

Booking systems for elective services: The New Zealand experience

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Abstract

This article provides a brief overview of New Zealand's experience in implementing booking systems for elective services in public hospitals. It identifies the basic features of the booking systems policy and explores the rationale and objectives for these policy settings. Progress with implementation of booking systems is explored and some of the challenges and recent developments are also outlined. The authors argue that booking systems represent a major improvement on waiting lists for patients, providers, purchasers and policy-makers.

Background

In 1992–93 major reforms were made to the New Zealand public health system as part of wider national micro- and macro-economic reforms (Ashton 1993; Scott 1994). The most commonly discussed change was the purchaser–provider split which was implemented through the creation of four Regional Health Authorities to act as Crown purchasing agents.

Another major component of the health reforms was the creation of a National Advisory Committee on Core Health and Disability Services, now known as the National Health Committee. The Committee has responsibility for providing independent advice to the Minister of Health on the types of health and disability support services that should be publicly funded.

It was initially expected that the Committee would formally specify a list of ‘core’ publicly-funded health services to which all New Zealanders would be entitled. However it quickly dismissed the notion of a list of services which were in or out. From the outset the Committee preferred to define eligibility in terms of the types of circumstances under which patients are likely to derive substantial health benefit from the service or

intervention, rather than the types of treatment which were core for all patients. Under this approach eligibility for services is therefore informed by clinical practice guidelines and/or explicit assessment criteria (Hadorn & Holmes 1997). It was against this background that the booking systems policy was developed and has been progressively implemented since 1996.

Hospital waiting lists

In New Zealand, as with most publicly-funded health care systems, there has long been a difference between the public resources allocated to non-urgent surgical, medical and diagnostic services (elective services) and the demand for those services (McDonald et al. 1998). The consequent waiting lists which have been used to manage this supply gap have been an ongoing concern which well predates the 1992–93 reforms. In fact, reduced hospital waiting times was one of the seven major goals of the reforms themselves (Upton 1991).

The National Advisory Committee on Core Health and Disability Services considered the issues surrounding waiting lists shortly after its formation. Based on the findings of a commissioned report (Fraser, Alley & Morris 1993) and consultation with the community, the Committee noted some particular concerns which included:

- increasing (or at least static) waiting lists in some specialities, despite increasing rates of surgery
- unfair selection of patients for treatment as their position on the waiting list does not reflect either their true level of need or their ability to benefit from the treatment
- the relative ineffectiveness of some interventions being provided on a publicly-funded basis
- inconsistency of access to elective services across the country
- a lack of explicit communication to patients about the circumstances under which services are available on a publicly-funded basis and the likely timeframes for treatment.

See Foote, Houston and North (1999) for a fuller discussion of the complexities and dynamics of waiting lists.

A further concern relates to the deficit of information available from waiting lists. It is difficult to make meaningful assessments (based merely on the length of a waiting list) of, for example:

- the level of access to services in each region
- the level of unmet need in the community, and
- the likely effects of proposed funding and policy decisions on that level of unmet need in the community.

Even data on actual waiting times, which are sometimes considered more meaningful than waiting list numbers, fail to provide this type of information.

It was in response to such concerns that the Committee proposed the replacement of waiting lists with booking systems as a much more effective method of managing patients' access to elective services. The Government, the Ministry of Health and the Regional Health Authorities accepted the Committee's advice.

The booking systems policy

The first time the booking systems policy was formally articulated in a single document was in the *1996–97 Policy Guidelines for Regional Health Authorities* (Shirley 1996). There are three main aspects to the policy, as follows.

First, patients referred for elective services have their condition and circumstances assessed by clinician(s).

Second, on the basis of that assessment, clinicians decide whether the patient's level of need and ability to benefit from treatment, relative to others', is sufficient to justify the offer of a publicly-funded operation or procedure.

