NIHR | Applied Research Collaboration South London

Maximising the impact of health care systems: effectiveness, efficiency and equity through fair prioritisation

Peter Littlejohns

Emeritus Professor of Public Health, Centre for Implementation Science, King's College London,

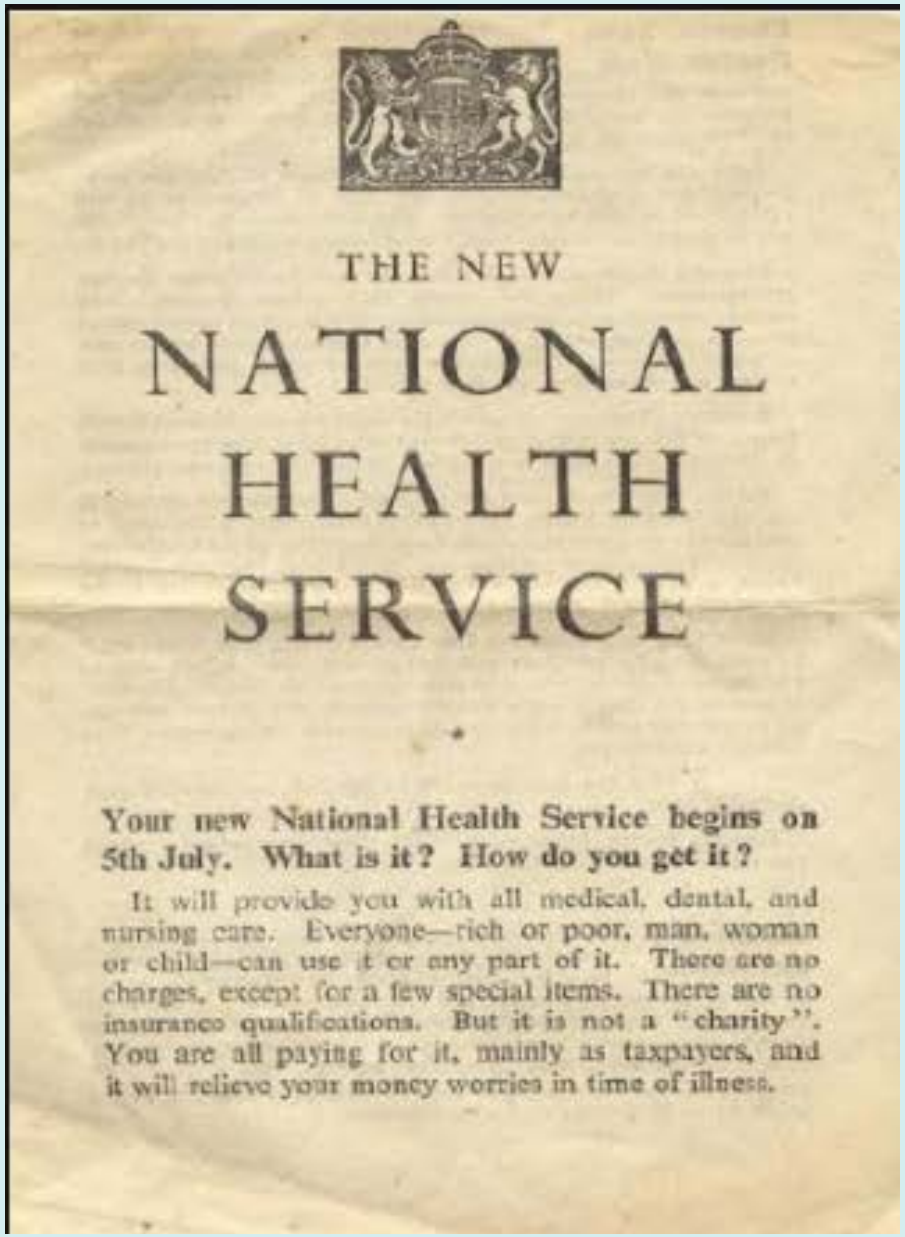
Deputy Director of the NIHR Applied Research Collaboration, South London

