involves lengthy periods of time. Knowledge about the outcomes of interventions would involve eliminating each level of uncertainty noted above.

There are questions about not only how much time the overall process takes, but also when an innovation should be evaluated (through, for example controlled clinical trials) and how long the evaluation period should be. Outcomes may depend on the setting in which clinical trials take place; medical procedures may not be equally effective if undertaken by less experienced practitioners. Further, who should evaluate outcomes - professionals or patients? What should be done about possible ambiguities in the results of scientific trials? A more difficult question is what to do if some interventions are selectively effective and depend on the particular circumstances of the patient.

Moreover, new knowledge leads not only to the abandonment of old and ineffective practices but also to the development of new and effective ones. Thus, innovations may lead to interventions that are more effective in terms of outcomes but also more (or less) costly than those they supersede. The development of new and effective technologies in recent years has been partly responsible for the so-called cost explosion in health care. On balance, it is not possible to know whether innovations will reduce or increase costs.

Evidence on the outcomes and effectiveness of medical practices therefore can and should inform choices, but only within the limits discussed above. Moreover it cannot make a dramatic contribution to the problems of rationing and resource allocation in a short period of time.

**Defining a minimum or basic package of health care services**

A package of health care services refers to the set of services which are offered by the statutory health care system. While the term package suggests a tightly defined set of services, specifying in detail each included service, in practice this is not often the case. Rather, packages
Key issues in rationing and priority setting for health care services

of care tend to define broader categories of services, and stop short of specifying everything that is included in each category. In practice, this leaves varying degrees of leeway for clinicians and other decision-makers to decide what specific services can be included or excluded for specific patients or groups of patients. This is what allows implicit rationing to take place. As noted earlier, efforts to introduce explicit rationing have focused for the most part (although not always) on limiting this freedom of clinicians.

From the point of view of the basic package, we can distinguish four ways for countries to make priority setting explicit. The first is to try to restrict the basic package to a very tightly defined set of services specifying inclusions and exclusions. All possible interventions are listed in order of priority, and the budget determines the cut-off point for the interventions that can be included. Only the state of Oregon in the United States has used this approach, which involved the detailed listing of over 500 specific interventions that were included in the package of care. Thus, the included services can be likened to a positive list.

This approach allows no freedom to clinicians, who are ordinarily involved in micro-level rationing, to make adjustments or choices regarding the kind of care they can provide or particular patients they can treat. Nevertheless, as medical services are rendered in confidential circumstances and outside brokers are seldom present at the point of delivery, we should not underestimate the innovative and imaginative talents of both patients and clinicians in twisting the rules to their benefit.

The second option is to try to define a set of core services to be contained in the basic package. Normative or technical criteria or both are used to determine priority areas for inclusion. This approach should be distinguished from that of option 1. It differs from the positive list in that, even within the core services defined by the selected priorities, further prioritization and rationing will take place to determine the order in which a service will be received and even who is to receive it.

In other words, not everyone may be eligible to receive the core services, and those who do receive them will not do so in the same order. Thus, this option clearly offers varying degrees of freedom to make adjustments or choices within the benefits package. In this case, the choices could be made not only by clinicians but also by social insurance funds (in the case of social-insurance-financed systems) or health authorities who act as purchasers of services for their respective populations (if there is a purchaser–provider split). In other words, the various actors have leeway to make rationing or priority-setting decisions. Examples of countries taking this option are the Netherlands and New Zealand; Germany appears to be headed in this direction. Option 2 allows more clinician freedom than option 1, but its extent depends on how tightly the core is defined, which can be highly variable.
The third option is to have an even more loosely defined set of statutory services, consisting of broad categories of services, which allows an even greater degree of freedom for choice by various actors. Rather than an attempt to define a core, normative or technical criteria or both are used to determine broad areas of priorities (as in Finland, Spain or Sweden), or to make plans to purchase services on behalf of citizens (as in the United Kingdom). Here, too, technical rules and normative valuations can impose restrictions on services.

The fourth option is to define a list of services that are to be excluded from the benefits package. The Oregon approach (option 1) in effect accomplished this by making a detailed listing of many interventions not all of which were included in the package of statutory services. A negative list, however, need not go hand in hand with a positive list. It can be used in combination with options 2 and 3, where prioritization by use of core services or broad areas of priorities is accompanied by a list of specific services that are to be omitted from statutory provision. Germany, the Netherlands, Spain, the United Kingdom and other countries have either begun to implement such negative lists, in the absence of any other effort towards consistent priority setting (that is, without options 2 or 3). Ideally, the services to be included in a negative list should be identified as those of lowest priority, as determined by normative and/or technical rules.

In practice, few if any countries consistently apply such rules in determining their negative lists. In the countries of central and eastern Europe (CCEE) and the newly independent states (NIS), for example, where resource constraints have limited health systems’ abilities to offer the broad range of services provided under the previous regimes, initial efforts to introduce negative lists have focused on such services as cosmetic surgery, some prosthetic devices and health sanatoria. Some countries have further attempted to use burden-of-disease and DALY methods as guides in priority setting, but they have not gone much farther than measuring the burden of disease in terms of morbidity, mortality and disability; they have not used cost–effectiveness analysis or attempted to assess social preferences.

A tightly defined set of health care services (option 1) could be an unattractive option for many countries for several reasons. First, equity in access and financing would be undermined: the first because access would be reduced for the individuals seeking services excluded from the basic package and the second because these individuals would have to seek care in the private sector. Second, there are difficulties in deciding what to include and what to exclude, especially in view of the weaknesses of the technical criteria. Who would decide on the choices, and on the basis of what criteria? Further, as the medical profession argues, there are always exceptions to rules; patients are heterogeneous, so that what holds for one may not hold for another, and rigid rules allow
no room for adapting to individual needs. Moreover, a narrowly defined package of care could inhibit advances in medical knowledge. In brief, such a system is highly inflexible, and inflexibility may not be in the best interests of a society and its health care system.

The second approach, defining a core of health services, may also be subject to some of these limitations, especially in the degree to which the core is tightly defined. In general, the less tightly defined the package of benefits, the greater the flexibility in provision.

**Combinations of approaches and their normative implications**

In contrast to theories of distributive justice, which are mutually exclusive, techniques of rationing and priority setting may sometimes be used together and complement each other.

Quite clearly, evidence-based medicine can complement cost-effectiveness analysis, as it can provide new knowledge on the effectiveness of alternative interventions. Similarly, evidence-based medicine can benefit from cost-effectiveness analysis, which permits the financial valuation of alternative interventions. Techniques used in cost-effectiveness analysis, specifically QALYs and DALYs, can be used in conjunction with needs assessment, as they can shed light on relative rankings of needs. Both needs-based approaches and cost-effectiveness analysis (including QALYs and DALYs) can be further used as the basis for defining a basic basket of health care benefits.

