- 11 Bahra MS, Alexander AM, Lowen N. Changes in the purchase and prescribing of intravaginal imidazoles since the reclassification from POM to P. *Pharm J* 1994;253:R10.
- 12 Consumers' Association. Pharmacists: how reliable are they? *Which? Way to Health* 1991, December:191-4.
- 13 Rogers PJ, Fletcher G, Rees JE. Patient medication records in community pharmacy. *Pharm J* 1992;248:193-6.
- 14 Rogers PJ, Fletcher G, Rees JE. Clinical interventions by community pharmacists using patient medication records. *Int J Pharm Pract* 1994;3: 6-13.
- 15 Noyce PR. How high street chemists could cut NHS costs. *Parliamentary Brief* 1995;3(5):85-6.
- 16 Heath I. The creeping privatisation of NHS prescribing. *BMJ* 1994;309: 623-4.
- 17 Head S. Privatisation of NHS prescribing. *BMJ* 1994;309:957.
- 18 Blenkinsopp A, Jepson MH, Drury M. Using a notification card to improve communication between community pharmacists and general medical practitioners. *Br J Gen Pract* 1991;41:116-8.
- 19 Termin P. Costs and benefits in switching drugs from Rx to OTC. *J Health Econ* 1983;2:187-205.

For Debate

Setting priorities: can Britain learn from Sweden?

Martin McKee, Josep Figueras

The Swedish government recently published a report on priorities in health care. It was written by a cross party group of politicians and drew extensively on the views of the public, health professionals, experience of earlier local exercises in priority setting, and research based evidence. It laid down an ethical framework for approaching issues of health care rationing. Underpinning the framework are the principles of human dignity, need and solidarity, and cost efficiency. The Swedish approach thus contrasts with the British experience of many local initiatives but an absence of national political guidance. The absence of political consensus on many aspects of social policy in the United Kingdom is a major obstacle to developing an agreed ethical framework within which decision makers in the National Health Service can work.

Throughout the industrialised world there is concern about the apparent mismatch between demand for health care and the resources that governments are prepared to commit to meet it. The reasons are complex, the effects vary between nations, and most of the reasons are poorly understood, although they include the effects of aging populations, the introduction of new technology, and rising public expectations. The responses by countries have also varied widely, depending on factors such as the relative power of governments, the medical profession, insurance companies, and national pharmaceutical industries.

Five possible approaches to the mismatch between demands and resources exist: increasing resources either from government revenues or from individuals; controlling either demand (through cost sharing) or supply of services; withdrawing funding from services that are ineffective or where there is a cheaper alternative; increasing the efficiency of service provision; or creating a mechanism explicitly to identify health care priorities.¹ With the possible exception of controls on supply, using capital and manpower ceilings or global budgets, as in the United Kingdom and Germany, there is little evidence that the first four have been successful in controlling the apparently inexorable rise in health care expenditure. Some, however, such as reducing ineffective care, have been difficult to implement. Consequently, there is growing interest in the fifth—explicitly trying to define what types of health care might no longer be provided from public resources. In the United Kingdom this approach has been variously described as rationing or priority setting, the choice of term partially reflecting the speaker's political perspective, with the government favouring the latter but many other commentators the former.²

The British experience

The introduction of the purchaser-provider split has stimulated many exercises in explicit priority setting in the United Kingdom.³ Each has included, to varying degrees, the views of health professionals, the public, and research based evidence. In contrast to most other countries, however, the British experience is characterised by the extent to which these attempts have been undertaken locally, by health authorities. Elsewhere such exercises have been conducted nationally⁴⁻⁶ or, in the USA, at state level.⁷ Indeed, the reluctance of the government to become engaged in a national debate on priority setting and, in particular, the ethical issues that underpin it, has been striking.

A speech by the former Secretary of State for Health that set out the government's views on this issue was noteworthy for the absence of any attempt to provide ethical principles to guide these many decision makers, or even to recognise that such principles might be needed.⁸ Furthermore, the Health of the Nation

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Sweden has managed to produce an ethical framework for making hard decisions about health care provision because there is broad political support for the exercise

strategy, which sets out the government's priorities for health, as opposed to health services, ignored several ethical issues such as the widely held view that socioeconomic differentials in health should be addressed. This refusal to become involved in a national debate has been maintained despite many calls to do so.