My proposition is that……

Prioritisation in health care is inevitable, indeed it is essential ……it can be based on ethical criteria and evidence of cost-effectiveness **or** on unfair "market forces" and "ability to pay"

To prioritise fairly you need to articulate " values" and then develop a "fair" process to ensure the best for individual patient and public health

The NHS as a case study



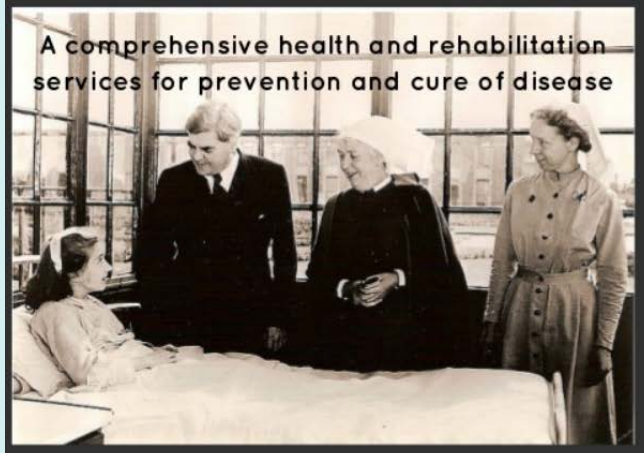
THE NEW

NATIONAL HEALTH SERVICE

Your new National Health Service begins on 5th July. What is it? How do you get it?

It will provide you with all medical, dental, and nursing care. Everyone—rich or poor, man, woman or child—can use it or any part of it. There are no charges, except for a few special items. There are no insurance qualifications. But it is not a "charity". You are all paying for it, mainly as taxpayers, and it will relieve your money worries in time of illness.

A True National Service



Following World War II, the elected Labour government went to work implementing a plan to create new ways to care for Britain's people. After three years of work, and cooperation across the political spectrum, the NHS was officially started on 5 July 1948 with the opening of the Park Hospital in Manchester.

On 5th July we start together, the new National Health Service. It has not had an altogether trouble-free gestation! There have been understandable anxieties, inevitable in so great and novel an undertaking. Nor will there be overnight any miraculous removal of our more serious shortages of nurses and others and of modern replanned buildings and equipment. But the sooner we start, the sooner we can try together to see to these things and to secure the improvements we all want . . . My job is to give you all the facilities, resources and help I can, and then to leave you alone as professional men and women to use your skill and judgement without hindrance. Let us try to develop that partnership from now on.

Message to the medical profession. Aneurin Bevan[1]

72 years later the NHS remains special

But that has not stopped politicians constantly trying to change its structure and management processes

Nigel Lawson, Margaret Thatcher's Chancellor of the Exchequer, was frustrated by public reaction to plans to replace the NHS with some sort of commercial or insurance-based alternative. In his memoirs, Lord Lawson complains that the NHS is the closest the English have to a religion and that they treat the medical profession as a priesthood.

However, research in 2018 showed that many people were "quite shocked" at that idea. They saw it as an insult: they supported the NHS as **"a good thing",** not because it was a religion.

Highlights of the 2012 London Olympics opening ceremony featuring parts of Danny Boyle's interpretation of the NHS.

Rationing health care: a logical solution to an inconsistent triad

Albert Weale, Professor of Political Theory and Public Policy at University College London

BMJ 1998;316:410

The basic principle of the NHS is simply that comprehensive, high quality medical care should be available to all citizens on the basis of professionally judged medical need without financial barriers to access. In seeking to enact this principle, the NHS is not alone..... Yet, in the face of increasing healthcare costs this basic principle threatens to become what logicians call an inconsistent triad; a collection of propositions, any two of which are compatible with each another but which, when viewed together in a threesome, form a contradiction.

