

Rationing in Health Care – A New Zealand Perspective on an International Dilemma*

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Introduction

Explicit priority setting (or rationing) of health services is being debated in an increasing number of countries – notably, Oregon, the Netherlands, Sweden, New Zealand, Norway, Denmark, Israel, and the United Kingdom. Politicians and governments in their role as policy makers or health funders, health insurers, and health professionals are asking which health services should be publicly funded, for whom. Switzerland has also begun to discuss this issue.

In August 1999, seminars on priority setting or rationing of health services were organised by Swiss health professionals. Your initiative reminded me of the comment of a US health commentator, David Eddings, who urged fellow health professionals to grasp the challenge of priority setting: “You are in the best position to make judgements about where savings can be made. Do it yourselves with a scalpel or have it done for you with a meat cleaver”.

Significant differences in health provision exist between our two countries. It is important to acknowledge those differences in assessing the relevance of New Zealand’s experience of health rationing. Notably, Switzerland invests over 40 billion Swiss francs per year for health services for 10 million people; New

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Zealand invests the equivalent of 6 billion Swiss francs for 3.8 million people – that is, 4,000 francs per person in Switzerland compared with 1,600 francs per person in New Zealand. While there are cost differences, which may explain some of the difference in per capita spending on health, it is reasonable to suggest that over two times as much is spent in Switzerland as in New Zealand on health care per person.

In practical terms, people wait very few days for treatments in Switzerland. In New Zealand, people may have to wait many months for some treatments (for example, non-urgent surgery for cataract removal or hip replacement). At the August seminars, it was emphasised by speakers that life saving treatments would not be withheld in Switzerland. In New Zealand, quite difficult questions are being asked about the quality of further life people will have if some treatments are given to save people’s lives. Treatments, such as dialysis, have been declined when professionals, patients and families have assessed the limited benefit of treatments to patients.

Given the differences between Switzerland and New Zealand, is health rationing necessary or inevitable in Switzerland? I believe it is.

Rationing health care

A number of countries which spend about the same on health services as Switzerland (10% of GDP) are concerned about the continuing rise in health care costs. Many accept that even if they can afford services now, rationing is inevitable in the future because rapid increases in medical costs are outstripping economic growth. New technologies and existing treatments are being applied to an increasing number of people, many of whom may be very sick, elderly and frail. The growth in treatment possibilities for a wider range of people is outstripping countries’ ability to pay.

The question of rationing is not “whether it needs to happen”, but rather “when”.

In New Zealand since 1991, we have recognised that not all possible services can be funded for all those who might benefit. Despite increased spending on health, resources remain limited. Funding for services always runs out at some point – and at that point, services are rationed. We believe it is essential to have fair and consistent ways to make rationing decisions – to decide which services to fund, for which people, within available funding. Discussions focus on “how” we can ration – in clinically sensible ways, fair to all people who need health services.

Parties to the rationing debate

Four broad groupings have an interest in health rationing – politicians and policy makers; funders or insurers; health professionals; consumers and the public.

Tensions are inevitable. Politicians find it hard to acknowledge financial limits. Typically, providers want to do as much as possible to benefit individual patients. Patients themselves are keen to get the services they need, even if there is only a slight chance of benefit. Funders are caught in the middle. It may be difficult to see beyond individual cases, and take account of the wider needs of a whole group of patients, or the relative merits of different health services. However, if decision-makers at all the levels recognise that resources for health are finite, they are more likely to acknowledge the hopes – and the constraints – faced by each of the other parties with an interest. If they do not do this, the health system gets out of balance. The noisiest people get an unfair share of the resources.

New Zealand's public debate on health priorities

We have been attempting to have an open, public debate on health rationing in New Zealand since 1992. The 'public' focus is deliberate, to achieve wider public understanding of the necessity to set priorities or make rationing decisions. The debate sharpens when there is media coverage of decisions not to fund services for people. In 1995 and 1997, when two men were denied access to renal dialysis using explicit rationing criteria, there was significant media and public comment – and considerable discomfort because the men faced inevitable death.