This approach is consistent with government policy throughout the public sector, which argues that those at local level are provided with resources to achieve their objectives and they must then choose how best to do so. The advocates of this policy see it as a means of empowering those with most knowledge of local circumstances. Its critics complain that the resources are inadequate to respond to the increasing amount of central, and often very detailed, direction and the consequences of changes in other government policies.

An alternative approach

A recent report from Sweden offers an alternative approach.⁹ The Swedish health service has many similarities with that in the UK. Some counties have introduced a purchaser-provider split, and since 1994 Sweden has spent about the same percentage of its gross domestic product on health. It too has had a series of local priority setting initiatives.¹⁰ The new report provides a comprehensive agreed national statement on priorities.

The Swedish Priorities Commission was established by the government to consider the responsibilities, demarcation, and role of health care services in the welfare state, to highlight the fundamental ethical principles which can furnish guidance and form a basis for open discussions, and recommend guidelines for priority setting in health services. The commission comprised representatives of the five leading political parties, with none in a majority, and of central and local government. It worked in two stages. The first, from June 1992 to November 1993, involved administering questionnaires and consulting experts and other authorities. It also drew on examples of priority setting in other countries. The second phase began with the publication of a discussion document, which was circulated widely in November 1993¹¹ and was followed by a series of regional meetings, attitude surveys, and responses from interested parties.

ATTITUDE SURVEYS

There were four attitude surveys directed at each of the key interest groups. They included a nationwide random survey of 1500 people aged 18-84 years, which achieved a 78% response rate. This asked about the relative value to be placed on different forms of care and care for different age groups. A second questionnaire was designed to examine the attitudes of health professionals and was sent to 300 doctors and nurses. A third examined ethical values and concepts of justice among a sample of 168 politicians, 144 administrators, and 259 doctors. Finally, a study of the impact of changes in health service management was sent to 671 doctors and nurses in Stockholm. Subsequently the information collected and the views expressed on it were used to assemble a final report.⁹

ETHICAL FRAMEWORKS

The report describes several examples of attempts to set priorities at national or state level such as those in Oregon, Norway, New Zealand, and the Netherlands. It finds each wanting in important aspects, usually their superficial exploration of ethical issues or their tendency to gloss over methodological problems in measuring efficiency. Specification of the ethical context is seen as crucial as there are many possible ethical frameworks within which it is possible to set

priorities. A full discussion is beyond the scope of this article, but they include, for example: desert, in which judgments are made about who deserves what depending on their contribution to society or the extent to which they are seen as responsible for their illness; utilitarianism, or the greatest good for the greatest number; and need, in which individuals are offered treatment on the basis of their ability to benefit, however defined.

On the basis of the consultation process described above, the commission established three ethical principles to underpin its work. These were, in order of importance: human dignity, need and solidarity, and cost efficiency. The human dignity principle is that all people have equal dignity and the same rights regardless of their personal characteristics and their function in the community, thus explicitly rejecting theories based on desert. The need and solidarity principle encompasses both the requirement to direct resources to those whose needs are greatest but also to pay special attention to those who are less able to voice their needs or exercise their rights. The cost efficiency principle is that there should be a "reasonable relation" between cost and effect, but it also notes that comparisons of interventions are possible only for the same diseases, thus rejecting some of the more ambitious utilitarian approaches such as those based on QALYs (quality adjusted life years). They also rejected or subordinated several other principles including ability to benefit, lottery, demand, and autonomy.

PRIORITY GROUPS

Arising from these principles, the report identifies client groups who should be accorded priority. Such priority is based largely on the seriousness of their illnesses. Although there was a widely held view among the public that, other things being equal, resources should go to the young rather than the old, the commission rejected any link with chronological age but accepted that the consequences of the aging process may be relevant. They also rejected some forms of prioritisation, such as those based on factors related to premature underweight babies, on whether injuries were self inflicted, on economic capacity, and on social position and they argued that long term care should be protected from spending cuts.