The Health Service Ideal : High Quality, Comprehensive, Universal

High Quality, Comprehensive, Universal

High Quality, Comprehensive, Universal

High Quality, Comprehensive, Universal

The Same in Business

The ideal Product : Good Fast Cheap

Good Fast Cheap

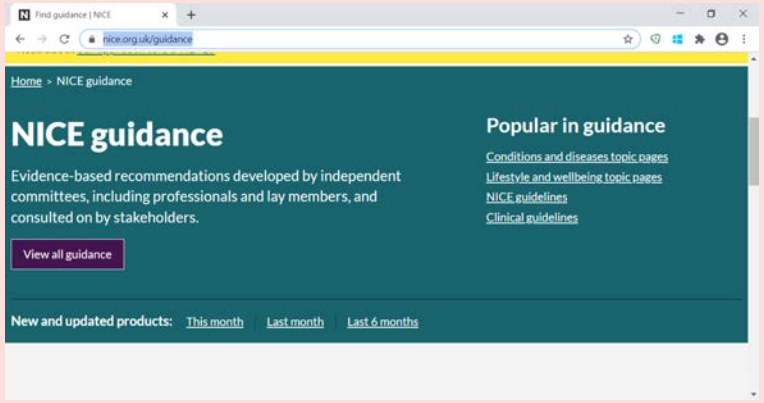
Good Fast Cheap

Good Fast Cheap

1999 – Tony Blair formalized the prioritization of health care in the NHS through the creation of the National Institute for Clinical Excellence (NICE)

The **National Institute for Clinical Excellence (**NICE) is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. It was established in 1999 as a NHS Special Authority. In 2005 it was expanded to include the public health functions of the Health Development Agency to become the **National Institute for Health and Clinical Excellence.** In 2013 it become the **National Institute for Health and Care Excellence** with the expansion of its remit to cover social care .

Why the need for a NICE ?



https://www.nice.org.uk/guidance

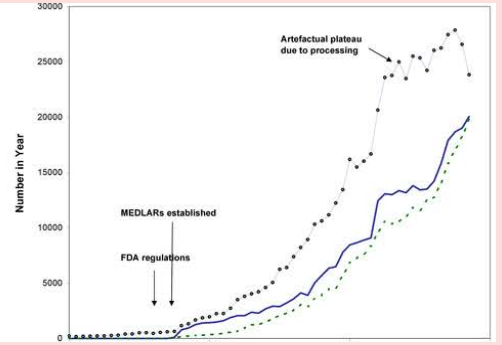
Address inappropriate variations in clinical practice and “post-code” access to expensive treatments

Support clinicians to keep up to date with relevant new evidence

Assess the “value” (cost effectiveness) of new and existing treatments

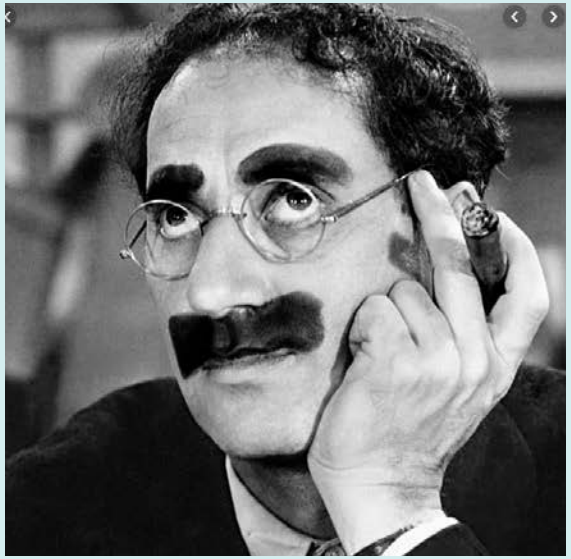
Encourage innovation


Uphill struggle: six-year-old Aarin Bhatt with his mother Rajhina, who was refused NHS funding for his treatment. 1 of 1



All NICE Guidance is underpinned by core principles:

- Comprehensive evidence base
- Expert input
- Patient and carer involvement
- Independent advisory committees
- Genuine consultation
- Regular review
- Open and transparent process



There are my principles and if you do not like them ……..…
I have others

Groucho Marx

A framework was needed - procedural justice was attractive

Publicity
Both the decisions made about limits on the allocation of resources, and the grounds for reaching them, must be made public.

