Non-market Health Care Allocation

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Lecture 8: Non-market health care allocation

This lecture should enable you to:

- Understand different philosophical bases for (market vs non-market) resource allocation
- Explain how these relate to concepts of equity (and equality)
- Describe broad techniques available for non-market resource allocation

Revision

- (Perfectly) competitive markets provide the most *efficient* allocation of resources
  - Often markets fail and governments intervene, as we have seen in lectures 5, 6 and 7
- In health (care) governments often intervene for other reasons – principally equity/justice
  - Not market failure, but additional/alternative objective to (constraint on) efficiency
- Remember, having no 'market' does ***not*** remove central problem of allocation of scarce resources
  - Resource allocation = rationing = priority-setting = …

Revision

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  - …rce allocation = rationing = priority-setting = …

"The word 'rationing' is invoked to make the flesh creep, not to prompt argument about how to deal with the inescapable"

(Rudolph Klein, 1992)

Means of resource allocation

- Market system
  - price mechanism establishes equilibrium (efficient allocation)
- Non-market system
  - absence of price as allocative tool leads to other, *non-price*, techniques
  - requires means to 'plan' (how much of) what to produce and who will receive (how much of) it
- Issue is two-fold:
  1. philosophical basis for resource allocation
  2. applied technique for (non-market) resource allocation

1. 'Philosophical' basis for resource allocation

- Market (primary objective = efficiency)
  - Consumer (individual) sovereignty
  - Utility maximisation (utilitarian)
  - Allocation by price mechanism
- Non-market (primary objective = equity)
  - Citizen rights and responsibilities
  - Maximize(?) what: utility, health, access, ...
  - Allocation by whom according to what (need?)
- But remember…
  - market (price) is allocative system ***not*** philosophy and can be compatible with different ethical constructs
  - trade-off between max. health and equal distribution of health – *opportunity cost* of reducing inequalities

Clarity of terminology

- Philosophy, ethics, moral, justice, equity, equality, fairness, etc.....
- Ethics is a branch of philosophy concerned with (moral) *choices* and the (personal and social) values that lie behind them
  - Rights and responsibilities
  - Freedom and duty
  - Individual versus collective (society)
- Justice is concerned with fairness ('equity of...')
  - Procedural justice (unconcerned with outcome/result)
  - Distributive justice (concerned with outcome/result)
- Equity defined with respect to equality of ...
  - Income, utility, opportunities, health care, health?

Classifying ethical theories

	Individual	Society
Process	Entitlement Deontological Virtue	
Outcome		Utilitarianism Rawlsian Egalitarian

- Different principles can apply and co-exist at different levels of decision

Utilitarianism

- Jeremy Bentham/John Stuart Mill
  - "Actions are right in proportion as they tend to promote happiness, wrong as they tend to produce the reverse of happiness. By happiness is intended pleasures, and the absence of pain; by unhappiness, pain, and the privation of pleasure"
  - Pleasure/pain measurable (utility) and comparable
  - Find distribution that gives greatest total happiness
- Underlies 'efficiency'
  - Maximise greatest 'utility' (health) for greatest number
- Issues
  - domain (whose utility) and malevolence (utility from suffering)

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"Man does not strive for happiness; only the English do that"
(Friedrich Nietzsche, 1888)

Rawlsian Maximin

- John Rawls, 1971 proposed social contract where allocation conducted under 'veil of ignorance'
- Optimal decision here is to choose to maximise the position (well-being) of the least well off
  - Prioritise the one who's got least health
- Inequalities are accepted as long as they are to the benefit of the worst off
- Issues
  - assumes total risk averseness
  - 'bottomless pit' argument – ignores opportunity cost

Egalitarianism

- Equal shares in the distribution of a good
  - General egalitarianism (income, utility, well-being)
  - Specific egalitarianism (primary goods, health)
- 'Differences between' over-ride 'levels of'
  - A distribution of life expectancy between three groups at 60, 60, 60 is better than 65, 75, 85 even though *everyone* is better off under the latter distribution
- Issues
  - Equality of what? health, services, access?
  - According to what criteria? age, 'need'?

