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Discussion

Rationing Health Care: From Needs to Markets?

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Paper One: The Politics of Destruction: Rationing in the UK Health Care Market

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Abstract

Rationing health care is not new. As governments world wide struggle to contain the costs of health care, health policy analysts debate how rationing should be done. However, they too often neglect how the mechanisms for funding and allocating health care resources are themselves vehicles for rationing treatment. In the UK, where health care rationing debates currently abound, there has been no formal evaluation of the role of the market in allocating scarce health care resources.

The market in health care has increased administration, fragmented services, eroded local accountability, and decreased choice.

This fragmentation, and the associated competition between purchasers and providers, means that resource allocation can no longer be monitored and evaluated in a national context. The loss of a population focus has left a vacuum in planning. Services cannot be planned rationally, and so are not able consistently to avoid duplication or to respond cogently to estimates of need.

The loss of accountability means that decisions about the allocation of health care resources are no longer open to scrutiny by local people. Increasingly, especially in social and long term care the cost of care is being transferred to the individual. The new mechanisms for resource allocation are distributing resources unfairly: away from the poor, the sick and the elderly.

The great myth of the market is that it has enabled decision-making to become explicit. This is not the case. To make health care resource allocation appear rational and acceptable to the public, health authorities have resorted to exercises in consumer consultation, and value laden guidelines where clinical cloaks are used to disguise political decisions on funding. In the UK, until the true role of the internal market is acknowledged, myths and subterfuge will conceal the winners and losers in the new system of rationing health care.

Introduction

This paper tries to untangle some of the complex arguments which have dominated UK rationing debates, and to place them in the context of the internal market.

Health care rationing (or withholding potentially beneficial treatments from some groups of people) has occurred throughout history. Rationing is inevitable where there are insufficient resources to meet needs. The question is: if rationing has to take place how should it be done? The present answer in the UK is that the internal market should determine who has access to treatment and care. The introduction of the market was supposed to increase efficiency, reduce centralisation and inflexibility, and increase accountability and patient choice.[1]

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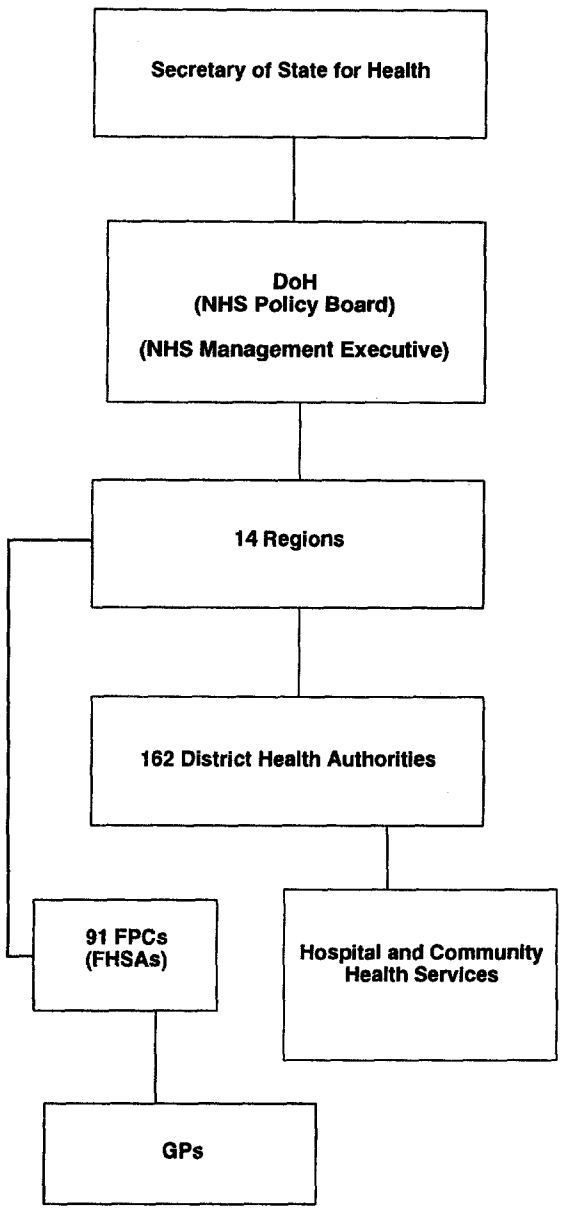

Figure 1 NHS organisation until 1991.

