

Commission on the  
Future of Health Care  
in Canada



Commission sur  
l'avenir des soins de santé  
au Canada

DISCUSSION PAPER NO.6

# A Framework for Determining the Extent of Public Financing of Programs and Services

by

**Alan Shiell**

University of Calgary

**Gavin Mooney**

Curtin University of Technology

Perth, Western Australia



July 2002

**The views expressed herein are solely those of the authors and do not necessarily reflect those of the Commission on the Future of Health Care in Canada.**

# Contents

<b>Highlights</b>	<b>iv</b>
<b>Executive Summary</b>	<b>v</b>
<b>Acknowledgements</b>	<b>vii</b>
<b>Introduction</b>	<b>1</b>
<b>Potential Criteria for Priority Setting</b>	<b>4</b>
<b>Experiences with Priority Setting from Overseas</b>	<b>6</b>
Oregon	6
The Netherlands	7
Sweden	7
New Zealand	8
The United Kingdom	9
<b>Lessons from This Experience</b>	<b>10</b>
(1) Responsibility for Priority Setting Rests at Different Levels in the Health System	10
(2) Rationing Involves a Combination of Evidence and Value	11
(3) Rationing Involves a Combination of Technique and Judgment	11
(4) Whose Values Should Count?	12
(5) De-listing Is Ineffective and Inconsistent with a Solidaristic System	13
(6) Process of Decision-Making Is Important	13
(7) Decision-Making and Implementation	13
<b>A Way Forward for Canada</b>	<b>15</b>
Current Proposals	15
A New Approach	16
(1) A Canadian Constitution for Health Services	17
(2) Strengthen the Evidence Base	18
(3) A Decision-Making Framework	18
(4) An Appropriate Incentive and Institutional Structure	20
<b>Unanswered Questions</b>	<b>21</b>
<b>Conclusion</b>	<b>23</b>
<b>References</b>	<b>24</b>

## Highlights

- The Medicare system is sustainable if we are prepared to tackle the need to set priorities over what services are provided, to what extent, to whom and when. Some form of rationing is inevitable. The biggest threat to the system has been our reluctance to tackle this issue.
- Priority setting can never be a wholly technical exercise. It involves balancing values and evidence, and requires judgments as well as the use of techniques.
- Other jurisdictions have grappled with the problem of priority setting. None has solved the problem, but Canada can and should learn from these experiences.
- Distilling these lessons, we suggest four essential elements to any successful effort to establish priorities:
  - The first is a Canadian 'constitution' for health services.
  - The second requires strengthening and broadening the evidence base for decision-making by guiding research efforts into evaluation of the costs and outcomes of marginal changes in health service provision.
  - Third, we need a decision-making framework such as that provided by program budgeting and marginal analysis to translate principles into practice.
  - Fourth, there needs to be appropriate incentive and institutional structures to ensure that recommended changes in the system are implemented.
- Of these, the constitution is the most important. It provides a statement of the principles that should guide the health system and the trade-offs that we are prepared to make between them. It is the mechanism for obtaining meaningful public participation, providing procedural justice and therefore legitimacy to the decisions to be made.
- Our suggested approach incorporates community values and professional judgment and provides a structure in which both can be brought together to determine policy. It also provides a means of shaping expectations and providing legitimacy to the tough decisions that need to be made. Where yet more thought is needed is in how to get from recommendations arising from priority setting exercises to implementation. It is this issue that now needs to be addressed.

## Executive Summary

The increasing cost of health care is making it more difficult for Canadians to realize the aspirations they have for a health system that offers comprehensive, high quality care to all citizens irrespective of their ability to pay. Indeed, the widening gap between private expectations and public willingness to pay is supposedly endangering the very existence of Medicare. The problem Canadians face, however, is not strictly the result of an inevitable clash between uncontrollable costs, increasing demands and finite resources. It is instead a reflection of political reluctance to stimulate public debate about the principles that Canadians want to underpin their health services and the priorities they wish to attach to different competing aspects in an inevitably resource constrained environment.

The Commission asked the authors to consider three questions. What should be the criteria for determining the extent to which a program or service should be publicly financed? Which Canadian policies are most consistent with these criteria and which are least defensible? Where should public financing be extended and where might it be reduced? The solution to Medicare's problems does not lie simply in specifying which *services* should or should not qualify for public cover. To reconcile private wants with community willingness to pay we need to think also about to whom those health services delivered, to what extent and when. We need to establish priorities.

To address this issue we looked at principles that could be used to prioritize access to health care and at the experiences gained in jurisdictions that have attempted to square the circle between private wants and finite resources.

A number of ethical principles could be used to guide priority setting in Canada. These include maximization, egalitarian and claims-based approaches. None is likely to prove acceptable in isolation. There is evidence to suggest that the public would prefer a mixed approach, ensuring some degree of fair access to health services subject to the caveat that the care provided is effective.

The question of how to set priorities in public health systems has been addressed in several places, most notably in Oregon, the Netherlands, Sweden, New Zealand and the United Kingdom. Each of these adopted a slightly different approach; none has fully resolved the problem; all continue to amend the processes they introduced. Oregon has de-listed services. Sweden identified broad principles and left it to local agencies to decide how to make these operational. New Zealand has focused on the development of evidence-based guidelines and the use of a managerial decision-making process to ration access to healthcare. The UK looks as if it will take a similar path to that of New Zealand.

Several lessons can be drawn from these experiences. First, priority setting must involve decision-makers at three levels, namely the clinical level; the planning level; and the national and provincial level. Since the type of rationing decision that needs to be made varies at each of these levels, so too will the precise way that any method of establishing priorities will be made operational. Secondly, priority setting involves a mix

of evidence and values, and of techniques and judgments. There are no simple answers and no ready-made technical fixes. Priority setting can be made more explicit, more structured and more consistent with broad social objectives, but it will remain largely messy and intuitive in nature. There is no point in seeking a completely technical, evidence-based approach. It does not and cannot exist. Thirdly, de-listing services is not an effective approach to priority setting. Very few services are always ineffective or inappropriate. Those that are tend to be insignificant in terms of overall health care. Clinicians find ways around the restrictions. The benefits of de-listing are slight: the harms in terms of galvanizing opposition to rational planning are great. The final lesson is the importance of having a fair and just *process* of establishing priorities in order to ensure the legitimacy of the decisions that are made.

Distilling these lessons, we suggest four essential elements to any successful effort to establish priorities. The first of these is a Canadian 'constitution' for health services. Secondly, the evidence base for decision-making needs to be strengthened by guiding research efforts into evaluation of the costs and outcomes of marginal changes in health service provision. Thirdly, there is a need for a decision-making framework to provide a practical mechanism for translating principles into practice. We recommend an approach such as program budgeting and marginal analysis. This makes the question of priority setting more tractable by focusing attention first on the pattern of services that is currently being provided and considering the scope to make changes at the margin. Fourthly, there needs to be appropriate incentive and institutional structures to ensure that recommended changes in the system are implemented.

Of these, the constitution is the most important. It would provide a statement of the broad principles that should guide the health system in Canada and the trade-offs that Canadians are prepared to make between these principles. The failure to address the issue of priority setting adequately is undermining support for Medicare. It is worth revisiting and perhaps even reshaping the principles upon which the system is or at least ought to be based. The constitution would also be the mechanism for obtaining meaningful public participation, providing procedural justice and thereby legitimacy underlying the decisions to be made.

These recommendations are predicated on the belief that some form of rationing of health care is inevitable. The key question then is one of priority setting: how are scarce health resources to be allocated to different competing ends? We have rejected rationing by price as being inconsistent with Canadians' desire for a health service that promotes equality of access. The Medicare system and the social principles upon which it is based are sustainable but only if Canadians acknowledge the constraints that collective funding of the system place upon their individual expectations. The approach that we recommend here will help to achieve this objective.

## **Acknowledgements**

The authors gratefully acknowledge the contribution made to this paper by Stephen Birch, Cam Donaldson, Penny Hawe and Stephen Lewis who each provided comments on an earlier draft, and Bonnie Rush, who provided research assistance. Alan Shiell is supported by the Alberta Heritage Foundation for Medical Research, Gavin Mooney by the Health Department of Western Australia. The views expressed in this paper and any remaining errors are those of the authors alone.