The techniques can therefore borrow from each other to lead to better and more refined techniques for rationing and priority setting. They are not, however, wholly consistent with each other, and there are limits to the extent to which they can be combined. Specifically, the needs-based approach can arrive at a ranking of alternative interventions based on considerations of need and regardless of considerations of cost. Similarly, the evidence-based-medicine approach may suggest that one intervention is more effective than another, regardless of cost, while cost–effectiveness approaches reveal the cost which is associated with different interventions.

The above suggests that the approaches conflict. What does it mean then to say they can complement each other? The answer to this question can be illustrated with an example.

Let’s suppose that the equity or needs-based approach has been used to arrive at a particular ranking of priorities. We may further suppose that more than one intervention is suitable for the achievement of a particular priority. Cost-effectiveness analysis can be useful in determining which
intervention should be pursued; namely, the lower-cost one.\textsuperscript{7} Thus, up to this point the two techniques are consistent. The difficulty or conflict arises when a choice has to be made between a low-cost, low-priority intervention, and one of higher cost and higher priority. The techniques of needs assessment and cost-effectiveness analysis cannot tell us which intervention to choose. The solution to the dilemma involves making a normative choice or value judgement on which technical rule should take precedence.\textsuperscript{8} Such normative choices cannot find their justification by reference to a particular technique.

In practice, a particular technique is often upheld as being superior, and is made the normative rule for making choices. Economists and others, for example, frequently maintain that cost–effectiveness approaches are superior to needs-based approaches because their consideration of costs would make service provision more efficient, and ultimately enable more health gain to be achieved for society as a whole. (This is utilitarianism creeping in through the back door.) There is nothing wrong with this \textit{per se}, since a value judgement must be made to decide between the alternative courses of action. The problem arises when the value judgement asserting the superiority of one technique over another has not been made explicit. Since no technique is inherently better in one technique than another, the superiority of one can be decided only by reference to an external normative rule. This rule must be made explicit. If it is not, then the traditional, crude form of implicit rationing is merely giving way to a more sophisticated version.

The problem arises because, while the techniques are merely tools, they have different normative implications. We may therefore very easily confuse the technique itself with what it implies is good for society. Worse, decision-makers usually do not consult the members of society about decisions that are presumably being made in their best interests, or even inform them about these decisions. This is what the demand for explicitness is all about.

\textbf{Country efforts to develop priority setting systems}

This section considers nine examples of efforts towards explicit priority setting. They illustrate the difficulties encountered on both the technical and moral/ethical levels. They are grouped under three broad headings, in accordance with the relative degree of tightness in their definitions of a package of services. The first group, involving the most tightly defined package of services with explicitly stated inclusions and exclusions, comprises only the state of Oregon (USA). In the second group, efforts have centred on defining core services, with different degrees of freedom

\begin{itemize}
    \item In Sweden, for example, the parliamentary Priorities Commission has recommended that the cost-effectiveness principle should only be used in comparisons of methods for testing for the same disease (see the section on priority setting in Sweden).
    \item In Sweden, the decision was that the principle of need should take precedence over cost–effectiveness.
\end{itemize}
Key issues in rationing and priority setting for health care services

to vary the services offered, either by insurance funds, as in the case of Germany and the Netherlands, or by tax-financed purchasers of services, as in the case of New Zealand. Members of the third group have tried to develop systems of priority setting in the most loosely defined set of statutory services; they comprise Finland, Norway, Spain, Sweden and the United Kingdom.

Defining a list of health care services

The Oregon reform (USA)

Medicaid, a public programme offering health care services for the poor of the United States, constituted the first effort to institute rationing and priority setting on a broad scale in that country. Funding constraints faced by the Medicaid programme in general, combined with the initiative in the state of Oregon to extend access to services to the uninsured, led to efforts to establish a list of priorities covering the entire spectrum of health care. The objective was to establish a basic package of care, and to extend coverage to all the poor (of whom only 58% were covered), as well as to all uninsured people in the state.

A Commission of 11 members (5 doctors, 1 public health nurse, 1 social worker and 4 consumers of health care, all serving in a voluntary capacity) tackled the task of making the priority list.

The commission used QALYs in its first attempt to establish a list of priorities. QALYs and their corresponding costs were computed for 1680 procedures which were ranked as condition–treatment pairs, starting with the lowest-cost QALY at the top of the list. The cost–QALY technique gave rise to so many anomalies, however, owing in part to much guesswork that had gone into quantifying costs and outcomes, that this approach was dropped. In Oregon, the QALYs method was soon dropped, owing serious anomalies.

In the second attempt, the commission established 17 categories of care. It then conducted numerous community meetings and public hearings to determine public values. The public chose 13 values, ranked in order of the frequency with which they were expressed:

1. prevention
2. quality of life
3. cost effectiveness
4. ability to function
5. equity
6. effectiveness of treatment
7. number of people benefiting

For example, appendicitis–appendicectomy.
For example, cosmetic breast surgery had received a higher rank than open hip fracture, and tooth capping higher than appendectomy.
The number of people affected by the condition and benefiting from the treatment.
8. mental health and chemical dependency  
9. personal choice  
10. community compassion  
11. impact on society (mainly with regard to infectious disease)  
12. length of life  
13. personal responsibility.

The commission then made its own subjective valuations to allocate the 13 values into 3 classes of items:

1. essential to basic health care  
2. valuable to society  
3. valuable to an individual needing the service.

In effect, these categories classified the values as:

1. essential  
2. important  
3. less important.

This process was used to rank the 17 categories of care in order of priority. Table 1 shows the categories of care and their rank as determined by the commission’s three criteria.

Next, certain adjustments were made to the original condition–treatment (QALY) pairs, so that less emphasis was placed on cost and more on the duration of benefit and quality of wellbeing. The condition–treatment pairs were placed into one of the categories, resulting in a totally different ranking from the original one. The Commission changed certain rankings based on intuition and political realities. The final list included a total of 709 pairs, of which the first 587 were to be funded by Medicaid.

Table 2 shows some examples of condition–treatment pairs, the category into which they were inserted, and its corresponding rank (from 1 to 708). Again, the basic package included those with a rank between 1 and 587.
Table 1: Seventeen categories of care as determined by the Oregon commission and their corresponding rank as determined by the commission’s three criteria

<table>
<thead>
<tr>
<th>Disease-oriented categories</th>
<th>Rank</th>
<th>Health oriented categories</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fatal conditions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment that prevents death</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full recovery</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Maternity care</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Residual problems</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Preventive care for children</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Treatment that extends life and quality of life</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Reproductive services</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td><strong>Comfort care</strong></td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Preventive dental care</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Adult preventive care (I)</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td><strong>Non-fatal conditions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment that provides full cure</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Chronic condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single treatment that improves quality of life</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Acute condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment that achieves partial recovery</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Chronic condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repeated treatments that improve quality of life</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Acute, self-limiting condition</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Treatment that speeds recovery</td>
<td>15</td>
<td>Infertility</td>
</tr>
<tr>
<td>Adult preventive care (II)</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Fatal or non-fatal conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment provides that minimal or no improvement in length or quality of life</td>
<td>17</td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Ranking of selected condition-treatment pairs in the Oregon priority setting experiment

