Rationing in a Beveridge system: Adopting Bismarckian patient choice a conundrum?

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Overview

- Optimisation of healthcare systems
- How achieved – equal access, universal, comprehensive, free?
  - Beveridge vs Bismarck
- Rationing measures – explicit, implicit
- Introduction of patient choice in the NHS
  - Convergence towards Bismarck?
- Role of patient choice in cost containment

Optimisation of healthcare system?

- Universal
- Comprehensive
- Equitable
  - geography, needs, severity of ill-health
  - waiting time, age, lifestyle
- Free/low cost to the patient
  - Cost containment and cost effectiveness
- Quality of healthcare? Patient choice?

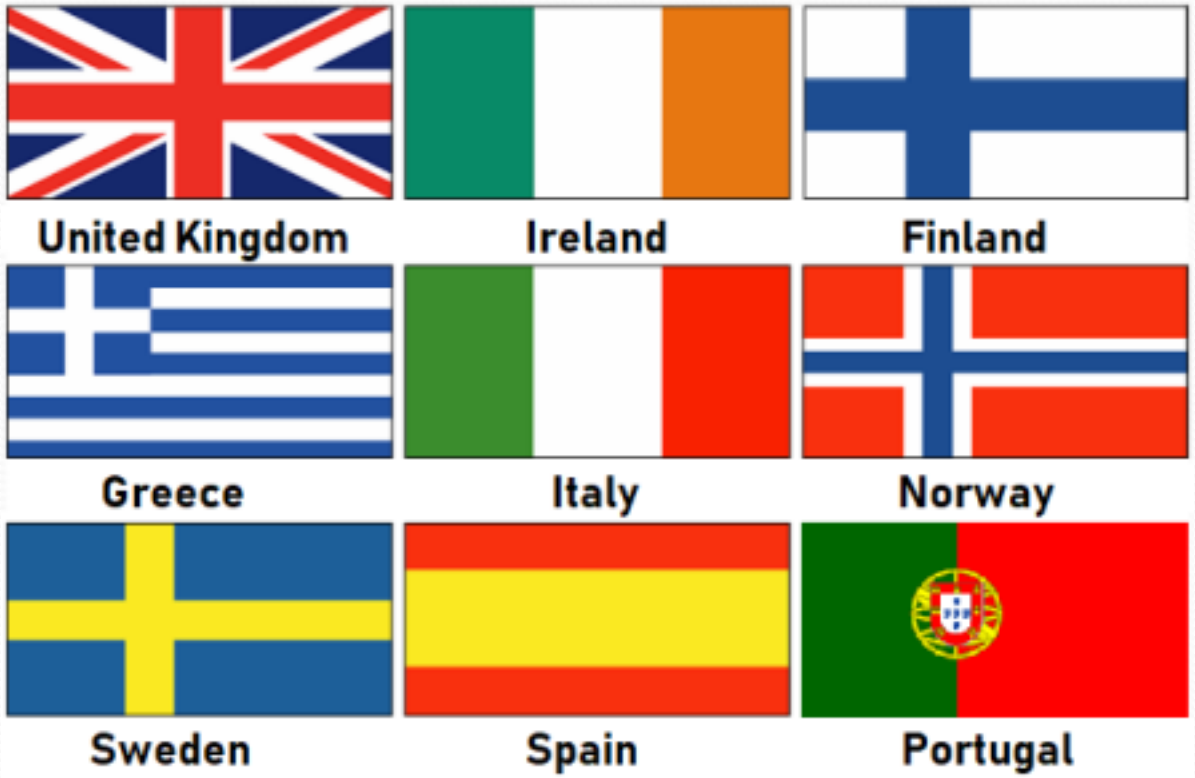
Two basic types of health systems in Europe

- Beveridge
  - tax-based
  - more equitable access/ universal coverage
  - Cost containment
  - But: choice? Waiting times?