The Latest Rationing Structure: The Internal Market

Before 1991 District Health Authorities were responsible for providing health services to meet the needs of their resident population by planning and administering local health services within their geographic boundaries (Figure 1).[2] In 1991 the NHS and Community Care Act (1990) separated these functions. The role of the District Health Authority (DHA) is now to purchase health care for its local residents, but the administration of local hospital and community health services no longer falls within its jurisdiction (Figure 2). Most hospital and community services are provided by self-governing trusts accountable directly to the Secretary of State for Health through the new regional tiers. Trusts earn their income through winning contracts from the various purchasing authorities. They are required to draw up an annual business plan; they determine their own management structures and can set their own terms and conditions of service for the staff they employ. Importantly, these 'providers' are not responsible for meeting the local population's health needs.

Purchasers contract with providers at the start of each financial year for 'cash-limited' services. Their contracts are not based on need but historical activity. If a provider goes over its spending targets (i.e. does more than it is paid for) it will not be reimbursed by the purchaser and risks 'going out of business' (so in effect it can no longer respond to need). The introduction of the Patient's Charter (which stipulates that no patient can stay on a waiting list for more than two years) should, in theory, mean that everyone will be helped. But the numbers of people waiting under two years has risen to record heights and politicians find creative ways of concealing waiting lists.[3,4] No data are collected on those waiting to go on the waiting list or on unmet need.

The government has also created a second group of purchasers, general practitioner (GP) fundholders. GPs provide primary care to patients and make referrals to hospital and community services. In 1991 the government allowed practices with a list size of over 9000 residents to hold their own budgets. Funds 'top-sliced' from district budgets could be used to purchase a limited range of elective hospital and out-patient services (a ceiling of £5000 per patient protected GPs from the risk of expensive patients). More recently both the budgets and the list of procedures have been extended to include community nursing services.[5] In October 1994 the government released plans to extend the

