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PRIORITISING HEALTH - The Debate about Health Care Rationing

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C O N T E N T S

Keith Cuninghame
Education & Social Services Section

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1. INTRODUCTION

It is a truism amongst observers of health policy here and abroad, that choices must be made between competing demands on health spending. No country has been able to afford to provide every possible treatment for all its citizens, choices must be made and "every choice involves a sacrifice" as Kierkegaard said (quoted by Smith[1]). So the decision to devote resources to one area of care means that less will be available for others. If there are priorities there must also be non-priorities.

Countries throughout the world have been taking steps to limit the apparently inexorable rise in health spending which has resulted from the pressures from new medical technology and from the extra costs imposed by an ageing population.

This research paper looks at the way in which health care spending has risen steadily both in the UK and elsewhere but is now being reined in in the face of a rising demand which governments feel increasingly unable to meet. The arguments about the UK level of spending, low when compared to similar countries, are touched on (Part 2). The concept of health care rationing is examined (Part 3). There is then a look at the ways in which the UK has rationed health care in the past, at the implications of the NHS reforms, and at the available evidence of actions being taken by health authorities (Part 4). The widely reported "Oregon experiment" is described (Part 5). There is then an examination of the ways in which health care can be prioritised and at what is needed to make that process effective, ethical and equitable, at the level of individual treatments, at local levels and at the national level. This includes an explanation of the QALY (Quality Adjusted Life Year) process for comparing health procedures. Finally, under the heading "Ways forward" (Part 7) it is recognised that there is a wide divergence of views ranging from those who argue the subject should not be discussed because it diverts attention from arguments for more money, to those who advocate rationing by exclusion of a range of treatments from the NHS, with a middle view of what one commentator calls "muddling through elegantly".

2. THE GROWTH AND REINING IN OF HEALTH SPENDING

Levels of spending

Throughout the developed world one of the features of recent years has been a perceived need to rein in the growth of health spending as a proportion of national wealth. From around 1950 until around 1980 expenditure grew steadily. An often quoted remark by a Swedish politician of the 1960s was "Health care shall cost what it has to cost. We will pay". While not everyone would have gone as far as that it did encapsulate common feeling. In the 1980s, however, growth levelled off although continuing to rise (see figure 1). The rise between 1990 and 1991 seems likely to be because health spending has generally held up despite the recession.

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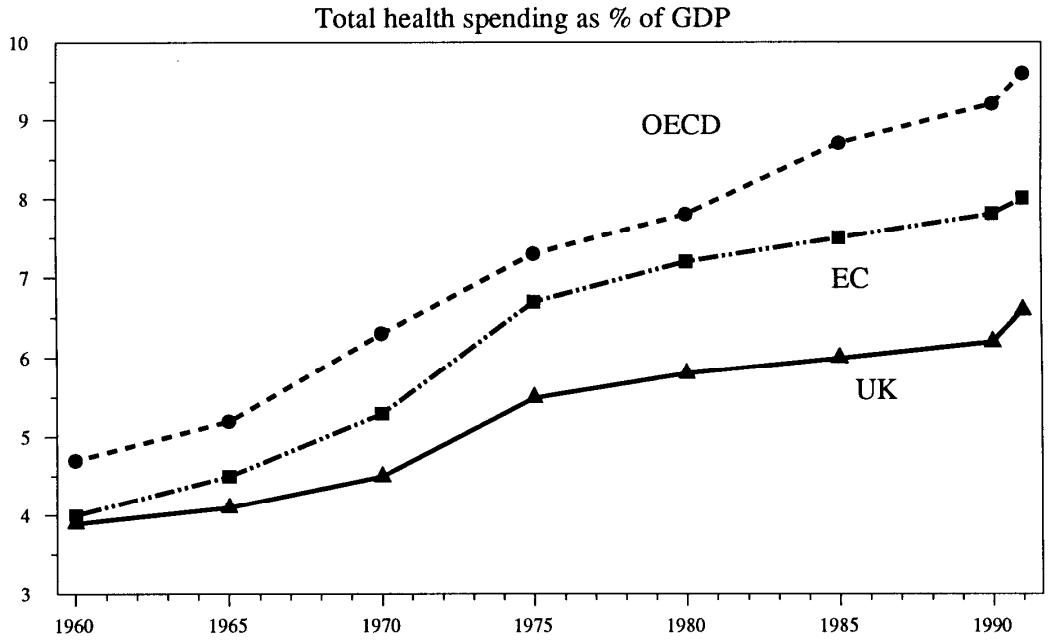
[1] SMITH Richard (1991) Rationing: the search for sunlight. British Medical Journal 21-28 December 1991, p 1561



Source: OECD Health Statistics 1993 Database. More detailed international spending comparisons are given in appendix 1.

As can be seen the UK spends a lower proportion of its national income on health than other comparable countries.

The argument about UK levels of spending

There are arguments about whether the UK should be spending more on health care and what is the "right" level of spending on health. There are also arguments about the extent to which "real" increases on health spending in the UK have kept pace with the level of inflation in the NHS (as opposed to that in the economy as a whole) and with the demand arising from an ageing population and the development of new medical techniques. These arguments are important but are not discussed in detail here. They do, however, impinge on the rationing debate and need to be briefly summarised.

Some would argue that if UK spending were increased to European average levels as a proportion of national wealth many of the problems would be alleviated. They would attack as a "convenient myth" the notion of infinite demand and would argue that discussion of rationing is a diversion from the case for higher spending on health. The Radical Statistics Health Group, for example comment that "The rationing debate proceeds from the premise that the NHS cannot be helped by more funding. We suggest the figures show otherwise".

Others would point to the fact that some of the other countries that are finding it necessary to restrain health spending because not all demands can be met, such as Sweden and the Netherlands, spend substantially more as a proportion of their GDP or health than does the

UK. It is not necessarily contradictory to argue that levels of UK spending need to be increased while accepting that prioritisation and choices would still be needed.

A further important element in the argument about health spending is that of the extent of "real" increases in spending, a subject that has been regularly tackled by the Social Services and Health Select Committees. There are two main elements to the argument:

- How to measure "real" increases: The Government quotes figures which show spending increases in relation to the movement of pay and prices on the economy as a whole (the "GDP deflator"), critics argue that these figures ignore the fact that in most recent years NHS costs have risen faster than those in the economy as a whole so it is more meaningful to measure increases in funding in relation to the NHS pay and prices index.

- Expenditure needs to rise in real terms to take account of the costs of new technology and of the ageing population. The Social Services Committee's most detailed look at the subject was in its 1st report of 1987-88[2] which argued that a gap had grown up between identifiable need and increased spending to the extent that between 1980-81 and 1987-88 actual spending was short of their target by £1.9bn. The Government argues that increased spending in relation to the GDP deflator demonstrates the priority given to health.

Why restraint?

McLachlan and Maynard[3] identified a trend towards restraint a decade ago. In a book which included studies of a range of healthcare systems they commented:

> "A careful analysis of the essays on foreign systems and other sources which set out the characteristics and problems of health care systems across the Western world ... shows that there is a striking similarity in the problems facing most health care systems. Although the terminology differs, most policy makers in most countries identify control of expenditure, efficiency and distributional equity as the primary problems in their health care systems."