## **Introduction**

Canadians want a health system that offers comprehensive, high quality health care to everyone irrespective of their ability to pay (Graves, Beauchamp, and Herle 1998). Achieving this might be impossible, however, since any commitment to universal, high quality health care will inevitably be thwarted by fiscal measures designed to control public spending (Naylor 1999). This is so, even though national incomes continue to grow. There is a need to find mechanisms to establish more realistically what Canadians want from their health services, and the trade offs they are prepared to make between the competing objectives when they do or are forced to recognize that not all can be met in full.

The cause of the problems underlying Medicare is frequently attributed to uncontrollable 'cost pressures' including technological advances, new pharmaceutical and demographic changes that increase the costs of health care faster than the country's capacity to pay. Rising expectations from a population that is becoming better informed about its health care options also supposedly feed into increased demands on the health system. This thinking leads inevitably to the conclusion that publicly funded systems, such as Medicare, are unsustainable in their current forms (Ferriman 1999; Premier's Advisory Council on Health 2001).

We reject this argument. The problem with Medicare is not the result of some inevitable clash between uncontrollably increasing demands and finite resources (Mays 2000). It is instead a reflection of a reluctance to manage politically the limits that collective funding of health care must impose (Ham and Coulter 2001). The aspirations that Canadians have for the health service constitute an 'inconsistent triad' (Weale 1998). It is possible to have a high quality, universal system that is not comprehensive, or a comprehensive system that is freely available to all but which is not of the highest quality. In a world of finite resources, however, Canadians cannot have free access to a comprehensive, high quality service. There is a need to bring the aspirations of the people and the scarcity of resources together. Some form of priority setting or rationing (and following Ham and Coulter (2000) we use these terms interchangeably) is inevitable; the only questions are which form and to what end.

Canada is not alone in facing this problem. Around the world, governments have sought methods of 'squaring the circle' between individual wants and a limited public budget. With the exception of the USA, policy makers have rejected the option of dropping universality since this leads to the denial of health cover to segments of the population (Anderson and Poullier 1999). Instead, solutions have been sought by reconsidering the notion of comprehensiveness, e.g. by trying to identify a restricted package of core or basic services that the public system should provide, as for example in New Zealand in the early 1990s (Health Funding Authority 1993).

Most of the debate about health care reform has focused on mechanisms such as public versus private finance or case-mix versus per diem funding of hospitals. It is not possible however to decide rationally on such questions before there is some idea of what



principles should underlie health services. Nor can it be expected that these issues can be resolved unless the strengths of preferences for competing principles are also addressed. This is not an easy task, but choices are already being made, only opaquely and without the transparency that will allow the Canadian people both to have their say and to see what sorts of trade-offs are being made.

The Commission put three questions to us:

- (1) What should be the criteria for determining whether a program or service should be wholly, partly or not publicly financed?
- (2) Which Canadian policies and approaches are most consistent with these criteria and which are least defensible?
- (3) Where in general should public financing be extended and where might it be reduced?

The first of these questions is a normative one. As economists, we can discuss what criteria *could* be used to determine which services should be fully or partially funded from the public purse, but the decision about what criteria *should* be used must be left to the people who will pay for and benefit from the health system that results, i.e. the Canadian public. The question of what should be public and what should be private cannot be addressed in a value vacuum. The principles on which the health service is to be based must be established before this question can be decided. In any case, the solution to the problems faced by Medicare lies not just in specifying which services should or should not qualify for public cover. There is a need to think about to whom those services are to be delivered, to what extent and when.

This still requires an articulation of the principles upon which priorities in services should be determined, but the real challenge is in how to translate these principles into practice (Klein 1995). How to determine the *trade-offs* that Canadians are willing to make between the criteria if they cannot have all of each that they would like? How best can this information be conveyed to decision-makers? How can it be ensured that their decisions are consistent with these principles? How can decisions be reflected in actual implementation?

In this paper, we consider principles and criteria that might be used to define the scope and content of publicly funded health care in Canada, and look to international experiences for lessons on how they might be made operational. We then assess some Canadian proposals for establishing priorities before making our own recommendations. Finally, we discuss some outstanding questions before drawing conclusions.

Strictly, we are not concerned with how much public money should be spent on health services in total or whether more can be done to improve efficiency in the public sector. Greater organizational efficiency is possible and along with increased funding, would ease the point at which resource constraints bind but neither mechanism provides a way around the need to set priorities or ration health care.

Neither do we consider whether a private system is better than a public one, though the issue cannot be wholly ignored. The question of whether private is better than public will inevitably arise, at least for those who can afford to contemplate using a private system. This issue is complicated by the fact that what constitutes 'good' may be different in the two systems making judgments of 'better' difficult. For example, is the individual concerned only with his or her own family's health and their access to health care or with such matters at a more social level? Where some concept of 'social solidarity' is strong such as in Scandinavia, then the social concern will be more prevalent and investment in public health services greater. Where the society is more individualistic, as in the United States, then private health care will be more pronounced.

## **Potential Criteria for Priority Setting**

The gulf between private expectations and public willingness to pay in health care is an inevitable even if unfortunate side effect of an institutional response to a more fundamental characteristic of health care. The incidence of ill health, its future course, and the costs of health care, are all uncertain. The institutional response to this uncertainty is insurance to pool risks. This drives a wedge between one's use of health care and the price that one must pay for it. In markets for more conventional goods, demand and supply are brought into line through the price mechanism. Access is rationed by one's willingness and ability to pay. In health care, third party payment, through public or private insurance, frees one from the discipline of the market, such freedom, according to economic theory, leading to increased demands.

The solution, according to some, is to reinstate a partial role for the market by introducing user-fees (co-payments). The arguments in favour of such an approach are simple. User fees will close the gap between individual expectations and the collective willingness to pay by reducing demand, by increasing revenue or by some combination of the two. The counter-arguments are more complex. Health care is not a conventional commodity and its supply and demand do not necessarily behave in the way predicted by market analysis. Moreover, tax-financed, public health insurance not only pools risks (and does so more efficiently than private health insurance), it also plays a valuable redistributive role, removing financial barriers to access and transferring wealth from taxpayers to the sick in the process (Stoddart, Barer, and Evans 1994). Advocates of a greater role for private financing of health services play down this aspect of Medicare.

Rather than ration access to health care according to ability to pay, an alternative is to consider who gets priority access to what sorts of health care service, to what extent and when? There are several mechanisms available to limit access (Harrison and Hunter 1994). What is important here are the principles on which priority setting should be based to ensure that available resources are allocated to where they are socially most justified. A number of potential principles can be identified (Hurley, Cosby, Giacomini et al. 2000). Here we mention three: maximization, egalitarian and claims-based.<sup>1</sup> In the first of these, the aim is to allocate resources to where they produce the greatest outcomes. Maximization typically refers to health outcomes (Culyer 1997) though other aspects of benefit can be included. Inherent in this approach is also a form of egalitarianism since simple health maximization treats a year of healthy life as equal in value no matter who receives it. In this sense, the approach is fair since it is 'blind' to the characteristics of the recipients. Health gains could be differentially weighted however in order to give priority to some social groups over others.

---

<sup>1</sup> We do not consider 'needs-based' approaches as a separate category (Cookson and Dolan 2000). If need is defined as capacity to benefit then these are subsumed under maximization. If need is instead defined in terms of severity etc then they are subsumed under claims-based approaches.

In contrast, egalitarian approaches seek more explicitly to allocate resources in order to reduce inequities between social groups. These might refer to unequal access to health services, differences in health status or differences in (health-adjusted) life expectancy (Williams 1997).

Claims-based approaches to rationing health care recognize the duty owed to some members of society, and in this case by the healthy to the sick. In this view, all individuals have a right to some level of health care. According to Harris (1997), this right is absolute and exists irrespective of any personal characteristics of the person, including the relative effectiveness of treatment. In contrast, Mooney's version of 'communitarian claims' seeks community input into specifying the legitimacy and strength of the various claims that could be made upon collective health resources (Mooney 1998). The strength of a claim can depend on any number of factors, which it is for the community to determine, including for example capacity to benefit or the reduction in inequities.

