Implicit Versus Explicit Rationing of Health Services[1]

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"At least as long I am Minister of Health, I shall never lead a debate on rationing or prioritization, for ethical reasons" (Philipp Rösler 2010).

Introduction[2]

In many developed countries, the concept of rationing healthcare services is treated as a taboo in the political debate. If someone argues in favor of certain types of explicit rationing, s/he immediately encounters fierce reactions by politicians and medical leaders and is sometimes even treated as if s/he had proposed euthanasia. The quotation above from the former German Health Minister Rösler, a Free Democrat, shows that this attitude is widespread in all political parties. Physician representatives like the late president of the German Medical Association, Jörg-Dietrich Hoppe, usually draw a line between the concepts of rationing (which they oppose) and prioritization (which they advocate). But even the latter concept is harshly rejected by office-holding politicians.

The purpose of the present paper is to contribute to a more sober and rational debate on this extremely emotional topic. To this end, the next section *(two definitions of rationing)* compares the two most popular definitions of the term rationing with respect to health services and contrasts them with the general concept of rationing in economics. The third section *(the euphemism of "prioritization")* shall analyse its relation to the concept of prioritization. The fourth section *(levels and types of rationing)* defines different levels and types of rationing, while the fifth section *(rationing in practice: a comparison of England/Wales and Germany)* uses these terms for a comparison of two real-world rationing schemes. The sixth section *(how to replace implicit with explicit rationing)* subsequently discusses options for the further development of explicit rationing, and the last section offers some conclusions.

Two definitions of rationing

Rationing as "withholding necessary services"

In the political sphere, healthcare rationing is commonly understood as "withholding necessary medical services".[3] This definition is potentially useful only if the concept of a "necessary medical service" is well-defined. Moreover, it is critical that the term "withholding" can be applied whenever a service delivered to an individual is not financed by a third party such as a sickness fund or the taxpayer.

When is a medical service necessary? The answer depends upon what the consequences would be if the patient does not get the service. Is it:

- an immediate danger to life,
- the risk of a severe and lasting health impairment, or
- any, even only temporary, deterioration of health?

Similarly, a health service cannot be called necessary if it is not even suitable for improving a patient's health, and even if this is the case, what is the minimum expected benefit to call the service "necessary": is it, for example, the gain of a few weeks life expectancy in a critical health state? Moreover, should costs be considered in the definition of what is "necessary"? Ubel (2000, 25) argues against mixing "necessity" with cost-effectiveness, but would he

[1] The author is grateful to Marlies Ahlert, Thorsten Kingreen and Hartmut Kliemt for valuable comments on an earlier version of this paper.
[2] A related paper in German appeared as Breyer (2012). Other papers on the same topic are Althammer (2008), Breyer and Schultheiss (2002) and Kliemt (1996), (2010).
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[3] See, for example, Zentrale Ethikkommission der Deutschen Ärztekammer (2000, A-1019).

stick to this opinion if the costs of a life extension by one month were to be one million Euro? And what about 10 million or 100 million Euro? This shows that the concept of "necessary services" is so vague that it would not be wise to base the definition of rationing on it, but it would be better to replace it with a more meaningful term such as "useful services", as Buchanan does (1996, 335–36).[4]

The term "withholding" for "not giving free of charge" is equally problematic. Firstly, it contains an implicit value judgment because it suggests that the person from which something is "withheld" has a legitimate claim to the goods or service in question. Not only do value-laden words impede rational discussions, but in this case the reference to an (previously existing) claim is based on a misunderstanding because the very act of rationing can serve as a justification of legal claims to services; and thus the term should not presuppose the existence of those claims to begin with.[5] Consequently, Ubel (2000, 28) avoids this error when he defines "healthcare rationing" as "implicit or explicit mechanisms that allow people to go without beneficial services"

Rationing as "limited allocation"