Relevance
The grounds for reaching decisions must be ones that fair-minded people would agree are relevant in the particular context.

Challenge and revision
There must be opportunities for challenging decisions that are unreasonable, that are reached through improper procedures, or that exceed the proper powers of the decision-maker. There must be mechanisms for resolving disputes; and transparent systems should be available for revising decisions if more evidence becomes available.

Regulation
There should be either voluntary or public regulation of the decision-making process to ensure that it possesses all three of the above characteristics.

Norman Daniels
Mary B. Saltonstall Professor of Population Ethics

HARVARD
School of Public Health

"we cannot avoid confronting disagreement regarding substantive values if we wish to arrive at ethically justified and broadly acceptable decisions"

2020 HTAi Global Policy Forum Meeting background report

I won't let Daddy die

Girl of six raises £4,000 for life-saving drugs the NHS won't provide

By Lucy Laing

FACED with the prospect of losing her father to cancer, Chantelle Hill reacted a little differently to the average six-year-old.

Instead of letting the grown-ups deal with it, she decided to save him herself.

Now, she has raised more than £4,000 to buy the life-saving drugs David Hill needs after he was told [illegible]

Clinical Excellence found it was not "an effective use of NHS resources".

The £4,000 Chantelle has raised will pay for only two months of treatment, but she is determined to keep going and raise more, Mrs Hill said.

Mr Hill, 45, a builder, was diagnosed with lung cancer in December 2004.

A few months later he had an operation at the James Cook Hospital in Middlesbrough to remove the tumour from his right lung.

The father of four then had 14 weeks of chemotherapy to kill off

Doctors then told the couple that Mr Hill wouldn't be able to cope with any more chemotherapy as he had lost three stone and his body was too weak. His only hope was Tarceva.

Although it is not a cure, Tarceva has been shown to extend the lives of patients with cancers such as Mr Hill's and to improve their quality of life. It has been welcomed by cancer specialists around the world and is used extensively in Europe and the US..

Hero helps others fight for cancer drug

By Graham Satchell
BBC Breakfast Reporter

Kate Spall has become an unlikely hero. A 36-year old housewife from Chester, she's become a life-saver to cancer patients around the country.

Kate is not a doctor, she has no medical training at all, but she's become successful at obtaining new cancer drugs for patients that have yet to be approved for use on the NHS.

Life-extending cancer drugs wait for NHS approval

GoodHealth

Sentenced to death by NICE

GoodHealth VIEWPOINT

It's the body that decides which drugs are allowed on the NHS. But in this blistering attack, a leading GP argues the organisation set up to improve care is obsessed by costs, discriminates against the elderly — and ultimately is killing patients