Two key agencies, the National Health Committee (NHC) and the Health Funding Authority, have led the rationing debate in our country. Ministers of Health and increasing numbers of other politicians have also expressed their views publicly.

The NHC was established by the New Zealand government in 1992 to give independent advice on *the kinds, and their relative priorities, of services to be publicly funded*. The advice was originally seen as a list of core health services, similar to the Oregon list – the basic minimum package of services which the funder (the Health Funding Authority) would be responsible for buying on behalf of New Zealanders. The NHC was instructed to consult widely in developing its advice.

Setting health priorities

The NHC's work on priority setting has involved:

- *annual policy advice to the Minister of Health* and the Government on service priorities, based on:
 - evidence of service effectiveness or best practice
 - service priorities identified through public consultation
 - issues of service configuration nationally (eg, number of transplant units)
- *work with the funder to define access criteria*, for example, to decide the priority or order in which people receive elective (non-urgent) surgery

- *work with providers and consumers to develop evidence-based statements* about effective services, or guidelines of best practice under usual circumstances, to influence individual provider decisions and patient expectations about treatments or services.

Three major decisions have underpinned NHC advice.

First, *start with those services currently funded*.

In effect, there was a core list already – it included primary care (general) services; pregnancy and child-birth services; children's dental services; primary diagnostic and therapeutic support services; secondary and tertiary medical services; secondary and tertiary surgical services; mental health services; and disability support services. (Adult dental services, the cost of eye-glasses, and alternative therapies such as homeopathy have never been publicly funded.)

Second, *a simple listing of the services is not enough*.

If 'surgical services' are listed as part of the core, it does not make clear whether a hip replacement is covered or how long people must wait for the service. And third, *a list which includes or excludes services categorically is neither fair nor workable*.

Different people benefit from services by different degrees. Even for cosmetic surgery (an area of service that many people would suggest should not be publicly funded), people accept that a person with a facial disfigurement such as a hare lip or severe port wine birth mark should receive publicly funded treatment.

As opposed to the original conception of a core list, the Committee saw its task as making clear *when* services should be publicly funded – that is, under what circumstances services would be beneficial, *who* should receive the services first, and *how long* they should have to wait.

The NHC has evaluated key services where there are high overall costs or large numbers of people; there is significant public concern; there is good information; and there is a good chance of influencing change in health professionals' practice.

Services have been evaluated according to four rationing principles, which were agreed following wide public consultation. Those principles are:

- *benefit* or effectiveness of the service (does it do more good than harm)
- *value for money* or cost-effectiveness (is the service effective enough to justify the cost, if an equally effective but cheaper alternative is available?)
- *fairness* in access and use of the resource (is this the best way to use the resource or should it be used for a different service, or for someone else?)
- *consistency with communities' values* (are these the services most valued by communities?)

Working with expert clinicians, service users and patient groups, researchers, purchasers, professional Colleges and other health sector providers, the NHC has developed advice on service priorities and principles for rationing; evaluations of service-effectiveness; and the development of explicit methods to define access to services.

NHC advice

I would like to describe one example of NHC advice – *Methods to define individual access to non-urgent services – clinical priority access criteria for elective surgery.*

For years now, New Zealand has had long waiting lists for non-urgent surgical and diagnostic procedures.

In 1993, the NHC recommended that the Minister of Health replace waiting lists with booking systems, so that people would have much greater certainty about whether, and when, they would receive elective surgery. Booking systems would be supported by the development of tools to assess patients' overall clinical priority or urgency for surgery. The NHC and the HFA worked jointly with clinicians to develop the clinical priority assessment criteria (reported previously [1]).

There are three aims to this work:

- to the extent that resources allow, to provide non-urgent services for people, and treat them fairly and consistently, no matter where they live or who their doctor is;
- to ensure that those who stand to gain the greatest benefit from the service get it first, within a reasonable waiting time;
- to implement booking systems – so that those patients who meet the access criteria can be given a booked time for the procedure. Patients who do not meet the criteria are referred back to their GP for monitoring and review (and they are not implicitly promised the service by being placed on a waiting list).