Third, patients who are offered treatment (and accept) are scheduled for the procedure within the next six months. Patients who do not meet the criteria are provided with a plan of care which may include regular reviews by their primary care provider if their condition is likely to deteriorate. If a patient's condition changes and he or she subsequently becomes eligible for publicly-funded treatment, then that treatment must be provided within six months.

In essence, this booking systems policy means that after their initial assessment patients either:

- receive immediate treatment, or
- are given an approximate date for treatment within the next six months, or
- (if they do not meet the criteria for the procedure) are provided with a plan of care and review which primary care providers are principally responsible for implementing and monitoring.

Under the policy clinicians are expected to assess the relative priority of patients based on their need and the benefit they are likely to experience. In order to help clinicians make consistent decisions about which patients are eligible for publicly-funded services, priority assessment criteria (including referral guidelines) are continually being developed by clinicians across all specialities. The criteria provide a framework for clinicians to assess a patient's relative priority by considering a range of medical, social and complicating factors. These factors contribute to an overall picture of the patient's level of need and likely benefit from treatment which is usually expressed as a priority score out of 100.

The priority criteria are used to assist in treatment decision processes. They do not determine the treatment decision but are merely aids or guides to decision-making. Clinicians are expected to use their judgement. Further information is provided on priority assessment criteria and priority scores below.

The rationale for not placing patients who cannot be offered treatment on a waiting list is simple. By definition, these are patients who are not eligible for publicly-funded treatment at their current level of need and ability to benefit from treatment. To place them on a waiting list creates a dishonest expectation of treatment which is not affordable in current circumstances. However, it is important that both the patient and referring health professional have this information so that they can work out the best management plan within the options available. In many instances this will be ongoing medical care and review. Should the patient's circumstances change, they may be referred for reassessment and, if appropriate, provision of treatment within six months.

The notion of running booked admissions rather than waiting lists has naturally been greeted with suspicion by some members of the health professions and public. Some have viewed the policy as simply a convenient way of hiding unmet need by reducing politically embarrassing waiting lists. Others, particularly some journalists, have portrayed booking systems as a way of hiding funding cuts.

In fact, the opposite is true for reasons discussed more extensively below. Booking systems make explicit the services which will, and will not, be available on a publicly-funded basis. This move from implicit rationing (waiting lists) to explicit rationing (booking systems) effectively makes the clinical and human implications of funding decisions known publicly. There is nothing politically convenient about unmasking a picture of unmet need and, in fact, this unmasking has helped to strengthen the case for increased funding of elective services.

Patients not offered publicly-funded surgery are provided with a care and review plan, usually based in primary care, which details their likely review dates and the pharmaceuticals or other care strategies which they should receive in the meantime. While it is a fact of life that demand for elective services outstrips supply in New Zealand, it is important that all the available care is accessible to patients. The concept is an extension of the euphemism that one should 'care always – cure when you can'.

The policy objectives

The booking systems policy was designed to help address the problems associated with waiting lists by giving patients more certainty about access to elective services. The specific objectives can be broken down into two areas:

- certainty and timeliness, and
- transparency and consistency.

These are discussed below.

Certainty and timeliness

Patients often languished on waiting lists for months or even years with very little information. They did not know if or when they would receive treatment and many patients complained of having insufficient information to be able to make informed choices about other available options (including privately-funded surgery). In some cases, patients were even placed on waiting lists for procedures which were not available under the public system.

The anxiety associated with being on a waiting list was significant for many patients. Some reported postponing holidays for years due to fears of missing their turn if they happened to be unavailable when the hospital called.

Under booking systems patients have access to elective services on the basis of need and ability to benefit, rather than on the basis of date of referral to a waiting list. This is the expectation that consumers have of most other health services – that services will first go to those most in need of help.