Which approach should be used to inform priority setting? Evidence from the UK suggests public support for a mixed approach (Cookson and Dolan 1999; Cookson and Dolan 2000). More specifically, the work of Nord and others in Australia shows that people feel it unfair to discriminate against patients with severe illnesses or illnesses that are costly to treat and therefore less cost-effective, other things being equal (Nord, Richardson, Street et al. 1995a; Nord, Richardson, Street et al. 1995b). Similarly, in the UK, Dolan and Cookson (2000) found support for equal access to health care as long as the treatments that were provided met some unspecified effectiveness threshold.

This means that a statement of guiding principles is of limited practical value if it is too broad (Harrison, Dixon, New et al. 1997). At the same time if it becomes too detailed, the citizens asked to handle it are likely to suffer information overload. There is a fine balance needed to establish the appropriate level at which to set principles and it can be argued that it is for the citizens themselves to decide what that level is (Wiseman, Mooney, Berry et al. forthcoming). Further work is needed to articulate the important features of each principle and explore how best to elicit the trade-offs that people are prepared to make between these features. Some additional mechanism, such as a constitution for health services (Mooney and Wiseman 1999), is needed to ensure that decision-makers are cognizant of the community's values. This will also allow the public's voice to be heard in the process of setting priorities at those levels for which the community wants its voice heard and without it necessarily being party to every decision.

## **Experiences with Priority Setting from Overseas**

Canada is not alone in considering how to define the scope of public health insurance coverage, and before considering further the steps that have been taken here, we look briefly at international experiences, focusing on efforts made in Oregon, the Netherlands, Sweden, New Zealand and the United Kingdom.

### **Oregon**

One of the most famous large scale attempts to tackle the problem of rationing explicitly occurred in Oregon where, in 1989, a Health Services Commission was appointed to recommend to the State legislature ways of expanding Medicaid coverage. The Commission hoped to restrict the range of services covered under Medicaid in order to ensure that a larger number of people would benefit from the scheme. The aim was to rank-order procedures according to their cost-effectiveness and then, starting at the top of the list, fund procedures until the budget was exhausted (Kitzhaber 1993).

The Commission consulted the public, reviewed the evidence on cost-effectiveness and drew on professional expertise and the judgments of its members to overcome data deficiencies. A formula was used to integrate the information and to rank 709 medical conditions and their associated treatments (known as condition-treatment pairs) in terms of their cost-effectiveness. The initial list of treatment-condition pairs contained a number of well-publicised 'anomalies' (tooth-capping was ranked higher than treatment for appendicitis) and was generally received with hostility. In response, the Commissioners dropped the cost-effectiveness criterion and adjusted the rankings by hand to remove the anomalies and to respond to the allegations of discrimination against disabled people. The final list contained 696 treatment-condition pairs of which the top 565 were deemed affordable under Medicaid. The list of eligible services was kept under review (and continues to be so) and a new list was introduced in 1999 with 574 eligible treatment-condition pairs.

One implication of this is that the Oregon process would have benefited from there having been some more explicit and transparent debate early in the piece to allow participants to have had a better understanding of the value base from which they were supposed to be operating. This might have provided some set of principles on which to base the subsequent decision-making process. (This issue we discuss at greater length later.)

The Oregon approach succeeded in increasing insurance coverage, reducing the percentage of people without health insurance from 17 % prior to the scheme's introduction to 11 % in 1997 (Office for Oregon Health Plan Priority and Research 1999). The services that were de-listed were small in number and of marginal significance. As a result, there were minimal cost savings (Oberlander, Marmor, and Jacobs 2001).

## **The Netherlands**

The Netherlands has a population of nearly 16 million people and in 1998 spent 8.7 % of its GDP on health care at a cost of US\$ 2,150 per person. Nearly one-third of this spending (31.4 %) comes from private sources (Organization of Economic Co-operation and Development 2001). Health care is predominantly funded through a mandatory social insurance system, plus private health insurance for those whose incomes exceed a specified threshold and those who wish to take it out. The insurance carriers are all private, not-for-profit organizations but both the cover that they must provide and the premiums that they can charge are highly regulated.

In 1992, the Committee on Choices in Health Care (the Dunning Committee) was appointed to advise the Dutch government on what services ought to be covered in a basic insurance package to be offered by all insurance carriers. Their final report made a number of recommendations including the introduction of medical technology assessment, the use of guidelines, and protocols and criteria for determining access to and priority on hospital waiting lists (Committee on Choices in Health Care 1992). The committee also set out a framework to decide what services should go into the basic health care package. This had four screening questions. Was the service necessary? Was it effective? Was it efficient? Could its payment be left to the individual? The framework was never implemented however as, before the committee had a chance to report, the government announced that the basic package would comprise 95% of the services that were currently being provided.

## **Sweden**

Sweden has a population of nearly 9 million people. Health spending in 1998 comprised 7.9 % of GDP or US\$ 1,730 per person, of which 83.8 % was paid for from the public purse. Health services are funded by a combination of local income taxes and a state contribution, the size of which is based on local demographics. Responsibility for the delivery of health services lies with the county councils and large municipalities.

During the 1980s, Sweden, as elsewhere, faced increasing health care costs at a time when its national income was rising only very slowly. In 1992, a Parliamentary Priorities Commission was established to provide advice on how health care priorities might be set. It published its final report in 1995. Rather than identify potential high and low priority services, the Commission saw its task as one of identifying the ethical principles upon which such rationing decisions should be made. Three such principles were specified: (1) Human dignity, (2) Solidarity, and (3) Cost-effectiveness. In setting priorities, policy makers were to keep in mind that all individuals were of equal value. No one should receive preferential access to services because of any personal characteristic. Secondly, under the solidarity principle, preference was to be given to people who needed support the most and, in particular, to vulnerable groups such as people with a mental illness whose personal autonomy was threatened by their illness. Finally, if everything else were equal, then only the most cost-effective method of delivering a service should be provided. The difficulty with this is that not everything else is equal. There is a need for a

broader or perhaps deeper value base (or set of principles) on which to be able to determine trade-offs and priorities.

While the Commission did not favour particular services, it did provide some guidance as to how these principles ought to be translated into priorities. The commission asserted that everybody had a right to prompt diagnosis after which top priority was to be assigned to treatment of acute disease otherwise leading to death or disability. After that, priority ought to be assigned to population-based preventive measures. Lesser priority would then be assigned to less severe acute and chronic diseases, with capacity to benefit determining who would have first call on resources within this group.

The Commission provided an ethical platform on which to base priority setting decisions but little guidance as to how these ethical principles should be translated into practice. This task has fallen to the county council and municipal authorities that have responsibility for delivering health services (Holmstrom 1999). Here, different approaches are being tried in different areas. In Falun, for example, where the most progress has been made, clinical and service managers have been working together to determine a method of classifying medical services that is consistent with the agreed ethical principles. The aim is to use the resulting classification to align health care needs better with available resources. This will ensure more equitable access to resources to patients with different conditions but similar levels of need (a form of horizontal equity) and to prioritize access to resources to patients in the greatest need (vertical equity). It is too early to judge how effective the Falun approach will be however.

## **New Zealand**

The population of New Zealand is only 3.8 million. In 1998, the country spent 8.1 % of its GDP on health care, which is equivalent to US\$ 1,440 per person. Of this, 23 % comes from private sources.

The health system in New Zealand has undergone drastic reorganization in the past decade. New Zealand was among the first countries to introduce universal publicly funded health insurance, and among the first to move towards a more competitive, market-orientated approach in the early 1990s. A purchaser-provider model was introduced and the intention was to move eventually to a system of managed competition with public and private providers competing for contracts for service provision from crown purchasing agencies. Once these reforms were established, the plan was to limit public insurance to a restricted core of services. People would be able to purchase supplementary private insurance for coverage outside this core and eventually to opt out of the public system all together. These plans were later dropped.

The idea of defining core services as a means of controlling health care costs had taken hold however. The statutory body established to look into the question (the National Advisory Committee on Core Health and Disability Services, later renamed the National Health Committee), considered the paths taken in Oregon and the Netherlands and rejected both (Cumming 1997). Instead, the committee sought to make changes at the

margins of the range of services that were already being provided. Four principles to direct these changes were enunciated: effectiveness, value for money, fairness and consistency with the community's values and priorities. Specific allocation decisions were to be guided by the development of evidence-based practice guidelines. A separate body, the Public Health Commission, was responsible for devising a parallel strategy for prioritizing population health interventions.