More recently, in a study of European Community countries Brian Abel-Smith[4] notes that "containing the cost of health care has become the aim of virtually all countries in the world - both developed and developing".

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[2] SOCIAL SERVICES COMMITTEE (1988) Resourcing the National Health Service: Short Term Issues. 1st Report of 1987-88, HC 264

[3] McLACHLAN Gordon & MAYNARD Alan (1982) The Public Private mix in health care: The emerging lessons, in The Public/Private Mix for Health eds McLachlan and Maynard. Nuffield Provincial Hospitals Trust.

[4] ABEL-SMITH Brian (1992) Cost containment and new priorities in health care: A study of the European Community.

Abel-Smith goes on to comment on the general pressures governments have been facing:

> "But the lesson which stands out from the experience of Europe over the past fifteen years is that what was previously regarded as unthinkable cannot only become to be thought, but adopted as policy once a government comes under strong enough pressure to act. This pressure came with the successive increases in oil prices and consequent recession which hit different countries with varying severity at different times. Once the containment of public expenditure became a critical aim, governments faced with low or declining rates of economic growth and tax resistance, became determined to combat the secular increase in public health expenditure which had been faster than that of the economy as a whole".

But why has the cost of health care risen faster than the general rate of inflation? The two reasons most commonly put forward are medical advances and the costs imposed by the increased number of elderly people.

"The good news" say Aaron and Schwartz[5] "is that modern medicine can work miracles. The bad news is that it is very expensive and that many health expenditures do not seem to yield benefits worth their cost". Medical technology enables more to be done for many patients than before. A commonly quoted example is the hip replacement which did not become practicable on a large scale basis until the late 1960s but which is now common. More recently the knee replacement has become more readily available. New techniques of medical imaging are potentially beneficial but costly and the availability of such new techniques creates demands from health professionals and patients. Such new technologies do not invariably add to costs but commonly do so.

The Department of Health has in the past accepted that the demands of new technology adds about half a per cent a year to meet the cost of new technology.

The future implications of new technologies are less clear. A range of new techniques mean that fewer people will be treated as hospital inpatients and those who do are likely to have shorter stays. There has for example been a growth in "hospital at home" and similar schemes leading to many people who would have had to enter a hospital ward receiving care at home. Many more operations can now be done as day surgery. Techniques of "minimal access surgery" can mean that for those who do go into hospital stays can be shortened. New drug treatments may lessen the need for surgery for some conditions.

Some of the techniques may lead to lower costs but the position is far from clear. In a recent study of medical advances Barbara Stocking[6] says of future technologies "It is extremely difficult to predict which will reduce costs and which will increase them".

The rising number of elderly (and particularly very elderly) people has led to a steady increase in the demands on health services if quality is not to be reduced. Government

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[5] AARON Henry J and SCHWARTZ William B (1984). The painful prescription: Rationing hospital care

[6] STOCKING Barbara (1992). Medical Advances: The future shape of acute services. King's Fund London Initiative Working Paper No 7

estimates show that the average cost to the NHS hospital and community health services of someone aged 85 and over it was £1,275. By comparison the figure for someone in the 16-64 age group was £185 (Source: Sackville[7]). Demographic change has been accepted to add about 1% a year to the level of need.

3. WHAT IS MEANT BY RATIONING?

The term "rationing" tends to evoke a picture of wartime rationing with coupons and queues limiting access to food and other goods. Although some would argue the case for this kind of explicit bureaucratic system for health care, the use of the word is much broader than that. Ruddle defines rationing as "the process by which an equilibrium between demand and supply is achieved"[8]. While Richard Smith defines the concept as follows:

> "Suddenly, within health services we are becoming much more aware of having to make choices between different treatments, services, facilities and patients. The word that has been attached to this activity is rationing - with its depressing overtures of queues and denial - but what is happening is less that people are being denied and more that the choices are becoming more explicit."

Not everyone likes the word. As Tony Delemothe noted when reporting recent conferences:

> "Importing the word `rationing' into the debate is regarded as unhelpful because it describes, unnecessarily emotively, an everyday activity: choices have always been made between competing demands for scarce resources and always will be. What are needed are ways of deciding how to allocate these scarce resources: in the words of Professor Alan Maynard `to maximise health to the greatest extent at the least cost.'"[9]

On the other hand, economists would not consider the word emotive, and perhaps its use helps to concentrate minds more than a neutral phrase such as "allocation of resources".

In this paper the term "rationing" is used in its broad sense to describe the process of making choices between competing priorities.

Another term that causes confusion is "explicit". Some use the phrase "explicit rationing" to mean drawing up of a list of services which will and will not be provided, or of people who will and will not be treated. Others when they add "explicit" to "rationing" are talking more about the bringing transparency into the process by which choices are made, in contrast to the traditional method of leaving decisions to individual clinicians.

While there would be broad agreement on the need to make choices and set priorities in health care there is less agreement about either the necessity or desirability of any system of

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[7] SACKVILLE Tom MP (1992). Written answer 27.11.92 col 876W

[8] RUDDLE Sue (1991) Rationing resources in the national health service. Institute for Health Policy Studies occasional paper, March 1991

[9] DELAMOTHE Tony (1992) Getting rational over rationing British Medical Journal 21.11.92

"explicit rationing" in the sense of excluding groups of services or groups of people from treatment.

There is nothing new about the prioritisation (or rationing) process. It has never been possible to provide what an American commentator described as "presidential medicine" for all citizens. What is changing is that there is a growing concern that health spending will rise out of control and that has led to a growing interest in how rationing decision are arrived at and a growing demand that there should be greater transparency about the process. Some would argue that the end result should be an explicit rationing process, and look to the Oregon experiment in the USA, discussed later in this paper, as a possible model. Others would see such a process as being dangerously simplistic and unnecessary but would nevertheless seek greater clarity about the way decisions are taken as between competing needs. The NHS reforms with their separation of purchaser and provider (or the commissioning and delivering) of health care mean that such decisions must be more explicit since deciding what to buy by implication means deciding what not to buy.

4. WAYS OF RATIONING HEALTHCARE

Introduction

If, as has been suggested, it is a truism that all health systems ration care there is a wide range of ways in which it can be done. Chris Heginbotham[10] suggests some of them:

> "The United Kingdom health service rations through non-availability, primary care gate keeping and waiting lists. The United States service rations partly by income and partly by insurance companies funding either a core group of services or by placing treatment and lifetime caps on the cost of an individual patient's care.
>
> Social insurance systems such as that of Germany ration through protocol agreements with doctors and by payment for a basic service to which the individual consumer can add by additional contribution. Central and eastern European countries have until recently rationed according to the degree of `cunning' that the individual consumer was able to bring - the key skill was knowing the way around the system and who to bribe."

How healthcare has been rationed

The passage quoted from Chris Heginbotham sets rationing in the UK in an international context. This section discusses in more detail the ways in which rationing has taken place in the UK.

Rationing can be both formal and informal. Two obvious formal ways in which the NHS has traditionally rationed care are through waiting lists and through charges, both of which have been a feature of the NHS virtually since its inception. Charges were first introduced on teeth and spectacles in 1950 and on prescriptions in 1951. But there are numerous informal techniques as well.