Booking systems also ensure that patients have clearer information about the types of circumstances under which treatment is publicly funded. Under booking systems patients know at the time of first assessment if (and approximately when) they will receive the service. Patients are not placed on a waiting list for an unknown time period. Rather, any undertakings of treatment must be firm and accompanied with maximum time frames. Once a patient has been given a firm and formal undertaking of publicly-funded treatment this commitment becomes legally binding on the provider. Under New Zealand's *Consumer Guarantees Act 1992* a court can enforce the provider's commitment to provide services to the patient.

In essence, booking systems move New Zealand's publicly-funded elective services onto the same footing that citizens expect in other service industries through the setting of minimum standards. It is hard to identify any other industry where consumers do not know if or when they will receive the service they have requested. By setting minimum standards for timeliness and consumer information, booking systems aim to improve access to elective services so that they are provided on a similar basis to other modern services.

Transparency and consistency

Even if waiting list data were reliable it is doubtful that numbers of people presenting can be used to accurately predict the level of unmet need or the likely health benefits which will eventuate from funding of additional services. There are two main reasons for this.

First, it is reasonable to assume that the inverse care law (that is, the notion that those populations with the worst health status actually utilise health services the least) leads to a lower rate of referral for elective services in the most deprived populations. This

would mean that the populations which have the greatest health needs may have misleadingly short waiting lists. Emerging profiles of priority within waiting lists suggests that this has been the case in New Zealand.

The second and related problem is that waiting list or waiting time data do not give reliable information about the clinical characteristics of the patients on the waiting lists. The severity, urgency and likely benefit from treatment cannot be accurately estimated from these types of statistics. Without this information it is difficult to estimate accurately the human and clinical consequences of current service levels.

In an environment of competing demands for health funding, this lack of information represents an important barrier to making rational funding decisions. Booking systems help to address the problem. By looking at the clinical profiles of patients who are and are not being treated at current funding levels it becomes possible to assess the likely human and clinical effects of funding decisions. For example, after a switch from waiting lists to booking systems at one New Zealand hospital, the staff discovered that their cataract surgery funding was only sufficient to treat patients with a priority score of about 35 points out of a possible 100. These patients had moderate-to-severe eyesight deficits, they could no longer be helped by glasses, could not legally drive, needed a magnifying glass to read and glare was a major problem for them. On discussion with the health authority the hospital's funding was increased. This allowed the hospital to lower its eligibility threshold to approximately 28 points. Patients in this group had less severe cataract conditions. They were generally characterised by problems in more than one eye, most could still legally drive (but they usually had problems with glare) and most could still read a newspaper with glasses (but with some difficulty).

It is this type of information that is needed to make informed funding decisions. By looking at the patients who are just missing out it is possible to accurately assess the likely effects of funding increases at the margin and weigh these benefits against those likely to result from other competing priorities for health funding.

This information about patients and their clinical characteristics has also helped to increase patients' consistency of access to elective services throughout New Zealand. By making explicit details of the types of patients who are receiving treatment, booking systems highlight regional inequities in access to services. The New Zealand experience is that this type of information about relative service levels is very useful in addressing regional inequities through the movement of funds, especially when used in conjunction with other data such as overall intervention rates. New Zealand has already seen some significant improvements in equity of access across regions due to purchasing decisions being made with the assistance of booking systems information.

Development of priority assessment criteria

The implementation of booking systems in New Zealand had already begun two years before publication of the *1996–97 Policy Guidelines for Regional Health Authorities* (reference?). The National Advisory Committee on Core Health and Disability Services, in cooperation with the four Regional Health Authorities, led the development of clinical priority assessment criteria for several high-volume, high-cost procedures:

- cataract surgery
- hip and knee joint replacement
- coronary artery bypass graft and angioplasty
- cholecystectomy, and
- tubes for otitis media with effusion.

Table 1 shows the criteria for cataract extraction and Table 2 shows those for hip and knee replacement. The development task included input from specialists, general practitioners and consumer representatives.