<table>
<thead>
<tr>
<th>Condition</th>
<th>Treatment</th>
<th>Category</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>pneumonia</td>
<td>medical</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>appendicitis</td>
<td>appendectomy</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>ischemic heart disease</td>
<td>cardiac bypass oper.</td>
<td>3</td>
<td>149</td>
</tr>
<tr>
<td>HIV disease</td>
<td>medical</td>
<td>5</td>
<td>158</td>
</tr>
<tr>
<td>imminent death</td>
<td>comfort care</td>
<td>7</td>
<td>164</td>
</tr>
<tr>
<td>cancer of uterus</td>
<td>medical and surgical</td>
<td>5</td>
<td>186</td>
</tr>
<tr>
<td>end-stage renal disease</td>
<td>medical (dialysis)</td>
<td>5</td>
<td>319</td>
</tr>
<tr>
<td>cataract</td>
<td>extraction</td>
<td>11</td>
<td>337</td>
</tr>
<tr>
<td>Condition</td>
<td>Treatment</td>
<td>Category</td>
<td>Rank</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>----------------------------</td>
<td>----------</td>
<td>------</td>
</tr>
<tr>
<td>Osteoarthritis hip replacement</td>
<td></td>
<td>11</td>
<td>399</td>
</tr>
<tr>
<td>wisdom teeth surgery</td>
<td></td>
<td>11</td>
<td>480</td>
</tr>
<tr>
<td>tonsils and adenoids surgery</td>
<td></td>
<td>11</td>
<td>494</td>
</tr>
<tr>
<td>hernia (no obstruction) repair</td>
<td></td>
<td>11</td>
<td>504</td>
</tr>
<tr>
<td>back pain spondylisis medical and surgical</td>
<td></td>
<td>13</td>
<td>586</td>
</tr>
<tr>
<td>varicose veins stripping / sclerotherapy</td>
<td></td>
<td>11</td>
<td>616</td>
</tr>
<tr>
<td>bronchitis medical</td>
<td></td>
<td>13</td>
<td>643</td>
</tr>
<tr>
<td>cancer (treatment will not result in 10% of patients surviving five years)</td>
<td>medical and surgical</td>
<td>17</td>
<td>688</td>
</tr>
<tr>
<td>tubal dysfunction In vitro fertilization</td>
<td></td>
<td>15</td>
<td>696</td>
</tr>
<tr>
<td>haemorrhoids haemorrhoidectomy</td>
<td></td>
<td>17</td>
<td>698</td>
</tr>
<tr>
<td>AIDS, end stage of HIV</td>
<td>medical</td>
<td>17</td>
<td>702</td>
</tr>
<tr>
<td>extremely low birth-weight babies (under 500gm)</td>
<td>life support</td>
<td>17</td>
<td>708</td>
</tr>
</tbody>
</table>

While President Bush was expected to approve the list, it was rejected owing to protests from groups who claimed it discriminated against disabled people by attaching less value to them. The commission was told to eliminate the quality-of-life value, and then replaced it with additional subjective valuations of its own. President Clinton approved a revised ranking in March 1993, and the programme began operation in February 1994.

The Oregon programme succeeded in its objective of broadening access to health care services, and it effectively replaced one form of rationing (completely excluding people from services) by another (restricting services, but making them available to more people). It has received a great deal of attention internationally because it stands as a model for a particular type of rationing: the explicit exclusion of particular services from the benefits package. While the Oregon programme has been commended for attempting to put into effect an explicit form of rationing and to ensure popular legitimacy by involving the broader public, it has also been strongly criticized as a model for emulation in other countries.

Some criticisms center on the use of QALYs, which provided ample demonstration of their limitations as a tool. For example, owing to the heterogeneity of patients,, and variations in individual responses to treatment within particular condition–treatment groups may be as wide as variations between these groups. In addition, the Oregon programme points out the severe weaknesses of cost-effectiveness analysis. While this was abandoned in favour of the introduction of community values, the methods finally used to determine rankings were based at least as much on the subjective valuations of the commission as on the values of
the community. Thus, the initial efforts to achieve transparency and explicitness gave way to obscurity and the subjective valuations of a handful of people. The end result involved arbitrary judgements not far removed from those that occur in implicit rationing. Finally, most countries reject the very tight specification of inclusions in the basket of benefits in the form of a list.

**Defining a core of health care services**

The distinguishing feature of this group, it will be recalled, is that its members attempt to use normative or technical criteria or both to define core services.

**Core health care services in the Netherlands**

The health care system in the Netherlands is based on social insurance and private insurance. Reform proposals of recent years have attempted to introduce statutory coverage for the entire population. In 1990, the Secretary of State responsible for health established the so-called Dunning Committee to determine how priorities should be set for health care. Specifically, the Committee was to “examine how to put limits on new medical technologies and how to deal with the problems caused by the scarcity of care, rationing of care, and the necessity of selection of patients for care.” The Committee’s report has received a great deal of attention as an example of a proposal to achieve priority setting, although it has not been implemented.

The Dunning Committee adopted a community approach, as distinct from an individual approach and a medical–professional approach. According to the Committee, in the individual approach, health is related to autonomy and self-determination, which would entail letting individuals decide what they need. This, it is argued, would prevent a societal definition of necessary care. The medical-professional approach identifies health with the absence of disease; it focuses on normal biological functions, as opposed to psychosocial functioning. In the community approach, health is defined as the ability of every member of a society to participate in social life; necessary health care can make this participation possible. The three approaches form a hierarchy, in which the community approach should rule decision-making at the macro level, the medical–professional approach, at the middle level, and the individual, at the micro level, although within the limits defined by the other two levels.

While emphasizing the role of the community in determining what is necessary care, the community approach is not utilitarian because what is

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12 The commission’s valuations, attaching greater importance to social over individual benefits, appear to lean toward the utilitarian view of distribution.


14 The second section discusses the community approach.
in the interests of a community is determined, not by the principle of the greatest happiness of the greatest number, but by social values and norms. The three social values upheld by the Dunning Committee are:

1. the fundamental equality of people
2. the fundamental need for protection of human life
3. the principle of solidarity.

The Committee decided that four criteria or sieves should be used to determine a basic package of care. Each of the sieves asks four questions.

1. Is care necessary from the point of view of the community?
2. If so, is it effective?
3. If so, is it also efficient?
4. If so, can it still be left to individual responsibility?

Figure 1 illustrates the sieves. The first sieve retains care that is unnecessary. What is not retained (or passes through) is necessary care from a community point of view. Three groups of services are permitted to go through this sieve: those that guarantee care for people who cannot care from themselves (the elderly, the disabled, etc.), those that restore people’s ability to participate socially and those whose necessity is determined by the severity of a disease and the number of people with that disease.

