Systems and Organisations

Oregon and the UK: experiments in resource allocation

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Why this matters to me

Issues of rationing and cost control are particularly salient now, as we enter a very financially constrained health economy. As a GP in a diverse part of a diverse city, I am concerned that healthcare spending is, and is seen to be, equitable. When one

looks around the world to see how others do it, it is remarkable how similar the issues are. I am attracted by the notion of democratic input to healthcare allocation decision making and the experience of the state of Oregon informs that thinking.

ABSTRACT

Decisions about how to spend money allocated to healthcare are complicated and merit a fully reasoned approach. Sources of moral justification for such decisions are examined and the innovative system engineered in the US state of Oregon described. Contrasts are drawn with the UK model

and the conclusion is drawn that some public influence on such decisions is useful and should be explored.

Keywords: healthcare rationing, Oregon experiment

Introduction

Other than language, there may not be too many obvious similarities between the US state of Oregon and our European island. However, both jurisdictions share, by world standards, advanced medical systems and a democratic style of government. These two qualities are conjoined in an interesting way in Oregonian healthcare, a way which may have echoes for us in London.

Both jurisdictions also share the need to allocate relatively scarce healthcare resources to populations where need, or at least want, outstrips the ability to pay for it. This ineluctable fact transcends the very different healthcare systems between Oregon and the UK: where we in the UK have essentially socialised and equitable healthcare provision (with some exceptions), Americans split their system between those insured by work, or another, those covered by a publically funded *Medicaid* (or *Medicare*) arrangement, and those without insurance. As a state, Oregon pioneered an effort to extend coverage for universal access to healthcare in a manner not done before in the

US. Oregon's experiment in how to set priorities within the provision of universal healthcare may be instructive.

What Oregonians have further done is introduce a formally democratic impulse into the rationing decisions that need to be made, and that is something we might well take account of, as GPs stand at the advent of another wave of commissioning from the 2010 change of government. As the largest and most diverse conurbation in the UK, London cannot stand in isolation from these influences.

The Oregon experience

It is telling that a single Oregonian patient brought about the profound changes that eventually ensued in 1989 with the passage of Oregon's Basic Health Services Act. GPs in the UK, who are more numerous and

more comprehensively provided for than their US colleagues, will understand such a driver well. The single patient sometimes does bring about a change in healthcare provision in the UK, via the agency of common law.¹

In any event, a seven-year-old Oregon boy with leukaemia failed to get a stem-cell transplant on public funds, and the subsequent political and personal events led to a desire on the part of the state legislature (led by an emergency physician) to rationalise entitlements under law. The Act required all those in employment to be covered for health insurance by their employers, and extended Medicaid (for the poor) cover from 42% to 100%. The price of this universal coverage was an explicit, democratically led, system of healthcare rationing. Around 700 medical conditions were paired with treatments, and a state Health Services Commission decided on priority setting between them. In doing so, they used a measure of cost utility analysis, but also input from community meetings and 'citizen's juries' to aid their deliberations.²

Oregon embraced at least two of the ethical approaches to distributive justice, in a way that had not been done before. It is significant that the process also took forward a notion of transparency to this area. By contrast, rationing in the UK has always been fairly implicit, decided by professionals in closed session if it was decided at all, and for the most part hanging on the patients position in a queue. Though there has been more transparency in the UK as part of the commissioning changes from 1991, this has generally been around the edges of the general provision of healthcare. Before tackling in detail the lessons for the UK, a diversion into the ethics of resource allocation is perhaps apposite. For those familiar with the Four Principles of Medical Ethics, the next section analyses the criteria that might underlie the principle of justice.³

Ethics and rationing

If our healthcare resources are to be regarded communally, then group interests would seem to overwhelm individuals' interests.⁴ Thus we are entitled to make decisions about the allocation of (inevitably) limited resources: the questions that then arise are to do with how that might be done. Or, rather, how resources can be allocated equitably. I assume that fairness and equity follows from the commonality of resources as stated, though this could be described as legitimacy, in a legal context.⁵ On what grounds can an equitable basis be engineered for healthcare resource

allocation? Ethical reasoning would suggest several approaches to this problem, summarised as follows, in achieving solutions with distributive justice.⁶