Equality of what?

- Equal ‘chance’ of treatment - lottery
- Equal expenditure per capita - geography
- Equal resources per capita - geography
- Equal expenditure/resources for equal ‘need’
- Equal access (opportunity to use) for equal need e.g equal waiting time per ‘condition’
- Equal utilisation (use) for equal need e.g. equal length of stay per ‘condition’ (enforcement?)
- Equal treatment for equal need
- Equal ‘health’ (life expectancy, QALYs, dead?)

Equity and 'need'

- 'Need' = ambiguous and confusing
  - Who determines need
    - Producer (SID?), individual, 'elite'?
  - Need is often supply driven - what is available determines what is needed
  - Need versus 'capacity to benefit'
    - treat worse off even if health improvement less than treating better off
  - Need versus 'preference'
    - 'objective' versus 'subjective' need

Vertical vs horizontal equity

- Horizontal: the like treatment of like individuals
  - Extent to which individuals with the same need for health care have the same use of health care
  - Applies especially to delivery of health care (equal resources, utilisation, access for equal 'need')
  - Based on 'egalitarian' ethic, but compatible with others
- Vertical: unlike treatment of unlike individuals
  - Extent to which individuals with different needs for care have appropriately different levels of use of care
  - Applies especially to finance (inequality in contribution where rich contribute more to cost of health care)

Coming to a consensus?

- No universal agreed ethic for equity objectives of health care sector, but consensus seems to be…
- Horizontal equity = equality of access/opportunity
  - consistent with most ethical theories
  - consistent with efficiency
    - preserves consumer sovereignty (choice)
    - does not imply coercion (eg diet)
- Vertical equity = progressive payment by income
  - consistent with most ethical theories
  - inconsistent with efficiency
    - 'price' (tax) differentiation across 'markets' (income groups)
    - taxation removes consumer sovereignty (causes market failure)

2. Applied technique for (non-market) resource allocation

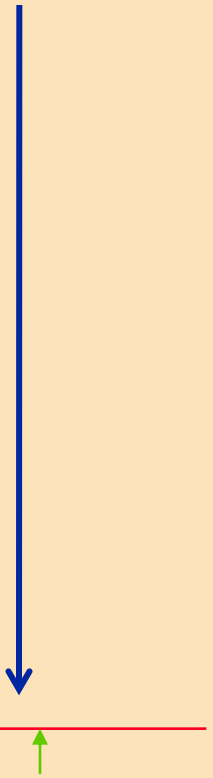
- Implicit techniques
  - HC is limited, but neither the decisions, nor the bases for those decisions are clearly expressed
  - "… silent conspiracy between a dense, obscurating bureaucracy, intentionally avoiding written policy for allocation, and a publicly unaccountable medical profession privately managing allocation to conceal life and death decisions" (Crawshaw, 1990)
- Explicit techniques
  - HC is limited and the decisions are clear, as is the reasoning behind those decisions
  - Technical methods versus political processes