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[10] HEGINBOTHAM Chris (1992). Rationing British Medical Journal 22.2.92

Six rationing techniques occur throughout the NHS as set out in Box 1:

Box 1: How the NHS has rationed care	
Delay	The waiting list is a formal method of rationing by delay. Less formally appointment systems may delay patients being seen, or health professionals may decide they should wait longer before treatment.
Dilution	This essentially means spreading the service more thinly for example by increasing caseloads so that less time can be given to individual patients, or community nurses visiting less patients.
Deterrence	If a service is only provided at an awkward location or at inconvenient times for many of those who need to use if they may not seek treatment. Charges may be set at a deterrent level. The "gatekeeper" role of the GP acts as a filter.
Diversion	Shifting the cost to other agencies, eg social services if the needs are seen as mainly social.
Ignorance	Not all patients are well informed about services that are available, or know how to make their needs known. "Most NHS consumers are not aggressive patients. They do not shop around." (Higgins and Ruddle (1991)).
Non-provision	The ultimate form of rationing is not to provide a service at all. The NHS has been criticised for slow introduction of some new treatments, and patchy availability of some services (such as infertility services) and some health authorities are contemplating ceasing to fund certain services. Again, the gatekeeper role of the GP may lead to some people not getting a service.

[This list is adapted from Higgins and Ruddle[11]]

In their study for the Brookings Institution, Aaron and Schwartz sought to compare British and American health spending in specific areas and to look on the ground at how British spending was limited. It was published in 1984 so its detailed data are outdated but it provides a useful retrospective study of the UK. One of the areas they looked at was kidney dialysis and transplants. At the time they were writing the available information was that while the two countries had virtually identical rates of transplantation, the proportion of the population undergoing dialysis was more than three times as in the US than in Britain. They looked at the ways treatment was limited and found that while for younger age groups dialysis rates in the UK were comparable with those in similar European countries, over the age of 44 a growing gap appeared. They also found a range of medical reasons such as vascular complications or diabetes which were likely to lead to non acceptance. Also the availability of facilities varied with the West Midlands for example having about half the number of

[11] HIGGINS Joan and RUDDLE Sue (1991). Waiting for a better alternative Health Service Journal 11.7.91

centres to be expected for its population compared to Greater London. And yet most dialysis unit directors reported that they were "coping with demand". The answer to this paradox was seen in the "gatekeeper" role of the GP, who quickly became attuned to the policy of the local dialysis centre and developed justifications for non-referral. Aaron and Schwartz quote one GP as describing how he would talk to the family:

> "I would say that mother's or aunt's kidneys have failed or are failing and there is very little anyone can do about it because of her age and general physical state, and that it would by my suggestion or my advice that we spare her any further investigation, any further painful procedure and we should just make her as comfortable as we can for what remains of her life".

The authors comment that "Remarkably few of the criteria for rejection are explicitly stated. Age, for example, is not officially identified as an obstacle to treatment". They go on to say that even if resources were unlimited different attitudes would be likely to mean that fewer patients would be treated in the US. They also comment that "Because of the respect most patients have for physicians, the recommendation of the doctor is usually followed with little complaint".

Aaron and Schwartz studied other areas and came to similar conclusions in some of them but certainly not all. They found spending on hip replacements was quite high. Spending on total parenteral nutrition (ie feeding other than by the gastrointestinal tract) was very low because, it seemed, British doctors were sceptical about its value, rather than for resource reasons.

Generally they noted that "The British physician often appears to rationalise, or at least redefine, medical standards so that he can deal more comfortably with resource constraints". They also noted that some patients developed ways of "working the system".

Another example of the way healthcare has been rationed in the UK is given by Dudley and Burns[12] in a study of age related policies for admission to coronary care units. In a survey they found that one fifth of units had an age related admissions policy and two-fifths an age related policy for thrombolysis (dissolving of blood clots). The authors conclude "The abolition of age-related policies would help to ensure that thrombolysis is made more readily available to the group of patients most likely to benefit from treatment".

The implications of the NHS Reforms

The NHS reforms have done much to bring the debate about rationing in Britain out into the open. This is a consequence of the separation between the purchasers or commissioners of health care (principally district health authorities) and the providers (hospitals, community units etc, whether they are NHS Trusts or not). In carrying out their role DHAs have to

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[12] DUDLEY N J & BURNS E (1992). Influence of age on policies for admission and thrombolysis in coronary care units in the United Kingdom. Age and Ageing 1992 vol 21 p 95-8

- assess the health needs of the local population;

- develop service specifications to meet those needs;

- place contracts with providers in line with the specifications.

In deciding which services to buy and at what level DHAs are unavoidability deciding what not to buy.

William Waldegrave[13], then Secretary of State for Health, put it as follows in an interview with Richard Smith, editor of the British Medical Journal, on the eve of the introduction of the reforms of 1 April 1991. Discussing London as "an extreme case of how the present [ie pre reform] system does not work" he said:

> "What the new system will do will force some decisions out of us cowardly politicians, who for 20 years have put them off. The new system will bring things to a sharp crunch in a number of places."

In response to a question about whether there was an "unbridgeable gap" between what could be done clinically and what could be afforded he said:

> "I don't think that there's an unbridgeable gap between what should be done and what can be afforded. But there will always be unaffordable procedures. There will always be tension on resources. But I think that we can get closer towards a consensus that we are doing what should be reasonably done."

He then spoke about the need for public discussion and the effect of the reforms:

> **Smith**
> "Do you think politicians should be more up front that not everything can be afforded?"
>
> **Waldegrave**
> "I do, and I think that it will be utterly necessary under the new system - because one of the things that will be thrown up will be a much more explicit definition of what we are and are not buying. That will cause those decisions to have to be justified - not only by politicians but also by the clinicians. The system will become more open and explicit, and therefore more argumentative. I think that must be a good thing, although it will take a little getting used to."

Mr Waldegrave's successor as Secretary of State, Virginia Bottomley, spoke on the subject in her speech to a BMA conference on "Priority Setting in the NHS" on 11 March 1993[14].

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[13] WALDEGRAVE William (1991). Thinking beyond the new NHS [Interview with Richard Smith] British Medical Journal 23.3.91.

[14] BOTTOMLEY Virginia, MP (1993). Priority setting in the NHS. Speech to BMA/King's Fund/Patients' Association Conference on 11 March 1993.

She said that the NHS reforms had made the process of priority setting explicit rather than implicit. After speaking about the need to take account of patients' views and the importance of clinical and cost effectiveness she concluded by saying:

> "Politicians are taught early on to talk about challenges rather than problems. However, none of us should buy into the fashionable theory that the NHS is rushing towards some sort of rationing armageddon. Sensible practitioners and politicians have known all along that hard decisions about priorities have to be taken. We have been taking these decisions all the time, perhaps without even realising it."

What are Health Authorities doing?

So if one of the consequences of the NHS reforms is to make the need for rationing more explicit, how are health authorities adapting to the change? The evidence at this stage is limited. The emphasis in the first year of the reforms was in getting the new system in place with changes in spending patterns being discouraged, so 1992-93 is the first year in which any significant change has been feasible. However health authorities are only beginning to come to grips with the new role of purchasing and it seems unlikely that there will be rapid change in the kind of services provided. The place where those services are provided is changing more rapidly - one of the main causes of the problems of hospitals in inner London and other cities is that purchasers are switching some of their contracts to more local hospitals, but that is separate from the priorities debate.