- **Age** We might favour the elderly as they have earned their healthcare by virtue of contributions to society and the state over many years; and have paid into common funds by means of taxation similarly. Thus the diseases of the older person are accorded a higher priority than others for remediation.⁷
- **Youth** We are all entitled to a reasonable expectation of life (say, 75 years) and once this is achieved, entitlements to continuing life are to be attenuated. This fair innings approach would favour children's care: neonatal intensive care, child health programmes and the like.⁸
- **Desert** Those who take risks with their health (by smoking or overusing alcohol for example) would lose entitlements to medical care as they have made freely autonomous decisions that undervalue their health. Thus they should take responsibility for their actions.⁹ This rather challenging way of looking at resource allocation has never been fully implemented, though it can operate in covert ways. Often the obese are denied access to certain treatments as they may be held to be more at risk of complications: this is, relatively speaking, a covert moral decision.
- **Utility** We might calculate as a cold economic process the value of individual treatments in terms of health gain, and allocate accordingly. The Quality Adjusted Life Year (QALY) is an example of this: here treatments are assessed in terms of years of life gained, mediated for quality. Thus health economists can calculate a financial cost in £/QALY for each treatment and rank accordingly. Expensive treatments of low empirical benefit will tend to be excluded. The language of utility is often expressed as clinical effectiveness or similar: essentially numerical indicators are derived to inform health policy decisions.
- **Public will** Let a democratic process inform our healthcare decisions: if the democratic route is good enough for 'macro' decisions as declared by political parties, then it might be good enough for 'micro' decisions about healthcare spend. On its face this method of allocation is unarguable, though inevitably leads to majority decision making, which may mitigate against minorities or the disadvantaged.

Though the above points represent a skeleton version at best of the possible ways of bringing about a just healthcare allocation, they contextualise the choice Oregon has made to tackle this issue.

Implications for the UK from Oregon

Despite the considerable systemic differences between the UK and USA, both countries share a need to, rationally and justly, allocate the scarce resources available for healthcare. I suggest there are several reasons why we could learn from the Oregon example.

Firstly, the context of patient preference and patient satisfaction is taking greater prominence as time goes on. In its barest form this has been described as a 'new consumerism' affecting healthcare choices. Collectivised preferences about healthcare spending could easily be conceptualised as a democratically driven, and thus ethically respectable, way of justifying choices. There is a leap of thinking between respecting patient choice or preference in their individual healthcare and respecting a style of collective choice in priority setting. Nonetheless, it seems to be consistent with political changes that empower local populations that make decisions about their education arrangements or other social policy. Already we have some UK healthcare providers established as 'social enterprises': in this arrangement managerial responsibility is shared between doctors and lay executives or non-executives, under lay chairs. Should commissioners be established the same way, then the voice of the non-professional is injected into the allocation process.

Secondly, the notion of transparency merits consideration. This issue conflates many others: if the previous UK system depended on implicit choices between patients and between diseases being made in closed rooms, then it was surely associated with a high degree of trust that the people who did so (usually doctors) were worthy of that trust in so doing. Whilst trust in UK GPs remains high, at a personal level, dilemmas of funding are increasing as individual patients are denied healthcare interventions. Trust may not survive an environment of financial constraint if GPs motives are unclear, and democratic input may help to assuage this.

Thirdly, as stated, GPs may be at the start of a new commissioning role and questions remain as to how this is going to work. Whilst the expectation is of further influence on funding from primary to secondary care, this may turn out to be a 'poisoned chalice' of bearing responsibility for unpopular priority setting. Of course it may offer real innovation in integrated care as well, potentially conferring the opportunity for GPs to augment their clinical role.

At the time of writing, speculation is centred on a GP-led total commissioning system, akin to the total purchasing experiments of the 1990s.¹⁰ It is fair to say that the last ten years of the NHS have seen a number of experiments in practice-based commissioning with

variable effect. Should GPs find themselves in the position of commissioning on some other basis, and the likelihood seems to be within a federated model, then the patient voice will be worth including despite its complexities. Transparency would be enhanced and the conflicts of interest that marred fundholding in the 1990s less evident. How, it might be asked, should this work? One easy option would be to enlarge and formalise the role of Patient Participation Groups whose work has enormously expanded in recent years. They are an accessible (though not as yet fully representative) way of democratising the patient's voice in any commissioning function that a GP federation might exercise. Other routes may lie in relationships with local councils or other elected bodies.

