Depoliticization and Politicization in the Allocation of Health Care: Decision-Making Procedures in International Comparison

1. Introduction

The debates about the future of European health care systems still widely assume that the distribution of health goods follows the principle of need alone: everyone gets what they need, neither more nor less. Remaining regulative challenges such as the appraisal of new pharmaceuticals and technologies are regarded as purely technocratic problems to be solved by experts. Ever increasing costs for new drugs, demographic change and decreasing employment rates, however, have in most countries long made cost containment policies necessary. Their failure to effectively control expenses enhances the pressure for explicit priority-setting in health care and increases the probability of its politicization. The challenge of fairly distributing health care under conditions of limited resources draws attention to the dangers and shortcomings of depoliticization and technocratic decision-making as well as to those of politicization and emotionalization. The increasing significance of rationing in health care makes the problem a particularly relevant one with regard to both the limits of purely utilitarian concepts of efficiency and need for output-legitimacy derived from a productive health care system.

The explicit definition and confinement of health services is thus a markedly interesting example for the conflict between efficiency and democracy. In hardly any other policy area are the challenges of decision-making under conditions of uncertainty and overcomplexity, in face of conflicting fundamental values and clashing interests, equally
obvious as in the allocation of health care. Moreover, health policy decisions immediately affect citizens in their everyday life. Far from being a purely regulative task, the allocation of health care under conditions of budget constraints constitutes an essentially distributive conflict. Any decision benefits some groups of patients at the expense of others, thus giving rise to questions about justice and a democratic definition of its standards. At the same time, politicization and emotionalization bear the risk of “irrational” decisions disregarding the state of medical research, or “inefficient” ones forgoing utility gains. Irrational or inefficient allocation of limited resources is not merely a financial problem, but means unnecessary suffering or even death. Given that some groups of patients are publicly far more visible than others, and that diseases such as addiction, AIDS or lung cancer are frequently regarded as results of irresponsible behavior, the politicization of allocation decisions may well lead to a society letting down its most needy members and risk the violation of fundamental rights and equality.

The paper proceeds in four steps. In section 2, I point out the inevitability of rationing in health care and discuss advantages and disadvantages of implicit and explicit rationing strategies. In section 3, I address the conflict between efficiency and democracy and the problems of politicization and depoliticization. I come to the conclusion that purely expertocratic decisions are neither possible nor desirable, as necessary compromises between conflicting allocation principles are eventually contingent. Consequently, the focus should be directed to *procedures* rather than *principles*. For this purpose, I define ideal-types of forums by two properties, discursiveness and coordinativeness (section 4). For illustration, I present four case studies of empirical procedures approximating these ideal-types (section 5). On the basis of results from the case studies, the conclusion seeks to define the possible and necessary role of different types of forums in decision-making processes and attempts an answer to questions about the limits of both democracy and efficiency.

2. Limited Resources and the Allocation of Health Care

Expenditures in the health sector are limited by the simple fact that no society can use its entire resources for health care and that expenses in one sector effect opportunity costs in others. With a limited budget, however, it becomes impossible to fulfill all medical needs or desires. The necessity of cost containment is partly a consequence of the success of medical research and technology, which increase life expectancy and survival rates even for formerly fatal diseases (Daniels/Sabin 2002: 2). Rationalization, i.e. the (financially) more efficient use of resources, alone will hardly suffice to control the costs incurred by medical progress and
demographic changes. This necessitates rationing, or curtailing, of health care, which brings up questions about the justice and efficiency of its allocation.

A common and useful distinction in this context is that between implicit and explicit rationing strategies. Implicit rationing takes place through limited budgets for single sectors and thus effectively relocates decision-making from the macro- to the meso- or micro-level, i.e. to the single hospital or physician. Explicit rationing strategies, by contrast, specify criteria by which funding for services is denied priority or entirely refused. Three sets of criteria may be distinguished. The first are criteria concerning the recipient, such as age, gender or lifestyle. Secondly, there are criteria concerning the condition to be treated, i.e. whether and under what circumstances it qualifies as a disease. Finally, there are criteria concerning the effectiveness and risks of technologies to be funded. So far, mainly criteria of the latter two types have been applied in practice.

