

On the Oregon trail: rationing health care

More politics than science

The introduction of the purchaser-provider principle into the NHS will have at least one uncomfortable consequence perhaps not fully expected by its authors. It will direct public attention even more to decisions about the level and distribution of resources, both nationally and locally. In the past decisions about who should (and should not) get what medical treatment have been perceived, and accepted, as matters of clinical judgment—constrained but not shaped by national budgetary policies. In future as health authorities move towards buying packages of health care through contracts, so they will increasingly have to make explicit decisions about what they want (and do not want) to buy on behalf of their populations. Political and managerial resource rationing priorities will therefore be visible instead of being largely hidden under the cloak of professional practices. Hence the interest in the Oregon experiment, seen as the first attempt to develop an explicit system of rationing health care.¹ What lessons can be drawn for the NHS from the experience of Oregon so far?

To answer this question, it is essential to explore first what the Oregon “experiment” is about. It has been widely perceived as an attempt to put medical services in some sort of objective order of priority by using the best available scientific methods. Accordingly, it has been either hailed as a pioneering attempt to show that resource allocation can be depoliticised or criticised as showing a naive faith in scientism. In fact, the most discussed and controversial aspect of the Oregon experiment—its ranking of different forms of medical intervention in order of priority—is perhaps its least interesting aspect. The method is now being changed, and a different list of priorities will eventually emerge. The real importance of what has been happening in Oregon lies in the problems that have driven the experiment and the political processes that are shaping its progress.

Most importantly, the Oregon experiment represents an attempt to deal with a specifically American problem: rationing by exclusion. It seeks to “change the debate from who is covered to what is covered” in the words of John Kitzhaber, a doctor who, as the president of Oregon’s senate, was the driving force behind the 1989 initiative.² In the past Oregon sought to contain health care costs by limiting eligibility for Medicaid—the programme of last resort for the poor—and by denying even those eligible access to certain expensive forms of treatment, notably organ transplantation. The result is that only a third of Oregon’s population with incomes below the federal poverty level—some 400 000 people out of a population

of almost 3 million—are covered by Medicaid and that decisions about allocating funds within the Medicaid system for expensive treatments have had to be taken at public confrontations in front of television cameras. Both problems are exacerbated because Oregon has imposed on itself a balanced budget rule but has a very limited tax base, relying exclusively on local income tax for its revenue: a sense of fiscal crisis is thus endemic to the system.

The proposal for ordering medical services by priority represents the response to this crisis, as well as to the more general problems of American health care, and is an attempt to devise a financially acceptable form of universal coverage. The strategy is to define what constitutes a basic package of health care, which can then be used as the benchmark of minimum entitlements either in publicly financed programmes like Medicaid or in mandatory requirements for private insurance by employers. There are therefore powerful political incentives that make such an approach attractive in Oregon; limiting entitlements may make it possible to extend eligibility or coverage. The first step in the process is to show the nature of the trade off: to work out how far entitlements to specific forms of treatment for the existing Medicaid population would have to be cut to create the resources to cover those who now have no insurance. This is, of course, the reason for the whole exercise in ranking priorities: to see where the axe would fall. If that were all there were to the Oregon experiment it would simply mean redistributing resources among the poor; it would be a rather shabby expedient. But the expectation of its sponsors is that the exercise will produce such unacceptable results—in the sense of disclosing the denial of treatment—that the Oregon legislature will come up with more money; that what started primarily as an exercise in rationing will unlock extra resources and become a national model for expanding access to health care.

But if that is to happen Oregon would first have to show that it is indeed possible to define a universally acceptable minimum benefit package. So the argument returns to the priority making exercise—basically a fairly mechanical ranking exercise which took some 2000 conditions and calculated the cost-benefit ratio for each of them. The formula for calculating the benefits was a variant on the quality adjusted life years (QALY) approach—that is, duration of beneficial outcomes weighted by the quality of life (with the values for the weighting exercise being derived from a telephone survey of local citizens). The result produced some bizarre results—

for example, cosmetic breast surgery was ranked higher than treatment for an open thigh fracture—and sent the commission charged with carrying out the exercise back to the drawing board. The commission's revised strategy is to make its approach technically more sophisticated—for instance, by seeking better information about outcomes—and also to add new dimensions. In particular, it is trying to use the results of public consultations to generate social priorities for general categories of medical intervention rather than for individual conditions: to elicit the weighting given by citizens to preventive rather than curative treatment, for example.