The second error in equating rationing with withholding lies in the fact that it is not compatible with the textbook definition of the concept of rationing in Economics. There, "rationing" is defined either as synonymous with "allocation" or as a specific type of allocation. Some textbooks use the term rationing for any kind of determination of how scarce goods are distributed among competing uses or users. In this vein, Case and Fair (2008, Chapter 4) attribute a "rationing function" to the price, and Samuelson and Nordhaus (2001, 61) write: "… *competitively determined prices ration the limited supply of goods among those who demand them.*"

Summarizing this reasoning, it is useful to distinguish between a wide and a narrow sense of the word "rationing". In its wide sense, rationing coincides with "allocation" and refers to any method to determine who receives what quantity of a scarce good or service. These methods can be divided into those that make use of the price mechanism ("price rationing") and those that do not ("non-price rationing"), the latter being synonymous with rationing in its narrow sense. More specifically, this latter concept can be defined as the *allocation of limited amounts below market price*, which often means "free of charge". An allocation below market price implies that somebody else – the government or the community of insured people – bears the difference to the supply price. Rationing thus presupposes some kind of collective financing of the good in question.[6] This, in turn, precludes an unlimited allocation, in particular the provision of "optimal diagnosis and treatment" at the public's expense because, as Victor Fuchs (1984, 1572) states, "*No nation can provide 'presidential medicine' for all its citizens.*" The term "optimal treatment" refers to all services with a positive medical benefit, no matter what their costs are.

This implies that, in publicly financed health systems, the state must decide on the criteria by which the allocated quantities are limited. For healthcare services, common criteria for rationing are medical urgency, cost-effectiveness and sometimes waiting time. However, even if only part of all citizens have received positive allotments of a collectively financed resource, this does not necessarily imply that all others have to go without. On the contrary, it is conceivable that there are other ways in which citizens can procure the resource (at market price), either in a legal market for private treatment or by travelling abroad (see *Levels and types of rationing* for further details).

The euphemism of "prioritization"

As mentioned above, medical officials try to avoid the "R word", at least in public debates, and prefer to talk about prioritization. According to the Oxford Dictionary, the verb "to prioritize" has two meanings: 1) to designate or treat (something) as being very or most important, and 2) to determine the order for dealing with (a series of items or tasks) according to their relative importance. Prioritization 2 is somehow a prerequisite for prioritization 1: you need to have an order before you can privilege some

[4] "*Rationing – which means the withholding of care expected to be of net benefit – occurs throughout every healthcare system and is unavoidable*".

[5] This error in reasoning has already been criticized by Jeremy Bentham (1843, Article 2): "*But reasons for wishing there were such things as rights, are not rights; – a reason for wishing that a certain right were established, is not that right – want is not supply – hunger is not bread.*"

[6] At the moment of utilization, even private insurance companies allocate the good below market price. The insurance contract grants the right to participate in this rationing process.

item. Moreover, giving priority (higher rank) to something is equivalent to giving posteriority (lower rank) to all competitors; but nobody likes to talk about that because "prioritization" sounds better.

Prioritization as a prerequisite to rationing

If "rationing" is understood as the "limited allocation of health services", it opens up the question what rules the allocation process should follow. A plausible and transparent procedure for determining an allocation rule is to start with compiling a rank order of services (defined by illness type, patient group or treatment type) on the understanding that this rank order will be followed in the allocation process from the top down until the capacity is fully exhausted, or the available funds are fully spent. In this interpretation, prioritization is an important first step towards a (rational) rationing process.

The most famous example of such a combination of prioritization and rationing is the Medicaid program of the state of Oregon in the US in the early 1990s (see Garland 1992). In the Oregon Basic Health Services Act of 1989 a rank order of 709 disease-treatment pairs for Medicaid beneficiaries according to urgency was compiled. In 1991 the funds that were allocated by the state to the Medicaid program were sufficient to finance only 587 of these 709 services.