Arguments have been made both for implicit and for explicit rationing strategies. The principle of subsidiarity and the possibility of individual scrutiny militate for implicit rationing. In addition to this, it has been argued that explicit rationing decisions and public debates over them might challenge and erode shared values, in particular the value of life (Calabresi/Bobbit 1978). Hospitals and practices at the meso-level, however, are frequently overtaxed by decisions over individual cases. In consequence of this, informal decision rules are set up which are neither transparent to patients nor publicly justified or democratically legitimated. Besides the necessity of public justification, general bindingness, transparency and confidence in expectations thus represent strong arguments in favor of explicit rationing strategies.

While implicit rationing leaves the allocation of limited resources to market forces and the discretion of professionals, explicit rationing requires authoritative political decisions. This brings up questions about the rationality and justification of allocation principles, but also about how and by whom they are to be selected and applied. That is, explicit rationing raises questions about efficiency, democracy and possible conflicts and trade-offs between them.

3. The Conflict between Efficiency and Democracy

Where health care is publicly funded or publicly sanctioned, explicit rationing decisions must be generally binding and thus political decisions. But can democratic procedures be expected to effect an allocation that meets the requirements of rationality and efficiency? On the one hand, priority-setting definitely entails distributive conflicts. That is, certain groups of patients
or potential patients are privileged over others and their claims and needs attended to prior to those of others. Such distributive conflicts, it is widely acknowledged, cannot be depoliticized and solved in an expertocratic fashion. On the other hand, allocation decisions immediately affect the welfare of citizens. The expectation to achieve optimal results with limited means grows in the face of cut-backs of entitlements. It seems that where the government curtails entitlements, it must increase productivity. Apparently sub-optimal outcomes that fail to meet expectations might undermine the acceptance and legitimacy of decisions more profoundly than a lack of transparency and participation on the input-side. In so far as depoliticizing decisions increases welfare, it may not only be desirable under ethical aspects, but also preferred by a majority of the population.

The allocation of health care is efficient, health economists would say, where services optimally meet requirements and neither too much or too little, nor the wrong kind of care is provided in any place. Where resources are finite and some requirements cannot be met efficiency can only plausibly measured in terms of the absolute utility produced. The problems of establishing such an interpersonally comparative measure for utility have long characterized utilitarian theorizing. Do we consider subjective wishes or objective needs? How do we determine or weigh either? In health care, though, objective needs seem to be easier to determine than in most other areas and a respective calculus has been proposed and applied. For the assessment of medical technologies, the “Quality Adjusted Life Years” (QALY) calculus registers only the costs of each life year in “improved quality” that on average is gained by the treatment (Loomes/McKenzie 1989). Who receives the benefit and whether the treatment is particularly urgent or even life-saving is irrelevant to the calculation. In consequence, the purely utilitarian QALY-calculus leads to decisions which, while “efficient”, are regarded as unjust and therefore rejected by most people.

An alternative calculus that is more popular in public is that of most urgent need, measured for instance by remaining life expectancy without treatment. Under finite resources, however, the unconditional preference for the neediest is not without problems either. Available treatments for less serious conditions and benefits from prevention would need to be forgone and care might only be provided when a cure is no longer possible. The calculus of most urgent need thus privileges the critically ill while the utilitarian calculus privileges the less severely ill and healthy members of a society. Any necessary compromise between such principles is arbitrary in the sense that it cannot be deduced from higher-ranking principles. The challenge for policy-makers consists not in a lack of principles but in the contingencies arising in their combination and application under conditions of uncertainty.
Søren Holm uses a model of two phases to describe a learning process that has taken place in the rationing debate (Holm 2000). The first phase, Holm argues, was characterized by the search for an “objectively” rational and just method of priority-setting. Decisions taken on the basis of the correct principle would then be ipso facto legitimate (ibid. 30). According to Holm, the debate in most countries has now reached the second phase, which abandons the search for simple solutions and acknowledges the fact that a “correct” method of allocation does not exist. Instead, decisions are regarded as gaining legitimacy through the use of the correct procedure which is characterized by transparency and accountability. The acknowledgement of contingencies and of the fact that political decision-making cannot be replaced by the automatized application of a specific calculus brings democracy into play. The irreducible pluralism of norms and interests necessitates political decisions, for which democratic procedures are the only ones deemed justified on the grounds of equality and self-determination (cf. Greven 2000). However, Holm’s model neglects the problem of a regress of rules: How are we to choose procedures where requirements of transparency and accountability run into conflict with demands for expert knowledge and efficiency?