Another committee, the Health Funding Authority, then took on the task of translating these principles into a practical means of guiding decisions at the level of the purchasing authority. Its preferred approach was to return to the structure offered by economic methods of priority setting including cost-utility analysis and program budgeting and marginal analysis (Health Funding Authority 1993). Program budgeting and marginal analysis (PBMA) was seen as a way of combining the need for flexibility in how one considers the complexities of each decision with the degree of explicitness and transparency that is needed to ensure the process is accountable (Ashton, Cumming and Devlin 2000).

### **The United Kingdom**

The population of the UK numbers nearly 60 million. Health spending comprised 6.8 % of GDP in 1998 or US\$ 1,510 per person. All but 16.7 % of this is funded from the public purse.

As in New Zealand, interest in defining core services in the UK was prompted in part by reforms to the health service that led to the introduction of a purchaser-provider model. This spurred interest in priority setting among the newly created purchasing agents and fed renewed enthusiasm for techniques such as PBMA (Mooney, Gerard, Donaldson et al. 1992; Mitton, Donaldson, Dean et al. 2000). Central government, however, has limited its involvement to acknowledging the need to set priorities (Bottomley 1993) and to articulating a set of values on which decisions might be based (Department of Health 1995).

The initiative to act has been taken instead by the regional health authorities (e.g. the Oxfordshire Priorities Forum 2001), the professional colleges (Royal College of Physicians 1995) and other, self-appointed, groups such as the Rationing Agenda Group established by the King's Fund (New 1996). The approach has been described as 'pragmatic incrementalism, with policy emerging almost as a by-product of individual decisions' (Klein 1995), which has resulted in 'haphazard access to health care depending on where you live' (Dixon and New 1997).

It seems likely that the UK will explore the use of evidence based, practice guidelines (Ham 1995) whilst continuing to respect the autonomy of regional purchasers to set priorities locally. To this end, the government has provided support to health authorities by funding research into systematic reviews, technology assessment and guideline development (Ham and Coulter 2000).



## **Lessons from This Experience**

This brief review shows both variation and similarities in the approaches that have been adopted elsewhere. No one approach has yet proved satisfactory. Each is evolving as policy makers look for ways to improve practice. It is also likely that any 'best buy' in priority setting techniques will be to some extent culturally specific or at least health systems specific. Thus, it is possible to learn from elsewhere but to steal, without thinking through the implications for the local Canadian setting, is unlikely to be the best way to proceed.

Several lessons can be drawn from this international experience (Ham and Coulter 2000).

### **(1) Responsibility for Priority Setting Rests at Different Levels in the Health System**

At the very least, one can distinguish between macro, meso and micro levels of decision-making in all health systems. At the macro level, decisions need to be made about how much to spend on health care relative to other publicly provided goods and what the distribution of that allotment ought to be between regions. The meso level is more concerned with the allocation of resources across services or specialties within a health jurisdiction such as a provincial or regional health authority. Clinical decision-making dominates at the micro level, where priorities are set in terms of the care given to particular patients.

Methods of establishing priorities need to be cognizant of this and consider the implications for each level of decision-making. With the exception of Oregon, experience thus far has tended to focus on establishing broad principles and frameworks for decision-making and has tended to neglect the question of how these principles are translated into decisions at each level of responsibility (but there are exceptions - see below).

Furthermore, since the type of decision that is made at each level varies, so too will the way in which any particular method of setting priorities is made operational. Yet, ultimately decisions made at each level must be compatible. This is for two reasons. First and obviously, costs of services ordered at the clinical level cannot exceed the funds allocated at the macro level. In New Zealand, for example, it is not clear whether recommendations made by those involved in guideline development will ultimately be consistent with the purchasing recommendations that fall out of the PBMA exercises (Cumming 1997). In the UK, the two national bodies that have been established in Scotland and England have been criticized for failing to take into account adequately the costs of their recommendations. This threatens to distort efforts to establish priorities at the local level (Cookson, McDaid, Maynard 2001).

Second, the opportunity costs of clinical decisions do have an eventual impact at all three levels. In terms of gaining acceptance for any priority setting approach, if clinicians do not recognize these wider considerations but see the issue in terms only of 'their' patients, it will prove difficult to get priority setting accepted in principle or to work in

practice. The process of being explicit about priorities can help to bring levels of decision-making together, however. Thus, in Oregon, the effort that went into ranking the treatment-condition pairs prompted the legislature to increase funding for Medicaid in order to cover the extra costs of procedures deemed worthwhile that initially fell 'below the line'. Similarly, in Falun in Sweden, the discussions between hospital and clinical decision-makers promise to bring some consistency to decisions made at each of these levels.

## **(2) Rationing Involves a Combination of Evidence and Value**

In the approaches to rationing identified above, each emphasizes the need to base decisions on evidence of effectiveness. Each also, to a greater or lesser extent, suggests the role that values must play in decision-making. Rationing means limiting someone's access to some potentially beneficial service in order to improve that person or someone else's chances of receiving *more valuable* support. Health care decisions are not just technical: they also involve choosing between valued outcomes (Shiell 1997). Advocates of evidence-based decision-making have begun to recognize the role to be played by values, whilst neglecting the value-judgments implicit in the production and interpretation of evidence (Birch 1997). There is a danger if too much weight is attached to basing choices of how best to use scarce resources on the quality of the evidence. Currently and for the foreseeable future, the quality of evidence in the area of pharmaceutical interventions is higher than in most public health interventions. That does not necessarily mean that the quality of evidence should govern relative priorities for these two areas (Rychetnik, Frommer, Hawe et al. 2002).

## **(3) Rationing Involves a Combination of Technique and Judgment**

Rationing requires a combination of technique and judgment. Techniques such as economic evaluation and program budgeting and marginal analysis (PBMA) provide a structure in which evidence and values can be brought together. They also bring greater explicitness to the process of decision-making. It is not the case however that either technique is sufficiently well developed to deal with all of the complexities of priority setting. For this reason alone, there remains a role for subjective judgment and interpretation.

In Oregon, the initial prioritized list of services was rejected because the cost-utility rankings contained what seemed unacceptable anomalies. Some of this was because of errors in the way the cost-utility ratios were computed (Tengs 1996). Correcting the faults might have reduced the degree of discomfort with the cost-utility rankings, but would not have eliminated it. The usual methods of establishing utility values (which are based on individual trade-offs) are not necessarily consistent with the social values that people wish to see guide resource allocation decisions (Ubel, Scanlon, Loewestein et al. 1996).

It is, however, impossible to avoid the economic consequences of health care decision-making. Consequently, whatever the status of the techniques, economic evaluation must play some part in priority setting. The Swedish and Dutch approaches

imply that any service which is necessary, effective and the least costly option will be provided irrespective of the community's willingness to pay, but it was the growing gulf between health care wants and available resources that prompted interest in priority setting in the first place. Economic techniques can provide information on benefits gained versus benefits forgone, but a judgment will always be required as to whether the former is worth the latter.

It is also the case that economics tends to be suspicious of absolutes such as necessary and effective. These concepts raise more questions: necessary to whom? and in what circumstances? and *how* effective? to whom? and in what circumstances? In practice, this means that priority setting is likely to be quite difficult to handle in any simple way such as de-listing as in Oregon or lexicographic ordering with severity in Sweden. What priority setting seeks is to address more subtle questions such as: if there were an extra \$1 million available for health care how best could that be spent? Or, if the budget were reduced by \$1 million where would cuts fall to minimize damage? The answers to these questions may well be different when consideration is given to the second or third million. (We return to this point later as it constitutes a centrepiece of our thinking on how to prioritize in health care.)

#### **(4) Whose Values Should Count?**

This discussion raises questions of whose values need to be canvassed, how these are best elicited and what influence they should have in decision-making. The health system belongs to the people of Canada and therefore they must have a say in what form it takes. To be yet more precise, it is for the Canadian people to decide whose values are to be used in which circumstances. There is no intent however to compel people to exercise their preferences over issues or in ways that they would prefer not to.