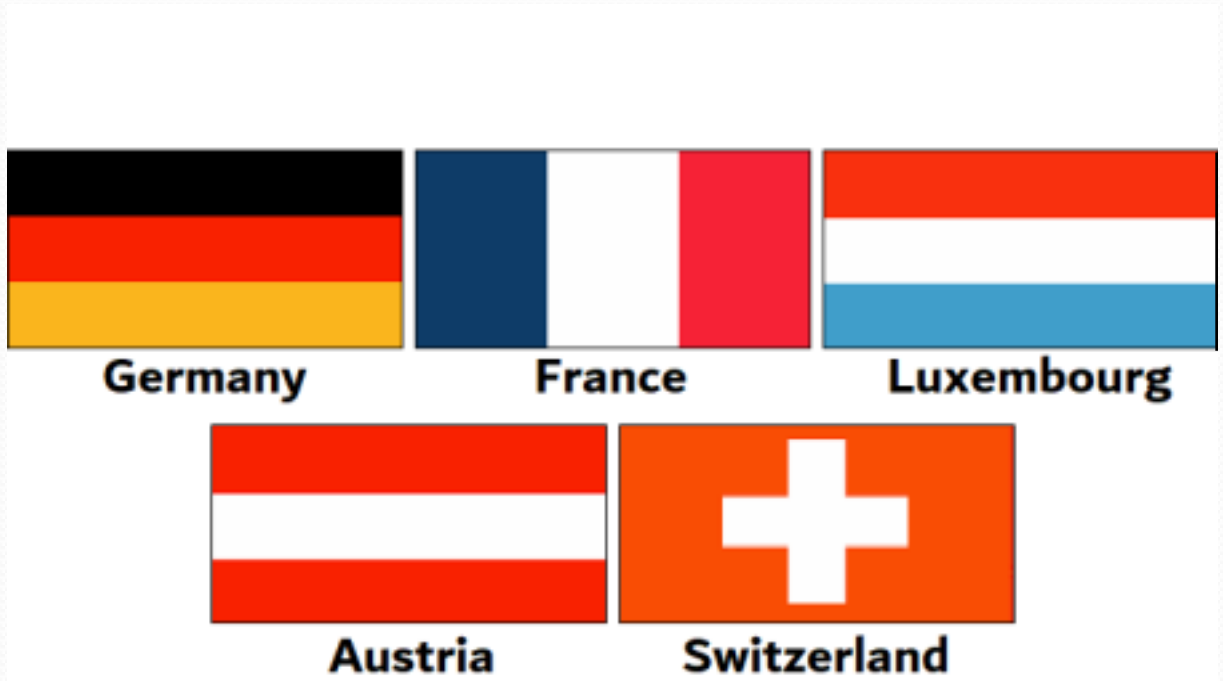
- Bismarck
  - insurance-based
  - abundance of choice.
  - But: cost containment?
  - government control/regulation

Beveridge and Bismarck

Beveridge

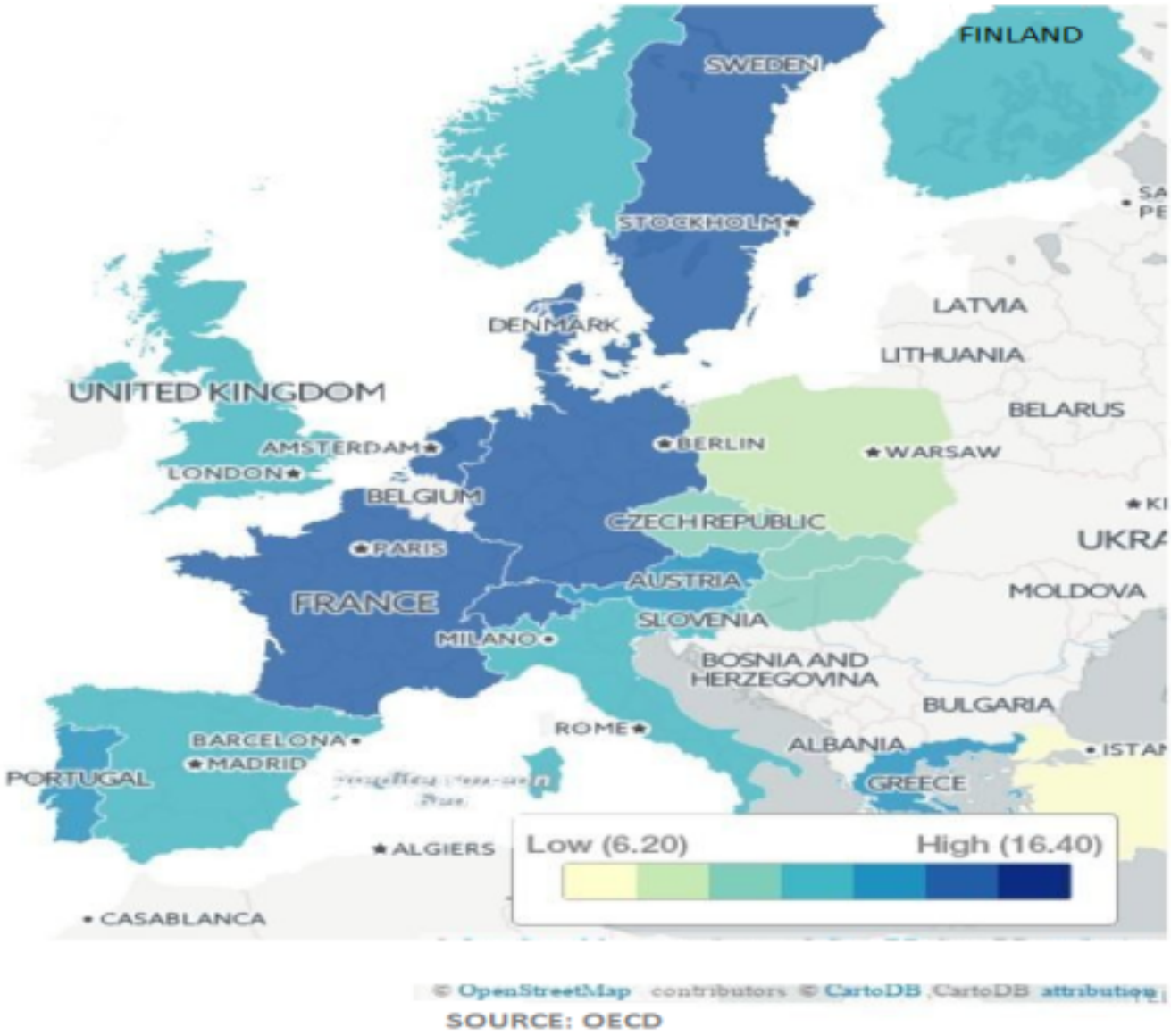


Bismarck



Total expenditure on healthcare

Percentage of GDP (2013)



WORLD ECONOMIC FORUM

COMMITTED TO IMPROVING THE STATE OF THE WORLD

Healthcare budgets are finite: how to contain costs?