The conclusion that a “correct procedure” is as illusionary as the “correct method”, though, does not imply that an assessment and evaluation of different procedures is pointless. In the following section, I propose a possible framework for such an analysis in the form of institutional ideal-types. These ideal-types are not defined by input (democracy vs. delegation) or output properties (efficiency vs. inefficiency) but by “throughput” properties: the extent to which the procedure enables discourse and coordination. An examination of these forum’s possible and necessary contribution to decision-making, however, allows for inferences about the role of democratic and participatory institutions as well as about the limits of utilitarian concepts of efficiency.

4. Discourse and Coordination

When explicit rationing decisions become necessary, the first expectation the selected procedure has to meet is that it provide satisfactory reasons for decisions. At least two institutional properties can be identified that promote reason-giving. The publicity of a procedure forces participants to justify their positions and decision under reference to generalizable, “public” reasons (cf. Elster 1995). What is required is not necessarily mass media attention. Even where a forum is in principle accessible for a wider public, incentives for bargaining and appeals to non-generalizable, “private” reasons are stifled. In-depth justification of positions and their premises, however, is only warranted in a situation of
dialogical interaction, where hearers can challenge and reject a speaker’s assertions. As the realization of dialogical interaction becomes more difficult with the size of a forum, a conflict between dialogue and publicity may certainly arise, albeit not necessarily.¹ I therefore define forums in which interaction is both public and dialogical as discursive ones.

Besides justification, any collective, generally binding decision calls for the coordination of different positions and reasons for action. The larger the coalition required for a decision, the higher is the necessary amount of coordination. Advocates of deliberative models of politics assume that coordination may be achieved through discursive interaction. If reaching understanding is the “inherent telos of human speech” (Habermas 1984: 287), any kind of linguistic interaction contributes to the coordination of action plans – even if the quality of results depends on properties of the discourse. The prerequisite for this would be the complete fusion of practical and doxastic reasons for action, that in “communicative action, reasons constitute motives” (Habermas 1994: 188). Under conditions of incomplete information on the one hand and pressure of time on the other hand, however, communication alone is unlikely to suffice for coordination. Rather, additional incentives or forces to coordinate action plans and preferences seem to be required. These always necessitate compromises of different kinds. In the first place, the coordinative quality of an institutionalized forum thus depends on factors other than its discursiveness. Besides the decision rule, the definition of the conflict (as conflict over facts, values or interests), the definition of actor roles (expert, citizen, representative or interest group) and the definition of the respective task (preparation, evaluation, distribution or decision) seem to be essential. The coordinativeness of forums will thus be defined by the presence of incentives or sanctions for the coordination of action plans through compromises, which are constituted primarily by decision rules and the definition of the situation.

Crossing the two institutional factors of discursiveness and coordinativeness yields a matrix in which four types of forums are defined by these two properties. I have assigned types of political forum to each of the four fields. These are not to be understood as concrete models or categories, though, but as ideal-types.

¹Jon Elster sees a trade-off between publicity and the quality of a discourse, which leaves a choice only between the second-best options of public, but rhetorical and non-coordinative arguing and non-public bargaining (Elster 1995: 252). On conflicts between publicity and discourse quality, see also works by Simone Chambers (Chambers 2004; Chambers 2005).
The expert commission and the consensus conference are discursive types. With a limited number of participants, both are designed in an expressly dialogical fashion. Moreover, both are, at least in their underlying logic, public procedures, so that reasons have to pass a test for generalizability. Distributive bargaining and the parliamentary debate are non-discursive types. The debate, while public, is better characterized as a sequential monologue than as a dialogue, so that in-depth justification cannot be claimed. Classical procedures of distributive bargaining, while necessarily dialogical, take place behind closed doors, where private, non-generalizable reasons can dominate public and generalizable ones.

Both distributive bargaining and the consensus conference are coordinative procedures. In bargaining situations, a decision requires consensus, and the focus on interests makes compromises not only possible, but necessary from the point of view of actors. For the consensus conference, too, consensus is the implicit goal. In the sense of the definition of actor roles (citizen) and task (evaluation), however, compromises in the citizen conference are not between private reasons and interests, but between equally and jointly accepted norms and interests which conflict in application. The ideal-type goal is to find out which of several equally justifiable option the participants prefer as citizens for the community. By contrast, expert commissions, just like parliamentary debates, are characterized by antagonistic logics of interaction: compromises about the truth do not seem acceptable.