Methods of involving the public in decision-making are many and include opinion surveys, focus groups, consumer panels (Bowie, Richardson and Sykes 1995) and citizens' juries (Lenaghan, New and Mitchell 1996). These methods vary according to the extent to which participants are provided with information on the matter at hand or just encouraged to express their (uninformed) opinion, and to whether the process of eliciting this information allows for deliberation and reflection (Jordan, Dowsell, Harrison et al. 1998).

The methods can also vary according to the role that the participant is asked to take and the task they are asked to consider (Lomas 1997). Roles can include those of citizen, taxpayer and patient. Tasks include eliciting the principles and values that ought to underlie decision-making and the incorporation of this information into the decisions themselves. Work in the UK (Coast 2000) suggests that the public is keen to contribute towards establishing the criteria by which rationing decisions should be made but less than happy at being party to the decision-making itself, especially when this involves the denial of care. The degree of comfort appears to depend at least in part on the effort made to provide information and allow participants to deliberate on their answers (Jordan, Dowsell, Harrison et al. 1998).

The question of just what the role of community preferences should be is under-researched (Frankish, Kwan, Ratner et al. 2002). That role can be anywhere on the spectrum from simply being consulted, to informing decisions to decision-making. The decision on this is one for the community to take and is, in a very real sense, likely to be one of the principles on which the health service will be based.

### **(5) De-listing Is Ineffective and Inconsistent with a Solidaristic System**

While it is true that none of the countries surveyed has found an answer to the question of how best to set priorities, some conclusions can be drawn about what not to do. The evidence suggests that de-listing services is difficult to achieve and is unlikely to be effective – at least in a health system that aspires to be comprehensive and based on principles of solidarity. Very few services (typically tattoo removal, gender realignment, some cosmetic surgery and in vitro fertilization) are ready candidates for de-listing and these tend to be insignificant in terms of total expenditure. After a long search, New Zealand's Core Services Committee reported that it could not find any area of service that could be completely excluded (National Advisory Committee on Core Health and Disability Support Services 1994, 67). In Oregon, only 2 % of the budget was saved in the first five years that the limited list was in operation and this was attributed to the use of managed care contracts rather than de-listing per se. Clinicians found ways to continue providing the de-listed services to patients whom they believed would benefit from them (Oberlander, Marmor and Jacobs 2001). In the Netherlands, de-listing succeeded only in galvanizing opposition to the process of priority setting.

The idea of de-listing stems from a misunderstanding of what priority setting is about. There may be situations where complete services can be cut. More often however, priority setting is about how much of a service to provide or to cut and to whom. De-listing is all too crude a weapon for addressing such marginal questions.

### **(6) Process of Decision-Making Is Important**

The penultimate lesson is the realization that there is unlikely ever to be a way of rationing care that yields priorities with which everyone agrees. Priority setting is a complex and contested activity. It is too much to expect that any technical exercise on its own will resolve all value-conflicts (Klein, Day and Redmayne 1996). Decision-making about priorities will always be a messy, value-laden exercise. The best that can be done is to try to ensure that the *process* by which decisions are made is explicit, subject to scrutiny and fair. Procedural justice therefore becomes an important criterion (Lenaghan 1996).

### **(7) Decision-Making and Implementation**

Finally, no priority setting approach guarantees that anything will change. If there is a recommendation from a priority setting exercise that resources could be redeployed in some way that is judged to be an improvement then clearly, what is wanted as an outcome is that that this actually happens. Dealing with this aspect is not well reported in

the international literature. It would be wrong to place the blame for any lack of implementation at the door of the techniques but equally wrong to argue that this is an issue that can be ignored.

## A Way Forward for Canada

### Current Proposals

The notion of medical necessity enshrined in the Canada Health Act provides the current mechanism for delimiting the scope of public insurance. The term is not defined however and there is considerable leeway in how the term could be and has been made operational (Hurley, Birch, Stoddart et al. 1997, Charles, Lomas, Giacomini et al. 1997). Coverage is essentially left to the provincial and territorial ministers to decide in negotiation with their medical practitioners.

Evans and colleagues (1993) provide one rationale for understanding what services might or might not be covered by Medicare and add some substance to the term medical necessity in the process. They suggest that public coverage for a particular service or health intervention should depend on the answers to four questions: (1) Is the service in question health care? (2) Is it effective for a well-defined medical condition? (3) Is it necessary? (4) Are there alternative, equally effective methods of delivering the service? A positive answer to each of the first three questions would ensure that a service would be covered under the public system, but coverage would be limited to the least cost method of delivery.

The authors argue that the principle captured by each question is clear, though they agree that it will not always be easy to say whether a particular service does or does not pass each test. The ‘necessity’ condition undermines their claim to clarity however. The inclusion of this question in a process that is supposedly about *defining* medical necessity is explained by the need to exclude services that are technically beneficial since they yield positive outcomes, but the outcomes achieved are not as highly valued as their opportunity cost. The question therefore relates more to the economic efficiency of the service rather than its necessity. It follows that what constitutes ‘necessary care’ will depend on what factors are included in the measure of benefit. This can be defined very narrowly (in terms of physiological changes experienced by the individual receiving care), very broadly (to include general changes in well-being of both the recipient of services and the people who care about him or her), or anywhere in between these two extremes (Hurley, Birch, Stoddart et al. 1997). The definition of necessity therefore requires a prior judgment to be made about the rightful objectives of health service provision.

Three further proposals for determining the extent of public provision have been made in the Canadian context. The most recent of these is the Alberta government’s decision to establish an expert panel to review and possibly de-list insured health services (Alberta Health and Wellness, 2002). The panel has not yet been established, but there is no reason to believe that it will succeed where previous attempts to de-list services have not.

The second proposal is the Canadian Medical Association's framework for determining core and comprehensive services (Wilson, Rowan and Henderson 1995). This recognizes the three levels of decision-making and suggests three dimensions to be considered at each level - quality of care, ethics and economics. The levels of decision-making are mapped against the three dimensions of importance to form a matrix within which it is possible to locate a series of questions to be considered in respect of priority setting. The authors of the framework candidly admit however that it does not prescribe which services should be publicly insured. Further, to argue that quality of care, ethics and economics are wholly independent of each other is unlikely to hold true in practice.

The third suggestion is the four-screen model advocated by Deber and colleagues (1998). This is similar to the Dutch approach in utilizing four questions arranged hierarchically. The first screen rules out interventions that are proven to be *ineffective*. The second screen serves to identify whether the intervention is *appropriate* for the particular individual in need. The third screen relates to *informed choice* and considers whether the patient wants the service.

Only interventions that are effective, appropriate and wanted pass through to the fourth screen, which is used to consider whether the service should be *publicly funded*. The authors suggest a number of factors to be taken into account at this stage including the question: is it acceptable for society to withhold a treatment that is effective, appropriate and wanted from people who are unable to pay for it themselves? The answer to this question is clearly critical. The previous screens weed out easy candidates for exclusion – the ineffective, the inappropriate and the unwanted – but since intuition and the international experience suggest that so few services fall clearly into these categories the impact of the screening process is unlikely to be substantial. The problem then still remains of deciding how to determine whether a service should be publicly funded or not.

Such structured approaches appear logical but are not consistent with the way resource allocation decisions are made in practice (Hurley, Cosby, Giacomini et al. 2000). In particular, the question driving each of these approaches is not the appropriate one. There is much more of a need to grapple with how much of which services to provide for whom rather than the question of which services to provide at all. The former is a much more subtle question. It is also a much more realistic question. It requires consideration of the trade-offs between dimensions.

## **A New Approach**

One advantage that stems from Canada's delayed efforts to confront the issue of priority setting is that it is possible to learn from the experiences of others. No other country has completely solved the problem but in their efforts, the key components of a comprehensive approach to priority setting in public systems can be identified. We suggest four essential requirements. The first is a constitution for health services in Canada that among other things would state the principles upon which the Medicare system should be based. The second is to strengthen the evidence base upon which resource allocation decisions are made. The third is for a decision-making framework that

allows the principles articulated in the constitution to be translated into policy and practice, supported where possible by evidence. Finally, there needs to be an appropriate incentive structure to ensure that recommendations are acted on.

Each of these requirements is explained further below.