These decisions thus imply, at least, an entitlement to medical assessment by those who suspect they may need care. The priority placed on them subsequently will depend on the nature of their condition. To facilitate discussion, nine categories of health care were generated (see box), as well as preventive interventions, considered separately.

CLINICAL AND ADMINISTRATIVE PRIORITIES

The commission explicitly recognised that the priorities of those responsible for planning and purchasing care may differ from those required to deliver it. It thus distinguished political or administrative prioritisation from clinical prioritisation. The former is population oriented, anonymous, and often planned

Categories of health care

- (1) Care of life threatening diseases
- (2) Care of severe chronic diseases
- (3) Palliative terminal care
- (4) Care of persons with reduced autonomy
- (5) Habilitation/rehabilitation and provision of artificial aids
- (6) Care of minor acute and chronic diseases
- (7) Borderline cases
- (8) Care for reasons other than disease or injury
- (9) Care with no documented benefit
- (10) Prevention

in advance. The latter is personal and often must reflect rapidly changing circumstances. This distinction led the commission to generate a series of priorities (see boxes). In practice the two sets are almost the same, but in the case of clinical priorities life threatening illnesses have been separated from chronic diseases as they override all other priorities in terms of the need for speed of action.

Political or administrative priorities in Sweden

- (1) Treatment of life threatening acute diseases and diseases which, if left untreated, will lead to permanent disability or premature death. Treatment of severe chronic disease. Palliative terminal care. Care of people with reduced autonomy.
- (2) Prevention with a documented benefit. Habilitation/rehabilitation etc, as defined in the Health and Medical Services Act.
- (3) Treatment of less severe acute and chronic diseases.
- (4) Borderline cases.
- (5) Care for reasons other than disease or injury.

The commission identified a series of borderline conditions where it questioned the justification for funding, arising from continuing uncertainty about what was appropriate. This uncertainty reflected widely differing views put before the commission by various interest groups and included interventions for infertility (which it was felt were often, on balance, justified), and hormonal treatment for shortness of stature in the absence of an identifiable cause and psychotherapy where evidence of psychiatric illness is doubtful (both of which were felt to be rarely justified). Finally, it recommended that care for reasons other than disease or injury should not be communally funded.

IMPLEMENTATION

On implementation, the commission explicitly avoids prescribing specific approaches such as guidelines or financial incentives. This derives from a consideration, informed by the surveys and other evidence, of the health care framework within which its recommendations will be set, including issues of ownership and the role of markets. Instead, it notes that successful implementation will depend on developing sufficient insight, determination, and ability at an administrative level and knowledge, leadership, and interest among clinicians. As noted in the title of the initial Swedish report, there are no easy solutions.¹¹ The commission does, however, support the creation of advisory committees on prioritisation, with both lay and professional members, and has proposed a series of legislative changes to enshrine its proposed ethical basis in law.

Differences between Swedish and British approaches

The differences between the British and Swedish experiences are striking. The most obvious is that a document exists in Sweden whereas there is no equivalent in the United Kingdom. The Swedes have concentrated on tackling underlying principles, such as what general categories of ill health should receive greater priority and how priorities should be weighted. The commission advocated that higher priorities should receive more resources than lower ones. It thus rejected other approaches such as only funding care for patients with priority 2 conditions once all priority 1

need has been met, or funding the first three priorities equally with nothing for categories four and five. This recognises the impossibility of developing and implementing detailed explicit and rigid guidelines¹²

In contrast, many British attempts have focused on methodological challenges such as the design of questionnaires and development of sampling frames to ascertain the views of the public.¹³ Discussion of more fundamental issues, such as the relationship between the individual and the state and the ethical principles that should guide our thinking on it, have, with a few exceptions,¹⁴ been almost completely lacking from the British debate.

What can we learn?