- Implicit/explicit rationing
  - Clinical discretion
  - Rationing by delay
    - Waiting lists (*Watts* and patient mobility in EU)
  - Rationing by restricting the types of medical problems to be treated/range of treatments available on NHS
  - Rationing by exclusion, dilution, deterrence etc.

NHS: Explicit rationing?

- Rationing on the basis of clinical guidelines and 'objective' cost effectiveness appraisals
  - NICE (National Institute for Health and Care Excellence (NICE)
  - **QALYs (Quality-Adjusted Life Years)**
- Problems with approach:
  - NICE guidelines not binding
  - QALYs: lack of fairness: emphasis on life expectancy and QoL
    - Discrimination of elderly and disabled? Needs?

Choice in the NHS – a paradox?

Aneurin Bevan

The principles of the NHS

- ‘to provide the people of Great Britain, no matter where they may be, with the same level of service’.
- ‘will provide you with all medical, dental, and nursing care. Everyone – rich or poor, man, woman or child – can use it or any part of it. There are no charges except for a few special items … But it is not a charity. You are all paying for it, mainly as taxpayers.’

Choice as a new policy in the NHS – convergence with Bismarckian approach?

- The NHS Choice Framework (2016)
  - Choice of GP
  - Choice of hospital or hospital consultant
  - Choice in maternity services
  - Choice in end of life care
  - Choice of a personal health budget
  - Choice of access to required treatment in another EU member state
    - Patient Mobility Directive 2011
- Does choice (as a neoliberal/market-based concept) fit into the tax based national healthcare model?

Consistency of patient choice policy with core values of NHS?

- Equity
  - Choice has negative effect on distributive justice when resources are finite
    - Wealthy/articulate able to take advantage of choice
    - Differences in health literacy of different socio-economic groups
- Comprehensiveness
  - Demand for inappropriate treatment/ineffective treatment?
- Universality
  - Wants/choice by everyone exceeding available healthcare budget

Different strands/meanings to patient choice

- Choice as liberal right
- Choice/personalised healthcare as consumer right
  - Patient empowerment?
  - Electoral gain
- Choice as a mechanism/political strategy to achieve change

Choice as political strategy

- New Labour (*High Quality Care for All*, 2008)
  - Importance of 'self-management and personal responsibility'
- Coalition government (*Liberating the NHS: Greater Choice and Control*, 2010)
  - 'taking responsibility for choices,…and the implications that the choices have on healthcare and lifestyle'
  - emphasis on 'shared responsibility' and on 'healthcare partnership'
- Personal health budgets/personalised care (2015 to date)
- NHS Constitution 2015
  - 'recognise that you can make a significant contribution to your own … good health and wellbeing, and take personal responsibility for it.'

Choice is a proxy for other policies

- At the level of the patient/micro-level
  - Patient empowerment
  - Giving individuals more control over the management of their health
  - Making patient responsible for his health

  = supportive of social solidarity
- At the level of the healthcare organisation/macro-level
  - greater responsiveness of the NHS
  - quality improvement
  - institutional/ administrative modernisation
  - Public service reform

  = cost containment

Conclusion: convergence of healthcare systems?

- Balance between promoting choice, preserving equity of access and cost containment is major driver of health reform in European countries
  - without necessarily any convergence of the healthcare systems
- Choice in the NHS is a response to social change and an instrument of change
  - to encourage reform, greater efficiency and responsiveness and cost containment.
- Choice not simply a proxy for marketization
  - But may reduce cost but, counter-intuitively, reduce need for rationing

Thank you very much for listening!

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QALY – QUALITY-ADJUSTED LIFE YEARS

- QALY is an attempt to compare the cost-effectiveness of different treatments
- Quality of life scale: 0 = death to 1 = full health
- QALY score = (Post-treatment life expectancy x quality of life score) – (pre-treatment life expectancy x quality of life score)
- Pre-treatment patient X has 2 years life expectancy at 0.5 quality of life. Treatment would give patient X 6 years of full health/QoL.
  - QALY score = 6 x 1 – 2 x 0.5 = 5
    - cf for patient with same life expectancy pre-treatment but lower life expectancy post-treatment
- Treatment costs A for patient X is £50,000. Cost per QALY would be £10,000.
  - Cf higher treatment costs and costs per QALY
  - **NICE accepted affordability threshold in NHS for treatment is £30,000 per QALY**