How can the respective forums and procedures meet requirements for explicit and well-justified allocation decisions? The following hypotheses may be derived from the model: expert commissions, although their discursive structure contributes to the assessment and evaluation of assumptions, lack coordinative properties. In particular where conflicting principles and criteria need to be weighed, they will have difficulties arriving at explicit decisions. Their potential lies in the identification of justifiable options for choice. Consensus conferences are both discursively structured and, with the target of a unanimous vote and the definition of the situation (citizens seeking a shared evaluation of options), may be expected to produce strong incentives for coordination. Disregarding considerations about lack of information and democratic legitimacy, they seem to provide optimal conditions for consensual and justified decisions. Distributive bargaining rounds possess a high coordinative pressures and can, in the sense of the Coase theorem, maximize the utility of participants. The
probability of explicit decisions with comparatively small implementation costs is thus high. Due to the lack of discursive qualities, however, these will not be adequately justified and are likely to be at the expense of non-participating third parties. In parliamentary debates, the coalition required for a decision already exists, so that further coordination of action plans and search for compromises are no longer necessary. Because of its lack of discursiveness, the debate may serves for public justification, but not for the assessment and evaluation of options. Rather, it presupposes forms of information and preparation of decisions that take place in the other three types of forums.

In international comparison, we find procedures for the allocation of health care which approximate the ideal-types set up above. For purposes of exploration and illustration, four examples are discussed in the following section.

5. Case Studies

a) Expert Commission: The National Institute of Clinical Excellence (NICE), UK

The National Institute of Clinical Excellence (NICE) was set up in 1999 as an expert commission, with the task of evaluating new and existing technologies to be funded by the National Health Service (NHS). The NHS charter requires that any person living in Britain is entitled to medical care and that no medically necessary and useful services may be denied to patients. Given the limited and comparatively short budget, however, the NHS has a long tradition of implicit rationing that surfaces in waiting lists, shortages of hospital beds and overloaded medical staff. Although the system of public health care still enjoys public support, dissatisfaction with services has increased in the 1990ies. Tony Blair’s labour government has not only increased the budget, but also targets a series of changes to improve transparency, participation and quality control. In this context, NICE is expected to play a central role (cf. Niebuhr et al. 2004).

Within NICE, the ‘technology appraisal committee’ is of particular relevance in the present context. Authorized by the Department of Health, it evaluates drugs and technologies. Working with three independent chambers, the committee charges universities or research institutes with a report before it assesses a specific treatment. Besides academic experts, practicing nurses and physicians, patient representatives and representatives of the pharmaceutical industry are members in the committee’s chambers. The committee aims at consensual decisions; however, the chairman can call a simple majority vote if consensus cannot be reached.
With regard to the criterion of discursiveness, NICE seems to perform well. Meetings are at least partially public, and the heterogeneous membership serves to control private reasons and bargaining. Reports and decisions are published promptly in an expert and a lay version and justified extensively. In case of negative votes, patients can make use of an appeals procedure and explicitly challenge the reasons named for the decision. With regard to the criterion of coordination, by contrast, NICE deviates from the ideal-type expert commission. The available option of a majority vote increases incentives for coordination, as all members have to bear the decision. The fact that the committees are staffed not only with experts, but also with interests groups and patient groups increases the relevance of interests compared to medical and economic controversies, which makes compromises easier.

The example of NICE thus fails to confirm the hypotheses that expert commissions will have difficulties producing explicit decisions or recommendations. However, NICE’s high productivity can be accounted for by higher coordinative pressures and lower decision costs than assumed in the ideal-type. The increased willingness to compromise is also reflected in its decisions. So far, drugs and treatments were rarely denied funding categorically, but only for specific indications or groups of patients.\(^2\) An evaluation of NICE by the WHO, though, criticizes that ethical and social aspects which affect decisions are, in contrast to economic and medical ones, not sufficiently articulated (Devlin et al. 2003). Others have argued that under pressures from patient representatives and the pharmaceutical industry, NICE typically passes positive votes on only marginally superior, but extremely expensive new drugs. Given the finite overall budget, the resulting increase in expenses for drugs is argued to lead to aggravated forms of implicit rationing and regional inequalities (Cookson et al. 2001). In fact, NICE deals primarily with the assessment of new pharmaceuticals and is less concerned with distributive decisions. Comparative evaluations for the justification of priority setting and ‘tragic choices’ do not take place.