Explicit allocation: technical methods

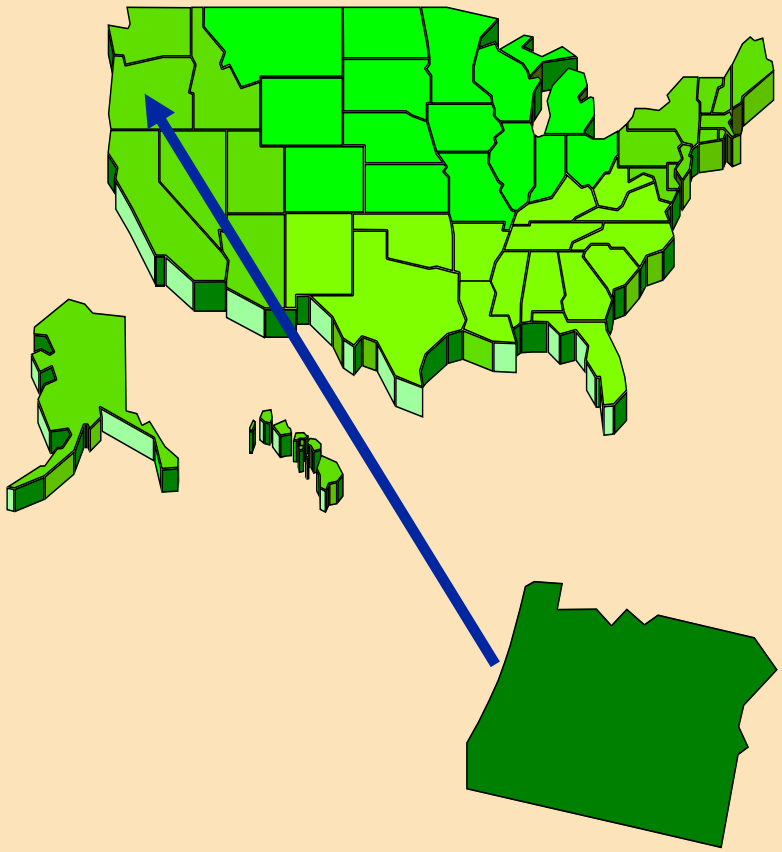
- Single principle, such as
  - maximising health gain, subject to:
    - need-based
    - age-based
- Little distinction between different levels
  - National, regional, local...
- Often use of some form of economic evaluation (see lecture 9 for detail)
  - 'league tables'
    - Oregon 'experiment'

‘League tables’

	Cost per QALY gained (£)
GP advice to give up smoking	500
Pacemaker implant	1,500
Hip replacement	2,000
Colorectal cancer screening	2,500
Breast cancer screening	3,500
Sildenafil (Viagra)	4,000
Heart transplantation	10,000
Hospital haemodialysis	25,000
Surgery for intra-cranial tumours	150,000
Interferon for multiple sclerosis	800,000



The Oregon 'experiment'



- 1987 - decision to stop Medicaid funding for organ transplantation
- 1989 - Oregon Health Services Commission begins work
- 1990 - List version 1
- 1991 - List version 2
- 1994 - plan begins

Oregon List Version 1

- Efficiency principle
- 1600 condition/treatment pairs
- Cost/QALY gained
  - Teeth capping>appendectomy
- Harvey Klevit, member, Oregon Health Services Commission
  - "... looked at the first two pages of that list and threw it in the trash can"
  - "... the presence of numerous flaws, aberrations and errors"

Oregon List Version 2

- Principle not explicit – appears to be equity principle of 'equal treatment for equal need'
  - need defined as ability to benefit & those with greatest need given priority ("rule of rescue")
  - achieve breadth of coverage, rather than depth
- 709 condition/treatment (C/T) pairs
- Method:
  - Development & ranking of categories
  - Ranking C/T pairs within categories
    - Public preferences
    - Outcome
  - 'Professional judgement'