So what can Britain learn from the Swedes? They have clearly succeeded in stimulating a nationwide debate on priorities in health care, bringing together the views of all the key actors—the public, whose views were ascertained through surveys and public meetings; experts; health professionals; and political parties. The careful attention to detail has enabled them to identify the limitations of many of the technological fixes that have frequently been proposed, by, for example, saying explicitly that the benefits of health care “cannot possibly be stated in economic terms.” This is consistent with both the theoretical arguments against expecting cost utility analysis to provide easy solutions¹⁵ and the observation by Klein in evidence to the House of Commons health committee that such measures are not being used in practice.¹⁶ This approach has also enabled them to tackle difficult issues such as how health care should be financed and organised and whether providers should be private or public. Of course, it is still too early to judge the success of their project, which will depend on the ability to implement it. At least it has provided a clear framework within which to move forward.

The next steps involve collating the responses from the many organisations to which the report has been distributed. Their comments were due by mid October 1995, following which a draft bill will be presented to parliament in early 1996. The commission’s report is, however, already having an impact on debate about health care at local and national levels.

QUESTIONS FOR BRITAIN

The questions for Britain are twofold. The first is whether this approach could be adopted here. The second is that if it cannot be, why not? In answer to the first question, there are many voices calling for national ethical guidance in the United Kingdom. The Commons health committee has called for “an honest and realistic set of explicit, well understood, ethical principles at national level to guide the NHS into the next century,” suggesting that such principles should build on those implied by various government documents: equity, public choice, and effective use of health

Clinical priorities in Sweden

- (1A) Treatment of life threatening acute diseases. Treatment of diseases which, if left untreated, will lead to permanent disability or premature death.
- (1B) Treatment of severe chronic diseases. Palliative terminal care. Care of people with reduced autonomy.
- (2) Individualised prevention during contacts with medical services. Habilitation/rehabilitation etc as defined in the Health and Medical Services Act.
- (3) Treatment of less severe acute and chronic diseases.
- (4) Borderline cases.
- (5) Care for reasons other than disease or injury.

Britain's health authorities have to make rationing decisions without the benefit of a national ethical framework

service resources.¹⁶ Interestingly, these are similar to those adopted by the Swedish commission. Unfortunately the Commons committee did not indicate how such principles might be arrived at, except to imply that they might be produced by the government.

The British Medical Association has sought to stimulate debate through a national conference and subsequent publication of the proceedings.¹⁷ The need for a national view has also been expressed by the Royal College of Physicians, which has advocated the establishment of a national council on health care priorities,¹⁸ although it gave more weight than the Swedes to expert rather than lay membership and to professional and technical rather than ethical issues. And any fears that national ethical guidance would conflict with local decision making do not seem to be borne out by the calls for guidance made by many officers of health authorities.¹⁶

Despite these calls for national guidance, the government has consistently rejected the idea of an authoritative national commission, thus effectively blocking it. So if this is not possible in the United Kingdom, why not?

NEED FOR CONSENSUS

Perhaps the key issue, addressed explicitly by the Swedes, is the need for consensus. It is necessary, although not sufficient, that an ethical framework within which hard decisions will be made should command broad political support. Could this be achieved in the United Kingdom? In the current political context in the United Kingdom it is difficult to see how cross party agreement might emerge on anything as potentially contentious as this, given the divisions on most areas of social policy. Indeed, as noted above, it is not even possible to agree on whether to call this process rationing or priority setting.

The Swedish example would require a committee that includes all the main political parties as well as representatives of local government, with no party having a majority, something quite different from a parliamentary committee. Recent experience of cross party committees tackling difficult issues, such as members' financial interests, does not give cause for hope. In the more consensual politics before 1979 such an issue might have been tackled by a royal commission. These bodies lost favour with the present government in the 1980s,¹⁹ although the Labour Party has stated

that it will convene one to look at the related topic of long term care.²⁰ Even so, an appointed body composed of "the great and the good" does not have the democratic mandate necessary to yield legitimacy. Despite these difficulties, however, it is striking that the Swedish commission was working during a period, for Sweden, of unprecedented political polarisation and conflict, although this was still much less than in the United Kingdom in recent years.