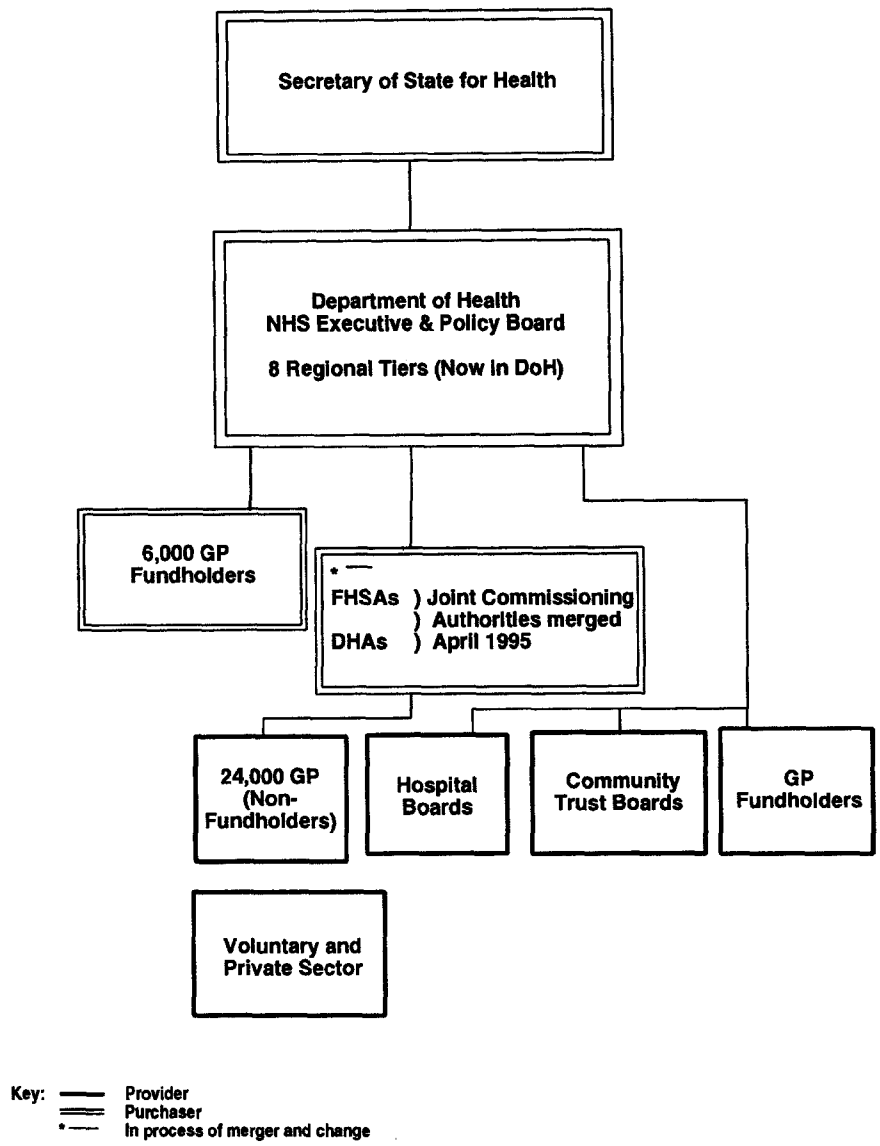

Figure 2 NHS internal market 1995.

scheme to all GPs. From April 1996 there will be three types of GP fundholder purchasers: standard, community and total. Standard fundholders will continue to purchase specified elective services, community fundholders will be responsible for purchasing community health services and total fundholders will purchase all care. By May 1995, of the 30 000 GPs in England and Wales, 10 412 had signed up to become fundholders and 40% of the population were covered.

Accountability for Rationing Decisions

The purchaser–provider split has been accompanied by far reaching changes in accountability. In 1991 DHA boards were

reduced in size and locally elected councillors and trade unionists were excluded from them.[6] Board members are now mainly directly appointed by government. The remit of health authority boards is to *purchase health care for their residents in line with national and local priorities and a local assessment of health needs*. Each local hospital and community trust (the providers) also has its own board whose remit is *to manage the trust effectively and to make a return on capital stock*: not, one notes, to improve patient care or give satisfaction to the community it serves. These trust boards too are mostly made up of government appointees, and have little local representation. They are accountable to the Secretary of State, but now have only contractual obligations to the DHAs (no contract, no obligation). GP fundholders are currently not accountable to local people for their purchasing or providing decisions (they are accountable only to the Secretary of State for health).

Thus there has undoubtedly been a centralisation of accountability. Indeed, the erosion of accountability extends across the public sector services in the UK, and has been described by Howard Davis and John Stewart[7] as signalling 'an impending crisis in accountability'. Davis and Stewart write of the many services formerly under central government and local authority administration which have been replaced by independent funding agencies headed by central government appointees. By 1993 quasi-autonomous non-governmental organisations (QUANGOs) were spending a fifth of all public funds, and it is now estimated that the sum is probably closer to two-fifths.[8]

Myths and the Internal Market

> 'It is useless for Ministers to repeat barely relevant multiples of past expenditure, staff employed, or numbers going in and out of hospital doors. What matters is the volume of services not provided or too long delayed...'.[9]

Three myths are commonly used to justify the changes made to the administrative structures of the NHS:

- the myth of spiralling demand
- the myth of inefficiency

and

- the myth that NHS costs are spiralling out of control.

These have been comprehensively reviewed and refuted elsewhere.[10] Waiting lists and cases of overspending have been used to illustrate the supposed inefficiency of the NHS. However, there is an alternative interpretation of the evidence—namely that these figures simply reflect unmet need and under-funding.