NICE’s apparently limited capability for distributive decisions seems to be at least in part a consequence of its lack of democratic legitimation. In a centralized system like the NHS, the politicization of rationing decisions is both more probable and more dangerous for the government than in more fragmented systems, as there are fewer opportunities for blame avoidance. The establishment of an assumedly independent institute like NICE may be regarded as such an attempt to diffuse accountability. The reports and recommendations

\(^2\) A decision over the use of the drug Beta-Inferon for multiple sclerosis shows that such conditional recommendations are not based on medical and economic reasons alone: NICE recommended that the drug should be funded for patients already receiving it at the time of the decision, but that no further treatments with Beta-Inferon should be taken up.
presented by NICE have officially only advisory function, but are widely treated as binding both by the Department of Heath and the media. Although NICE presently seems to improve trust in the NHS, genuine distributive decisions would bring it to the limits of both its democratic legitimation and coordinative capabilities. The majority decision of an expert body will hardly meet with public acceptance, and an expert consensus appears highly unlikely in such cases.

b) Consensus Conference: The Oregon Health Plan, Oregon, US

All over the world, there have been different kinds of attempts to get citizens involved in health policy decisions (see Jorgensen 1995). The majority of procedures, however, were concerned with implementation and funding of single measures. The focus was either on the handling of risk (such as severe side-effects) or on the improvement of service provision (prevention, attendance and information). The only well documented example for extensive citizen participation in decisions over priority setting of public health care providers is the Oregon Health Plan, which was passed in 1991/2 and implemented in the following years.\(^3\) In the late 1980s the US-state Oregon set itself the goal to extend the state-funded Medicaid-program to all its poor and uninsured citizens. The measure was to be funded by deleting less essential and less effective services from the Medicaid list. After a priority list worked out by experts on the basis of the utilitarian QALY-calculus had been met with broad public resistance, the health authorities decided to call 47 community meetings, in which over 1000 citizens participated. The goal of these meetings was to identify ‘community values’ which were to guide the allocation of health care (Daniels 1996: 596).

Both with regard to discursiveness and with regard to coordinativeness, the community meetings held in the context of the Oregon Health plan seem to score high. The meetings were completely public and were apparently experiences as dialogical by participants. Since the number of participants in the 47 single forums varied between seven and 132, it may be expected that dialogical qualities were easier to maintain in smaller rounds (Rothgang et al. 2004: 209). On the whole, however, there seem to have been few complaints about unequal participation or domineering organizational staff. Although the results of the single meetings were aggregated by a commission (so that no aggregation of preferences and judgments of all participating citizens took place), the weighting of competing principles was

\(^3\) In several other countries, including New Zealand, Sweden and Norway, public hearings have been held by respective expert or parliamentary commissions, although their influence on the eventual reports and decisions remains unclear. A further interesting example from the private sector are decisions over services to be provided by Health Maintenance Organizations in the US, where different models of patient involvement have been tried (Daniels/Sabin 2002).
apparently similar in all meetings. However, a problem with regard to the participants’ self-definition as citizens consists in their lack of (statistical) representativeness with regard to the community as a whole. Participants were mainly members of the middle and upper class, a high percentage working in the medical sector. These people were not affected as patients by decisions over the Medicaid program: “the plan could not avoid the appearance of ‘haves’ setting priorities for ‘have-nots’” (Daniels/Sabin 2002: 152). It was less about what is important “for us as citizens and members of this community” than about what we deem important for “the others” – the poor and uninsured (ibid.). The lack of representativeness thus exceeded the typical problems of lopsided self-selection which we find in all participatory procedures, as a majority of participants was not directly affected by the decisions they sought to inform.

With regard to the impact of participatory procedures on rationing decisions, two points are remarkable. First, the politicization of priority-setting, which the Oregon health authority’s strategy effected in an unprecedented way, apparently leads to a prioritization of urgent need over total productivity and welfare gains. The resulting priority list and its justification seem to better supported by affected values and societal norms than the original one that was compiled by experts. However, while the community meetings served to assess and weigh abstract values, the explicit decision over the ranking of different services remained in the hands of experts. Second, the result indicates that participatory procedures by themselves will fail to produce explicit allocation decisions (Lomas 1997: 106). Among other things, the public debate resulted in a rise of the overall Medicaid budget, which is surely to be welcomed from a normative perspective, but does not militate for the procedure’s distributive capabilities. To conclude, procedures of the consensus conference type like the one in Oregon require extensive preparation and involvement by experts, while the representativeness of participants is notoriously deficient. Moreover, and despite their promising potential with regard to discourse and coordination, the contribution of participatory procedures to the legitimation of concrete distributive decisions remains limited.

