From the Editor

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Rationing of medical care by age

Food rationing, using a points system, was a familiar feature of the Second World War and its aftermath. As a small boy in a Derbyshire village, the main impact was on the weekly sweet ration. Being one of five children seemed to generate sympathy among the older members of the community so that 'points' from their own ration often found their way into our hands. Their generosity benefited the younger generation.

The introduction of the NHS at around this time, which was free at the point of care, was of course widely welcomed among the community who had struggled until then to pay the doctor's bills for even basic treatment. Since that time the apparent inexorable rise in healthcare costs has become a challenge and concern for the general public, government and funding agencies. The USA outspends other nations in healthcare which now consumes a remarkable 15% of their annual gross domestic product. Even at this level, many of the population are either poorly or incompletely covered for healthcare and healthcare costs are still rising by 10% per year.[1]

The next most expensive healthcare systems, in order, are Switzerland, Norway, Canada and Germany. Until 2001, spending on the healthcare system in the UK was considered almost frugal and in 2002 it was still less than half of that in the USA.[2] The concept of controlling expenditure by healthcare rationing first came to prominence in Oregon in 1987 when a boy of seven died of leukaemia after being refused a bone marrow transplant under the Medicare programme. This refusal was based on the argument that Oregon could not conceivably afford to pay for every medical care service for every patient, but it would be able to expand insurance to cover all uninsured individuals and still control expenditure if it were willing to ration care.[3,4]

Through a process of community meetings, public opinion surveys on quality of life preferences, cost–benefit analysis and medical outcomes research, the Commission ranked a list of more than 700 medical conditions according to their net benefit. The ranking was intended to reflect community priorities regarding different medical conditions and services and included physicians' opinions on the value of clinical procedures as well as objective data on the effectiveness of various treatment outcomes. In 1999, for example, the Oregon healthcare package only covered 574 of the 743 listed medical treatment options. Since then, in order to control expenditure, the state legislature has been forced to reduce the number of medical treatment options covered. In practice, however, most of the services excluded from the list have little more than marginal medical benefit.[5]

In a series of important papers, Thomas Bodenheimer has sought an explanation for high and rising healthcare costs. He concludes that the explanation lies in part in the ageing population and the lack of well-developed competitive healthcare markets. Key features also include the spread of new, relatively unrestrained, technologies and the rise in pharmaceutical prices. Attempts at constraining the healthcare budget have included moving the financial risk of healthcare costs from the insurers to the providers. This has been achieved, for example, with Medicare diagnostic-related group payments and capitation reimbursement.[1,6,7]

Personal visits to developing countries and the desperate plight of sick and impoverished communities regularly relayed to our television screens demonstrate only too clearly that rationing based on available funding is an inevitable worldwide practice.

The BMA has recently encouraged continued public debate on the rationing of medical care.[8] Overt discussion of rationing in the West, however, immediately raises major philosophical concerns. Indeed the Oregon experiments have often been criticised on moral grounds alone.[9]

The NHS, in 2005/6, is funded by taxes and will spend more than £80 billion per year, some £1,600 for each person. Raising taxes to pay for every possible need is politically unacceptable and would require a massive increase in the income tax burden. Some treatments may therefore be restricted or rationed. Should the Government accept responsibility for rationing decisions and consult the public over which treatments should be restricted on the NHS?

Age, obesity, smoking and alcohol intake have all been considered as a basis for rationing healthcare. In respect of age, the National Institute for Health and Clinical Excellence draws an important distinction between appropriate discrimination where, for example, age affects the benefits or risks of treatment and using age *per se* as a means of

rationing healthcare.[10] Rationing medical care on the basis of age has recently been considered in a remarkable analysis of the complex, medical, social and moral dimensions of the predicted funding crisis and the provision of healthcare. The paper offers a reasoned defence of appropriate rationing based on age alone.[11]

Were the generous seniors in that Derbyshire village passing on ration points to the younger generation hinting at something more profound than they or their grateful younger recipients appreciated? Is increasing age an appropriate basis for rationing medical care? Economic progress may defer a decision for the moment, but it could also provide time for constructive debate.

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ROBERT ALLAN

Robert Mahler – Editor, 1987–94

We are sorry to announce that Robert Mahler passed away on 28 May 2006. Robert was deeply involved and interested in the College and will be much missed by all of us who knew and worked with him.

• A thanksgiving for his life and work will be held at the College at noon on Wednesday 27 September 2006. Would anyone wishing to attend please contact Guler Eroglu (guler.eroglu@rcplondon.ac.uk).

An appreciation by Peter Watkins FRCP

Robert Mahler reached Edinburgh in 1939, aged 13 years, arriving without his parents by one of the Kindertransport trains from Vienna.[1] He excelled in his career from that time onwards, first in English at school, later in basic science and clinical medicine. He 'gloried simultaneously in Latin, Greek and science'[2] and had a passionate love of music. He unhesitatingly undertook research on himself – fed himself through a Ryles tube for three weeks, was the first person in Britain to experience renal vein cathetisation, was spun in a human centrifuge and learnt to fly while in the RAF. He took particular delight in demonstrating that muscle can synthesise glycogen from lactate, said by Sir Hans Kiebs to be thermodynamically impossible. Robert Mahler published continuously from 1953 to 1991 and added two papers in 2005 on the effects of eradicating helicobacter on his own Parkinsonism.

With this exceptional background in clinical science he was appointed editor of the *Journal of the Royal College of Physicians* in 1987, retiring eight years and 31 editorials later. These editorials covered a vast range of topics, including such titles as Medical education in chaos, A time to think, Courses for horses, and Sabbatical for UK doctors. He was a master, literally, of editing – turning manuscripts, whether 'turgid, convoluted, polemic, naïve, ungrammatical or twice as long as they should be, into concise, well ordered, readable English. Nothing escaped his eagle eye'.[2] Robert continued to support the Journal using these exceptional skills as Editor Emeritus under the editorship of David Kerr (1994–98) and myself (1998–2005). His insights in selecting manuscripts suitable for publication containing outstanding clinical science from amongst the bad and mad were remarkable, as was his advice on how to reject papers without offending their authors; and he protected me more than once from including rash propositions in my editorials. He continued this support with wit and humour even as his Parkinsonism inexorably progressed. During this time he described with penetrating insight and humour his observations on the care he received from doctors, nurses and receptionists during his frequent hospital admissions – contrasting genuine, loving personal care with those showing casual indifference, or consultants on teaching rounds who ignored their patients – lessons in professional behaviour for all who care for patients.

David Pyke (Registrar, Royal College of Physicians 1975–92) once wrote of Robert that he was 'not only a brilliant academic, but an equally good and kindly physician'. I would add to that his wonderful gift in the ability to deliver advice combining wisdom simultaneously with wit. Generations have benefited from this rare talent and are sad at his passing.

References

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