By DR SARAH JARVIS

LIFE-SAVERS DOCTORS CAN'T PRESCRIBE

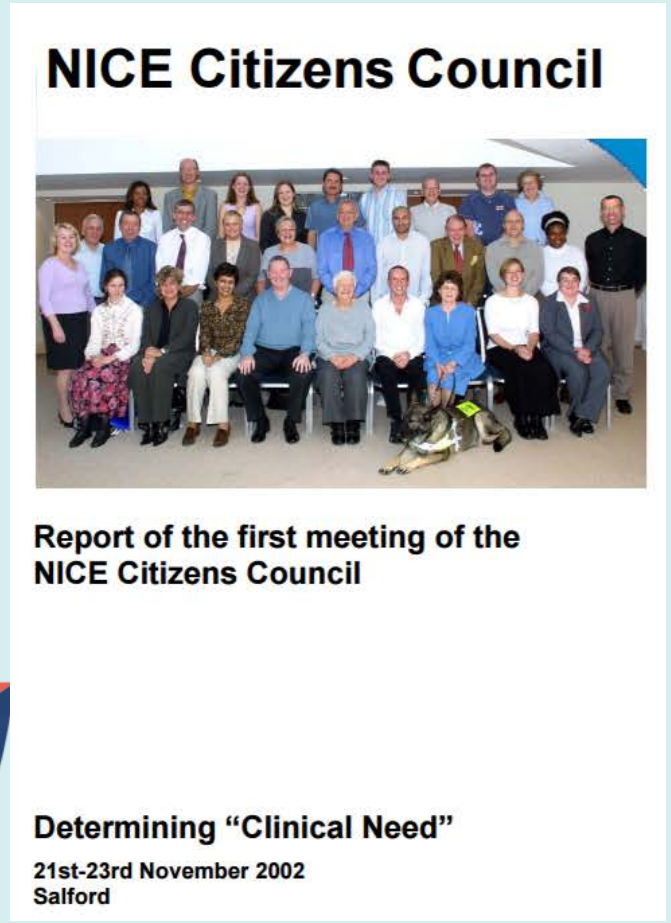
MULTIPLE SCLEROSIS

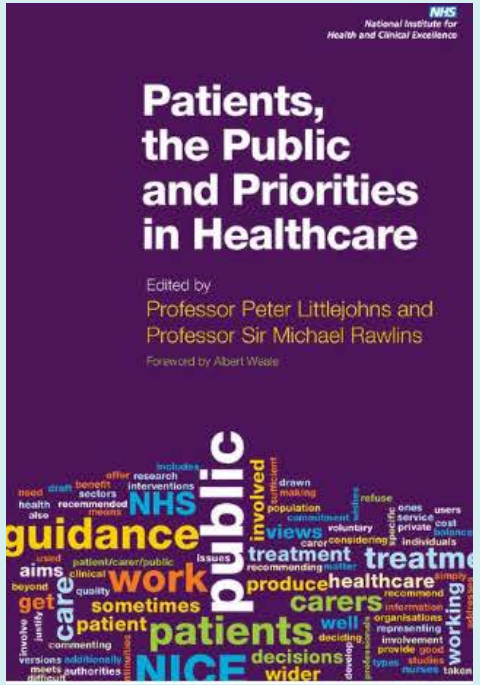
DIABETES

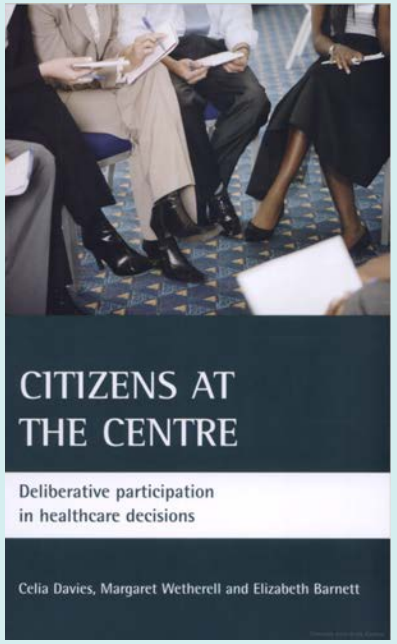
BOWEL CANCER

ALZHEIMER'S DISEASE

NICE considered Social as well Scientific Values







Health Econ Policy Law. 2013 Apr;8(2):145-65. doi: 10.1017/S1744133112000096. Epub 2012 May 1.

NICE's social value judgements about equity in health and health care.