The UK's spending on health care has remained almost static at 6% of Gross Domestic Product (GDP), and its administrative costs have been 4%–8% (less than half those elsewhere).[10] Public expenditure on the NHS has never kept pace with official Department of Health estimates of the resources required to meet need, the effect of an ageing population, new technologies and the salary review boards wages increases. In 1988 the Select Committee on health published evidence which showed that the NHS had been systematically underfunded by around half a percent of total costs per year throughout the 1980s.[11]

It is worth pointing out that the ability of the UK to contain its health care spending and also to provide universal coverage has, at one time or another, been the envy of every government in the world. Indeed, many countries have attempted to follow suit.[11]

Does Openness Equate with Fairness?

It was said of the market reforms that the presence of purchasers would mean more efficient rationing by making explicit the services to be provided for their population.[12] The allocation of health care resources would no longer be the preserve of clinical decision-makers but would fall under the public gaze. The assumption that openness would ensure both fairness of distribution and the retention of the principle of 'equal access for equal need' won a number of distinguished allies to the internal market, including the editor of the *British Medical Journal*. Taking his cue from the Oregon experiment, he urged that the UK should

introduce democratic decision-making in the allocation of health care resources.[13]

However, as the 'Oregon Experiment'[14] was comprehensively analysed there came the gradual realisation that rationing has 'no simple technical fix'.[15] Klein has explained some of the complexities, and has pointed out that there are several layers of decision-making within the NHS which conceal how and where decisions are made about priorities.[16] He identified two levels of priority-setting: the macro level where financial decisions predominate (how resources are allocated to regions, district purchasers and GP fundholders) and a micro level where decisions are made, on a clinical basis, about individual patients.[16] Klein notes that:

> 'it is not yet self evident that there is adequate information about how broad macro decisions about priorities taken at the top of the hierarchy translate into clinical decisions at the bottom about who should be treated and how'.

The Internal Market: A Fair Means of Resource Allocation?

District Purchaser Allocations

One of the triumphs of the NHS has been its ability to distribute resources on the basis of health care needs. The NHS strove to overcome the enormous inequities in provision it inherited in 1948 in a number of ways: by controlling the distribution of GPs, through the hospital plan of the 1960s, and by means of a resource allocation formula (RAWP) in the 1970s.[17]

In 1991 a new funding formula came into being. Resources are now allocated to regions according to 'per head of population payments'. This allocation includes weighting factors, such as the standardised mortality ratio and age cost curves, which take into account the higher needs and costs of young children and older people.[18] Different regions have developed different formulae to allocate resources to districts, but it is not known how equitable these formulae are. In general, however, the formulae favour populations with large numbers of healthy elderly people and work against areas with young populations which have high morbidity and mortality.[19] The result has been a transfer of resources away from the North of the country and most deprived inner city areas towards the prosperous areas of the South East of England.

GP Fundholder Allocations

Unlike the DHAs GP fundholders are not yet funded on a per capita basis but on the historical use of services. Currently this payment is higher than the capitation allowance.

It has been estimated that in the North West Thames region (population 3.6 million) GP fundholders received between 13% and 40% more per capita for their patients than the health authority for equivalent fundholding type activities.[20] In this region in 1993/94 GPs not only cleared their waiting lists and bought in extra services and fundholding clinics but also made 9.3 million pounds savings overall and 7.5 million pounds savings on the hospital budget. Similar pictures emerge all over the country with fundholders having made around 30 million pounds in so called underspends.[21] In contrast, patients of non-fundholding GPs have not done so well. In many districts money has run out early in the financial year and has resulted in lists being closed to non-fundholding patients.[22] Although the government set up a national committee to review fundholding allocations, attempts to derive a fair formula for fundholders have been unsuccessful to date.[23]

How Are Purchasers Allocating Scarce Resources?