Prioritization as an alternative to rationing

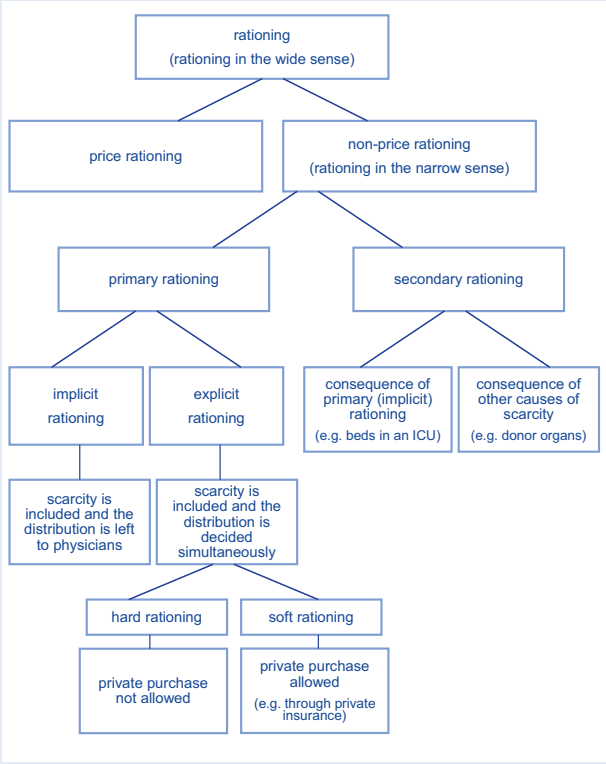
In contrast to this interpretation, medical leaders often understand prioritization as a substitute for rationing, which they define as the withholding of services. As an example, the president of the German Medical Association, Frank Ulrich Montgomery (2011) referred to the swine flu pandemic of 2009. He first emphasized that everybody could have received the vaccination (no rationing), and subsequently explained that certain risk groups and groups that could have passed on the virus to others (e.g. medical personnel) were prioritized because the vaccine became available only gradually over time. In this example, prioritization applies only to a temporal sequence of service delivery so that eventually everybody would get treated at public expense. In the same interview, Montgomery justified the need to prioritize with the scarcity of funds in the healthcare budget and the necessity "to allocate the limited funds in a just way". But the latter case would imply that some patients near the bottom of the priority list would have gone without. This can be for two different reasons:

1. The patients would have been cured even without the service because the illness was only temporary. In this case, the cost-effectiveness of the treatment is questionable and it is debatable whether the treatment should have belonged to the benefit package of social health insurance to begin with.
2. The patients would have died from the disease: this implies that the treatment would have been necessary, and what Montgomery calls prioritization was, in fact, rationing, at least by his own use of the word.

Finally, there is the case whereby a rank order of urgency is compiled, but is not used as a basis for rationing decisions (because everybody gets the service anyway). In this case, prioritization is a useless

Figure 1

Types of rationing



Source: The author.

task which, if it requires any scarce resources, should remain undone.

Levels and types of rationing

Even if it is agreed that rationing is understood as limited allocation of collectively financed services below market price, it is useful to distinguish several levels and types of rationing (see Figure 1) under the headings primary – secondary, hard – soft and explicit – implicit.

Primary versus secondary rationing

Many authors use the term rationing exclusively to refer to the allocation of non-augmentable resources such as donor organs or beds in an intensive care unit. This level of rationing, which Calabresi and Bobbitt (1979) call "second-order tragic choices", and which we have therefore named "secondary rationing" (Breyer and Schultheiss 2002), is mainly characterized by questions of distributive justice: Shall the only available liver be given to the alcoholic or to the young woman who has fallen off a horse? Or shall the owner of a donor card be privileged in organ allocation to a person who has explicitly refused to donate his organs? Shall the last free bed in an ICU be given to the patient with the greatest risk of dying, to the one with the largest probability of success or to the one who has waited the longest time?

Choices like these will always be unavoidable, no matter how large capacities in healthcare grow. But for this very reason, they show that rationing cannot be equated with withholding: if there is only one donor heart available with two potential recipients and if it is given to one of them, who would claim that it is "withheld" from the other patient? Moreover, these decisions require value judgments and are least accessible to health economics reasoning.