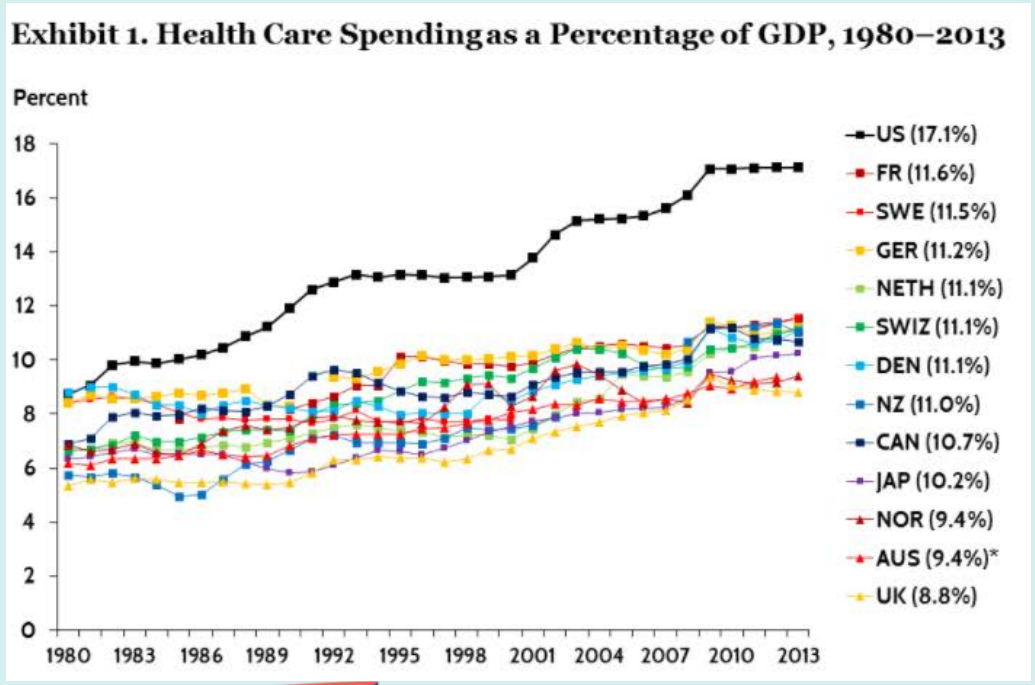
Shah KK[1], Cookson R, Culyer AJ, Littlejohns P.