The second sieve retains all ineffective interventions, as determined by evidence-based medicine. The third retains inefficient practices, as determined by cost-utility analysis. The Committee decided that a lower limit of efficiency should be set, defined by low effectiveness and high costs; activities falling below the lower limit should be excluded from the package. The fourth sieve thus retains care that can be left to individuals. This in effect involves setting a limit to solidarity, so that interventions with high costs and small chances of effectiveness are left to private financing. Everything that successfully passes through all four sieves forms the basic package of services.
Examples given by the Committee include the following. First, *in vitro* fertilization may be necessary from an individual point of view and from a medical–professional point of view, but not from the community point of view, as infertility poses no danger to the community and does not interfere with normal functions in society. Moreover, *in vitro* fertilization is only about 30% effective. Second, homeopathic medicines would be excluded on the grounds that their effectiveness has not been conclusively demonstrated. Finally, dental care for adults is necessary, effective and efficient, but would be left to individual responsibility. Dental care for the young, however, would be included among care services.

As in the Oregon approach, the Dunning Committee proposed to have condition–treatment combinations that should be ranked within categories and in an order determined by its chosen criteria. In addition, political considerations would play a role in determining necessary care, so that the categories and their rankings are politically acceptable.

Nevertheless, the Dunning plan also differs from the Oregon approach. First, the Committee did not go so far as to define a basic package of care. It proposed that the nature, content, and extent of rights to health care be defined by law. Within the limits defined by law, however, insurers would be free to make variations in the basic package. This is a feature required by the competition between insurers that health care reform proposals in the Netherlands are trying to introduce. Thus, consumers of care would have a voice in making certain minor adjustments to the core package of care defined by law, through their free choice of insurer and the competitive implications of choice.

Second, in contrast to the Oregon plan, which tried from the beginning to incorporate public opinion on values, the Dunning Committee based its plan on the community approach from the outset, with no prior consultation with the public. While the plan emphasizes participation by consumer and patient groups, this is only at the level of assessing alternative programmes offered by insurers. Thus, the entire construct upon which rationing and priority setting rests is based on the values chosen by the Dunning Committee.

Criticisms of the approach taken by the Dunning Committee have focused on the community approach that defines necessary care. The central question that the community approach tries to answer is what care is necessary to sustain normal participation in a community; this begs several more questions. What is normal participation? Who decides what is normal and what is not? Even more important, how is the decision to be made, and who decides what care is necessary or not necessary to sustain normal participation? Using the example the Committee’s exclusion of *in vitro* fertilization from core services, we could easily argue that childlessness interferes with some people’s normal functioning in society. As to the Committee’s view that childlessness does not pose a
danger to society, we could argue that many conditions that pose no
danger to society would be included in the core package. Further,
individuals vary widely in the ways that different conditions affect their
ability to function normally. Is it possible to decide on these unilaterally
at the macro level, without taking individual conditions into
consideration? Finally, even if it could be decided what conditions
should be included in the package, rules for the decision say nothing
about what kind of care is appropriate to treat different conditions.

A new report by the Scientific Council for Government Policy recently
appeared to reject the Dunning Committee’s approach. The new report
notes the following:

The tendency to regard publicly guaranteed services as “acquired
rights” means that decisions to reduce benefits meet with resistance
from citizens who will be affected. Such adverse reactions are
reinforced by the fact that these discussions always focus on one
benefit at a time. The members of the specific interest groups affected
then try to retain their “acquired rights” without regard for the
consequences of their action for other services. consequently, there is
little political support for removing access to specific services form
collective responsibility.

A new approach is therefore recommended, which focuses on what
should be included in the benefits package rather than make specific
exclusions. It is presumed that health policy has two objectives: the
promotion of health, and the care and nursing of the sick. Health is
defined narrowly as “the absence of disease and other health problems,
both of physical and psychological nature”, thus confining the scope of
statutory services provision to affordable limits. Priorities are proposed
in the areas of prevention, curative services and care. In the area of
prevention, the priorities are:

- collective goods and infectious disease control;
- health promoting measures aimed at influencing behaviour
- early detection of life-threatening diseases and diseases that
  lead to disability.

In the case of curative services, the priorities are:

- acute care in the event of life-threatening diseases;
- acute care in the case of health problems that lead to loss of
  essential functions;
- non-acute care in the event of life-threatening illnesses;
- non-acute care in the event of illnesses that can lead to loss
  of essential functions;
- care for chronic diseases to prevent or reduce permanent
  disability.
Priorities in care services are:

- care for the severely mentally and physically handicapped, terminally ill patients, psychogeriatric and psychiatric patients;
- professional nursing in home care;
- support in the personal care of the chronically ill in a home care setting;
- support with domestic activities in the home setting.

Priorities within and between categories should be set in accordance with the principle of effective interventions (which would exclude, for example, homeopathic medicines), as well as the principle of cost-effectiveness. The latter would be carried out by calculations of cost per Disability Adjusted Life Years (DALYs) for alternative services.

**Core health care services in New Zealand**

New Zealand has a tax-financed health care system. In 1993, health care reform created a purchaser–provider split intended to develop an internal market along the lines of the United Kingdom. The four newly formed regional health authorities can purchase care for their populations from public, private or voluntary providers. An intention of the government within this new institutional framework has been to restrict the range of services to an essential core, while retaining the principle of universal access. In March 1992, the National Advisory Committee on Core Health and Disability Support Services was set up. Its role was to represent the views of the community to the government. Its objectives were:

- to find an acceptable way of identifying which services should be publicly funded;
- to make the process of deciding what should be publicly funded more obvious;
- to recommend changes to the core of publicly funded services that reflect community values;
- to define the terms of access: who gets what services and within what time frame.

In contrast to the Dunning Committee of the Netherlands whose task was completed once it produced its report, the New Zealand Committee has a continued existence, and is expected to continue to advise the government on priority setting over time. It gives advice annually to the government on what services should be publicly funded. Upon government acceptance of this advice, the regional health authorities are obligated to purchase these services for their respective populations.

In contrast to the Netherlands, however, the approach to be taken by the Committee has not been spelled out explicitly. Initially, the Committee
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The Committee recommended a gradual shift towards most effective interventions.

concentrated on inventorying existing services and identifying broad priority areas. It began with the premise that existing services were necessary and suitable, as they represented the values and priorities of generations of New Zealanders. Thus the Committee recommended to the government in 1993–94 that the existing range and volume of services should continue, resources should gradually shift to reflect community preferences, that the most effective services should gradually receive more resources and that waiting times for these services should be reduced. The concept of the list of services was explicitly rejected as a basis for priority setting.

In the following year, 1994-95, the requirement to continue existing services was removed, and regional health authorities were given greater leeway to adjust their purchasing policies within limits set by national standards and service priorities.

The Committee has developed five criteria to use in deciding on which services are to be publicly funded:

- the cost of the service
- the effectiveness of the service
- the availability of the service
- the responses from consultations with the public
- assessment of the impact of recommended changes.