Reviewing 160 District Health Authority purchasing plans, Redmayne and Klein found a great deal of pragmatism and 'muddling through', both in districts set to lose and those set to gain from the capitation formula. They found that very few authorities were excluding treatment conditions or groups of patients from care. The decision in some regions and districts to exclude treatments such as infertility and cosmetic surgery appear to have been made for emotive rather than clinical reasons.[24] In any

case, these exclusions make little contribution to savings on the budget overall.

Where purchasers are set to suffer losses in their budget allocations, purchasing plans reveal either planned reductions in activity, or requests to providers to become more efficient, or both. How this translates into which patients will lose out, which needs will not be met and how quality of care will be affected is never made clear to local residents.[25]

Lack of good information on which to make purchasing decisions is only a partial explanation for the failure of purchasers to quantify and make explicit how they will deal with losses or gains in health care delivery. It must also be recognised that the contracting process simply fails to link population needs to service provision and use. The focus of most contracts is to keep activity and length of stay within fixed budgets—not on the numbers of patients requiring treatment and care and the outcomes of care.

The competitive market ethos and the new emphasis on financial viability inhibits purchasers and providers from admitting that there are problems with their budgets. The new structures for accountability[26] mean that their business is increasingly conducted in secret and out of the public domain.[27,28]

How Have Providers Responded To The Funding Allocations?

The internal market also affects providers. Before 1991 'overspends' were used to lever more resources from the treasury. Now the fear of losing contracts means that providers resort to less politically explicit tactics to deal with threatened overspends. The two main methods presently open to providers are 'efficiency savings' and 'income generation'.

The government requires all providers to make efficiency savings (i.e. to do more for less) of around 1.5%–2.5% per year.[29] Throughout the 1970s and 1980s efficiency savings were achieved relatively easily, first by selling off assets such as staff accommodation and hospital sites and then by privatising ancillary, catering and laundry services. But since the 1980s, when the UK Audit Commission drew attention to the fact that efficiency savings could not be expected to continue, the government has continued to demand savings of around 1%–3% per year on contracts. How these savings have been achieved (and their effect on patient care) has never been fully monitored or evaluated.

Measures to reduce the number of beds available, and to close theatres and wards have been accompanied by staff reductions and the introduction of changes in skill mix (where posts are often downgraded).[30] Small savings have also been generated by levying car park charges for staff, by not employing locum cover and by providing neither study leave nor payment for the further training of nurses and doctors. Costs are not only being transferred to staff. Patients and carers are also absorbing many costs, through faster turnover and decreased length of stay, or through the increasing use of the private sector, all of which not only place costs directly onto individuals but which also depress standards and quality. In addition, providers manipulate activity measures so as to appear to be doing more than they are. For example, they may double count admissions under different specialties,[31] or select fitter, less costly patients—which makes them (and the reforms) look more efficient.

Constraints on spending have been accompanied by the recognition that some types of health care are more lucrative than others—some care generates income. Many providers are changing from NHS to private pay-bed use, and are at the same time diversifying into more profitable activities, i.e. they are 'cherry picking' by selecting low-risk patients and by developing services for the private sector in order to remain viable. At the same time there is anecdotal evidence emerging of supplier restricted demand where access to certain treatments for some groups is discouraged.

National surveys repeatedly show that providers are being asked, as a condition of contracts or otherwise, to give preference to fundholding patients and extra contractual referrals (see glossary).[32,33] The Royal College of Surgeons Survey revealed that 62% of surgeons had been told to stop or reduce activity and that 33% had been told to give priority to fundholders patients and extra-contractual referrals regardless of clinical priorities.[34]

The Substitution of Consumerism for Accountability

Health Authority members and purchasers are keen to demonstrate that they are making NHS resource allocation more rational and more open to the public, in line with government policy.[35] The NHS Management Executive has urged purchasers to consult the public about its views on health care provision. This purchasers are anxious to do, and a number of initiatives have taken place under the banner of 'Listening to Local Voices'. The two main approaches are to include patients in drawing up service specifications for contracts and to involve the public in priority-setting exercises. Curiously, the scientific and ethical basis of these exercises is seldom examined and yet tens of thousands of pounds have been spent (which might have gone to patient care) with no evidence that there has been any improvement in the process of planning and providing services. This is partly because the methodologies have been shown to be so poor as to make the results uninterpretable and of no value either to the public or to local decision-makers.[36,37]