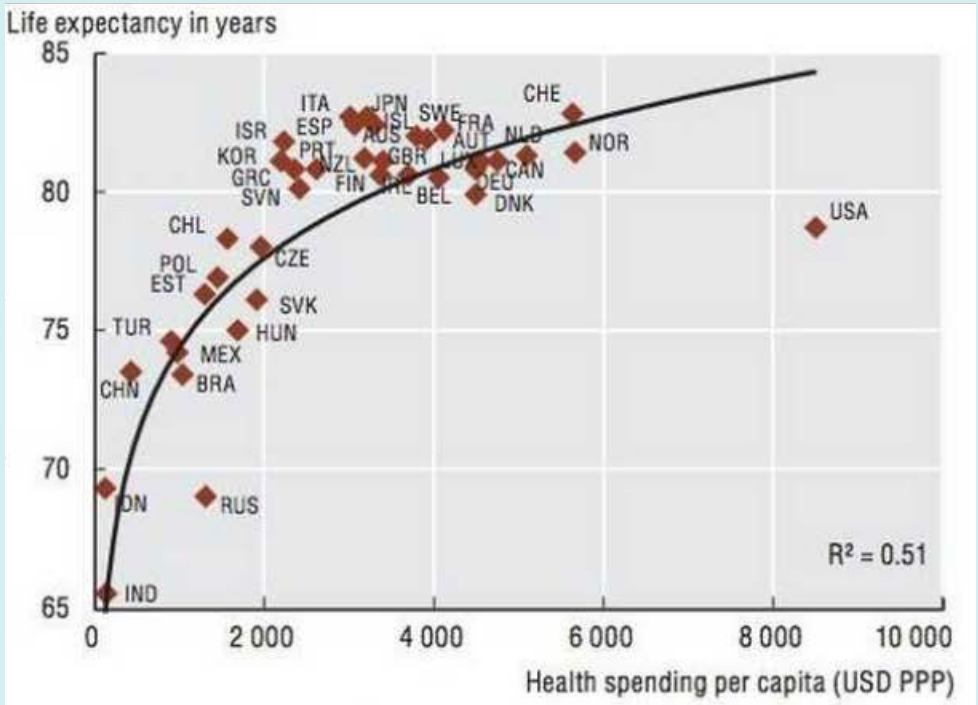
Author information

http://journals.cambridge.org/abstract_S1744133112000096

https://books.google.fr/books?id=yXfO1qsosBgC&pg=PA236&lpg=PA236&dq=Davies_C._Barnett_E._Wetherell_M._and_Seymour-Smith_&source=bl&ots=qcJ0m0eYmd&sig=ACfU3U057pypLBMcIeKqPtN4nTm7R8nRZQ&hl=fr&sa=X&ved=2ahUKEwifpoLLkufmAhWh2eAKHdM2BKEQ6AEwA3oECAYQAQ#v=onepage&q=Davies_C._Barnett_E._Wetherell_M._and_Seymour-Smith_&f=false

How does the USA and UK compare





https://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-global-perspective

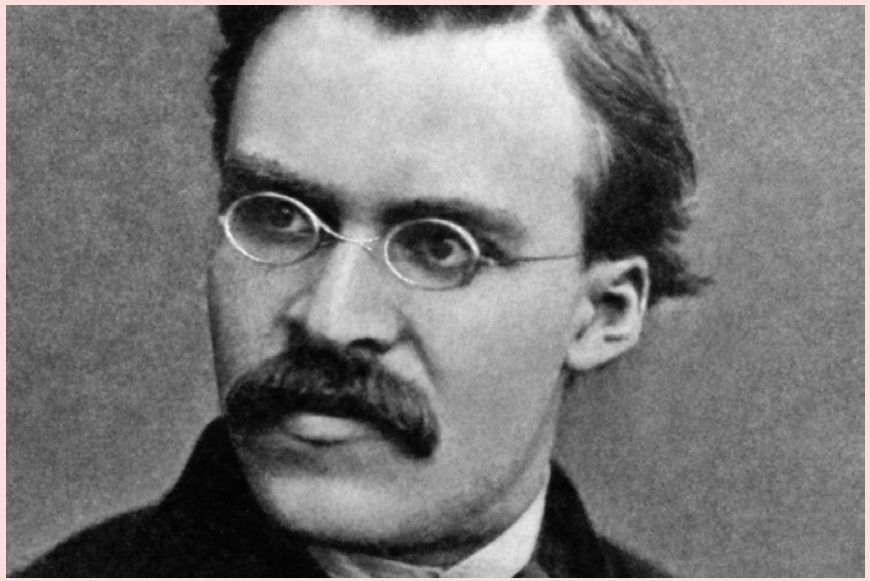
Covid a dramatic case study in prioritisation

- Prioritisation happening at all levels eg ventilators and ITU, PPE, testing, lock down versus economic recovery
- Personal versus Public Health ethics debated…..often unbalanced (health disparity increasing)
- Opportunity costs highlighted
- “Based on the Science” …….but ultimately political decision (evidence contested)

https://blogs.kcl.ac.uk/clahrc-south-london/2020/04/29/covid-19-the-reality-of-opportunity-costs-will-need-to-be-debated-openly/

https://blogs.kcl.ac.uk/clahrc-south-london/2020/05/28/sweet-science-reigns-how-on-earth-did-it-come-to-this/

“There are no such things as facts…… only interpretations”



Friedrich Wilhelm Nietzsche 15 October 1844 – 25 August 1900) was a German philosopher, cultural critic, composer, poet and philologist,

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Phases of a Pandemic Surge: The Experience of an Ethics Service in New York City during COVID-19

Barrie J. Huberman and Debjani Mukherjee, Ezra Gabbay, Samantha F. Knowlton, Douglas S.T. Green, Nekee Pandya, Nicole Meredyth, Joan M. Walker, Zachary E. Shapiro, Jennifer E. Hersh, Mary F. Chisholm, Seth A. Waldman, C. Ronald MacKenzie, Inmaculada de Melo-Martín, and Joseph J. Fins