### **(1) A Canadian Constitution for Health Services**

The first and most important requirement for fair and acceptable priority setting is a constitution for health services (Mooney and Wiseman 1999) or health service charter (Harrison, Dixon, New et al. 1997). We opened this paper by restating Canadians' wish for a system that is comprehensive and universally available without barriers to access. It is timely to revisit the aspirations that Canadians have for their health care system to ascertain the trade-offs that they are prepared to make. This needs to be done in a way that is capable of being managed by those asked to do this (i.e. Canadian citizens) and it must produce answers that will be useful to the decision-makers.

However, the constitution needs to do more than just describe the characteristics of the system that are seen as desirable. There needs to be agreement that the principles will be used to prioritize publicly funded health care and, more fundamentally, to decide what is publicly funded and what is privately funded and to what extent. It is thus the constitution that, once set by the community, both legitimizes rationing decisions and allows an appropriate public/private funding mix to be decided. For example if equity is an important principle, that will point to more public funding; if choice, then private funding will be more likely to be favoured.

These are big issues. It is significant that most of the debates surrounding health care not only in Canada but worldwide revolve around the questions of mechanisms such as how to pay general practitioners, how to fund hospitals. The question of the value base or principles on which health services are to rest gets scant attention. Our thesis is that that needs to change.

Whose values to use is clear. This has to be the values of the community that these health services are to serve. They will be overarching values, for example at a national level or provincial level in Canada. They will provide the foundation on which any priority setting process is to be based. To form them will require an informed community. They will not generally relate to priorities between diseases or groups of patients when the information required will be perhaps too much for citizens to handle but will instead relate to a higher level where citizens will most want to be involved. Having set out such principles, i.e. a constitution, it will then be for the health service decision-makers to attempt to abide by these in their decision-making.

The word constitution in this context is drawn from a branch of economics known as constitutional economics. It is argued for example by Vanberg (1994) that organizations may have one of three foci: exchange, which amounts to a market base; goal directed, which involves the objectives of the organization being centre stage; or 'constitutional' which focuses on the values or principles on which the organization is based. As such,



there is no necessary link in this form of constitution to any legal framework or to rights or responsibilities as may occur with other uses of the term. At the same time, there will be a right of the community periodically (perhaps every five years say) to examine decisions that have been made to see whether the principles are being adhered to and to revisit the constitution to see if it needs adjustment. The constitution therefore also provides an accountability mechanism as well.

There are various ways of pursuing such a constitution including, as is intended in Western Australia later this year, a health service "Constitutional Convention". This requires an ambitious agenda of public deliberation and debate to establish the most appropriate mix of ethical principles on which to allocate health care – efficiency, equity or judicial claims, the trade-offs that citizens are prepared to make between such principles and the amount that they are willing to pay for a collective health system.

These questions cannot be answered in the abstract. Many people will be uncertain of their values and come to realize them only by considering the choices that those same principles are supposed to guide and inform. The trade-offs that people will be prepared to make will also be context-specific and depend on how much of which sorts of services are already available in an area. An iterative process of deliberation and decision is required and, to ensure this, we need to look towards British and Australian experiences in involving the public and incorporating their values in the priority setting process (Mooney, Jan and Wiseman 1995).

## **(2) Strengthen the Evidence Base**

Irrespective of the combination of principles that are chosen for the health system, decision-making must be informed about the likely costs and effects (broadly defined) of varying levels of and types of investment in health care. Only then will Canadians know how well they are achieving their objectives and what the price or opportunity cost of this is. There is a need for a commitment to provide this evidence and a requirement that relevant practice and policy guidelines embrace costs as well as outcomes.

The structure and possibly even the financial resources to generate this information are already available in both the Canadian Health Services Research Foundation and the Canadian Institute of Health Services Research. The need to set priorities and ration health services could provide a strategic focus for the research agendas of both organizations. At the same time, the criteria for assessing the quality of evidence will have to be widened and strengthened in order that a greater emphasis on evidence-based decision-making does not bias priorities in favour of those interventions where evidence is more easily obtained (Rychetnik, Frommer, Hawe et al. 2002).

## **(3) A Decision-Making Framework**

Thirdly, there needs to be a practical mechanism for setting priorities to ensure that resource-allocation decisions are consistent with the principles embodied in the constitution. The models that have been proposed for Canada provide a framework, but one that we suggest is deficient and of little practical value for decision-makers.

More useful is a practical mechanism for considering resource allocation decisions such as that provided by PBMA. This process starts with the services that are currently being provided and looks for marginal shifts in resources within and across programs in order to bring service provision in line with resource constraints in ways that are consistent with the objectives set for the system. This makes the complex question of priority setting more tractable and provides a structure that marshals the relevant evidence without supplanting the need for judgment.

PBMA recognizes that priority setting is about choice. It is about choosing what to do and about the extent to which competing policies, services and activities can and should be pursued. It is also clear that in choosing in this way, it is implied that it is better to make explicit that such choices also involve choosing what not to do.

Priority setting thus involves determining objectives and then setting up mechanisms to decide how choices are to be made to try to meet competing objectives as well as possible. In doing so economics provides two useful concepts.

1. *Opportunity cost* stems from the recognition that scarcity of resources exists and there is a need to choose. Opportunity cost is the benefit forgone in the best alternative use of resources. Thus every time a choice is made to devote more resources to, for example, education, there is an implication that the benefits forgone elsewhere (such as in health care) are less than the benefits obtained in education.

2. *The margin* relates to change, strictly a change of one unit. Thus, *marginal cost* is the cost of producing one extra unit of health care; *marginal benefit* the benefit of that extra unit. In practice, marginal cost and marginal benefit are often equated with incremental or decremental costs and benefits. The emphasis however remains on change.

In combination opportunity cost and the margin lie at the heart of any rational priority setting approach. If more resources are spent on prevention and fewer on cure, what are the resultant changes - what are the marginal changes - in costs and benefits? If fewer resources overall are available for health care what are the losses in marginal benefits from making the savings in acute services rather than in public health? in community care rather than general practice?

The PBMA process involves two stages. First *program budgets* are determined that provide an information framework, indicating what is being spent on what. Program definitions are normally along client group or disease group lines. The rationale behind such a set of programs is simply that if priorities are to be changed then this will mean altering the existing balance of resource use and to do that it seems like a good idea to know what the current balance is!

The *marginal analysis* part of the exercise is equally as simple, in principle at least. If \$X is taken from one program and spent on another, will the loss of benefit in the former be greater or less than the gain in benefit in the latter? While such judgments can be hard

to make in practice, they have to be made and this is the cornerstone of the whole process of PBMA. It is a simple process and perhaps the greatest problem in gaining acceptance of it is that so often the potential participants in PBMA exercises are looking for something more complicated than is in practice or in principle there. If it is possible to move \$100,000 from program A to program B and get greater benefit overall, should that not happen?

One possible argument against moving resources on the basis alone of maximizing benefit is that there may be unacceptable equity effects. These have to be built into the analysis and any possible conflict between equity and efficiency identified explicitly. One way of dealing with this is to assign greater weight to the benefits enjoyed by some groups in the community (e.g. poor people) compared to others.

The question of whose values to use in priority setting is important. There is a case for using community values, especially as issues about the relative weight and value to be attached to benefits to the most disadvantaged or those most at risk are in essence society or community issues and not professional. (There is still room for technical judgments at these levels and also for such technical values to dominate particularly at the 'sharper' end of the spectrum, e.g. in health care within specialities where decisions may have to be made about, say, which patients to take off the waiting list first.)

Turning to equity concerns, there are explicit formulae for allocating resources to health services on a geographical basis. However this is done or to be done, the normal mechanism involves some assessment of the needs of different populations weighted for various factors so that resources are then allocated on a 'fair' basis. The principles and practice underlying such approaches are relatively straightforward but benefit considerably from being spelt out explicitly and not allowing the measurement problems here to dominate.

The combination of PBMA and citizen involvement that would be encapsulated in a constitution for health services would also provide the institutional structures needed to support a systematic approach to priority setting (Ham and Coulter 2001).

#### ***(4) An Appropriate Incentive and Institutional Structure***

The final requirement is for a mechanism to ensure that the recommendations generated by priority setting exercises are acted on. Rules-based approaches to enforcement are too rigid and bureaucratic, allowing no leeway to accommodate individual circumstances. Discretionary approaches however are too easily exploited: all cases become special ones and priority setting is undermined. A better alignment between incentives and the objectives of the system should help but no single approach is likely to bridge this gulf entirely. Greater explicitness and the accountability mechanisms embodied in the constitution offer some protection against vested interests coming to dominate the priority setting dialogue. A 'mini-convention' could bring community representatives and managers together, perhaps annually, to review how resources have been allocated and how well this fits with established principles; and if there are departures then why.