In contrast, "primary rationing" (what Calabresi and Bobbitt call "first-order tragic choices") means that society deliberately limits the collectively financed resources for healthcare services because these services compete with other uses such as education, infrastructure or even private consumption. Unlike secondary rationing, which is one of the consequences of scarcity *within* the healthcare system, primary rationing is concerned with determining the level of scarcity of resources *for* the healthcare sector in response to the general scarcity of resources. These decisions are unavoidable as well, ever since medicine became so successful that it would, in principle, be possible to spend (nearly) all of GDP on *useful* health services. The question of what part of GDP to devote to publicly financed health services and what procedure to use to decide this matter is predominantly a question of efficiency and can therefore be analyzed in economic terms.

It must be emphasized that in a society which has neither a tax-financed national health service nor a mandatory social health insurance, primary rationing is not an issue because rationing presupposes the allocation of health services through some collectively financed institution.[7] In a purely privately financed health system, in which each consumer decides on his/her healthcare utilization – either directly or by signing an insurance contract – there is no point in a public discussion on the rationing of services (since rationing occurs only as individual self-rationing).

Hard versus soft rationing

Once a society has introduced a collectively financed healthcare system with (primary) rationing, two further principal decisions have to be taken. The first concerns the question of whether markets for those services shall be allowed that are not offered by the public system. If this is the case, we speak of "soft" rationing, otherwise of "hard" rationing.[8]

An example of hard rationing in practice is organ allocation, as laws everywhere prohibit markets for organs. Some authors argue in favor of extending this rule to all healthcare services in order to achieve equality of access to these services (see, for example, Krämer 1989, 87). In fact, many people share the judgment that it should be possible to buy a nicer, but not a longer life. However, it is questionable if this noble goal can ever be achieved in practice as there are major obstacles to it:

- the principle of a free society, which must accept that citizens have different desires and should be allowed to fulfill them as long as they bear the corresponding costs and do not harm others;

[7] In the United States, the rationing debate obtains its relevance through the tax-financed Medicare and Medicaid programs and through tax subsidization of health insurance premiums.
[8] Breyer and Kliemt (1994) introduced the terms "weak" and "strong rationing" for the same contents.

- the fact that markets exist for a variety of non-medical goods, which are highly relevant to a long and healthy life – sometimes even more so than medical services – such as healthy food, safer cars or healthy residential areas;
- the fact that even if the government was willing to ban markets for supplementary health services, in a world with open borders purchases abroad could not be prevented. Moreover, the ensuing "surgery tourism" would not only be inefficient due to unnecessary travel costs, but would primarily be used by the well-to-do, which is contrary to the goals of those who are in favor of hard rationing in the first place.

The result of soft rationing is some form of two-tier medicine, but one in which everybody has the right to choose the tier s/he wants to belong to.

Implicit versus explicit rationing

The second principal decision can be characterized as the choice between the following alternatives:

1. "Implicit" or "bedside rationing": here society only determines the share of GDP that is financed by taxes or mandatory contributions and devoted to the healthcare sector, but leaves it to physicians to allocate services to individual patients, particularly in the case of competing needs. Besides a global budget for the healthcare system as a whole, individual budgets for healthcare providers like hospitals are a typical instrument in this type of rationing.
2. "Explicit rationing": here society enacts precise and transparent rules that determine the circumstances under which certain persons can claim certain medical services. All services that are claimed must be financed so that, at least in the short run, total healthcare expenditure and hence tax rates cannot be fixed a priori.

Many people prefer implicit over explicit rationing because the former allows upholding the belief that death is always due to an unhappy fate, and never the result of specific rationing decisions, including one's own decision not to include a certain service in one's insurance contract (Hall 1994). Furthermore, it is argued that implicit rationing allows physicians to consider the specifics of each individual patient when taking their treatment decisions to a greater degree than rationing according to strict rules (see, for example, Mechanic 1992 and Hunter 1995).

This appeal to professional judgment is convincing if a number of conditions are fulfilled:

1. There is a consensus in society that a good criterion for the success of treatment is the expected benefit, measured, for example, in the quality adjusted life years (QALYs) gained.
2. All members of society have identical preferences with respect to length of life (in QALYs) and consumption.
3. The correlation between success of treatment and objectively measurable criteria such as chronological age is small.
4. Physicians dispose of a set of medical criteria (such as blood pressure, ECG), which, taken together, enable a fairly accurate forecast of the success of a treatment, whereas individual treatments cannot be operationalized well enough to base general allocation rules on them.