As in the Netherlands, no attempt has been made in New Zealand strictly to define a list of services that will be included in the basic package, and the approach appears to favour communitarianism. Nevertheless, New Zealand appears to be more cautious and flexible, with changes in service provision being introduced gradually, with a view to making changes in priorities over time as needed, and with greater flexibility in making choices in core services. In addition, the approach taken in New Zealand appears to be more concerned with incorporating public opinion into the priority-setting process. The Committee has worked closely with the medical profession to create consensus on the ways that resources should be used in dealing with the circumstances of individual patients, and to define national priorities for elective surgical procedures. In addition, from the outset the Committee’s work has included numerous public consultations in various forms such as public meetings and postal questionnaires. There are questions, however, about the boundaries of the responsibilities of the Committee, which presumably represents the views of the community nation-wide, and the regional health authorities, which represent their own populations.

The effort to introduce priority setting in New Zealand encounters a conflict between the value of equity in access and the freedom of purchasers to determine priorities. The ability of a set of core services to meet the objective of equitable access on a national level diminishes as regional variations in services increase. At the same time, the ability of
regional health authorities to determine local priorities in response to the needs and preferences of their populations (and hence to achieve better value for money) diminishes as a central prescription of core services becomes more rigidly enforced.

**Essential health care in Germany**

Germany’s health care system, which is based on social insurance, has undergone major scrutiny since the 1980s, when a series of reforms aiming at cost-containment were initiated. As part of this reform effort, in 1993 the health minister requested the Advisory Council of the Concerted Action in Health Care to prepare a report with advice on the development of the health care system in the next century. The questions the Council dealt with included the following. Which benefits should remain an essential part of the social health provision after the year 2000? Could some provided optionally rather than on the basis of solidarity and subsidiarity (rationing)? How could benefits be provided in an economically viable fashion without waste in the system (rationalization)?

The Council reported in 1994 that any cuts in statutory benefits should only be carried out after efforts to rationalize the system had been exhausted (after improvements in effectiveness and efficiency). It proposed medical, economic, and sociopolitical criteria for categorizing benefits. Medical criteria could include improvements in the quality of life as a result of interventions, and the extent to which interventions are lifesaving. Economic criteria could include cost–effectiveness, insurability and whether need for the treatment could have been avoided by responsible personal behavior. Socio-political criteria would be hardship and economic stress.

Several models were produced, with core elements for health care provision to be decided upon by insurance funds or the central government. Around the core, insurance funds would be advised to differentiate their tariffs providing more choices for the consumer. Specifically, under the principle of greater "self-responsibility", consumers would have to pay more for co-insurance or more accidental co-payments.

The German proposals, while suggesting the need for core health services, are far more general than those of the Dunning Committee in the Netherlands or the Committee of New Zealand. They do not attempt to work out a comprehensive system, or make detailed specifications as to how rationing and priority setting should be carried out. They also do not attempt a moral justification of the approach taken. Nevertheless, the German proposals are very explicit about the possibility of increased private financing. Moreover, the Advisory council goes a step further to evoke a principle that the other countries considered here explicitly reject: namely, the benefit principle. This principle is that those who will
benefit from a service should also pay for it. According to the Advisory Council, the principle would be used to exclude from the core health services those related to health problems on which the individual has an influence, such as illnesses related to smoking, excessive alcohol consumption, injuries from dangerous sports, etc. The benefit principle is therefore a version of the desert or merit principle discussed above.

The Advisory Council acknowledges that the benefit principle has little public support, but invokes it nevertheless as the rationale for excluding a benefit such as dentures from the core, on the grounds that in view of modern dental technology, people who have regularly received dental care would not need dentures.

**Broad delimitations of services**

**Priority setting in Spain**

Spain has a National Health Service (NHS) that is tax-financed. No purchaser–provider split has occurred to date. In 1994, a working group of the Interterritorial Committee, which coordinates Spain’s regional health services, worked out a proposal on a basic package of care to be provided by the NHS. Its objective was to establish the limits of health care entitlements and to establish criteria for inclusion and exclusion. While some effort was made initially to invite public debate, the public did not respond with great interest. In January 1995, the proposals were passed as a decree.

The list concept was rejected and entitlements are defined by categories of care (unlike the Oregon lists of procedures), and include the following:

- primary care
- specialized care
- drugs
- complementary services
- information and documentation.

The exclusion criteria have been defined as follows:

- there is insufficient evidence on clinical safety and effectiveness, or procedures are outdated;
- the effective contribution of procedures to preventive treatment, or cure of illnesses, to the improvement of life expectancy and to self-help and the elimination or reduction of pain and suffering has not been proved.
- The procedures are merely activities of leisure, rest or comfort or aesthetic or cosmetic improvements, etc.
Apart from these general criteria, six types of services were explicitly excluded:

- health reports and certificates not legally required;
- voluntary health checks;
- aesthetic surgery not required by accident or illness;
- spa and rest cure;
- sex change; and
- psychoanalysis or hypnosis.

In the case of new services that are to be publicly financed, the criteria for inclusion into the care package are:

- clinical effectiveness;
- absence of cost-effective alternatives;
- availability of technology and health professionals for the treatment; and
- care of groups with protection, at risk or with special needs.

Thus, the basic package is defined loosely, and for the most part remains unchanged from what was in effect prior to the decree. In the face of resource constraints, rationing and priority setting will continue to take place at the clinical level, as before. Except for the outright exclusion of certain interventions, the decree seems likely to have a minimal impact on the practice of implicit rationing at the clinical level.

**Priority setting in the United Kingdom**

The NHS in the UK is tax financed. Major health care reforms resulted in a purchaser–provider split within the NHS in 1991. District health authorities, family health service authorities and fund-holding general practitioners became Purchasers of health care services. In their capacity as purchasers, they became the citizens’ representatives in the internal market. Purchasers and providers were linked through contractual agreements for service provision. A key rationale behind the purchaser–provider split was to secure “more value for money” through demand-driven service provision. This had major implications for the problems of rationing and priority setting. It was believed that purchasers, by acting on behalf of their respective populations or clients, would secure services in accordance with needs, thus promoting the goal of equity in provision.

Moreover, the ensuing competition among providers eager to secure contracts with purchasers would give rise to improvements in quality and efficiency. A key byproduct of these processes would be increased explicitness in rationing and priority setting, as the age-old practice of rationing by waiting lists and other implicit methods would be replaced by explicit priority setting by purchasers. District health authorities, in particular, acquired major responsibilities for assessing the health care
needs of their populations and commissioning services accordingly from
providers. In this scheme, providers would be forced to provide services
in accordance with the populations’ priorities.

The system in the United Kingdom has received a great deal of attention
internationally because of the revolutionary nature of the reforms of
1991, which also pioneered the institution of an internal market within
the NHS. The discussion here is confined to developments that have a
direct bearing on the problems of rationing and priority setting.