A simulation exercise in late 1991 carried out by the King's Fund College and Southampton and South West Hampshire Health Authority[15] set out to look at the dilemmas facing health authorities in setting priorities. The "lessons learned" illustrate some of the difficulties facing health authorities:

The most important lessons which emerged were:

- priority setting and resource allocation is hard partly because evidence and information is patchy or unavailable and partly because the task is inherently complex;
- authorities must be able to explain the decisions they take to patients, service users and clinicians and to obtain the views of patients about `need' as one part of understanding health care requirements;
- rationing occurs now and will continue in some form;
- priority setting methodologies must be carefully considered to ensure that they are rigourous, compare like with like and provide useful, albeit small steps towards resource allocation decisions.

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[15] HEGINBOTHAM Chris and HAM Chris (1992). Purchasing dilemmas. A special report from the King's Fund College and Southampton and South West Hampshire Health Authority.

Klein and Redmayne[16] in a study for the National Association of Health Authorities and Trusts have looked at how health authorities have been making choices so far, based on the 1992-93 purchasing plans of 114 health authorities. The study looked at the priorities identified by health authorities and then looked at the extent to which the available development money was used to fund them. They found very little evidence that health authorities were shifting funds between different services. Developments were funded from a variety of sources including growth money, efficiency savings and top slicing (shaving money off all budgets to spend on developments). From whatever source the amount of money available to fund new developments was very limited - only £120.6m divided among the 114 purchasing authorities. The study found that there was often a discrepancy between what they described as the "aspirational" priorities of health authorities and those that actually got funded. Mental health, for example, was the top of both lists but while mental handicap was second in the list of "aspirational" priorities it was only ninth in the funded priorities. But the number of times a priority appeared on the list was a poor guide to how much was actually spent. The authors found that 55% of the money available to fund new priorities was spent on acute services (rather more than the 51% spent on these services overall) which 17% was spent on mental health.

The study found only very limited evidence of explicit rationing in the sense that certain treatments would not be purchased at all. Only twelve of the 114 authorities identified such treatments in their purchasing plans. Of these the most frequently cited were tattoo removal (7 mentions) and GIFTVF (six mentions). Health authorities on the whole were reluctant to choose between priorities instead adopting a strategy of what the authors describe as "spreading the money around". The authors also note what they call "priority overload" - that is, an excessive number of priorities, either imposed by the Department of Health, or created locally.

Chris Ham[17] has looked in detail at priority setting in six health authorities which may not be typical because they had all expressed an interest. In general he found that although priority setting was not new it was becoming more difficult. He found:

- DHAs had generally avoided excluding services from the NHS.

- Making comparisons of different services was very hard because there was no common currency.

- It was easier to examine priorities within individual service areas or disease categories - "but size chunks" as he described them. For example, the range of possibilities within heart disease could be compared.

- There was a lack of good information to guide purchasing decisions was a problem.

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[16] KLEIN Rudolf and REDMAYNE Sharon (1992) Patterns of Priorities: A study of the purchasing and rationing policies of health authorities. National Association of Health Authorities and Trusts Research Paper No 7

[17] HAM Chris (1993) Paper delivered at BMA Seminar on priority setting in the Health Service, 11.3.93

· DHAs had made a major effort to involve the public using a wide variety of techniques had been used such as questionnaires, consultation with CHCs and voluntary organisations and public meetings. They had also looked at the priority of different groups such as the public, GPs, hospital doctors and public health doctors.

He concluded that DHAs were still in the "foothills of the debate" and that there was much local variation.

5. THE OREGON EXPERIMENT

Much attention has been focused on the so called "Oregon Experiment" and it has been widely written about[18]. This is the proposal by the state of Oregon for the funding of health care for Medicaid recipients - the very poor. The intention behind the experiment was to increase eligibility for Medicaid to 100% of the federal poverty line and to fund this by reducing the scope of treatment available. Like other states, Oregon has been funding healthcare through Medicaid only to those whose income is less than a specified percentage of the federal poverty line, but providing fully comprehensive treatment to those eligible. Although aimed at the small proportion of the population eligible for Medicaid it is intended to act as a benchmark for the level of funding provided by employers to a wider section of the population. Nonetheless it is very different from the universally available NHS. The processes used have nevertheless attracted widespread attention in the UK. The experiment has not yet been put into effect. The Bush administration refused the necessary "federal waiver", but President Clinton has now given the experiment the go ahead[19]. The process and the arguments for and against are set out in box 2.

An Oregon approach for Britain has been rules out by Virginia Bottomley. In her speech to the BMA conference on 11 March[14] she said "We neither want nor need in the NHS Oregon's flawed approach".

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[18] DIXON Jennifer and WELCH H Gilbert. Priority Setting: Lessons from Oregon. Lancet 13.4.91.
HONIGSBAUM Frank. Who shall live? Who shall die? Oregon's health financing proposals.
CONGRESS OF THE UNITED STATES, OFFICE OF TECHNOLOGY ASSESSMENT Evaluation of the Oregon Medicaid Proposal

[19] ROBERTS John (1993). Clinton gives go ahead to Oregon's health plan. British Medical Journal 27.3.93

Box 2. The Oregon Experiment

How the Process Worked

● The Oregon process applies only to the very poor entitled to `Medicaid', through companion legislation encourages health insurance provision to others on a comparable basis.

● The plan is based on a prioritised list of 709 "condition-treatment pairs" (or "lines") that is medical conditions and linked methods of treatment (for example, Appendicitis-Appendectomy; hypertension + hypertensive disease-medical therapy). The state legislature had to decide how far down the list to fund, but could alter it. Responsibility for drawing up the list was given to a Health Service Commission, which was required to consult public opinion. Mental illness and drug dependency services were excluded since they were not part of the initial scheme.

● A preliminary list based on a "quality of well being" cost utility method had so many anomalies that it was abandoned.

● The starting point of the final list was the drawing up of 17 "categories of care" ranged in order with life saving treatments at the top. These ranged from No. 1: "Acute fatal, prevents death, full recovery" (eg appendectomy) to No. 17: "Fatal or non fatal, treatment causes minimal or no improvement in quality of life" (eg medical therapy for end stage HIV disease; life support for extremely low birth weight babies [less than 500 gm]). The full list of categories is in appendix 2, together with selected condition treatment pairs.

● Condition-treatment pairs were then assigned to categories and ranked within the categories, initially using a modified version of the cost-utility scale previously used. The list was then reviewed by a panel of doctors and finally adjusted by the Commissioners using a "reasonableness" which resulted in individual condition-treatment pairs being moved up or down the overall list. So a pair in category 5, say, will not necessarily be higher in the final ranking than one in category 8.

● The state legislature agreed to fund down to line 587 of the 709.

● Public input came in three forms:

- a telephone survey of 1001 Oregonians elicited their views on how they would rate suffering from 29 symptoms or limitations of their activity on a scale from 1 to 100. These weights were collated into a weighting factor used in the cost utility formula.

- 47 community meetings were held at which participants were asked to place values on nine broad categories of care and also to respond to a questionnaire on theoretical health care situations.

- 12 public hearings were held at which advocates of those most likely to use Medicaid were heard as were providers of services.