If conditions 1 and 2 are fulfilled, the appropriate criterion for including a service in the coverage of a collectively financed health insurance system is the cost per QALY ratio. If 3 and 4 are fulfilled as well, then the maximization of QALYs gained can be achieved by specifying a budget and letting physicians decide on the allocation of services among patients strictly according to medical criteria. As a result, the expected utility of the insured – as assessed behind the veil of ignorance – will be maximized.

It is obvious that some of these conditions are quite unrealistic. In particular, it is hard to dispute that people differ in their preferences for length of life versus standard of living. Furthermore, as physicians can be influenced in their decisions, there is the danger that better educated and more eloquent patients are favored in rationing decisions taken at the bedside.

An additional weakness lies in the way in which implicit rationing is often achieved in practice, namely by limiting medical capacity. Although this practice has the advantage that physicians do not have to deny individuals a treatment despite the availability of sufficient resources to perform the treatment (see, for example, Krämer 1993, 55 ff.), there is a significant disadvantage attached to it. Most of the bigger countries like Great Britain or Germany are divided into regional units, which act as service areas for medical capacity, and it is practically impossible to align capacity perfectly with demand for services in every region. Falling short of this target, however,

implies a problem of inequality; since equal demand will meet unequal intensity of treatment in different regions, so that the principle of horizontal equity is jeopardized.

A further objection against implicit rationing is that it is hard to see why the task of distributing survival chances should be delegated to physicians for the sole reason that they possess the technical knowledge of what specific services are necessary to achieve this survival. In particular, their superior technical competence does not at all give physicians a superior moral competence for placing relative values on human lives (Kliemt 1993, 266). Interestingly, this argument is often made by physicians themselves (see, for example, Loewy 1991).

Moreover, the potential advantages of *soft* rationing can only be achieved if it is also explicit, i.e. if it is clear to every citizen which services are covered by Social Health Insurance or a National Health Services and which are not, so that a supplementary private insurance contract could cover the latter.

Finally, it is a consequence of the rule of law that whenever the government uses coercion to influence citizens' behavior, it is obliged to define the rights and duties of those citizens clearly, so that they can be reviewed by the courts of justice. This principle is violated in the case of implicit rationing whereby insurance coverage does not guarantee a claim to specific medical services in every single case.

Rationing in practice: a comparison of England/ Wales and Germany

Healthcare rationing in the NHS of England and Wales

The National Health Service (NHS) has always been the prototype of healthcare rationing. Healthcare provision through the NHS is completely tax-financed and the performance rates of certain medical procedures such as X-rays or renal dialysis per capita used to be only a fraction of the rates in the USA (Aaron and Schwartz 1984, 33, 73). Moreover, explicit rationing criteria such as age seem to have played a role for a long time,[9] and for elective procedures such as hip replacement waiting lines were used (ibid., 58–61), which are also explicit in the sense that the patient knows why s/he is not getting the service immediately and can, in principle, purchase it in a market for private healthcare services.

As an additional explicit rationing criterion, cost effectiveness started to play an increasing role under the Labour Government of 1997–2009. In 1999, the "National Institute of Clinical Excellence (NICE)"[10] was created "*to promote clinical and cost-effectiveness by producing clinical guidelines and audits, for dissemination throughout the NHS*" (Nelson 2011, 210). The main purpose of NICE is to appraise the cost-effectiveness of new drugs or medical procedures on the basis of scientific evidence and make recommendations to regional health authorities (called "Primary Care Trusts", PCTs).

