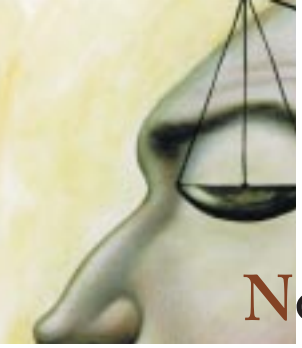

Notes from the Editor-in-Chief

HEALTHCARE RATIONING is a controversial topic that often incites a great deal of emotion. The very idea of rationing health services is viewed as heresy by some, while for many people the notion that most countries indulge in some form of rationing is considered, at a minimum, inappropriate. We are grateful, therefore, to Peter Ubel for having the courage to write his book *Pricing Life*, and for presenting his arguments in this issue of Healthcare*Papers*. His paper provides an excellent foundation for constructive debate.

In this issue of *Papers*, "rationing" might be defined as an economic strategy, with the caveat, as Ubel points out, that the word can be interpreted in a variety of ways. Other examples of our society's sensitivity to language abound. For example, the words *need, supply* and *demand* are often confusing and open to different interpretations.

Need tends to be seen as a subjective concept, unlike supply and demand, which are generally thought to be more easily quantified. Several different types of need have been identified. Health experts define "normative" need based on norms and averages across the system. "Felt" need and "expressed" need are defined as what patients experience and what impels them to obtain the services they want. "Comparative" need is concerned with equalities in access to services by different groups.

Supply commonly refers to the quantity and quality of services that providers are willing to offer for sale. Most attempts by governments to rationalize services have been to adjust the supply side on the basis of expert opinion. *Demand* is usually understood to mean the expression of a need by an individual or a group – there may be demands for new interventions, for convenience and quality of services and for greater involvement in decision-making. Demand may be interpreted in a negative way to equate "excessive demand." As the public becomes increasingly informed, there is likely to be an increase in the demand for many of these services.

So how do governments in Canada decide which services will be provided among competing demands – for example, increasing diagnostic capabilities, new treatments or drugs, more services in the home and so on? Governments as the main suppliers of health services in Canada must have a continuing interest in rationing, including analysis of the most cost-effective, appropriate and equitable healthcare services.

Rationing usually means restricting the supply of services by explicit or implicit means. One of the most common strategies is prioritizing, which consists of deciding who goes first, or how much of a scarce resource will be allocated to a patient, patient group, population or service. Other approaches used historically include: waiting lists that try to treat people on a first-come, first-served basis; use of co-payments or user fees; clinical guidelines and protocols; and a range of health promotion/disease prevention techniques that act to reduce demand.

So far, I have attempted to set the stage for the main debate. Two other very important points must be underscored. First, Peter Ubel is writing from the perspective of a physician living and working in another context – the United States. Most observers of health systems would agree that the main strategy for rationing health services in the United States is through managed care, which encompasses restrictions to services through capitation payments, user fees, disease management and so on – all techniques to increase efficiency. Second, and more important, the author is presenting arguments not from the system level, where we normally think of rationing taking place, but from the perspective of an individual physician at the bedside. These points should be kept in mind when readers analyze the various perspectives presented by commentators.

Ubel presents cogent arguments for his stance that physicians at the bedside are in the best position to make decisions about rationing. In his opinion, if rationing must take place then physicians, because of their expertise, have the most knowledge for making those decisions to contain costs. Ubel suggests that "at times physicians need to relax their advocacy duties, and give their patients less than the best possible healthcare services, in order to save money for society." He recognizes moral problems with this approach that must be minimized, including the possibility of eroding patients' trust.

It is clear that our respondents feel passionately in their critique of his paper. Each of them has given serious consideration to this very thought-provoking essay. The Canadian respondents see bedside rationing within the backdrop of the Canada Health Act where we would like to feel that every Canadian has an equal and fair opportunity to access high-quality services. Barrett, as President of the Canadian Medical Association, presents strong arguments for the use of alternatives to bedside rationing, such as rule-based rationing, peer feedback, capitation funding and practice guidelines. The usefulness of practice guidelines and protocols is also advocated by Rachlis as well as more systematic attempts to set priorities. Schafer suggests reducing overall system inefficiencies before putting rationing on the agenda. Hunter describes rationing as a "wicked issue" and calls Ubel's approach quite refreshing. Hunter suggests that attempts to ration will always be necessary but messy, and therefore he suggests a series of strategies for muddling through. Powell advocates a role for physicians in establishing the standards of care that will be acceptable to society. Gratton and Keatings focus on the advocacy role of health professionals and the underlying ethics of any decisions that might impinge on patients' trust. Weiner and Rice's view is that bedside rationing could increase disparities that already exist, especially in the United States in terms of access to care. They make a plea for better education of physicians (and other health professionals) in the sciences of cost-effectiveness. Physicians should move towards more evidence-based decisions in any treatment choices. What is clear from all respondents is that rationing is here; it will not go away, so we had better make the procedures and criteria as open and explicit as possible.

Ubel provides an insightful and well-crafted response to the commentaries. It is apparent that he is passionate about this topic, and that this is not the first time he has debated the issues. In the end, he holds to his main theme – this debate is at the bedside where the most critical decisions are made.

I hope you will find this issue of Healthcare*Papers* as stimulating as I have found it. There is, of course, no one right answer, yet we need to explore a variety of approaches vigorously so that the right decisions will be made most of the time.

Peggy Leatt

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Editor-in-Chief