The accumulating evidence on the UK experience suggests that the initial
expectations of purchasers for their priority setting and rationing roles
have failed to materialize. Four key problems can be summarized here.

First, difficulties in performing needs assessment, as discussed above,
arise from certain inherent ambiguities, not the least of which is defining
the concept of need. Once need is defined, for example, through
morbidity data, further questions arise concerning an appropriate service
mix to meet the needs. Moreover, different health authorities define
needs differently, raising the question of how a national standard on
needs is to be achieved so that the concept of equity in provision on a
national level will not be compromised.

Second are the difficulties relating to the need for information on costs
and services. Purchasers have lacked the information required to make
appropriate purchasing decisions; providers may be better equipped with
information. One health authority said that when purchasing started, it
was rather like going into a supermarket with a trolley and asking the
staff to fill it.

Third, there are difficulties relating to the need for systematic evaluation
and comparison of benefits yielded by existing services and by
investments in new services. This involves a task too big to be carried
out adequately by health authorities.

Fourth, important difficulties relate to the lack of an ethical/moral rule
for deciding among alternatives. Health authorities have attempted to use
various techniques for making decisions on resource allocation, such as
needs assessment and cost–effectiveness analysis. As discussed above,
these may overlap and conflict. In the event of conflict, who is to decide
how to proceed, and on the basis of what rules? The situation requires a
normative valuation that was never discussed, much less decided upon,
on a national level, or subjected to any public debate.

The first three of the above difficulties are technical; the fourth lies on an
ethical/moral level. Each has acted as a major constraint to the effective
operation of purchasers in their capacity as priority setters. These
constraints have led to the following results in the actual practice of
priority setting:
1. For most health authorities, there is a broad divergence between the priorities expressed in purchasing plans and those expressed by actual expenditure on services. In other words, the practice of resource allocation does not follow the rhetoric of priority setting.

2. Health authorities show wide variations between in the proportions of resources allocated to particular services. These variations do not result from demographic factors, as would be expected from epidemiological studies resulting in priority setting based on needs assessment, but rather from historical allocations, which for the most part have remained unchanged since 1991. This has serious negative repercussions on equity in provision.

Whatever changes have occurred as a result of changes in purchasing priorities, they have for the most part involved tinkering at the edges. While the historical allocation of funds, as noted above, did not change, the allocation of incremental funds did. For example, a growing number of health authorities have produced a list of services to be excluded from NHS funding (although the total number of health authorities doing this is still small, and the exclusions usually have escape clauses). These exclusions can be grouped under two broad headings, as treatments for: self-inflicted conditions (for example, tattoo removal), and needs defined, not by the medical profession, but by the individual (for example, cosmetic surgery). Both of these involve changes at the margin. Nevertheless, they entail a gradual redefinition of the responsibilities of the health care system, which is taking place without dialogue or consultation with the public.

1. Health authorities have in effect transferred the responsibility of rationing through priority setting away from themselves and back onto doctors. The imposition of limits on purchasers of certain services, with escape clauses, returns the final decision on who to exclude from the service to the doctor who deals with patients at the individual level. Thus, the drive for explicit rationing has come full circle, and the burden of decision-making has returned to the clinical level, where it was in the first place.

2. At the clinical (or micro) level, there are indications of rationing by age, a cut-off age which appears to be emerging in coronary and intensive care units. The questions that emerge here are the same as those that led to criticisms of the methods of implicit rationing. How do clinicians make decisions? Is there a way to ensure that they will apply consistent and socially acceptable criteria and, if so, what is it?

While improvement in equity was expected to result from priority setting by purchasers, it does not seem to have occurred. The goal of equity is
not served within health authorities because resource allocations do not follow any consistent criteria or normative rules. It is certainly not achieved between health authorities, where the problem of arbitrary decision-making is compounded by the absence of any normative rules or guidelines on the national level, resulting in wide geographical variations in access to the same service. As in New Zealand, purchasing freedom among health authorities appears to be inconsistent with the achievement of equity in access on a national level. The United Kingdom differs from New Zealand, however, by making no attempt to impose national level-guidelines or rules that would constrain the purchasing activities of health authorities. This intensifies the problem of wide geographical variations. Partly as a result of the above processes, growing numbers of people are turning to private health insurance, which may gradually lead to the development of a two-tier health care system.

Priority setting in Norway

Norway has a tax-financed national health service, and was the first of the Nordic countries to begin studying approaches to priority setting. The Lonning Commission, set up in 1985, published a report in 1987 analyzing the issues involved in priority setting. The Commission identified five levels of priority ranked according to the severity of the patient’s condition. A new report was published in May 1997; in addition to severity of condition, it identified effectiveness and cost-effectiveness of interventions as criteria for priority setting.

The 1997 report lists four groups of services (to replace the five priority levels of 1987):

- basic health services
- supplementary health services
- health services of low priority
- services excluded from statutory provision.

Particular importance was attached to care for people with mental illness, for those needing rehabilitation and in the community, and it was recommended that action be taken to make these high-priority areas. Further, the Commission recommended the following:

- The issue of direct patient payments should be kept under review, especially in the case of services in the third category (those of low priority).
- Health technology assessment and economic evaluation should receive greater attention in determining priorities.
- A permanent priority board should be created to set treatment thresholds for different conditions and interventions, in order to maintain consistency in setting priorities. The Commission anticipated that groups of
specialists would provide advice on priorities in their respective fields, on the basis of which the board would categorize particular services in the four groups of services.

Priority setting in Sweden

Sweden has a regional health service which is tax financed. The Swedish parliamentary Priorities Commission, set up in 1992, produced its final report on priority setting in 1993. Its findings and conclusions were based on extensive questionnaires, deliberations with experts and representatives of organizations, and meetings with politicians, health service employees and representatives of the general public over the course of this three-year period.

The Commission based its conclusions on three ethical principles, listed in order of decreasing importance:

- the principle of human dignity: that all human beings have equal dignity and the same rights;
- the principle of need and solidarity: that resources should be committed to the fields where needs are greatest, and that solidarity involves paying special attention to the needs of those who have less chance of making their voices heard or exercising their rights;
- the cost-efficiency principle\(^\text{15}\): that there should be a reasonable relationship between cost and effect, measured in terms of improved health and improved quality of life.

The cost-efficiency principle should only be applied in comparisons of methods for treating the same disease. Where different diseases are involved, fair comparison of the results is impossible.

The Commission made an explicit distinction between political/administrative prioritization (which is population-oriented, refers to anonymous groups and should be impersonal) and clinical prioritization (which is individualized, concerns individual people and is personal). Both priority levels are assigned five priority groups:

- treatment of life-threatening acute diseases and diseases that will lead to long-term disability or premature death if untreated;
- prevention with a documented benefit;
- treatment of less severe acute and chronic diseases;
- borderline cases;
- care for reasons other than disease or injury.