c) Distributive Bargaining: The Federal Joint Committee, Germany

In the late 1970s, German health policy made the first moves from service expansion to cost containment. Since then, the Joint Committee, where health insurers and doctors negotiate services and remuneration, has gained in importance. The move from expenditure-oriented

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4 Although the list compiled on the basis of results from community meetings included a ranking of different services, it was hardly used in practice. Cost containment was achieved through implicit rather than explicit rationing strategies, such capitation (Rothgang et al. 2004: 213/4).
revenue policy towards revenue-oriented expenditure policy was thus accompanied by an instrumentalization of the joint committee for the regulation of distributive conflicts (Döhler/Manow-Borgwaldt 1992: 584). In return for its commissioning for cost containment goals, the Committee received far-reaching instruments for its implementation (Urban 2001: 10). The Federal Joint Committee set up in 2004 merges several existing committees and covers inpatient and outpatient medical and dental care. It issues legally binding decisions and thus possesses remarkably far-reaching competences for the allocation of health care. The latest major health care reform, however, has also considerably restructured decision-making procedures.

The committee’s discursive quality was substantially strengthened by the 2004 reform. The participation of patient representatives, albeit only with initiative and consultative influence and without voting rights, improves the publicity of meetings. The fact that each of the separate panels is chaired by three experts not only increases pressures for justification but at the same time reduces decision costs. Whereas previously, each party at the bargaining table (insurers vs. doctors or hospitals) practically held veto powers, majority decisions are now possible. In case of a confrontation of interests, it is the experts who dispose of the deciding vote. As a minimal winning coalition requires either expert support or compromises with the opposite side, coordinative incentives nonetheless remain strong.

Increasing institutionalization and the reform of consultation and decision procedures have changed the Federal Joint Committee’s structures in a way that it no more seems to resemble the ideal-type of distributive bargaining. The apprehension of insufficiently justified decisions at the expense of third parties seems no longer warranted after the recent reforms. Nevertheless, the fact that a forum that was originally set up for bargaining purposes was charged with allocation decisions is in itself remarkable, as its lack of legitimation and justificatory faculties is so obvious. A lack of public visibility and transparency of decisions still remain and remain problematic: decisions are published only in a form entirely inaccessible to laypeople, and reasons are not named. However, several conflicts between the Federal Joint Committee and the German Ministry of Health indicate a notable development. When the minister revoked one of the Committee’s decisions, it insisted on its legislative capacities and took steps to justify the ruling to a wider public. Interestingly, the minister typically objects to negative decisions and thus contributes to the politicization of rationing decisions, which the delegation was seemingly intended to prevent.
In Sweden, too, growing demands and shorter budgets increased pressures for priority-setting in the allocation of health care. In accordance with Swedish tradition, a parliamentary commission was set up and charged with the development of a priority plan. The commission consisted of seven Members of Parliament, in proportion with the larger parliamentary parties, and nine experts without voting powers. In 1995, the commission presented a consensual report that was discussed in parliament. The parliament ruled that the general principles stated in the report were to be turned into an obligatory basis for concrete allocation decisions, which in the decentralized Swedish health care system were to be taken at the local level.\(^5\)

The discursiveness of the commission forum may be estimated as high. For one thing, the number of participants was, compared with a plenary debate, low, which eases dialogical interaction. At the same time, expert involvement and public hearings kept justificatory pressures high and prevented moves towards bargaining. The fact that the forum was uncoupled from the parliamentary plenum and the high standing of consensus in Swedish culture increased incentives for coordination and contained the effects of party competition.

Obviously, the commission has little in common with the ideal-type parliamentary debate. It is remarkable, however, that the formulation of a consensual report was achieved in a time of hitherto unprecedented polarization of Swedish politics. As the commission’s members were appointed in accordance with the parliamentary parties’ size, certain parliamentary logics were transferred into the forum. Moreover, the report was discussed and adopted by the plenum. On the whole, the commission contributed to the politicization of rationing questions and triggered a comparatively broad public debate. The result much resembles the one in Oregon: urgent needs are prioritized over overall productivity and the principles of equality and non-discrimination are highlighted. Still, the report limits to an enumeration of comparatively abstract principles, which are to be converted into concrete decisions only by other bodies. It seems that a consensus was possible only at the price of factoring out controversial issues. The far more explosive evaluation of specific treatments and services thus had to be relocated to a lower level. In this case, the majoritarian logic of the parliament seems to prevent coordination after all. In spite of general agreement on the necessity of priority-setting, any concrete cut-back would be met by a sufficient majority to prevent it.