Priority setting is an ethical issue

So a national priority setting commission seems unlikely to be established in the United Kingdom in the foreseeable future. This presents a major problem. If the adversarial and highly polarised nature of British politics makes it so difficult for politicians to offer guidance in priority setting, is it really fair of them to require health authorities and fundholders, both with even less democratic accountability, to do it for them? Moreover, while recognising the need to reflect local circumstances, it is far from clear that the emerging diversity in entitlement to treatment both between fundholders and health authorities and between different health authorities¹⁶ is consistent with the views of the public.

It may not be possible to produce an ethical framework to underpin priority setting that reflects all the major ideological strands in British politics. But if this is indeed so then this must be explicitly recognised. We can then begin to address the reasons why. For now, the Swedish experience provides a reminder that setting priorities is fundamentally an ethical issue, requiring those involved at least to acquaint themselves with the differing theories of social justice and indicate where they stand in relation to them.

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- 1 Abel-Smith B, Mossialos E, Figueras J, McKee M, Holland W. *Choices in health policy: an agenda for the European Union*. Dartmouth Press, Aldershot, 1995.
- 2 Smith R. Introduction. In: Smith R, ed. *Rationing in action*. London: BMJ Publishing, 1993: vii-x.
- 3 Ham C. Priority setting in the NHS: Reports from six districts. In: Smith R, ed. *Rationing in action*. London: BMJ Publishing, 1993: 59-71.
- 4 The Royal Ministry of Health and Social Welfare, Norway. *Retningslinjer for prioritering innen Norsk helsevesen*. Oslo: NOU, 1987:23.
- 5 *Choices in health care: A report by the Government Committee on Choices in Health Care*. Rijswijk, the Netherlands: Ministry of Health, Welfare and Cultural Affairs, 1992 (A J Dunning, chairman).
- 6 National Advisory Committee. *Core services 1993/4*. Wellington: NAC, 1992.
- 7 Klein R. On the Oregon trail: rationing health care. *BMJ* 1991;302:1-2.
- 8 Bottomley V. Priority setting in the NHS. In: Smith R, ed. *Rationing in action*. London: BMJ Publishing, 1993:25-32.
- 9 Swedish Parliamentary Priorities Commission. *Priorities in health care: Ethics, economy, implementation*. Stockholm: Ministry of Health and Social Affairs, 1995:5.
- 10 Honigsbaum F, Calltorp J, Ham C, Holmström S. *Priority setting processes for healthcare*. Oxford: Radcliffe, 1995.
- 11 Ministry of Health and Social Affairs. Health Care and Medical Priorities Commission. *No easy choices—the difficult priorities of health care*. Stockholm: Ministry of Health and Social Affairs, 1993:93.
- 12 McKee M, Clarke A. Guidelines, enthusiasms, uncertainty, and the limits to purchasing. *BMJ* 1995;310:101-4.
- 13 Bowling A, Jacobson B, Southgate L. Health service priorities: explorations in consultation of the public and health professionals on priority setting in an inner London health district. *Soc Sci Med* 1993;37:851-7.
- 14 Chadwick R. Justice in priority setting. In: Smith R, ed. *Rationing in action*. London: BMJ Publishing, 1993:85-95.
- 15 Carr-Hill R. Allocating resources to health care: is the QALY (quality adjusted life year) a technical solution to a political problem? *Int J Health Serv* 1991;21:351-63.
- 16 House of Commons Health Committee. *Priority setting in the NHS: Purchasing. First Report Session 1994-95*. London: HMSO, 1995 (HC 134-I).
- 17 Smith R, ed. *Rationing in action*. London: BMJ Publishing, 1993.
- 18 Royal College of Physicians. Setting priorities in the NHS: a framework for decision making. *J Coll Physicians Lond* 1995;29:379-80.
- 19 Jenkins S. *Accountable to none: the Tory nationalisation of Britain*. Harmondsworth: Hamish Hamilton, 1995.
- 20 Labour Party. *Renewing the NHS. Labour's agenda for a healthier Britain*. London: The Labour Party, 1995.

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