Based on feedback from consultation, the Core Services Committee decided that social factors (that is, non-medical factors such as ability to live and work independently) should be considered as part of the priority criteria (National Advisory Committee on Core Health and Disability Support Services 1993). Which social factors to consider and the weighting given to those factors were hotly debated questions among clinicians (see Hadorn & Holmes 1997). The selected social factors were ability to work, to give care to dependents or to live independently. These factors were combined within a single dimension of the assessment tool. They have been incorporated into most priority criteria now in use in New Zealand.

Table 1: Priority criteria for cataract surgery (maximum score 100)

Clinical features							Score
<i>Visual acuity</i>	6/9 or better	6/12	6/18	6/24	6/36	6/60	Count fingers/ hand movements
6/9 or better	0	1	2	3	4	5	6
6/12		7	8	9	10	11	12
6/18			14	15	16	17	18
6/24				21	22	23	24
6/36					28	29	30
6/60						35	36
<i>Count fingers/hand movements</i>							40
Glare							
None							0
Mild-moderate							5
Severe							10
<i>Ocular co-morbidity (for example, age-related macular degeneration, chronic simple glaucoma)</i>							
None							0
Mild-moderate							5
Severe							10
<i>Ability to work, care for dependents, or work independently</i>							
Not threatened or not applicable							0
Not threatened but more difficult							2
Threatened but not immediately							6
Immediately threatened							15
<i>Extent of impairment in visual function (for example, reading, recognising faces, seeing steps or kerbs, watching TV, driving and reading traffic signs)</i>							
None							0
Mild							5
Moderate							10
Severe							20
<i>Other substantial disability (for example, hearing loss, uses wheelchair)</i>							
No							0
Yes							5
Total score							

Table 2: Priority criteria for major joint replacement (maximum score 100)

Clinical features	Score
<i>Pain (40%)</i>	
Degree (patient must be on maximum medical therapy at time of rating):	
None	0
Mild: slight or occasional pain (patient has not altered patterns of activity or work)	4
Mild–moderate: moderate or frequent pain (patient has not altered patterns or activity or work)	6
Moderate: patient is active but has had to modify or give up some activities because of pain	9
Moderate–severe: fairly severe pain with substantially limited activities	14
Severe: major pain and serious limitation	20
<i>Occurrence:</i>	
None or with first steps only	0
Only after long walks (30 minutes)	4
With all walking, mostly day pain	10
Significant, regular night pain	20
<i>Functional activity (20%)</i>	
Time walked:	
Unlimited	0
31–60 minutes (for example, longer shopping trips to mall)	2
11–30 minutes (for example, gardening, grocery shopping)	4
2–10 minutes (for example, trip to letter box)	6
2 minutes or indoors only (more or less housebound)	8
Unable to walk	10
<i>Other functional limitations (for example, putting on shoes, managing stairs, sitting to standing, sexual activity, recreation or hobbies, walking aids needed):</i>	
None	0
Mild	2
Moderate	4
Severe	10
<i>Movement and deformity (20%)</i>	
Pain on examination (overall results are both active and passive range of motion):	
None	0
Mild	2
Moderate	5
Severe	10

continued

**Table 2: Priority criteria for major joint replacement (maximum score 100) –
*continued***

Clinical features	Score
<i>Other abnormal findings (limited to orthopaedic problems, for example, reduced range of motion, deformity, limp, instability, progressive x-ray findings):</i>	
None	0
Mild	2
Moderate	5
Severe	10
<i>Other factors (20%)</i>	
Multiple joint disease	
No, single joint	0
Yes, each affected joint mild–moderate in severity	4
Yes, severe involvement (for example, severe rheumatoid arthritis)	10
<i>Ability to work, give care to dependents, live independently (difficulty must be related to affected joint):</i>	
Not threatened or difficult	0
Not threatened but more difficult	4
Threatened but not immediately	6
Immediately threatened	10
Total score	

Views of the public and clinicians

Some clinicians continue to express concern that the results of priority assessments (usually reflected as a score) do not always accurately reflect clinical judgement. This concern has partly been generated by a misunderstanding that the priority assessment criteria would determine treatment decisions. Rather, the criteria are designed to assist clinicians to make decisions using their clinical judgement. Discrepancies between clinical decisions and the assessment scores are an important source of information for continuous improvement of the priority criteria and clinical practice. It is expected that the assessment criteria will be subject to refinement over time. This will occur as evaluations yield new information, new methods become available and societal values change or are better articulated.