Health Gain

Faced with a vacuum in planning as well as increasingly limited resources, service innovation and development is difficult to achieve. As a result some purchasers 'top-slice' large sums of money from their providers' contracts to reinvest in 'health gain' projects. (Health gain is sometimes euphemistically described as 'adding life to years and years to life'.) The projects vary in scale and scope but do have some common features. For example, in 1993 District X 'top-sliced' half a million pounds from its 80 million pound annual budget. Providers had to grapple with huge cuts in their contracts as a result of capitation losses and the further loss from 'top-slicing' for health gain. They were then presented with the option of applying for small sums of money (i.e. around £20–30 000) for service developments to reinvest in their service. But this approach creates new inequities. The top-slicing of monies affects the whole service and all patients within the provider unit, but in some instances reinvestment is targeted not at the whole service but only on selected patients, namely district X's patients. Before 1991 all the facilities in a hospital or community unit were available to patients on the basis of need. Now clinical staff are being asked to ration not on the basis of their clinical judgements and need, but on the basis of what the purchaser has paid for. Thus a situation can arise where patients with similar needs in neighbouring beds will receive different services. Ability to pay and not need can now determine who gets services. 'Health gain' bids create inequities and further fragment services, and so further disrupt the possibility of rationally planning service developments.

The Rationing Paradox

It is, of course, possible to devise guidelines which can also be used to ration care. For instance, some guidelines rate access to care on the basis of a clinical score. These assessments more often than not include some value-laden criteria such as age or even gender. Sometimes the logic behind these criteria appears rational, for instance where age is used as a pointer to the likelihood of survival for that individual. But the problem is more complex. To take the example of coronary heart disease. The incidence of coronary heart disease is highest in older age groups and trials of active treatment (such as thrombolysis) show that benefits accrue both for individuals and for the whole population.[38]

Thus while the risk of death following intervention in a 70-year old individual with a myocardial infarction is four times that of a person aged less than 60, the paradox is that the greatest benefits from treatment will accrue in the older age group because this is where the greatest burden of disease lies. Table 1 shows that 55 more lives will be saved per thousand for people aged over 70 years than for those under 60 years. And yet up to two thirds of Intensive Care Units (ICUs) and Coronary Care Units (CCUs) have age related admission and treatment policies where the age cut off can be as low as 55 years.[39] Clinical decisions focus on individuals rather than groups and so the

Table 1. Death rates and lives saved in patients in the ISIS–II trial by age group

Age group years	Death rate in untreated patients (%)	Death rate in treated patients (%)	Relative reduction in death rate (%)	Absolute reduction in death rate (%)	Lives saved per 1000 patients treated
<60	6.2	3.7	40	2.5	25
60–69	16.1	9.1	43	7.0	70
70+	23.8	16.8	34	8.0	80

Source: ISIS-II

benefits for the population may be discounted and not realised. Perhaps this should be termed the 'rationing paradox': where the process of excluding individuals from care to reduce costs may actually bring about decreased benefits for the population as a whole. And of course what follows from the above is that for many conditions, treatments and groups of people, more resources will be required to treat more people for a given benefit. Clinical guidelines rarely take into account the population benefits of treatment.

Scoring and rating systems commonly conceal value-laden judgements. A good example is a decision to exclude candidates for liver transplant if they have alcoholic liver disease. The 'deserving' and the 'undeserving' sick—whether these be smokers, sexually promiscuous, alcoholics, the obese or the disabled—may all find the values of the health care professional or certain sections of society operating for or against them either directly or in clinical guidelines or in treatment scores.

Ultimately, no matter how sophisticated the apparent technical approach to clinical decision-making, a judgement has to be made as to where the line should be drawn in order to restrict access to care. No amount of cost-benefit analysis will decide what are ultimately political decisions.