It will be some months before the commission produces its results, and some time after that before Oregon decides what to do about the commission's recommendations. Even the more complex, multidimensional approach now being pursued has its difficulties. Outcome measurement is not the cure all that is sometimes assumed.³ QALY type calculations are notoriously sensitive even to minor changes in the assumptions fed into them,⁴ quite apart from being open to the wider objection that they deal with the mythical average patient and do not allow for heterogeneity within conditions. Consultation exercises also raise the question of just how representative the public consulted is. In Oregon only 600 citizens turned up at meetings called to discuss priorities, and of these, 56% worked in the health care system.⁵

In short, producing a list of priorities—or defining an adequate minimum package of health care—will inevitably entail a process of argument, persuasion, and consensus building. If the Oregon experiment so far has shown anything it is that there is no technological fix: imputing values to statistics and decisions about what methods to use for cranking out rankings from computers are themselves a matter for political dialogue. Technical exercises may be a useful way of starting up the dialogue and providing statistical scaffolding that may subsequently be dismantled, but they cannot resolve conflicts of values or interests.

Assuming that this conclusion is sustained by what happens in Oregon over the next year, the implications for Britain's NHS are sobering. For while technologies are transferable, political systems are not. If the Oregon experiment were all about developing a new method for determining priorities, NHS health authorities could no doubt import it fairly easily. But since the Oregon experiment is anchored in the state's political system, and relates to the special problems of health care in America, it is difficult to see what NHS purchasers can learn directly from its success or failure. Only one message seems clear. Any attempt to determine explicit priorities of resource allocation—to specific groups or services—will necessitate opening a dialogue if it is to be seen as more than the imposition of arbitrary technocratic or managerial values. In turn this implies that health authorities will have to start thinking seriously about the nature of their constituencies and how they can best generate support, professional and public, for their priorities. This means not only a willingness to argue in public but also developing a system in which they have partners in dialogue: something that is conspicuously lacking at present.

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Primary medical treatment in breast cancer

May offer improved survival to women in high risk groups

Breast cancer has traditionally been regarded as a surgical disease, and chemotherapy has been reserved for treating locally advanced and metastatic disease and for adjuvant treatment in premenopausal patients with node positive disease. This traditional view is now being challenged by medical oncologists, who propose giving patients with operative breast cancer cytotoxic chemotherapeutic drugs as first line treatment.¹

The acceptance that breast cancer is often a systemic disease at diagnosis has led to changes in the surgical management of operable breast cancer, with conservative surgery increasing. Furthermore, conservative surgery and radiotherapy produce local control of early breast cancer comparable with that after radical mastectomy.²⁻⁶

Chemotherapy is already well established for advanced inoperable disease, in which response rates vary from 40% to 59% for standard cyclophosphamide, methotrexate, and fluorouracil regimens,⁷ but rise to 82% when doxorubicin is used.⁸ There remains controversy about whether chemotherapy prolongs survival in patients with metastatic disease,^{9,10} but a recent overview concluded that those who respond show a survival advantage.¹¹ The advantages of adjuvant treatment in patients with node positive breast cancer are now becoming more widely accepted, especially in younger patients, as both disease free interval and overall survival are prolonged.¹

Primary medical treatment was first used in 1973 to treat locally advanced tumours (T3b, T4), the idea being to achieve prompt tumour response with four cycles of doxorubicin and vincristine to facilitate radiotherapy.^{12,13} In this study 98 out of 110 patients responded, and 81 of these responders achieved complete clinical and radiological remission after radiotherapy.¹³ Thirty one patients, however, relapsed locally within three years.

After the success of these regimens this approach was extended to smaller operable tumours, with the aim of downstaging them to facilitate conservative surgery.¹ Such a study was started in Milan in April 1989, and 97 patients have now completed treatment. The chemotherapy regimen consisted of cyclophosphamide, methotrexate, and fluorouracil for three or four cycles or fluorouracil, doxorubicin, and cyclophosphamide for three.¹ Sixty two patients were premenopausal and 35 postmenopausal; tumour diameter was 3 cm in nine, greater than 6 cm in 10, and between 3 cm and 6 cm in the remainder. By clinical and mammographic criteria 16 achieved a complete tumour response after treatment, but this figure fell to four when histological criteria were used. A partial response was seen in 59 and an improvement in a further 19. After chemotherapy a quadrantectomy (accompanied by radiotherapy) was performed in 85 of the 94 patients in whom response could be evaluated. Interestingly, no difference in tumour response or rate of quadrantectomy was observed between the premenopausal and postmenopausal patients (83% and 91%). Only nine of the 94 patients underwent mastectomy because of disease progression, tumour size, or multifocality. The authors concluded that the classical indications for mastectomy might be challenged by this form of treatment.