## Unanswered Questions

These recommendations draw on the best of the experiences gained elsewhere, but they do not yet provide a complete solution to priority setting. A number of unanswered questions remain.

First, we have provided no *easy* indication of how the total spent on health care ought to be determined. There is no simple equation to determine the ‘right’ level of funding. Our recommended approach provides a flexible mechanism for responding to any level of funding, however. If health spending is increased, the mechanism identifies where the additional support should go to do the most good. If spending is reduced, it points to where cuts can be made with the minimum of harm. At an aggregate level therefore, it would be possible to say what gains would be realized if health spending were increased and what would be lost if spending were cut. This information could then be used to compare the benefits of reallocations between health and other public programs. The logistical problems of doing so are enormous, but conceptually this is the correct approach to determining the total spent on health care.

Second, the techniques of economic evaluation are not yet sufficiently well developed for people to have total confidence in the information captured in summary measures of cost-effectiveness. Cost-effectiveness ratios and league tables hide as much as they reveal (Birch and Gafni, 1994). Neither do they necessarily reflect the *social* value of health services (Menzel, Gold, Nord et al. 1999, Ubel, Scanlon, Loewenstein et al. 1996).

Third, despite its long history, there is still work to do done to improve the PBMA approach (Posnett and Street 1997). A critical weakness in practice is the problem in persuading decision-makers to identify candidates for dis-investment and re-allocate resources to services of higher value.<sup>2</sup> There are few incentives to do this and every reason for decision-makers to identify intra-marginal services that are unlikely to be candidates for cutbacks.

There is a major issue here and it is one that applies as far as we can judge to all priority setting techniques. Priority setting is about considering which resources as currently deployed might be better redeployed. In times of fixed or falling budgets (and also potentially even when budgets are increasing) this means shifting resources from A to B. The root problem here is getting decisions made that A will be cut. In turn, this relates to how one can gain acceptance that somebody has a responsibility for the maximization of whatever good it is that the Canadian people want from their health services and are given the tools and incentives to do this. Identifying where this responsibility is to lie and getting that responsibility exercised are at least as important as getting the priority setting approach right.

---

<sup>2</sup> Mitton and colleagues (2002) provide one of the first published examples of disinvestments being identified, with resources reallocated to service developments elsewhere.

Fourth, it is questionable whether a single structure can be used across the whole spectrum of health services, from population-based efforts to promote health through to palliative care. The limiting factor is the difficulty that decision-makers and the public will face when comparing the value of widely divergent programs. The beneficiaries of prevention programs, for example, are largely unknown and may not even be born yet. There thus needs to be some way of ensuring that their voice is heard along with clinicians and patients. Good public health programs are complex affairs requiring sophisticated research methods to evaluate them fully. Since such methods are rarely employed, the quality of the evidence in public health tends to be poorer than for other health services (Rychetnik, Frommer, Hawe et al. 2002). An over-simplistic interpretation of the evidence might then shift resources prematurely out of public health. In recognition of this danger, New Zealand introduced structures to prioritize separately preventive and clinical services. Sweden also recognized the special characteristics of preventive services and assigned them second priority behind life-saving interventions.

Finally, apart from the constitution, we have said little about what formal political or organizational structures need to be put in place to implement the priority setting model. It is likely for example that the trade-offs that Albertans are prepared to make will be different from those acceptable to Atlantic Canadians. Responsiveness to local values would lead to variation in the scope of publicly funded health care among provinces, which would challenge the integrity of the national system. The extent to which Canadians want a national system (and the implications this has for the Canada Health Act) should therefore be another of the values that a constitution should consider.

## **Conclusion**

Medicare is an important element in the social fabric of Canadian life but Canadians' commitment to the public health system is being undermined by political reluctance to confront the need to set priorities. The Medicare system is sustainable but only if steps are taken to bring private expectations of what the system should provide Canadians as individuals in line with what they are willing to pay for that system as citizens. Fortunately, there is no shortage of experience in addressing this problem and we can take advantage of lessons learnt elsewhere. The model that we suggest does this. It incorporates both community values and professional judgment and provides a structure in which both can be brought together to determine policy. It also provides a means of shaping expectations and providing legitimacy to the tough decisions that need to be made. Where yet more thought is needed is in how to get from recommendations arising from priority setting exercises to implementation. It is this issue that now needs to be addressed.

## References

- Alberta - Alberta Health and Wellness. "Alberta Government's response to the Premier's Advisory Council on Health", *Building a better health care system.*, 2002.
- Anderson, GF., J-P Poullier. "Health spending, access and outcomes: trends in industrialized countries", *Health Affairs*, 18, 1999, pp 178-192.
- Ashton, T., J. Cumming, N. Devlin. "Priority-setting in New Zealand: translating principles into practice". *Journal of Health Services Research and Policy*, 5, 2000, pp 170-175.
- Birch, S. "As a matter of fact: Evidence-based decision-making unplugged", *Health Economics*, 6, 1997, pp 547-559.
- Birch, S., A. Gafni. "Cost-effectiveness ratios: in a league of their own", *Health Policy*, 28, 1994, pp 133-144.
- Bottomley, V. "Priority setting in the NHS", In *Rationing in Action*, R. Smith (ed), BMJ, London, 1993.
- Bowie, C., A. Richardson, W. Sykes. "Consulting the public about healthcare priorities", *British Medical Journal*, 311, 1995, pp 1155-1158.
- Charles, C., J.Lomas, M. Giacomini, V. Bhatia, V. Victoria. "Medical necessity in Canadian health policy: four meanings and ... a funeral?", *Milbank Memorial Quarterly*, 75, 1997, pp 365-394.
- Coast, J. "Explicit rationing, deprivation disutility and denial disutility: evidence from a qualitative study". In *The Global Challenge of Health Care Rationing*, A.Coulter, C. Ham (eds), Open University Press, Buckingham, 2000.
- Committee on Choices in Health Care (Dunning Committee) - Rijswijk, Ministry of Health, Welfare and Cultural Affairs, *Choices in Health Care*, 1992.
- Cookson, R., P. Dolan. "Public views on health care rationing: a group discussion", *Health Policy*, 49, 1999, pp 63-74.
- \_\_\_\_\_. "Principles of justice in healthcare rationing", *Journal of Medical Ethics*, 26, 2000, pp 323-329.
- Cookson, R., D. McDaid, A. Maynard. "Wrong SIGN, NICE mess: is national guidance distorting allocation of resources?", *British Medical Journal*, 323, 2001, pp 743-745.
- Culyer, AJ. "The rationing debate: maximizing the health of the whole community. The case for", *British Medical Journal*, 314, 1997, pp 667-669.

- Cumming, J. “Defining core services: New Zealand experiences”, *Journal of Health Services Research and Policy*, 2, 1997, pp 31-37.
- Deber, R., Narine L., Baranek P., Sharpe N., Zlotnik-Shaul R., Coyte P., Pink G., Williams P. The public – private mix in health care. In *Canada Health Action: Building on the Legacy, vol 4. Health Care Systems in Canada and Elsewhere*, National Forum on Health, Editions MultiMondes, Quebec, 1998.
- Department of Health. *Government Response to the First Report of the Health Committee, Session 1994-95, Priority Setting*, London, HMSO, 1995.
- Dolan, P., R. Cookson. “A qualitative study of the extent to which health gain matters when choosing between groups of patients”, *Health Policy*, 51, 2000, pp 19-30.
- Dixon, J., B. New. “Setting priorities New Zealand style”, *British Medical Journal*, 314, 1997, p. 86.
- Evans, RG., ML. Barer, GL. Stoddart, V. Bhatia. “It’s not the money, it’s the principle: why user charges for some services and not others?”, *Report to the Premier’s Council on Health, Well-being and Social Justice*, 1993.
- Ferriman, A. “Report suggests the NHS is not sustainable”, *British Medical Journal*, 319, 1999, p. 801.
- Frankish, CJ., B. Kwan, PA. Ratner, J. Wharf-Higgins, C. Larsen. “Challenges of citizen participation in regional health authorities”, *Social Science and Medicine*, 54, 2002, pp 1471-1480.
- Graves FL, P. Beauchamp, D. Herle. “Research on Canadian values in relation to health and the health care system”, In *Canada Health Action: Building on the Legacy, 5, Evidence and Information*, National Forum on Health, Editions MultiMondes, Quebec, 1998.
- Ham, C. “Health care rationing – the British approach appears likely to be based on guidelines”, *British Medical Journal*, 310, 1995, pp 1483-1484.
- Ham C, A. Coulter. “Introduction: international experience of rationing (or priority setting)”, In *The Global Challenge of Health Care Rationing*, Coulter A, Ham C. (eds), Open University Press, Buckingham, 2000.
- \_\_\_\_\_. “Explicit and implicit rationing: taking responsibility and avoiding blame for health care choices”, *Journal of Health Services Research and Policy*, 6, 2001, pp 163-169.