Clinical Cloaks For Political Decisions

Current rationing debates mostly focus on clinical decisions—i.e. choosing between patients. This deflects attention onto providers and clinicians and away from politicians and purchasers. It has also allowed the politicians to determine the ground rules for priority-setting: these are that clinical decisions should give better value for money and greater efficiency in health care. This thrust prevents debate both on the values contained in guidelines and clinical scores and also on the effect of the rationing paradoxes. Yet more importantly, the emphasis on clinical decision-making also diverts attention from the consideration of the social conditions which give rise to the need for rationing in the first place.

Politicians are on safe ground in demanding that clinical decisions give better value for money and greater efficiency in health care. By painting clinicians as wayward, uncaring or even ageist, politicians have ready ammunition against the mounting evidence of widespread variations in clinical standards, practice and outcomes. Nor is the patient immune from accusations of irresponsibility (witness the recent debates on whether to treat those with 'unhealthy lifestyles').

Ultimately the success of this approach is in its attack on the credibility of the clinical decision maker, rather than the resource allocator. As with Oregon the politicians tell us that a line *must* be drawn? But why, where and by whom? In the final analysis entry to care within the market is determined by ability to pay and not need. But until the role of the internal market in the rationing debate is acknowledged myths and subterfuge will conceal the winners and losers in the new system.

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Glossary of Key Terms

Jargon in the New NHS

Definition	Explanation
Internal market	Competition in a public sector monopoly and private sector entry is restricted, in theory
Purchaser/provider split	The separation of service provision from health service planning and needs assessment
Purchaser	District Health Authorities and GP fundholders—they hold the budgets and buy in services on behalf of their clients using contracts with providers
Provider	Hospitals, GPs, Community Services, Primary Care, etc. (where these comprise units they are called Trusts)
Trusts	A service unit with an independent board which contracts with purchasers to provide services for patients
Contracts	There are three types of contracts: *Block Contracts*: placed on behalf of a client group or service, e.g. geriatric services. It may involve many specialties but individual service components are not disaggregated. A sophisticated block contract is where a level of activity is defined within a block contract for a given price *Cost and Volume Contract*: is where a specified level of activity is agreed for that contract within a set price *Cost per Case*: where each individual case is costed, e.g. heart transplant *Extra Contractural Referrals (ECRs)*: where the purchaser has no contract with the provider and purchaser agreement must be sought before care can be given. ECRs are normally tertiary referrals to centres of excellence, or where funding between social services and health is in dispute
GP Fundholder	Is both a purchaser and provider (see definition above)
NHS and Community Care Act 1990	The NHS part of the Act introduced the internal market in 1991. It separated out District Health Authorities from service units and created GP fundholders. Community Care was implemented in 1993, the budget and responsibility for community care was devolved Local Authorities. Local Authorities now purchase care on behalf of clients from providers but this is an open market
Capitation formula	Resources are allocated as per head of population payments
Underspends	These are the savings that GP fundholders make from the budgets they are given for purchasing care
Joint commissioning	A loose term where groups of purchasers join together to buy services for patients, e.g. Health Authorities, Local Authorities, Health Authorities and FHSAs, and Health Authorities and GP fundholders etc.
Skill mix	Change in nursing levels and staff mix—often results in a decrease in quality of care as lower grades of staff are employed
Income generation	The means by which Trusts raise extra money, e.g. car park charges, private patients
Historical allocation	GP fundholders are given budgets based on previous patterns of service use and volumes of care. District Health Authorities are allocated money per head of population
Competitive tendering	Since the 1980s the NHS has been forced to contract out most of its services to the private sector, e.g. laundry, ancillary, catering
Means-test	Where an individual pays for services but the payment is linked to ability to pay, e.g. in Local Authorities
Quango	Quasi autonomous non-governmental organisation. A term used to describe public sector organisations which are neither accountable to local people nor directly to government departments. The board is not elected but appointed by government

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