On 5 May 1998, I was invited to address the (then) South West Sydney Area Health Service and the Simpson Centre at Liverpool Hospital, south-west of Sydney. I chose to speak on rationing in the health services.

You are very brave to discuss rationing and to invite an outsider to discuss this awkward matter with you. Rationing there is, but the standard of breakfast out here is still excellent. We might start by asking why each of you does not have a Rolls Royce car. It is, after all, the best available car, has the best motor, the best body, the best fittings.

It is also the most expensive kind of car.

You might respond that you cannot afford to buy or maintain such a car. That is called budgeting. You do it every day at home. You make careful decisions about the use of your money. It is being done in the hospital and medical services too. They are not purchasing the Rolls Royce equivalents for hospitals. And it is being done by governments.

There is another thing about the choice of car. Each of you will have made a decision that involves trading off the cost of purchasing and maintaining a car with alternative uses of your money, with the cash flow you might have and with your judgment about what is most important to you. You probably could have afforded an expensive car but decided to put considerations of initial cost, of cost of spare parts, of insurance costs, of maintenance costs, of servicing costs, into a big equation and to make a judgment that takes all those factors into account.

What you did was to use opportunity-cost thinking. The use of a dollar for one purpose means that it is no longer available for another purpose. This is called an opportunity-cost decision by economists. You use opportunity-cost judgments
every day. You are skilled at making them. So do clinicians and administrators make opportunity cost judgments. So do governments. Now we are ready to consider rationing.

There is a story about this area that gives some flavour of south-west Sydney. My friend and predecessor Ian Webster set up a drug and alcohol service soon after he came here. It quickly became apparent that there needed to be a methadone maintenance program for heroin users living in the area. But he had to get authority for such a program. When he went before the august body which deals with such matters, he was asked did he want 20 or 30 places on his methadone program. He responded that he wanted 250 places—for a start. So we all understand that there is a lot of unmet need here.

A famous health economist once articulated three simple theorems for me. The first is that resources are finite. The second is that resources have alternative uses. The third is that people disagree about the alternatives and about their relative importance. Let us consider all three propositions.

First, there is the proposition that resources are finite. We could look at this by asking how much different economies spend on hospital and medical services. It ranges, in industrialised countries, from about 6 per cent of national income to about 16 per cent. Now that is quite a spread. The spread itself should set alarm bells ringing in our heads. It happens that the wealthiest of all countries spends the largest amount and the highest percentage on hospital and medical services and the United Kingdom spends towards the lower end. If trends continue almost all increases in the national wealth of the United States will be used in the hospital and medical areas over the next few decades. What is interesting is that such measures as we do have suggest that outcomes such as survival, patient satisfaction, infant mortality are no better in the country with the highest expenditure than in the country with the lowish expenditure. It seems that expenditure and outcomes are only proximately related at best; some say that there is little relationship between outcomes and services as far as society as a whole is concerned.

Some react to the shortage of resources by saying only that the cake should be larger. They say that they should exercise no discipline, they should be allowed to do whatever they wish—to meet the needs that individuals present to them, and that others should give more to allow all this to happen. Perhaps they are right—and incidentally, you here in south-west Sydney are gaining some money now under a complicated arrangement within New South Wales. But someday the increases will cease. And then you will be like most of us.
Let us return to the person who says the cake should be larger. Suppose it was larger. Just suppose for a moment that I was again minister for health and that, because of my eloquence, the Cabinet increased the percentage of the Budget going to health. Do you imagine that I could gain more than about 2 per cent—which has to come, incidentally, from other areas—or do you imagine that I could do the same thing year after year? Or do you think that after one or two years I would be back with a fixed cake—even if it was larger than it had been initially?

The second theorem says that resources have alternative uses. At the level of government those uses might be defence related, or education related, or for building dams or roads. Within an area or within a hospital there are also alternative uses for any dollar—and the competition for resources is unremitting and bitter. And do not forget—if we use a dollar for one purpose, we cannot use it for another.