Arguments for and against the Oregon process

The Oregon process has generated widespread debate far beyond the state.

Arguments in favour

- It brought out the issues facing healthcare systems throughout the world, and encouraged many beyond the state of Oregon to think carefully about the issues.

- It set out to introduce a decision making process based on a rational assessment of how to maximise the improvement in health care for a given sum of money, and how to ensure spending is concentrated on worthwhile treatments.

- By extending the scope of Medicaid it meant that rationing decisions would be based on whether the treatment was more or less effective not whether the individual patient could afford the treatment.

- The involvement of the public in decision making process was a valuable exercise, which had not been tried to the same extent elsewhere.

Arguments against

- Far from being a rational process based on sound evidence the Oregon list is a "crude questionnaire" as one commentator put it (Maynard[20]) as evidenced by the fact that the first list produced was so bizarre the Oregon Health Services Commission had to go back to the drawing board.

- Because of the problems with the original list and the cost utility analysis on which it was based they way the final list was drawn up was opaque, not clear and explicit as had been hoped.

- The public consultation, a much vaunted part of the process, was ineffective. The telephone survey produced many inconsistent responses (not surprising when being asked such complex questions over the telephone) and a high rate of refusal. Although over 1000 Oregonians attended the public meetings, two-thirds were college graduates, two-thirds were health care employees and only 50 were recipients of Medicaid, the people directly affected by the process.

- It does not take account of individual needs - a particular patient may benefit from a treatment while another would not.

[20] MAYNARD Alan (1991). On the Oregon Trail. Health Service Journal 23.5.91

6. HOW TO PRIORITISE

What is needed for effective prioritisation?

If it is accepted that prioritising of healthcare is inevitable then how should it be carried out? The recent British Medical Association discussion paper[21] poses three questions to be answered:

- Should rationing be done openly or should it be "hidden" as at the moment?
- Who will make decisions on rationing?
- How might rationing be achieved?

Klein and Redmayne have identified four "dimensions of rationing":

- Decisions about the allocation of resources to broad groups of services or clients.
- Decisions about the allocation to specific forms of treatment within those broad sectors or groups.
- Decisions about how to prioritise access to treatment between different patients.
- Decisions about how much to invest in particular patients through diagnostic procedures and so on once access has been achieved.

At a broader level still decisions must be taken about

- The overall size of the public spending programme.
- Within that programme how much should be spent on health rather than other claims on the public purse.

The answers to the BMA's questions will not necessarily be the same for each dimension. It could be argued, for example, that decisions on individual patients once they have gained access to treatment facilities (the fourth dimension), should be left to clinicians and that probably management and certainly under public participation would be inappropriate. On the other hand at the level of decisions about allocations to broad groups of services public and political involvement is desirable. Clearly at the broadest level of the size of the public spending programme and how much to allocate to health the decisions are political and part of the public debate. The extent of public involvement that is appropriate is less clear when the two middle dimensions are being considered.

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[21] BRITISH MEDICAL ASSOCIATION (1991). Leading for Health. A BMA Agenda for Health

Chris Heginbotham (reference 11) suggests that the following are needed for effective (and ethical) priority setting and resource allocation.

- A better understanding of disease and health care needs in the population.
- A clearer picture of all treatments available and their costs.
- More detailed information on the outcomes of specific treatments.
- Decisions on the importance to individuals and the population of particular needs being met.
- Decisions on resource allocation.

Heginbotham's list indicates the large information gap which needs to be bridged before effective priority setting can take place.

Understanding disease and healthcare needs

Developing an understanding of the **disease and health care needs** is now a core function of district health authorities. Public health departments of those authorities have a central role to play here. Directors of Public Health produce an annual report which will be a key source of information but is generally accepted that there is the need for the development of a wider knowledge base. Health authorities are still feeling their way, as for example the studies by Klein and Redmayne and by Ham reported earlier demonstrate. Government Guidance[22] suggests that the following information is needed as part of the process:

- Descriptions of current service provision.
- Utilisation rates of a speciality compared to other districts.
- The consensus views of service users in particular GPs.
- The views of service providers.
- Views on relative priorities.

Available treatments and their costs and outcomes

Available treatments and their costs and outcomes is another area where, despite a good deal of work the knowledge base is lacking, although this is changing.

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[22] HEALTH Dept of (1990). Developing Districts

There are wide variations in medical treatment for comparable conditions and a lack of certainty in many instances about which are most effective. Variations occur both within and between countries. There have been an increasing number of studies of such variations (eg Anderson and Mooney[23] and Ham[24]).

Gavin Mooney and Tavs Folmer Anderson in the concluding chapter of the study they edited comment that "Whatever best medical practice is, however `doing one's best for one's patients' is construed, not all doctors are doing it". This, they say, is the "basic point" of their book and is "fundamental to the challenges facing health care and the medical profession in the years ahead". They point out that while the existence of medical practice variation has been known for a long time, what is new is the amount of evidence becoming available. "There is no longer a black box in which medicine may be practised. In the age of information technology, patterns of medical practice will be a public issue. Everybody, including the medical profession, health care administrators, health policy makers, actual and potential patients, will have to acknowledge the existence of gross variations in medical practice ... it is becoming rather obvious that the basis for decision making at the clinical level, as well as at the administrative and policy making level, is inadequate".

Variations occur in the rate at which various procedures are carried out and also in the lengths of hospital stay associated with such activities and indeed whether they are carried out in hospital at all (the Audit Commission found wide varieties in the rate at which day surgery is carried out for instance). The problem is that it is often unclear what the optimum pattern of care is.

Knowledge is being improved in a number of ways including:

- The setting up (with Government funding) of an "Outcomes Clearing House" at Leeds University to gather, collate and disseminate available information.

- The publication of a series of "Effective Healthcare" Bulletins drawing together information on effectiveness and costs of different forms of treatment of particular conditions.

- The use of devices like "consensus conferences" to debate optimum forms of treatment.

- The development of protocols for the treatment of particular illnesses. For example, the Welsh Office has been publishing a series of "Protocols for Health Gain". Internationally the Copenhagen Collaboration Center (CCC) has been able to pool data across different countries for operations like prostatectomy, cholecystectomy and hysterectomy.

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[23] ANDERSON Tavs Folmer and MOONEY Gavin (eds) (1990). The challenges of medical practice variation

[24] HAM Chris (1988) ed. Health care variations: Assessing the evidence. King's Fund Institute Research Report 2

Despite the growing interest in the subject John Wennberg[25] was able to write in 1990 "In contrast to the well-established public policies and administrative mechanisms for promoting growth of the biomedical sciences, support for the evaluative clinical sciences - the measurement science whose job it is to test the validity of clinical theories concerning the prevention, diagnosis and treatment of disease - has been inconsistent and unsystematic. The result of this neglect is clinical uncertainty concerning the expected outcomes of care and the value of care for patients".

Outcomes measures provide only part of the information that purchasers and providers need to provide the best healthcare within the funds they have available. They also need to know about costs and cost effectiveness. Until recently the NHS had relatively little information on costs of particular procedures. Contracts for healthcare are providing more information, although most contracts are still relatively simple ones.