Based on research evidence of results from the intervention and expert practical experience, the NHC has developed clinical priority assessment criteria for cataract extraction, hip and knee replacement, coronary artery bypass graft surgery (CABG), prostatectomy for benign enlargement, cholecystectomy, and tympanostomy tubes for otitis media with effusion.

The development of access criteria, supported by booking systems, is now occurring in all hospitals in New Zealand. The Government has strongly supported this change and has provided additional funding, to allow the points threshold for access to services to be set at a level which clinicians are prepared to support. The changes have been implemented

through HFA purchasing strategies. Hospitals have identified a threshold for access for a range of procedures, sustainable in terms of current and expected funding in the future, and they have established booking systems to offer certainty to people who meet the defined thresholds, about when they will receive their surgery. People on current waiting lists who do not meet the criteria are advised clearly that they will not yet receive publicly funded services and they are referred back to their general practitioner.

This piece of NHC work has been used to debate with politicians, professionals and the public the relative priorities for funding of services and to inform overall levels of funding. As a result of an audit of patients with heart conditions, the Committee was able to describe which patients on waiting lists would receive coronary artery bypass grafts and which patients would miss out, based on assessed priority and current funding levels. It was able to describe the types of physical symptoms the people had, the degree of disability they faced in normal daily activities, and significantly, the additional funding required to provide and sustain services at different clinical thresholds (see table 1 and patient profiles, set on in table 2. The assessment criteria are contained in the full seminar paper, published on website).

Table 1

Annual costs to maintain annual CABG throughputs corresponding to different priority score thresholds.

Threshold	Number per year	Cost ²
44	884	\$ 14 550 000
42	936	\$ 15 430 000
40	988	\$ 16 320 000
39	1040	\$ 17 200 000
37	1092	\$ 18 080 000
*35	1144	\$ 18 970 000
34	1196	\$ 19 850 000
32	1248	\$ 20 740 000
31	1300	\$ 21 620 000
29	1352	\$ 22 500 000
27	1404	\$ 23 390 000
25	1456	\$ 24 270 000
21	1508	\$ 25 160 000
7	1560	\$ 26 040 000

² Figures rounded to nearest \$10k. Based on unit costs of \$17000 per elective operation and \$22000 per acute operation (10 per week).

* Current funding allows CABG surgery to be offered at 35 points. 25 points the threshold preferred by clinicians would require reallocated or new funding of \$5.3m per year.

Table 2

Typical patient profiles.

55 points or more
Markedly reduced quality of life – chest pain and breathlessness with almost any physical activity
Reduction of life expectancy of 1–2 years without surgery
35–54 points
Much reduced quality of life – pain on exertion eg walking 1–2 blocks
Moderately reduced life expectancy of 8–12 months without surgery
25–34 points
Intermittent pain or breathlessness when walking or climbing stairs rapidly
Modest reduction in life expectancy of 4–8 months without surgery

35 points has been agreed with cardiologists as financially sustainable given current funding levels. Current expenditure of about \$19m amounts to about 4% of total health funding.

In the case of coronary artery bypass grafting (CABG), current access thresholds are set at 35 points, within existing levels of funding. Clinicians would prefer to be able to offer surgery at 25 points. Based on current numbers waiting and the cost of the operation, improved access to a threshold of 25 points would involve an additional \$5.3 million per year for this service alone. Some of the additional cost would be offset by reduced doctor visits and drugs, but arguably, greater clarity about access levels might also increase rates of referral for CABG procedures, resulting in little change in surgery costs overall.

As a result of this initiative, additional funding was granted by the Government for elective services in general for 1996 to 2000, to provide services at a level more acceptable to clinicians. Instead of funding increases “blindly”, or dismissing claims for additional funding as “shroud waving”, the government was able to make a conscious decision about additional funding in full knowledge of the kinds of health improvements which might result.