The third theorem says that values are important, that people disagree about the relative values of different uses. This is important. Some people actually own Rolls Royce cars. Just because I see the importance of spending in hospitals or for medical services does not mean that someone else will give these matters the same relative importance. Most of us give lip-service to different perceptions—until someone disagrees with our set of priorities. But beware—on matters of judgment, they are as likely to be correct as we are.

Rationing has always been with us. It is just that it has been implicit and hidden away, made easier by two features of hospitals as they used to be. The first was the idea of hospitals as self-contained and self-serving entities instead of hospitals as area resources. In the old system of belief, they were answerable only to themselves; when I worked at Royal North Shore, we did not know and did not care what the health of the lower North Shore of Sydney was like. That is no longer the case.

The second feature had to do with the more extreme paternalism of the professions that made decisions and controlled resources back in the bad old days. You will have to decide for yourselves if that has changed at all. I think it is still a problem.

So let us state some basic points. There is not enough to go around. There is not enough to do for everyone what we would wish to do. Such a proposition may offend your sense of social justice. You may feel that people in medical need should be able to access whatever is needed.
Well, they cannot. People miss out. People suffer and die when treatment for them exists, or they wait, when treatment is available for some, but not for them. By the way, a wait of nine months for someone aged 70 is a substantial percentage of their remaining average life span.

We had an unwritten rule when I was a young doctor. Haemodialysis was new and rationing was essential; there were more people with renal failure than there were places on the then new dialysis program. We determined that no-one over the age of 60 could receive dialysis. I am now 63—and believe that was a ridiculous restriction. But it was never discussed, never justified, never argued, never made explicit, never publicised. It just existed and it was implemented. People won and lived and people lost and died with treatable renal failure.

Sometimes rationing is by failure to provide service at all, sometimes by restricting new modalities so that MRI machines or lithotripters are restricted in number and location, sometimes by making people wait—rationing by queues, we call it—and people get around that by fudging the urgency of their condition or by paying or by calling in political support. People do all kinds of things to get around rationing. Let me tell you a story about that.

Some years ago a person developed a form of leukaemia for which an unrelated donor marrow transplant was considered. The person was eleventh on the list but pulled out political stops; the local paper and television publicised the case—shock, horror—and the minister eventually ordered the area to give the treatment, irrespective of the medical imperatives, thus bumping someone else down the list. Incidentally, the patient died rapidly.

It does not matter how many resources the government gets into this area or how well Ken Brown deploys what is available. There will never be enough, people will always have to wait, some will find that they cannot access services, some new modalities will not exist here, and so on. Rationing will be as real here as it is elsewhere—and as it has always been.

One US philosopher has put up for consideration that we might have to limit use of publicly provided resources to those below a certain age. Above that age they would have to demonstrate poverty or provide for themselves. You may find this offensive but it is really no more reasonable or unreasonable than almost any other system of rationing.

What they did in Oregon in the United States was instructive. There they made a threshold decision that choices about rationing should be made by the public and not by the providers of services. Having made that decision, they then set up a process and ended up with a list of procedures in priority order, which they funded until the money ran out. Now, there were faults in almost every part of
the process—but the principle is what we need to look at. Oregon asserted that those who pay taxes and provide revenue should have some say in how that revenue is spent.

The United Kingdom took a different approach to what I will call explicit rationing. In one part of that country they established citizen juries, randomly selected, to hear submissions from experts, rather as barristers put submissions before a court. People argue for and against particular interventions and set out the opportunity costs of each. The juries then do as juries do elsewhere—and decisions are made. No providers can serve on juries. Neither can advocates for any particular group or disease.

The real questions for you include:

• do you believe that the public should make decisions about how their taxes should be used? If so, how might community input be obtained
• do you believe that ‘best decisions’ are being made now
• how might you design a process to make those decisions?

There are existing models elsewhere that you could use. There is a lot of interest in the subject of how we share what is available. There is a need for an important area like this one to get things correct.

Lest I be accused of cowardice, let me state my position. Those who pay taxes have the right to say how revenue should be spent. Providers have few rights to make decisions for competent people. And limited resources should serve citizens ahead of providers. It is over to you. This is the issue of the time. I hope you can provide some answers.
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