\(^{15}\) The term “cost-efficiency” is used in the Swedish report synonymously with “cost–effectiveness”.
In the case of clinical prioritization, those in charge of clinical activity must factor in need and anticipated benefit. The Commission noted that all priority groupings are a rough and ready approximation of a complex reality, and urged that the priority groups be seen as guidelines, to be interpreted in the light of individual circumstances.

The Commission also dealt with the issue of purchaser–provider splits. In the 1990s, some county councils in Sweden introduced management systems that established purchaser functions for public administrators and separated them from provider functions. Concerns were expressed that purchasers might ensure that needs coverage would be greatest in the top-priority groups, and that performance-related payments might create incentives for concentrating primarily on profitable patients. In this regard, the Commission admitted that the principles of need and demand might come into conflict. The Commission pointed out that the principle of need should take precedence in such cases, and that measures should be taken to ensure that it does so. In addition, the Commission pointed out that the issue at hand demands insight, determination and the ability to implement ethical principles at the political/administrative level, and interest, knowledge and leadership capacity at the clinical level.

The above discussion shows that efforts to establish priorities in Sweden differ broadly from others discussed earlier. First, they explicitly embrace the needs-based (or equity) approach, and reject cost–effectiveness analysis, except to the extent that this is consistent with the equity principle. This is in line with Sweden’s traditional needs-based approach to health care planning. The Commission noted that, since the principles of need and solidarity override the cost-efficiency principle, severe illnesses and substantial impairments of quality of life must come before milder ones, even though treating serious conditions is a good deal more expensive. As in the cases of Spain and the United Kingdom, the Swedish Commission did not consider the delimitation of health services through a core of services or basic package. It differs from both Spain and the UK in its emphasis on broad principles and rules that are ultimately at the discretion of administrators and clinicians. Further, the Commission appeared to recognize, at least implicitly, the limitations of rigid rules and stringent criteria whose inherent imprecision and impracticality are bound to lead to their violation when they are applied (as in Oregon and the Netherlands). The Commission dealt with these difficulties by explicitly recognizing not only the inevitability but also the desirability of a certain degree of rationing or prioritizing at the clinical (or micro) level. It thus gave legitimacy to an element of rationing or priority setting that had been implicit, but is now explicitly recognized, and that is accompanied by an appeal to the moral as well as technical qualities (interest, knowledge and leadership) of clinicians.
Priority setting in Finland

Finland, with a tax-financed national health service, was influenced by Sweden’s approach to priority setting. In 1992, the National Board of Welfare and Health appointed a working group on prioritization. Two further groups were appointed, and the report of the Working Group on Health Care Prioritization was published in 1995.\footnote{Report of the Working Group on Health Care Prioritization. From values to chores. Helsinki, National Research and Development Centre for Welfare and Health, 1995.} The Finnish investigation was more exploratory than the Swedish. It reviewed the major moral and ethical dilemmas of rationing and priority setting and the technical approaches being developed, and attempted to highlight the key issues that must be taken into consideration in priority setting. It did not attempt to make specific recommendations on how rationing and priority setting would be conducted. The recommendations were, rather, of a more general nature. The guiding ethical principles were:

- human rights
- self-determination
- equality
- justice.

In contrast to Germany and the Netherlands where some responsibility for health care financing is to be transferred to the patient, the Finnish Working Group noted that these objectives (or ethical principles) can be met only if most health care is financed out of public funds:

Unless the government and parliament grant funds in the budget to correct the injustice caused by the deficit (should this prove necessary), the prioritization work being conducted within health care is in danger of losing its credibility and possibly its ethical justification.

In support of the above objectives, the Group argued that the first priority should be given to cases in which intervention will preserve or restore age-specific functional capacity. As to the concept of functional capacity, the Finnish Working Group took the opposite of the community approach of the Dunning Committee in the Netherlands. The Finnish Working Group argued that “the patient’s own evaluation of the health benefit and opinion of the quality and length of life should receive special attention”.

Other recommendations made by the Working Group, in keeping with the more general nature of its investigation, concern the health and health care environment within which priority setting decisions are to be made. The Working Group recommended more education and knowledge for citizens, to increase their abilities to take care of themselves and help them:

- to participate in services prioritization;
to support health promotion activities;
• to support health care personnel in their professional decisions and education;
• to ensure well functioning collaboration between primary and tertiary care; and
• to ensure that health care methods are properly evaluated for quality, effectiveness and efficiency before moving into widespread use.

Rights-based approaches

There are two kinds of rights-based approaches to rationing: substantive rights and procedural rights. Each is discussed in turn.

Substantive rights to rationing essentially refer to the tight definition of the benefits package, but look at the benefits as individual entitlements. In this approach, individuals would be entitled to specific services and health care benefits by right, and these rights would be enforceable by law. The services or benefits that would form the entitlements must be defined and specified in detail, as in the case of the tight specification of a benefits package. Otherwise, rights to these could not be enforceable by law. This approach has rarely if ever been pursued in practice, because of all the disadvantages and difficulties discussed earlier: inflexibility, opposition by the medical profession, difficulties of implementation and so on.

Procedural rights are quite different. They are not concerned with specific entitlements, but with the rights of individuals to make sure that public bodies exercise their powers in a responsible way. For example, they can include the right to fair, consistent and relevant decision-making by authorities. Procedural rights are therefore a matter of giving social and legal protection to certain rights of individuals that are recognized as basic.

Procedural rights have never been used in practice, but they are a relatively new idea in health care which has generated some discussion, especially in the United Kingdom.

Procedural rights in health care could involve the following:
• a right to be heard: a person or body making a decision must consult the individual(s) affected;
• a right to consistency in decision-making: those giving treatment must do so in accordance with accepted practices;
• a right to relevance in decision-making: those making decisions must take into consideration all relevant factors;
• a right to unbiased decisions: those making decisions must act without bias;
• a right to reasons: those making decisions must provide reasons for their decisions to those affected; and
• a right to review: in the event of a refusal of, or complaint about a service, an individual must have the right to have the relevant decision reviewed.

Clearly, then, procedural rights are not concerned with the actual services provided, but with the way that they are provided. Advocates of procedural rights in health care argue that these would help reduce ad hoc decision-making on rationing issues, and would promote consistency and coherence in medical practice.

Putting a system of procedural rights into effect would involve setting up rules and institutions that would grant individuals rights and allow them to exercise those rights. First, boundaries would have to be set within which doctors were free to exercise clinical judgement, and a framework established within which public bodies would make decisions on resource allocation (rationing and priority setting). These frameworks would be based on consensus within the broader public about the aims and values of the health care system, which would include ethical and moral issues. The government and health officials would have to make decisions broadly defining the range and levels of services, and establishing priorities. These processes would involve public debate so that public opinion would be incorporated. In addition, formal mechanisms would be created to evaluate decisions and handle appeals.

What is distinctive about the rights-based approach is that all this would be institutionalized. An entire process, such as that described here, would be set out explicitly, perhaps by law, and specified as the formal mechanism for making allocation decisions in health care.