In general, clinicians who have been involved in the booking systems process are supportive of at least the concept and intent of the policy. It appears that many others who were initially sceptical now agree that the objectives are sound. However, as might

be expected, many clinicians and members of the public are suspicious of the Government's motives. Some see the booking systems as a politically convenient way of reducing embarrassing waiting lists and denying people operations.

We have found it important to convey clear information about the change to booking systems to the public. As good understanding develops, most people quickly recognise the advantages offered to patients. This increased understanding has also been helped by successive Ministers of Health who have consistently shown commitment to being explicit about what services will and will not be publicly-funded, and the human and clinical consequences.

In order to expedite a steady state whereby the public could depend on a stable threshold level for access to services, the Government was advised that a separate one-off allocation of funds should be made to deal with existing backlogs of patients on waiting lists. In response, the Government set up a NZ\$285 million Waiting Times Fund. The fund is now in its last year and residual waiting lists have reduced from 90 000 to 50 000. It is expected that full implementation of booking systems, including elimination of residual waiting lists, will be completed by 30 June 2000. The Waiting Times Fund and other additional elective services funding have helped to improve public and clinician confidence that booking systems are a positive step in the management of hospital services.

Booking surgery

Most hospitals have found it difficult to schedule patients well in advance of their operation (that is, giving patients a booking date). Factors such as fluctuations in demand, the number of acute admissions and internal staffing changes can all impact on a hospital's ability to give patients a firm booking date for their operation. However, there have been significant improvements in hospital infrastructure. For example, several software programs have been developed to assist in maintaining scheduling systems based on information such as patients' assessment results, funding levels, and theatre and staffing capacity.

At the time of writing, most hospitals were giving a proportion of their patients an assurance that they would be treated within the next six months – often with an indication of the likely month of surgery. These patients usually receive the exact date of their booking a few weeks prior to the surgery. While the numbers are relatively modest, feedback to hospitals from the patients involved indicates that it has been positively received.

National data collection systems have also been updated and now require hospital-based services to report individual-level data on priority assessments and bookings of patients. This information is being made more accessible for planning purposes through storage in a data warehouse.

Access to specialists

Improved liaison between primary and secondary care is a key factor in booking systems implementation. From a general practitioner and patient perspective, delays in access to secondary services result in considerable anxiety and sometimes have a direct impact on the health status of patients and their ability to manage their own care. Experience in New Zealand has shown that timely access to specialist advice and expertise is dependent on a combined primary/secondary liaison approach.

Several pilot projects have been launched with hospital services involving specialists and local general practitioners in a redesign process which makes better use of specialist knowledge and expertise as consultancy support for generalists, and more discerning use of hospital clinics. The pilots involve improved communications and integration between primary and secondary services through such activities as:

- locating general practitioners within clinics to improve referral quality through providing feedback, to reduce the load on consultants and to ensure referrals are directed to the most appropriate access or assessment option
- developing management plans for common conditions (an extension of the referral guidelines concept)
- developing general practitioner skills through education and a certification process to enable a better level of assessment and management to be undertaken in primary care (and in some instances enabling patients to be booked for treatment without the intermediate step of specialist assessment)
- enhancing general practitioner access to diagnostic services such as x-rays
- providing a greater role for certified general practitioners in follow-up assessment activities
- providing an increased role for general practice provider groups in profiling general practitioner referral behaviour and improving referral practice.

These are early days, however these projects are showing significant potential for establishing better outcomes of equitable access, timeliness and certainty, and more effective and efficient integrated care between primary and secondary providers.