This account thus far has focused mainly on principles, and not described the immense technical difficulties faced by those who set up the Oregon Health Plan in 1989. One such is the understanding of complex issues surrounding health and disease by lay-citizens, comprehensively demonstrated elsewhere.¹¹

It was noted at the time that the thousands of possible diagnoses for consideration were reduced to 1600 'condition/treatment' pairs for choice (709 in the second iteration). Priority setting was based on pathologies rather than individuals, though certain groups of individuals (drug misusers, for example) tended to receive low priority. There were a number of legal challenges to decisions on behalf of disabled persons who considered themselves more disadvantaged than before.

It is also worth noting that one of the original aims for the people of Oregon: that coverage under Medicaid should be universal just does not apply in the UK. We already have universal coverage, available since the inception of the NHS in 1948. Nonetheless, both Oregon and the UK do not have enough healthcare resources to fund all treatments that might be offered and thus have to confront the same prioritisation problems.

As we have seen, the potential of democratically driven resource allocation may be to disadvantage minorities, but that does not lessen the moral force that collective influence on decision making brings about. In practical terms it only reinforces the need for seeking a wide opinion. The organisation of London's healthcare is in a state of flux, and in a way that is not always popular, to the extent that it can be assessed. For example, local campaigns often seek to maintain hospitals deemed unnecessary by strategic authorities. It might be said that formal input from the citizenry of London would reach a morally justifiable position on such decisions, based on the prioritisations involved, beyond that offered by representative democracy.

In cases like these, the most powerful argument of all seems to be this: resource allocation is intrinsically

about making difficult choices in a cost-constrained environment. As we in the UK take our healthcare from a centrally funded and essentially socialised system, delivered locally, then the influence of the people on the decision making must have greater force. Where healthcare is essentially a market, as in most of the US, being bought and sold in common with other commodities then the purchaser as patient has immense power and where it is not, as in most of the UK, then democratic influence on decision making makes up the deficit in control.

As things are now, the role of citizens input into healthcare decisions in Oregon is less than it was, but it remains an example of public involvement in a challenging social policy environment, and one from which we in the UK could learn, particularly as we enter an era of constrained expenditure.

CONFLICTS OF INTEREST

None.

REFERENCES

- 1 See: http://genome.wellcome.ac.uk/doc_WTD020987.html
- 2 Coast J. The Oregon plan: technical priority setting in the USA. In: Coast J, Donovan J and Frankel S (eds) *Priority Setting: the health care debate*. John Wiley, 1996.
- 3 Gillon R. Medical ethics: four principles plus attention to scope. *BMJ* 1994;309(194):194–202.
- 4 Tauber AI. A philosophical approach to rationing. *Medical Journal of Australia* 2003;178(9):454–6.
- 5 Syrett K. Nice work? Rationing, Review and the 'legitimacy problem' in the new NHS. *Medical Law Review* 2002;10(1):1–27.
- 6 Tyler C. Liberalism and communitarianism. In: Ashcroft RE, Dawson A, Draper H and McMillan JR (eds) *Principles of Health Care Ethics* (2e). John Wiley, 2007.
- 7 Boyd K. Age as a criterion for health care rationing. In: Dracopoulou S (ed) *Ethics and Values in Health Care Management*. Routledge, 1998.
- 8 Lindley MC *et al.* Financing the delivery of vaccines to children and adolescents: challenges to the current system. *Pediatrics* 2009;125:548–57.
- 9 Schwarz RL. Lifestyle, health status and distributive justice. In: Grubb A and Mehlman MJ (eds) *Justice and Health Care: comparative perspectives*. John Wiley, 1995.
- 10 Mays N, Goodwin N *et al.* What is total purchasing? *BMJ* 1997; 315:652–5.
- 11 Gold MR, Franks P *et al.* Does providing cost-effectiveness information change coverage priorities for citizens acting as social decision makers? *Health Policy* 2007;83(1):65–72.

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