Information on the cost of a particular procedure does not, in itself provide what is needed to assess the cost effectiveness of that procedure. The Oregon process (see Box 2) attempted to do this using a "quality of well being" (QWB) cost-utility measure which set out to measure the improvement in health resulting from a particular treatment, the cost of the treatment and how long it is likely to last. A similar procedure has been advocated by some UK health economists (Williams[26] (1985) and Gudex[27] (1986). This is the Quality Adjusted Life Year or QALY [see Box 3].

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[25] WENNBERG John (1990). On the need for outcomes research and the prospects for the evaluative clinical sciences in Anderson & Mooney, op cit

[26] WILLIAMS Alan (1985). Economics of coronary artery bypass grafting. British Medical Journal 3.8.85.

[27] GUDEX Claire (1986). QALYS and their use by the Health Service. University of York Centre for Health Economics Discussion Paper 20

Box 3: The QALY (Quality Adjusted Life Year) Process

- Values placed on different levels of disability were assessed (originally by Kind and Rosser 1978). The level of disability was classified on an eight point scale ranging from I (no disability) through III (severe social disability or slight impairment of performance at work, or both, able to do all housework except heavy tasks) and V (unable to undertake any paid employment, unable to continue any education, old people confined to home except for escorted outings and short walks and unable to shop, housewives able to perform only a few single tasks) to VII (confined to bed) and VIII (unconscious). The level of disability was assessed for the distress caused on a four point scale (A, none; B, mild; C, moderate and D, severe). Values were assessed by a survey of each level of disability and distress and placed on a scale ranging from 1 (healthy) to 0 (dead).

- Years of life gained by particular procedures are assessed and the qualify of life of people undergoing those procedures is assessed using the Kind/Rosser scale described.

- The number of QALYs gained for each procedure is calculated by multiplying the length of extra life by its equality on the 1 to 0 scale. Thus 5 years of life gained with a quality assessed at 0.8 will be 4 QALYs.

- Using the cost of a procedure a "cost per QALY" can be calculated. Gudex in a study published in 1986, gives the following examples of cost per QALY:

Procedure	Cost per QALY (£1000)
Renal Transplant	1.4
Continuous ambulatory peritorial dialysis (CAPD - ie home dialysis)	13.4
Shoulder joint replacement	0.6
Treatment of cystic fibrosis with deftazidime	8.2

Even the most ardent advocate of QALYs and similar measures would accept that they are at present crude measures. Their advocates would however argue that more research would improve the data, indeed that the gaps in the data indicate were research needs to be done. Williams[28] argues that "Everyone making priority decisions in health will, wittingly or unwittingly, have adopted some position or other on every one of the issues highlighted in the QALY approach, if only to decide that it is not important enough to take into account (which may or may not be true, of course). It seems increasingly the case that decision-makers concede that they **should** take these things into account but are at a loss to find evidence that would enable them to do so with confidence".

Critics of QALYs and similar approaches would argue that, with David Hunter[29] that, "Their spurious objectivity and scientific basis are quite unwarranted". He argues that numbers have a "curiously mesmerising affect" on managers which is not justified by the procedure. As Roy Carr-Hill[30] puts it "Index numbers are not an observation on the world, they are **generated** and **produced** by a specific set of technical procedures". QALY supporters tend to compare their admittedly imperfect procedures with no analysis at all, which is to "erect a straw man", Carr-Hill says. In short, critics would argue that, to use Rudolf Klein's phrase, you cannot generate priorities simply by "turning a handle". Others would suggest that while QALYs can provide useful pointers but can never be a substitute for informed decision making.

The importance to individuals and the population of particular needs

Heginbotham's fourth necessary condition for effective priority setting was the taking of **decisions on the importance to individuals and the population of particular needs being met**. One of the criticisms of the Oregon approach, or indeed any approach which rules out the provision of specified treatments is that the importance to individuals of particular treatments is not taken account of, that there is a need for a more flexible approach than in the Oregon experiment or by using QALYs as a basis for decision making. As Klein and Redmayne[16] puts it "Decisions to eliminate certain procedures or interventions from the NHS menu run into a crucial problem common to all Oregon-style approaches to the rationing of services. Rationing by excluding particular forms of treatments ignores the heterogeneity of patients even those forms of treatment which apparently offer no health gains for the great majority of patients may yet be appropriate for at least some." If this argument is accepted at that level decisions would be left to individual clinicians.

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[28] WILLIAMS Alan (1991). Is the QALY a technical solution to a political problem? Of course not! International Journal of Health Services Vol 21 No 2, 1991.

[29] HUNTER David (1993). Rationing dilemmas in healthcare. National Association of Health Authorities and Trusts Research Paper No 8

[30] CARR-HILL Roy A (1991). Allocating resources to health care: Is the QALY (Qualify Adjusted Life Year) a technical solution to a political problem? International Journal of Health Services Vol 21, no 2

At a broader level health authorities are consulting the public in various ways. They were encouraged to do so by the NHS Management Executive publication Local Voices[31]. This says that

> "The aim should be to involve local people at appropriate stages throughout the purchasing cycle: a combination of information-giving, dialogue, consultation and participation in decision making and feedback, rather than a one-off consultation exercise".

As David Hunter comments "With great gusto health authorities across the country have feverishly been commissioning , conducting and analysing public opinion surveys of one sort or another as well as arranging public meetings and consulting various interest and lobby groups representing particular sections of the population". Most commentators agree that the process is worthwhile and that it represents a change from the previous attitude to health authorities which tended to be to keep the public at arms length. What is not clear is the extent to which health authorities have been able to make meaningful use of public views. Although the Oregon process has been praised for its efforts at involving the public it has also been noted that in practice the voices heard tended to be those of healthcare professionals or of the articulate middle class and that the values expressed in telephone surveys were often contradictory. Potential problems over consultation are:

- Explaining complex medical technology. Different answers can be got according to how questions are phrased. Some medical decision are just too complex for the public to be involved.

- Whose voice is being articulated? Who will speak up for people who are poor, old, mentally ill, mentally handicapped or inarticulate?

- What if public views conflict with national priorities? Treatment of AIDS victims say, might be downgraded. More broadly "rationing by lifestyle" could become more common by which those deemed to bear responsibility for their illness would be denied treatment. Some might argue that this was a reasonable approach, but how far should it be taken? Should butter eaters be denied treatment for heart disease for example?

- Some fear that consultation is a way of diffusing the blame for difficult decisions - health authority members can point to public consultation when they are criticised for their decisions.

So although there is widespread welcoming for the extension of consultation (health authorities used to consult mainly on hospital closures) there is uncertainty at the extent to which appropriate techniques have yet been developed.

A recent BMA survey (published at the time of the Association's Priorities Conference on 11 March) of doctors, managers and the general public points out the differences which can exist between the views of the three groups. In the survey, 51% of the general public thought

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[31] NHS Management Executive (1992). Local Voices: The Views of Local People in Purchasing from Health.

the NHS should have unlimited funds compared to 17% of doctors and 2% of managers. Respondents were asked "If budgets do need to be set, who should make the decisions on which treatment takes a higher priority?" and asked to select as many groups as they liked from a list. Full answers to this question are reproduced in the appendix to this paper. It is interesting to note that all groups put their main faith in doctors. Both doctors and the managers would place more weight on the views of the public than the public themselves. A significant number of managers, but hardly any of the general public, saw a role for national politicians. When asked which they would prioritise, life saving treatments which may mean people are unable to lead a normal life, or treatments that greatly improve peoples' ability to lead a normal life, all groups chose the latter. A further question asked respondents to prioritise a list of ten treatments, including preventive measures, high-tech surgery and treatment which would improve quality of life. While all three groups placed childhood immunisation first and cancer treatment for smokers last there were substantial variations in other treatments (see appendix 3). Doctors and managers, for example, rated "education to prevent the young smoking" higher than the public while the public placed greater importance on breast cancer screening and intensive care for premature babies than the other two groups.

