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 what treatment should be provided, 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—
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 operable breast cancer cytotoxic chemotherapeutic drugs as first line treatment. 1

The acceptance that breast cancer is often a systemic disease 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. 2,4

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, 2 but rise to 82% when doxorubicin is used. 3 There remains controversy about whether chemotherapy prolongs survival in patients with metastatic disease, 5,6 but a recent overview concluded that those who respond show a survival advantage. 7 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. 8

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. 11 In this study 98 out of 110 patients responded, and 81 of these responders achieved complete clinical and radiological remission after radiotherapy. 12 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. 6 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 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.