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

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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
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

A comprehensive health and rehabilitation services for prevention and cure of disease

Following World War II, the elected Labour government went to work implementing its 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 5th July 1948 with the opening of the Park Hospital in Manchester.
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 became the **National Institute for Health and Care Excellence** with the expansion of its remit to cover social care.
Why the need for a NICE?

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

https://www.nice.org.uk/guidance
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
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.
“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
NICE considered Social as well Scientific Values
How does the USA and UK compare

Covid a dramatic case study in prioritisation

- Prioritisation happening at all levels eg ventilators and ITU, PPE, testing, lockdown 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/2020/05/28/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,
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.
Ethical Support in the community in South London, UK

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. Those 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.

Involv e & 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, seek others for help and balance.
- Decision-making may present 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 unsafe. 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/transfer wanted or beneficial? (Resources/preferred location)

Support for complex cases & ethical questions in the community

GPs in the community can already access a range of existing advice routes, including established palliative care advice. Should our community ever reach a point where decisions exceed an available resource in addition to clinical necessity, these decisions will be made with informed colleagues and an appropriately constituted Ethics Committee.

Thank you for listening