Decisions on resource allocation

Heginbotham's final prerequisite for effective priority setting was **decisions in resource allocation**. Resource allocation, he notes "is often described as the balance of equity and efficiency. Equity refers to equal access for people of equal needs, and efficiency is concerned with achieving the greatest outputs for given inputs". He also includes effectiveness which would cover the growing interest in outcomes, and the effectiveness of individual treatments which has already been examined. At a regional level resources are allocated on the basis of "weighted capitation" under which the population is weighted according to age and mortality rates (as a proxy measure for morbidity). Regions are moving towards using this measure as a basis for allocations to District Health Authorities.
Under this heading too, can be considered the wider decisions about how much to allocate to health spending. This is partly a question of the overall level of public spending that is considered appropriate or affordable by the Government. It is also a question of what proportion of that spending should be on health care.

There is also a wider consideration of how to most effectively prioritise health (rather than health care spending). As the **Health of the Nation** White Paper recognises, spending on health is not only the business of the health service. Some would argue, for example, that spending more on aleviation of poverty would be a good way of prioritising health. The Royal Commission on the NHS, in 1979, commented that "It is at least arguable that the improvement in the health of the nation would be greater if extra resources were, for example, devoted to better housing"[32].

[32] ROYAL COMMISSION ON THE NATIONAL HEALTH SERVICE (1979). Report. Cmnd 7615, July 1979

7. WAYS FORWARD

The debate on the best way of prioritising health care (or rationing it, according to your preferred term) is really only just getting off the ground, although there has been a rapidly growing interest in the subject since the NHS reforms took effect. Views range from those who argue the case for a full scale "Oregon" style list of treatments included and excluded from NHS treatment, to those who argue that the subject should not even be discussed since it diverts attention from the need to spend more in total on the NHS.

Many in the middle would recognise the need for what may be tough decisions but would question any necessity to hit the Oregon trail, quite apart from the doubts expressed about the nature of such processes. There would, however, be quite broad agreement on

- The need to improve our knowledge of outcomes of individual treatments and of the most effective treatments for particular conditions.

- The desirability of improving our knowledge of the costs and cost effectiveness of individual treatments (without necessarily supporting a QALY type approach).

- The need for wider public debate than has been the case in the past.

One middle solution, advocated by David Hunter is "muddling through elegantly". This approach argues that "If overt rationing is such a minefield strewn with major problems each one potentially explosive then why blindly pursue it? Why not adopt a rather more subtle approach? Arriving at an optimal balance between various interests might be summed up as muddling through elegantly". Others would see such as approach as lacking in rationality (which Hunter would accept) and would argue that even if explicit rationing techniques are imperfect they can be improved and the result would be a clearer system which would maximise health spending. Such explicit rationing has, as we have seen, been explicitly ruled out by the Government[14] but it does not necessarily follow that the techniques used do not have a role to play in the wider debate. What is clear is that discussion about how to get the most health care from the available level of funds (whatever that level might be) will continue in this country as it will in others.

APPENDIX 1

International Comparisons of Health Care Spending as a Proportion of GDP

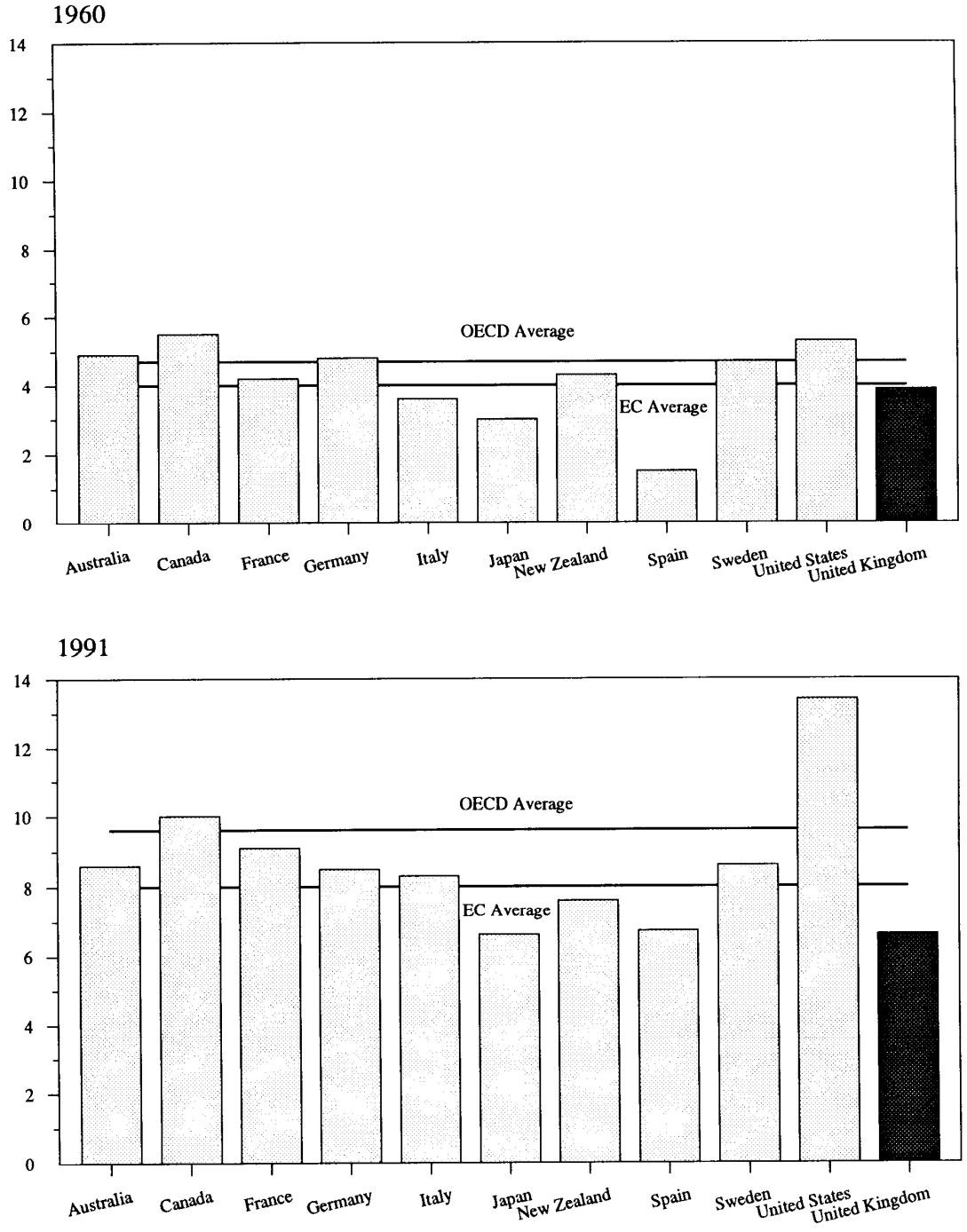
Total (public & private) health spending in selected OECD countries