The policy initiative to develop access criteria and establish booking systems has been criticised by some as “hiding the true extent of need”, because people with a condition warranting *future* action are no longer waiting on lists. Critics also claim that people have to become much sicker before they will receive a service, and this may not be the most beneficial time to perform the procedure.

Supporters counter that there is sufficient flexibility to allow people with unusual progression of their condition to be given a service. The GP monitoring their condition can re-refer patients at any time. Many applaud the move to booking systems for its honesty – not promising what cannot be afforded, by putting people on a list. Patients and clinicians alike acknowledge the greater certainty for patients

who now know clearly that they will, or will not, receive the service and when those eligible will receive it.

The future debate on this initiative is clearly around the threshold for access to different services and the funding required to sustain access which is affordable.

From advice to practice

I acknowledge the tensions in moving from service guidelines or access criteria set at a population level to clinical decisions for identifiable people, using transparent and publicly open processes. The tensions are acute, especially for a service such as dialysis, where death is the only outcome when the service is denied. Medical technological success has created a dilemma, however, which we all must face – the myth that death is an option, that all life can and should be saved if the technology exists, no matter what the likely quality of life or the cost.

Any definition of priority services will not become practice unless it is based on professional and wider community involvement and understanding. A description of priority health services or detailed access criteria for treatment is challenging. People find it hard to accept that there are limits on resources. Priority setting is an explicit acknowledgement that not everyone will have access to publicly funded services they may feel they need or want. Since 1992, the limit on health funding has been discussed openly in New Zealand, and sometimes with inevitable controversy.

Conclusion

Pressure on health resources is an international dilemma. It is probably the most significant driver of health care reform around the world.

Like New Zealand, many other countries face the tensions of:

- finite health resources;
- significant quality improvements in health care, often with increased costs;
- increasing ranges of treatments or services, possible for many more people;
- growing public expectations.

The “international” nature of health care has many positives – pooled research findings, rapid awareness of the many new drugs or treatment methods available. New developments and quality improvements are an essential part of health care.

Such developments must be set in a clear context, however, or they may raise unreasonable expectations and lead to unaffordable and unsustainable demand. If politicians, policy makers and the public are not to reach arbitrary conclusions about their worth, we must consider the likely benefits and harms of services, the costs, how many people must be treated to

achieve a cure or prevent an adverse outcome, and the relative claims of new developments compared with other ways of spending health money.

From New Zealand's perspective, we will always need to spend available health resources as wisely as possible, and decide on the most important services – or the priorities – if trade-offs are needed. Through guidelines work with professionals and consumers or the development of access criteria, the National Health Committee is focusing on the effectiveness of services, their benefits, harms and costs. Informed and open debate is part of that process. Increasingly, the debate is acknowledging the limits of technologies, the uncertainties of clinical practice – and other uses for available resources.

Are we having the community-wide, informed, rational debate in New Zealand that is needed? The honest answer is no, not yet. But there is growing recognition of the issues and the need to make rationing choices.

There are no simple or single answers to sharing scarce health resources. A 'list' of core services is too static to cope with the rate of technological progress. Simply listing services also implies a guarantee of access. It does not allow account to be taken of individual circumstances and the relative degree of ben-

efit people might gain. Consumer and public priorities also change. They need continual review and renegotiation as new procedures emerge, and as evidence changes about the benefits or harms of existing services. Health professionals too must be convinced of the clinical validity and sense of rationing decisions – because they are the ones who have to answer to their patients.

Health care priorities are not a list of services – they are a culture shift in professional and community expectations, with a requirement for informed and honest debate.

My best wishes on your initiative to start the process here in Switzerland. It will be challenging and frequently uncomfortable. If you agree that rationing is inevitable, you may find some of our New Zealand examples are useful to achieve fair, consistent and defensible rationing decisions.

Reference

- 1 Hadom DC, Holmes AC. The New Zealand priority criteria project. Part 1: Overview & Part 2: Coronary artery bypass graft surgery. *Br Med J* 1997;314:131-8.