Conclusion

As New Zealand nears the June 2000 date for full implementation of booking systems the experience is increasingly positive. Important contributory factors to this growing support have been significant shifts in funding to address identified variations in access levels, much improved scheduling infrastructure, and better liaison between primary and secondary care.

Booking systems represent a major improvement for patients seeking publicly-funded health services because they provide the means to meet minimum standards for

timeliness and certainty. Patients have clearer information about the circumstances under which treatment is publicly-funded and they know at the time of first assessment if, and approximately when, they will receive the service. Any undertakings of treatment must be firm and completed within the maximum time frame of six months.

This increased certainty seems to be well received by patients and holds the prospect for improved public confidence in the public health system. The focus of public debate has shifted to the most appropriate level of services and the consistency of access to services throughout the country. These are debates that are constructive and welcome.

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Commentary

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Booking systems for elective services

Benedict Hefford and Andrew Holmes present a clear description of an important endeavour on which impressive progress is being made. I will make four observations about the aims and methods of the New Zealand work and then consider its relevance to Australia.

First, the authors note that the initial intention was to create a simple list of services to be funded from public insurance. This approach allows only two views to be taken: a service is or is not to be funded. In Oregon, for example, the State decided to fund all appendicectomies and no hemorrhoidectomies. There were no half-measures.

In the event, New Zealand changed to a more logical and practical approach. Relatively few services are never of value to anyone. Rather, there are variable proportions of cases where funding is justified. A consequence of taking this view is that two levels of rationing must be established: one which defines an appropriate global level of service provision and the other which allocates the available resources among potential recipients. The former needs to be done centrally (with a population in mind) and the latter must be done by clinicians with access to details of individual patients.

Oregon managed the population-level rationing very well but took away opportunities for clinicians to apply judgement about individual patients. This is one good reason why doctors were mostly unsupportive of Oregon.

Second, New Zealand's scoring methods are interesting and sensible. A separate score is generated for each service. This is relatively easily done, and again has the important advantage of allowing early gains to be achieved.

However, it has a fundamental weakness (which will need to be addressed in the near future by New Zealand). The scales are incommensurate and therefore, while one can prioritise among patients with the same health problem, one cannot apply the scores in a valid way to allocate resources between services. Put another way, there is no crosswalk from (say) high-technology to high-touch care. It is necessary to use a generic measure of need, such as the QALY or the DALY, for this kind of task. Fortunately the current work will prepare the way for a more complete model in due course.

Some New Zealanders have argued that the scales are comparable in part because the same kinds of attributes (relief of pain, restoration of lost physical and social functioning, etc) underlie each of the scoring systems. I agree. However, the magnitudes of the scores have no common base. There is no way of knowing whether (say) a score of 40 on the cataract instrument is equivalent to the same score on the joint replacement instrument in terms of justification for funding.

Third, the authors point out the value of their scoring systems with respect to important matters like equity of access across sub-populations and overall adequacy of funding levels. This is a good illustration of the benefits of using valid processes. If the underlying logic is strong (and, in this case, if there is a logical link to the fundamental aims of the health care system) then the process will support (and be supported by) other good ideas. The converse of this systems idea is demonstrated by the old cartoon of the driver heading for Chicago who becomes lost in the cornfields of Ohio: on asking a local farmer, he is advised that 'you can't get there from here'.

Fourth, it is good to see that consumers have been involved in addition to expert clinicians. I agree that they have the right to be involved. Equally important, they will help ensure change is in the right direction. The authors note that consumers not only understand rationing but also have the correct view about its basis – that scarce resources should go first '...to those most in need of help'.

I suspect that many of the difficulties surrounding the core services work were a consequence of community perceptions rather than methodological errors. Progress was clearly disrupted by the association of definition of core services with implementation of the purchaser–provider split. In a technical sense, the definition of core services is a prerequisite to sensible purchasing. However, the Government's arguments for the purchaser–provider split made frequent reference to cost containment, efficiency and profitability. The community at large therefore tended to assume that the purpose of delineation of core services was cost minimisation rather than enhancement of value for money.