The memo, released 2 April 2020, emphasized the importance of identifying goals of care and the distinction between ***rationing*** *and* **prioritization**. *Under the latter, patients are not excluded from an intervention, but rather are prioritized based upon the availability and likely efficacy of treatment. This clarification reassured staff that patients who were assigned lower priority would still ultimately be intubated if and when resources became available.*

Politics

Hancock admits COVID testing issue could take weeks to solve - with certain groups prioritised

Ethical Support in the community in South London, UK

NHS South East London Clinical Commissioning Group · Health Innovation Network South London · KING'S HEALTH PARTNERS · NIHR | Applied Research Collaboration South London · StChristopher's More than just a hospice

ADVOCACY & DECISION-MAKING WITH VULNERABLE PATIENTS DURING A TIME OF CRISIS

During this Covid-19 pandemic, it is essential that as clinicians we advocate for our patients, and promote and support good decision-making about care. Understanding a patient's wishes and informing them of onward care processes, such as separation from family, potential sequelae from intensive care, as well as the risks of not attending hospital with an untreated myocardial infarction or pneumonia, are all part of assessment and, where relevant, obtaining informed consent.

Take 5 – Involve – Decide

Take 5 – taking time to reflect in difficult circumstances

The pressure of a pandemic means it's even more important to take a few moments to check decisions against potential biases and assumptions. As is always the case for complex decisions, we must watch out for subtle assumptions, bias and pressure. These could include:

- Patients and their clinicians fearing the risk of Covid-19 infection from a hospital admission, where the patient still wants and would benefit from acute care.
- Assumptions relating to quality of life for socially vulnerable or older individuals in our care.
- Concerns/assumptions about resource pressures, which may be incorrect or out-of-date.

A pandemic does not change the fundamentals

Involve & Decide

Care planning is complex and sensitive, and is usually done in the context of progressive disease and anticipated deterioration. Care planning is always voluntary. It is done with people, not for people.

- Involve the individual and be clear and open: what is the decision about?
- If your decision is outside your usual area of expertise, ask others for help and balance.
- Decision-making presumes that the patient has capacity. If you are concerned that a patient may lack capacity, take steps to assess this formally.
- Remember: you cannot conclude that a person has been unable to make a decision just because their choice seems unwise. Your role is to support them to make their own decision. If the patient lacks the capacity to make the specific decisions, involve any attorney, relevant family, carers or advocates to learn more about the patient's wishes.
- Advance Care Plans, if they exist, should be reviewed and used. If the patient has an advance decision to refuse treatment, this should be reviewed with

Five minutes, five questions

When making decisions under pressure, take five minutes to ask yourself:

1. Am I being an advocate for this person, first and foremost?
2. Am I starting from a point of providing access to the care this individual needs and would prefer?
3. Who have I involved in this decision?
4. Are assumptions about resources or wider system pressures influencing me, and if so, how can I check?
5. Am I recording this decision comprehensively and appropriately?

It's good practice to talk things through with a colleague. That's why there's more specialist support available.

Decisions

Decisions about the value of a treatment involve four elements:

1. Is it wanted? (Consent)
2. Will it work? (Efficacy)
3. Is it suitable? (Benefits & harms)
4. Is it available/is transfer wanted or beneficial? (Resources/preferred location)

Care planning is about access and establishing preferences. It should never start with questions about availability or resources.

Should our community ever reach the point where decisions depend on available resource in addition to clinical necessity, these decisions will be made with informed colleagues and an appropriately constituted Ethics Committee.

Support for complex cases & ethical questions in the community

GPs in the community can already access a range of existing advice routes, including established on-call palliative medicine, psychiatry, and elderly care consultant teams. In south east London, specialist palliative care advice is available 24/7 through existing local palliative care services.

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https://learninghub.kingshealthpartners.org/images/Community-resource-leaflet.pdf

Thank you for listening