The criterion used to arrive at a verdict is the "incremental cost effectiveness ratio" (ICER), which measures the additional costs and benefits, as compared to the best already available drug or procedure. Benefits are usually measured in "quality adjusted life years" (QALYs) gained, and a drug is approved if its ICER lies below a cost-per-QALY threshold. More precisely, PCTs are recommended to finance the drug if the ICER lies below 20,000 GBP, to give additional reasons if it lies between 20,000 and 30,000 GBP and to refuse financing if it exceeds 30,000 pounds (Walker, Palmer and Sculpher 2007, 56). So, at least as far as the use of pharmaceuticals is concerned, rationing is explicit in two respects: firstly, PCTs clearly state which drugs they do or do not finance; and secondly, the criterion used to justify the decision is also transparent.

The coalition government in power since 2009, however, announced that it would withdraw NICE's power to decide that drugs should not be provided based on cost-effectiveness determinations and introduce a new regime of negotiated drug pricing instead. Nelson (2011, 211–12) sees this as a clear indication of a transition from explicit rationing with transparent criteria to implicit rationing.

Healthcare rationing in German Social Health Insurance

In the German Social Health Insurance (SHI), explicit rationing is hardly ever used in the funding

[9] Aaron and Schwartz (1984, 34-37) report that this was true at least in allocating places for renal dialysis although physicians tried to conceal the fact that age as such was decisive.

[10] Later it was renamed as the "National Institute for Health and Clinical Excellence" without changing its acronym.

decision for new drugs and procedures. According to § 12 SGB V, services must be "sufficient, appropriate and economical, and they must not exceed the necessary quantity". If there is no appropriate alternative to a drug, it is automatically included in the benefit package of SHI. In 2004, an element of explicit rationing was introduced into the drug approval rules. An institute was founded with a similar design to that of NICE, the "Institute for Quality and Efficiency in Healthcare" (IQWiG), and it was commissioned to develop procedures for health technology assessment. In the first draft of these procedures, which were issued in early 2008, it was proposed to introduce a price ceiling for new drugs that should be defined by the relevant part of the "efficiency frontier" of competing drugs already in the respective market. In particular, the incremental cost-benefit ratio of the two best drugs in the market should be used to determine a price ceiling for the new drug. This would have been a clear case of explicit rationing because if the supplier of the new drug had refused to offer the drug at this price, it would not have been made available to members of SHI. However, a new law (AMNOG) in place since 2011 removed this possibility.

Decisions on the (non-)inclusion of new drugs or procedures in the benefit package of SHI are taken by the "Federal Joint Commission" (*Gemeinsamer Bundesausschuss, G-BA*), which comprises representatives of sickness funds and healthcare suppliers. In principle, this commission could reject a new drug if its extra benefit were to be deemed too small relative to its costs, compared to the next best alternative. In practice, this has never happened because the GB-A interprets the term "economical" in such a way that this requirement is always fulfilled if there is an additional benefit through the new drug, no matter how much extra it costs (Wasem 2012). If anything, the G-BA has in the past postponed the decision on the funding of a new drug, sometimes by several years, and has thus resorted to a kind of temporary explicit rationing (ibid.)

In the absence of explicit rationing devices, Germany uses a variety of regulations to contain healthcare expenditure such as a global budget for all ambulatory services, reference values for prescriptions and so-called efficiency checks, which force physicians to make decisions on the allocation of scarce resources (not least their own time). The criteria used to make such decisions were recently examined in surveys (see, for example, Schultheiss 2004, for a meta-analysis see Strech, Synofzik and Marckmann 2008). The authors show that it is not always medical criteria that determine physicians' decisions, but also contextual and individual factors like a patient's ability to articulate his/her wishes. A negative side effect is that rationing occurs not only implicitly, but is also concealed since the physician who must not lose the patient's trust will try to suggest that s/he has done everything to treat the patient in the optimal way.

A somewhat different approach was used by Thielscher, Schüttpelz and Schütte (2012) to quantify the extent of rationing related to patients suffering from one specific illness (schizophrenia). They determined the amount of time that a psychiatrist devoted to each patient in the year 2010, given the SHI reimbursement rates, and compared the result (10 minutes per month) with the time recommended by the respective clinical guideline (50 minutes per month). As the former number falls short of the latter one, the authors conclude that the services in question are rationed.