As an aside, the authors may be unfair in suggesting the health care system is weak because '...it is hard to identify any other industry where consumers do not know if or when they will receive the service they have requested'. They have perhaps not tried to obtain water system repairs or telephone installation. I also like to remind my friends who live in Auckland that in the recent past they could not obtain electricity or a reasonable estimate of when it would become available.

I am sympathetic of health care professionals trying to schedule admissions to public hospitals, whether in Australia or New Zealand. They are working in a highly stochastic environment where key resources (like beds, surgeons and operating theatres) are being over-used. This said, we can do better and one way of ensuring this happens is by continually emphasising consumers' rights. However our own expectations of what we could do if we tried harder (or collaborated more) are a better benchmark than what other simpler and less stressed and stressful industries manage to achieve.

Finally, it is good to hear that New Zealand Ministers of Health continue to show '...commitment to being explicit about what services will and will not be publicly-funded'. Rationing is believed by most politicians to be a bad word in politics. The Australian Prime Minister certainly believes this, and has been careful never to admit that it is necessary or that it exists over the last two years. The Australian Labor Party has been no more open and even Tony Blair has consistently denied reality.

What can Australia learn from New Zealand? There is no need for Australian health care professionals to be told about rationing. It is part of their daily life. Many clinical teams have their scoring systems for prioritisation of patients, and some share their ideas with others around Australia – and even with colleagues across the Tasman. We have produced some national health strategies which address rationing issues, albeit without saying so. State health authorities have involved clinician groups and the community at large in discussions about priorities from time to time. We will learn little that is new about measuring waiting times, subjective scaling, or even about the value of needs data in assessing equity of access.

However Australia has no equivalent national process. As a consequence, we ration well in places and poorly overall. The rich and articulate receive better health care than the elderly poor who live alone. Spectacular and clinically interesting treatments are more likely to be funded than simple preventive activities.

Much has been said about factors which encourage explicit rationing, but none seems entirely convincing. One is that there must be a strong sense of community. This has been claimed in the Netherlands, with some justification.

It does not appear to be sufficient. There are relatively few differences in ideas about society in Oregon compared with other parts of the United States. The views of the Bush Administration, when it turned down the Oregon rationing proposal in 1992, were a model of vested interest dressed up in concern about risks to disadvantaged. See the paper by Al Gore to gain a picture of the style of US federal government opposition to the Oregon plan (Gore 1990).

An obvious difference in Oregon was that the issue of rationing became a matter of concern to the mass media. The impact of Coby Howard cannot be underestimated, and it was largely a matter of chance that his inability to access care became the centre of public concern. The media attention was important if only because it helped the community to believe rationing was a problem which affected them.

Political commitment certainly makes explicit rationing easier, but it is difficult to understand why New Zealand's politicians have supported explicit rationing, whereas Australia's have not. They may be better politicians, but it seems more likely that they are simply reflecting views which the community has already formed of its own accord.

Finally, there is a strong argument that health care professionals have an influence to the extent that they accept from colleagues and politicians what Dowie (1995) calls ponceing – partial or non-comparative evaluation, whereby the critics fail to apply the

same rigour when considering the options (if they consider any at all). Williams (1995) makes a related point. He notes that ‘...it is understandable that many people cling, with childlike naïveté, to the romantic illusion that if only more resources were devoted to health care they can escape from the (priority-setting) process altogether’.

There will never be enough resources to ensure everyone receives perfect health care when it is needed. This is obvious, and so is the conclusion: that rationing is inevitable, in Australia as well as in New Zealand. The choice is whether rationing is done well or badly. Is New Zealand on the right road? Yes indeed. Should Australia wait for a Coby Howard or a political leader? I hope there is a less risky way.

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