\(^5\) On the Swedish Parliamentary Priorities Commission, see Ham 1997; Calltorp 1999 and the Commission’s final report (Swedish Parliamentary Priorities Commission 1995).
In the Swedish case, the parliamentary procedure and decision hence seem to mark the beginning rather than the conclusion of a process. Adopted by the parliament, the commission’s reports sets a frame for concrete allocation decisions at the local level, in which experts play the central role. In addition, a similar commission was set up to succeed the first one. This “National Commission of Priority Setting” is to guarantee central control and evaluation and to ensure that concrete decisions are guided by the report’s framework.

6. Conclusion

Coming back to the original question, are democratic input to decisions and politicization of the rationing question reconcilable with efficient allocation as the presumably desirable outcome? Or do efficient solutions under conditions of over-complexity and incomplete information require a kind of expert involvement and depoliticization that incompatible with competitive party politics and broad public debates, as Philip Pettit has argued (Pettit 2003)?

Considering the four types of procedures discussed above with regard to the kind of democratic input and efficient outcomes they enable, two axes may be drawn through the matrix:

<table>
<thead>
<tr>
<th>Information, Expediency</th>
<th>Participation</th>
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<tbody>
<tr>
<td>Expert Commission</td>
<td>Consensus Conference</td>
</tr>
<tr>
<td>Parliamentary Debate</td>
<td>Distributive Bargaining</td>
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| Legitimation          | Effectiveness, Efficiency |

One of these axes (from bottom left to top right) represents demands for democratic legitimation and participation, the other one (from top left to bottom right) demands for expert information and efficiency. The case studies have indicated that procedures on the first axis are characterized by remoteness from practical application, while procedures on the second axis provide insufficient opportunities for a comparative evaluation of affected values and entitlements. An optimal rationing procedure must obviously remain as illusionary as an optimal rationing principle.

Moving from the matrix-model of alternatives, which seems to regard all empirical instances as incomplete realizations of an ideal type, towards a cyclical model of the decision making process, however, one may arrive at a more positive outlook. The ideal-types could
then serve not only as points of reference for the analysis of empirical forums, but might also provide clues to their respective limits and potentials. Regarding information about technologies and costs as an important task of expert commissions, venturing to politicize the comparative evaluation of needs and demands through participatory procedures and leaving space for bargaining between important interest groups without overriding parliamentary accountability, it may be possible to achieve decisions which are democratically legitimated, justified and publicly accepted.

Decisions would then qualify as democratic in so far as the accountability of parliament and government is kept intact, transparency is guaranteed, and different forms of participation are permitted. Decision-making would qualify as discursive and thus justificatory in so far as both discursive and non-discursive sequences are allowed for, without the latter offsetting the former (cf. Goodin 2005). Efficiency, though, cannot count as a criterion in itself. It may feature as an argument in justification, but remains a purely formal and thus empty criterion when it is de-contextualized (cf. Blühdorn 2006: 8). At the first glance, it seemed that in the case of health care rationing, efficiency represents a less disputable category: allocation is efficient if under a finite budget, suffering and death are maximally reduced. At closer consideration, however, serious problems emerged: How do we measure suffering? How do we weigh present suffering against future or potential suffering? That is, should we rather use scarce resources for last-chance-therapies or for prevention? While rationing decisions need to publicly and comprehensively justified, justification will never be “beyond all doubt” or “once and for all”. Any democratic political decision must be regarded as temporary and reversible rather than “objectively correct”. This should be expressed in appropriate appeals procedures, which open opportunities for reactive participation.

In the end, the politicization of rationing decisions may even contribute to a vitalization of democracy. In an exemplary way, it demonstrates that political questions have technical and factual dimensions as well as ethical and moral ones, but that decisions remain contingent in that several solutions may be justifiable without one of them being definitely the correct one. Choosing between feasible and supportable options is the essence of politics, and democracy, as Gerald Gaus puts it, is the only defensible “umpire” between them (cf. Gaus 1996, ch.11).
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