% of GDP

	1960	1965	1970	1975	1980	1985	1990	1991
OECD Average	4.7	5.2	6.3	7.3	7.8	8.7	9.2	9.6
EC Average	4.0	4.5	5.3	6.7	7.2	7.5	7.8	8.0
Australia	4.9	5.1	5.7	7.5	7.3	7.7	8.2	8.6
Canada	5.5	6.0	7.1	7.2	7.4	8.5	9.5	10.0
France	4.2	5.2	5.8	7.0	7.6	8.5	8.8	9.1
Germany	4.8	5.1	5.9	8.1	8.4	8.7	8.3	8.5
Italy	3.6	4.3	5.2	6.1	6.9	7.0	8.1	8.3
Japan	3.0	4.5	4.6	5.6	6.6	6.6	6.6	6.6
New-Zealand	4.3	n/a	5.2	6.7	7.2	6.5	7.2	7.6
Spain	1.5	2.5	3.7	4.8	5.6	5.7	6.6	6.7
Sweden	4.7	5.6	7.2	7.9	9.4	8.8	8.6	8.6
United States	5.3	5.9	7.4	8.4	9.2	10.5	12.4	13.4
United Kingdom	3.9	4.1	4.5	5.5	5.8	6.0	6.2	6.6

Source: OECD Health Statistics 1993 Database

Spending on health as % of GDP



APPENDIX 2

Categories of Care Used in the Oregon Process and Examples of Condition Treatment Pairs

Category	Description
"Essential" services	
1. Acute fatal	Treatment prevents death with full recovery. *Example: Appendectomy for appendicitis.*
2. Maternity care	Maternity and most newborn care. *Example: Obstetrical care for pregnancy.*
3. Acute fatal	Treatment prevents death without full recovery. *Example: Medical therapy for acute bacterial meningitis.*
4. Preventive care for children	*Example: Immunizations.*
5. Chronic fatal	Treatment improves life span and quality of life. *Example: Medical therapy for asthma.*
6. Reproductive services	Excludes maternity/infertility services. *Example: Contraceptive management.*
7. Comfort care	Palliative therapy for conditions in which death is imminent. *Example: Hospice care.*
8. Preventive dental care	Adults and children. *Example: Cleaning and fluoride applications.*
9. Proven effective preventive care for adults	*Example: Mammograms.*
"Very important" services	
10. Acute nonfatal	Treatment causes return to previous health state. *Example: Medical therapy for vaginitis.*
11. Chronic nonfatal	One-time treatment improves quality of life. *Example: Hip replacement.*
12. Acute nonfatal	Treatment without return to previous health state. *Example: Arthroscopic repair of internal knee derangement.*
13. Chronic nonfatal	Repetitive treatment improves quality of life. *Example: Medical therapy for chronic sinusitis.*
Services that are "valuable to certain individuals"	
14. Acute nonfatal	Treatment expedites recovery of self-limiting conditions. *Example: Medical therapy for diaper rash.*
15. Infertility services	*Example: In-vitro fertilization.*
16. Less effective preventive care for adults	*Example: Screening of non-pregnant adults for diabetes.*
17. Fatal or nonfatal	Treatment causes minimal or no improvement in quality of life. *Example: Medical therapy for viral warts.*

SOURCE: Oregon Department of Human Resources, Office of Medical Assistance Programs, Salem, OR, *The Oregon Medicaid Demonstration Waiver Application*, submitted to the Health Care Financing Administration, Aug. 15, 1991.

Source: Evaluation of the Oregon Medicaid proposal. Congress of the United States Office of Technology Assessment. 1992

Examples of Ranking of Condition Treatment Pairs

Condition	Treatment	Category	Line Ranking
Appendicitis	Appendectomy	1	5
Low birth weight (500g and over)	Medical therapy	2	22
Asthma	Medical therapy	5	151
Imminent death	Comfort care	7	164
Cancer of uterus, treatable	Medical and surgical	5	186
Cataract	Extraction	11	337
Hernia without obstruction or gangrene	Repair	11	504
Spondyloses and other chronic disorders of the back (back pain)	Medical and surgical	13	586
Chronic cystitus	Medical therapy	13	590
Absence of breast after mastectomy	Breast reconstruction	11	600
Cancer with distant metastases, treatment results in less than 10% survival after 5 years	Medical and surgical	17	688
Uncomplicated haemorrhoids	Haemorrhoidectomy	17	698
Extremely low birth weight (under 500g) and under 23 weeks gestation	Life support	17	708
Note: The Oregon State legislature agreed to fund to line 587.			

Source: Office of Technology Assessment op cit

APPENDIX 3

Extracts from BMA commissioned survey Healthcare Priority Setting: A survey of doctors, managers and the general public. Chris Heginbotham March 1993

Q.4 If budgets do need to be set, who should make the decisions on which treatment takes a higher priority?

	General Public %	Doctors %	Managers %
Hospital consultants	61	68	57
GPs	49	68	71
Managers working for local health authorities	25	Question not asked	65
General Public	22	30	52
Hospital nurses	19	21	22
National managers working in the Department of Health	16	23	26
Current patients	9	8	9
National politicians	6	18	36
Local politicians	3	6	11
All of the above	3	18	21
Don't know	5	2	-

Q.5 If you had to choose between one of the other, which would you prioritise?						
	General Public Age					
	15-24	25-34	35-44	45-54	55-64	65+
Unweighted base	384	423	380	296	235	318
Weighted base	398	354	304	288	284	384
Treatment that saves people's lives but often means they are unable to lead a normal life	153 38%	124 35%	89 29%	96 33%	78 27%	79 20%
Treatment that greatly improves people's ability to lead a normal life but are not life threatening	202 51%	187 53%	170 56%	161 56%	160 56%	256 55%
Don't know	43 11%	43 11%	44 15%	31 11%	45 16%	50 13%

Q.6 If you were responsible for prioritising health services, how would you prioritise the things on the list below, in rank order 1 to 10?			
Rank	GENERAL PUBLIC	DOCTORS	MANAGERS
1	Childhood immunisation	Childhood immunisation	Childhood immunisation
2	Screening for breast cancer	Care offered by GPs	2 = care offered by GPs; Education to prevent young smoking
3	Care offered by GPs	3 = Support for carers of elderly people; Education to prevent young smoking	
4	Intensive care for premature babies		Support for carers of elderly people
5	Heart transplants	Hip replacement for elderly	Screening for breast cancer
6	Support for carers of elderly people	Treatment for schizophrenia	Hip replacement for elderly people
7	Hip replacement for elderly people	Screening for breast cancer	Treatment for schizophrenia
8	Education to prevent young smoking	Intensive care for premature babies	Intensive care for premature babies
9	Treatment for schizophrenia	9 = Heart transplant; Cancer treatment for smokers	Heart transplant
10	Cancer treatment for smokers		Cancer treatment for smokers
	Variance 1.97	Variance 4.3	Variance 3.8

Note: Variance for these purposes is defined as the ratio of the highest mean score to the lowest. Boxes indicate equal rank.