It is worth noting the ethically questionable fact that the limitations described in both studies, which are not caused by the objective unavailability of a well-defined resource (such as a transplant), are not practiced with respect to privately insured patients.[11] This means that there is two-tier medicine not only in the financing of, but also in the delivery of healthcare, and most citizens cannot even choose their affiliation to a specific tier.

How to replace implicit with explicit rationing

The considerations above suggest that it would be desirable to move towards explicit rationing, and to limit the extent of its implicit counterpart. This requires specifying the benefit package of SHI much more explicitly to create transparency for patients, healthcare providers and sickness funds. To be both practicable and acceptable to the public, the criteria for inclusion in the benefit package must not discriminate against well-defined patient groups, physicians must be willing to abide by the rules and finally – to create legal certainty – the criteria should be based on objective data and leave as little discretion as possible to the physicians who have to apply them.

[11] On the contrary, because of higher remuneration, private patients are often over-doctored.

Possible rationing criteria

In discussions on rationing, the following criteria play a major role:

- *Cost-effectiveness:* this criterion, which is the overriding one in defining the benefit package of the National Health Service in England and Wales, is attractive from the "behind the veil of ignorance" viewpoint because it maximizes expected quality-adjusted life expectancy from a given healthcare budget for the (still healthy) citizen. It is even favored by bio-ethicists as a result (see, for example, Marckmann and Siebert 2002). It might, however, discriminate against people with congenital diseases that are expensive to treat like haemophilia.
- *Patient age:* this criterion, which was allegedly used in the NHS in the 1960s and 70s, has the advantage of being operational and therefore facilitating supplementary insurance (Breyer and Schultheiss 2002). Physicians obviously accept it because they already apply it in situations of implicit rationing. In contrast, it seems to be a social taboo because many people think it is discriminating.[12]
- *Novelty:* as the increase in healthcare spending seems to be driven primarily by medical progress, an effective means of curbing this rise would be the delayed introduction of innovative pharmaceuticals and procedures (Häussler and Albrecht 2010). The disadvantage of this criterion is its weak ethical basis. Moreover, it is unclear whether it should also hold for cost-saving innovations. If not, there is little difference to the cost-effectiveness criterion.

Procedures of decision-making

Besides criticism of the prevailing implicit rationing as such, lawyers such as Kingreen (2011), also find fault with the fact that major decisions on distributing scarce resources are taken by a body such as the Federal Joint Commission, which is not legitimized by democratic procedures. In principle, the basic rules should be determined by parliament.

Of course, such decisions should follow a phase of open debate in public, i.e. in the media and in political parties, on strategies to cope with scarcity of resources in the publicly financed healthcare sector. In this debate, the preferences of the citizens regarding the trade-offs between length of life and consumption should be taken into account.[13] However, an indispensable prerequisite is the confession of politicians in all countries that rationing is unavoidable; and that no healthcare system, no matter how expensive it is, can guarantee all potentially beneficial services to all patients at the tax-payer's expense.

Concluding remarks

Everywhere in the world healthcare services are allocated in limited amounts, i.e. rationed. In modern welfare states, this allocation occurs independently of an individual's willingness or ability to pay, which means that there is rationing in the narrow sense of the word. Unfortunately, politicians (and even physician representatives) usually declare rationing as a taboo and thereby impede an open and public debate on the topic. Moreover, the euphemism of "prioritization" does not help to objectify the discussion, but rather tends to obfuscate it.

Instead of the prevailing implicit and often concealed rationing at the bedside, a free society under the rule of law needs explicit soft rationing provided by a well-specified Social Health Insurance benefit package. In the literature on this topic, several potential rationing criteria have been proposed. Societies, and eventually parliaments, should lead an open and honest debate of these criteria.

[12] This is a popular misunderstanding because age-based rationing actually achieves fundamental equality of treatment since age is not an invariant characteristic of a person like gender, but a series of states that every person passes through.
[13] A recent attempt to elicit people's willingness to pay for longer and healthier lives in nine European countries was made in the EuroVaQ project (Donaldson et al. 2010).

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