- Harris, J. "Maximising the health of the whole community: the case against: what the principal objective of the NHS should really be", *British Medical Journal*, 314, 1997, pp 669-672.
- Harrison, A., J. Dixon, B. New, K. Judge. "Funding the NHS: is the NHS sustainable?" *British Medical Journal*, 1997, 314, pp 296-298.
- Harrison S., DJ. Hunter. *Rationing Health Care*, Institute for Public Policy Research, London, 1994.
- Health Funding Authority. *How Shall We Prioritize Health and Disability Services? A Discussion Paper*, Health Funding Authority, Wellington, 1993.
- Holmstrom, S. *Sweden and priority setting*. <http://swahc.org/priority.htm>. downloaded 16 August 1999.
- Hurley, J., S. Birch, G. Stoddart, G. Torrance. "Medical necessity, benefit and resource allocation in health care", *Journal of Health Services Research and Policy*, 2, 1997, pp 223-230.
- Hurley, J., JL. Cosby, M. Giacomini, B. Hutchison. *Making resource allocation decisions in the health care sector: a review of some proposals*, HEALNet Occasional Paper No. 4, Regional Research Centre, Saskatchewan, 2000.
- Jordon, J., T. Dowswell, S. Harrison, RJ. Lilford, M. Mort. "Whose priorities? Listening to users and the public", *British Medical Journal*, 316, 1998, pp 1668-1670.
- Kitzhaber, JA. "Rationing in action. Prioritizing health services in an era of limits: the Oregon experience", *British Medical Journal*, 307, 1993, pp 373-377.
- Klein, R. "Priorities and rationing: pragmatism or principles?", *British Medical Journal* 1995, 311, pp 761-762.
- Klein, R., P. Day, S. Redmayne. *Managing Scarcity: Priority Setting and Rationing in the National Health Service*, Open University Press, Buckingham, 1996.
- Lenaghan, J. *Rationing and Rights in Health Care*, Institute of Public Policy Research, London, 1996.
- Lenaghan, J., B. New, E. Mitchell. "Setting priorities: is there a role for citizens' juries?", *British Medical Journal*, 312, 1996, pp 1591-1593.
- Lomas, J. "Reluctant rationers: public input to healthcare priorities", *Journal of Health Services Research and Policy*, 2, 1997, pp 103-111.

- Mays, N. "Legitimate decision-making: the Achilles heel of solidaristic health care systems", *Journal of Health Services Research and Policy*, 5, 2000, pp 122-126.
- Menzel, P., MR. Gold, E. Nord, J-L. Pinto-Prades, J. Richardson, P. Ubel. "Towards a broader view of values in cost-effectiveness analysis of health care", *Hastings Centre Reports*, May-June 1999, pp 2-10.
- Mitton, C., C. Donaldson, S. Dean, B. West. "Program budgeting and marginal analysis: a priority setting framework for Canadian regional health authorities", *Healthcare Management Forum*, 13, 2000, pp 24-31.
- Mitton, C., S. Patten, H. Waldner, C. Donaldson. "Priority setting in health authorities: a novel approach to a historical activity", Mimeo, Centre for Health and Policy Studies, University of Calgary, 2002.
- Mooney, G. "Communitarian claims as an ethical basis for allocating health care resources", *Social Science & Medicine*, 47, 1998, pp 1171-80.
- Mooney, G., K. Gerard, C. Donaldson, S. Farrar. *Priority Setting in Purchasing: Some Practical Guidelines.*, National Association of Health Authorities and Trusts, Birmingham, 1992.
- Mooney, G., S. Jan, V. Wiseman. "Examining preferences for allocating health care gains", *Health Care Analysis*, 3, 1995, pp 261-5.
- Mooney, G., V.A. Wiseman. "constitution' for health services", *Journal of Health Services Research and Policy*, 4, 1999, pp 195-196.
- National Advisory Committee on Core Health and Disability Support Services. *Core Services for 1995/96*, National Advisory Committee on Core Health and Disability Support Services, Wellington, 1994 .
- Naylor, CD. "Healthcare in Canada: incrementalism under fiscal duress", *Health Affairs*, 18, 1999, pp 9-26.
- New, B. (on behalf of the Rationing Agenda Group). "The rationing agenda in the NHS", *British Medical Journal*, 312. 1996, pp 1593-1601.
- Nord, E., J. Richardson, A. Street, H. Kuhse, P. Singer."Maximizing health benefits versus egalitarianism: an Australian survey of health issues", *Social Science and Medicine*, 41, 1995a, pp 1429-1437.
- \_\_\_\_\_. "Who cares about cost? Does economic analysis impose or reflect social values?", *Health Policy*, 34, 1995b pp 79-94.

- Oberlander, J., T. Marmor, L. Jacobs. "Rationing and medical care: rhetoric and reality in the Oregon Health Plan", *Canadian Medical Association Journal*, 164, 2001, pp 1583-1587.
- Organisation of Economic Co-operation and Development. *OECD Health Data 2001*, OECD, 2001.
- Office for Oregon Health Plan Priority and Research. *The Uninsured in Oregon, 1998*, The Office, Salem OR, 1999.
- Oxfordshire Priorities Forum. *Priority Setting in Practice*, Oxfordshire Health Authority, 2001.
- Posnett J, A. Street. "Programme budgeting and marginal analysis: an approach to priority setting in need of refinement", *Journal of Health Services Research and Policy* 1, 1997, pp 147-152.
- Premier's Advisory Council on Health. *A Framework for Reform*, Premier's Advisory Council on Health, Alberta, 2001.
- Royal College of Physicians. *Setting Priorities in the NHS: A Framework for Decision-making*, RCP, London, 1995.
- Rychetnyk, L., M. Frommer, P. Hawe, A. Shiell. "Criteria for evaluating evidence of public health interventions", *Journal of Epidemiology and Community Health*, 56, 2002, pp 119-127.
- Shiell, A. Health outcomes are about choices and values: an economist's perspective on the health outcomes movement. *Health Policy*, 5, 1997, pp 5-15.
- Stoddart, GL., ML. Barer, RG. Evans. *User charges, snares and delusions: another look at the literature, Report to the Premier's Council on Health, Well-being and Social Justice*, 1994.
- Tengs, TO. "An evaluation of Oregon's Medicaid rationing algorithms", *Health Economics*, 5, 1996, pp 171-182.
- Ubel, PA., D. Scanlon, D. Loewenstien, M. Kamlet. "Individual utilities are inconsistent with rationing choices: a partial explanation of why Oregon's cost-effectiveness list failed", *Medical Decision-making*, 16, 1996, pp 108-119.
- Vanberg, VJ. *Rules and choice in economics*, Routledge, London, 1994.
- Weale, A. "Rationing health care", *British Medical Journal*, 316, 1998, p. 410.

- Williams, A. "Intergenerational equity: an exploration of the "fair innings" argument", *Health Economics*, 6, 1997, pp 117-132.
- Wilson, R., MS. Rowan, J. Henderson. "Core and comprehensive health care services: I introduction to the Canadian Medical Association's decision-making framework", *Canadian Medical Association Journal*, 152, 1995, pp 1063-1066.
- Wiseman, V., G. Mooney, G. Berry, KC. Tang. "Involving the general public in priority setting: experiences from Australia", *Social Science and Medicine*, forthcoming.