The point of the procedural rights approach is to create a democratic process for solving an extremely difficult problem. Its advocates claim that it would ensure, to the extent possible, fair treatment, responsiveness of the system to users, greater accountability and greater clarity, openness and explicitness.

Critics of this approach argue that rational rationing, or what this approach is trying to achieve, is impossible, as it is impossible to arrive at consensus on difficult decisions. In addition, this approach has been criticized for such factors as increased bureaucracy, the costs of administration, a limit on clinical freedom and the possibility of leading eventually to a discrete definition of benefit packages.
Concluding comments: are there alternatives to rationing and priority setting?

The need for rationing in publicly funded health care, it will be recalled, arises from a situation in which a demand for health care services that is not constrained by price meets a supply of services that is constrained by cost. Under these conditions, the demand for services will always exceed the supply. Thus eliminating the need for rationing is a virtual impossibility.

There seem to be certain ways to lessen the intensity of the rationing problem. These include the following:

1. allocation of increased public resources to health care;
2. a narrower definition of the responsibilities of health care provision;
3. increased private financing, whether through out-of-pocket payments or private insurance;
4. quality reductions in the services provided;
5. the use of evidence-based medicine;
6. improvements in the efficiency of provision;
7. increased patient education; and
8. a healthier population.

The first six of these methods would affect the supply of health care services; the remaining two, the demand side. Clearly, however, not all of these may be practicable, or are consistent with societies’ stated commitment to provide high-level health care while maintaining or even improving equity and solidarity. Finally, it is not certain that all can contribute to lessening the rationing problem.

The first, increasing public resources, would be the most obvious way to lessen the severity of the problem, but is highly impractical for most countries; resource constraints are one of the key factors that recently increased the prominence of rationing/priority setting in the first place.

The second method, narrowing health care responsibilities, is precisely what most organized efforts toward priority setting are trying to accomplish. Of the nine examples considered above, Sweden and perhaps Norway and Finland are the only countries that are trying to avoid this. Excluding the case of Oregon and the Nordic countries, all appear to be trying to redefine the responsibilities of health care so that their scope becomes increasingly narrow. Priority setting is undertaken in a way that excludes from the responsibilities of statutory provision the services that are considered to be marginal or peripheral to so-called essential or necessary health care. Thus this method does not reduce the

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17 Oregon is a special case in this regard, because it does not attempt to define the scope of health care, but only crudely to limit the services to be included in statutory provision.
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severity of the rationing problem, but reveals the difficulties and complexities inherent in rationing by priority setting.

The third method, increasing private financing, is simply another way of limiting the responsibilities of publicly provided health care. This is obvious in the cases of the Netherlands, which leaves to private initiative all care that is not necessary, effective or efficient, and of Germany, where the possibility of increased private financing is also explicitly mentioned. It is implicit in the other cases, however, as the exclusion of certain benefits or certain patients or categories of patients would either leave patient needs unsatisfied or induce patients to seek care in the private sector. Rationing by priority setting that excludes benefits or patients from the admissible range would therefore reinforce the trends toward increasing out-of-pocket payments and private insurance coverage. These clearly run counter to the principles of equity and solidarity. The continuation of implicit rationing, however, involving long waiting lists or other methods that discourage people from using the system, tends to have the same effect.

A fundamental challenge of explicit rationing is therefore to devise methods that will minimize this spillover of unsatisfied needs or wants in health care into the private sector, so as to protect the principles of equity and solidarity to the extent possible.

The fourth method, reducing quality, conflicts with societies’ objective and efforts to improve the quality of services provided, as well as with the growing public demand for high-quality provision. No country is likely to choose this route.

The fifth way, involving increased use of evidence-based medicine would result in the elimination of ineffective practices, thus lessening the severity of the rationing problem. Some argue that clinical guidelines and standardization would reduce the wide and unnecessary variations in treatments, which cannot be related to variations in needs. The extensive discussion above noted that waste could be reduced if ineffective practices were eliminated. There is serious question, however, about the degree of waste that can be so eliminated, owing to the uncertainties of medical intervention processes. In view of these uncertainties, there is always a danger that the establishment of clinical guidelines that will give rise to lower costs may include elements of rationing through the elimination of certain procedures. Although certain benefits could arise from this method, these may well be limited.

The sixth method, improving efficiencies in provision, differs from the others in that it can legitimately claim to lessen the intensity of the rationing problem. While the degrees of inefficiency prevailing in different countries vary widely, every health care system has room for further improvements in this regard. Clearly, inefficiency in provision requires more restrictions in the services provided (as a means to
conserve resources) than would be necessary if this inefficiency were reduced or removed. From the perspective of rationing, increases in efficiency are equivalent to increases in funds for health care that could lessen (although not eliminate) the need for rationing.

The seventh method would involve improving patient education, so that patients would have greater involvement in making choices between different treatments. Some have argued by that increased patient knowledge of benefits and risks could lead to a lower demand for particular curative care interventions. There is no reason in principle why this should be so, or why increased patient knowledge would alter demand in ways that would lead to cost savings. On balance, increased patient knowledge may lead to a demand for more or more costly interventions.

Like the seventh method, the eighth, involving improvements in health, could affect the need for rationing from the demand side of health care services. If it were assumed (somewhat unrealistically from a shorter-term perspective) that a strong prevention and health promotion perspective in a health care system led to significant health gains, then it might be argued that overall health care needs in the curative sector would be lessened; this would release resources for the satisfaction of a larger range of curative care needs, as well as for the provision of other health care services.

This argument on improved health, along with those on expanding resources allocated to health care (if it were possible) and improvements in efficiency, would never fully solve the problem. They could only help in a situation where health care needs and demands, as well as the technological capability to satisfy them, are static and unchanging. In reality, this is not the case. In reality, aging populations and increasing living standards change expectations of an adequate or acceptable health care system, and changes in medical treatments may increase costs or expand the range of curable or treatable conditions. All these factors contribute to making health care provision an open-ended system, in which health care needs, or perceptions of these, continually expand. Thus, the severity of the rationing problem could actually increase in coming years.

The importance of sufficient resources and improvements in efficiency and in health notwithstanding, there can never be a solution to the rationing problem in the sense of eliminating the need for choice. Efforts should therefore aim at improving the processes by which choices are made, and ensuring that these will, to the extent possible, reflect societies’ preferences and values.
Key sources


Bjork, S., "Ethical and Medical Basis of Health Care Rationing", *Quality of Life and Pharmacoeconomics in Clinical Trials*, Lippincot-Raven Publishers, Philadelphia 1996.


Edgar, W., "National Priority Setting in New Zealand: The Experience of the National Health Committee Over the Last Five Years", *In: First International Conference on Priorities in Health Care, Stockholm, 13-16 October 1996*.


Klein, R. "Can We Restrict the Health Care Menu?" *Health Policy,* 27, 1994, pages 103-112.