Oregon List Version 2

Top Five C/T pairs

1 Pneumonia - medical

2 Tuberculosis - medical

3 Peritonitis - medical/surgical

4 Foreign body - removal

5 Appendicitis - surgical

Bottom Five C/T pairs

705 Aplastic anaemia - medical

706 Prolapsed urethral mucosa - surgical

707 Central retinal artery occlusion - paracentesis of aqueous

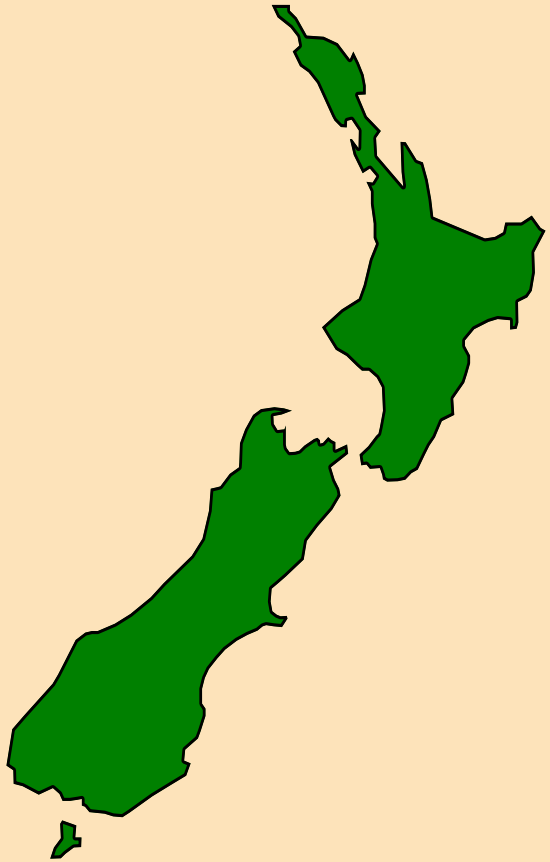
708 Extremely low birth weight, < 23 weeks - life support

709 Anencephaly - life support

Explicit allocation: political processes

- Debate and bargaining
  - "multiplicity of objectives"
- Participation in the debate:
  - Who should be involved?
  - What methods to obtain representative views?
  - How should information be presented?
  - How should public views be used?
  - What weight should public views be given?

Example: New Zealand's Core Services



- 1991 - Consultation Document
- 1992 - National Advisory Committee on Core Health and Disability Support Services
- 1992-3 - Public meetings about broad priority areas
- 1993 - Consultation over broad ethical framework
- 1994 - Panel discussions to formulate guidelines incorporating social factors

Example: New Zealand's Core Services

- Core Services committee
  - Identified broad priority areas (including mental health & children's health)
  - Developed ethical criteria
    - provides benefit
    - is value for money
    - is a fair use of public money
    - is consistent with communities' values
  - Developed guidelines - starting with cataract & CABG
- Public consultation at all of these different steps

Success of Core Services

- Incrementalism
  - but how much has actually changed?
- Public consultation
  - emphasis on "hearing many voices"
  - have public *actually* influenced priorities?
  - how have methodological problems been dealt with?
  - concern with "overconsultation"

Explicit allocation: advantages and disadvantages

- Technical methods
  - Advantages
    - (implied) neutrality and clarity of objectives
  - Disadvantages
    - data hungry, inherent value judgements, weaknesses in methods, rigidity, implementation (political) problems
- Political processes
  - Advantages
    - suited to uncertain and complex situations, decisions based upon compromise
  - Disadvantages
    - heavily dependent on which groups are included, slip back to implicit allocation

The problem with explicit allocation techniques

- Potential impact upon the stability of HC system (David Mechanic)
  - Lack of acceptance of explicit methods (see below)
  - Challenges to health authorities and techniques
  - Weakening resolve of health authorities
  - Return to implicit rationing
- Potential for disutility from explicit techniques
  - Deprivation disutility
    - patients who are aware that care is available but they are not eligible to receive it may suffer a sense of grievance
  - Denial disutility
    - citizens may suffer disutility from being asked to partake in the process of denying care to other members of society
- Consider current climate around NICE in UK?

A final word…

- Remember: all markets 'fail' to be perfect and adaptations are made to correct for these
- Equity is not a market 'failure', but a constraint or additional/alternative objective
  - Equity important objective in most HC systems, but what is meant by equity varies (social construct)
    - Horizontal and vertical equity distinction
    - Equity in finance (progressive tax) and delivery (access)
- But: desire for equity does not ***necessarily*** imply the need for a non-market allocation technique
  - Governments fail, and could revert to implicit systems
  - Could redistribute wealth 'at source'
  - Could adapt market system

The final word...

- "Economics is 'the science of means, not of ends'... It can tell us the consequences of various alternatives, but it cannot make those choices for us. These limitations will be with us always, for economics can never replace morals or ethics." (Victor Fuchs, 1998)