

new developments

Surgical Prioritisation and Rationing: Some Recent Changes

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In 1996 New Zealand introduced a system, sometimes referred to as the 'booking system', to replace waiting lists for surgery and other treatments by explicitly prioritising and rationing the access of patients. The booking system, which aimed to provide prompt access to treatment to '...patients who are in most need and who are most likely to benefit' (National Advisory Committee on Core Health and Disability Support Services, 1993, p. 20) has recently undergone significant changes. This article briefly describes the booking system and the recent changes, before discussing potential implications of these changes for individual patients and groups of patients. Whether or not to prioritise and/or to ration access to health care, the strategies of prioritisation and the intended outcomes (which may include efficiency, effectiveness or fairness), are ethical as well as practical issues (Evans, 1999). The changes to the booking system, somewhat courageously adopted in New Zealand, return us to familiar issues requiring further attention of ethicists, and also of health care purchasers, clinicians, patients and the general public. It is hoped that this article may stimulate this much-needed debate by highlighting these issues as they step out in new clothes.

The Booking System

The booking system, which has been described elsewhere (Derrett, 1999; Hadorn and Holmes, 1997), was a programme developed to more effectively manage and monitor the prioritisation of patients from the time of referral by general practitioners (GPs) through to provision (or denial) of surgery itself. For the prioritisation of access to surgery there were two main components. Firstly, following clinical assessment and diagnosis by hospital specialists, patients were prioritised for particular surgical treatments using Clinical Priority Assessment Criteria (CPAC) developed to prioritise patients requiring the same

procedure¹. A range of CPAC tools were developed by specialists to evaluate an individual patient's need for surgery, and included a number of variables such as clinical measures of health status, patient-experienced health status and social factors. Typically points were awarded to each CPAC variable and these points were then added to provide a total score for each patient ranging between 0 (lowest priority) and 100 points (greatest priority). Patients with 90 points would therefore be deemed to have greater priority, and ought to obtain quicker access to surgery, than patients with 70 points.

Secondly, CPAC score thresholds were established to permit the rationing of access. Each hospital would negotiate with the former Health Funding Authority (now the Ministry of Health) a CPAC threshold, known as the financial threshold, according to historical and anticipated surgical throughput, case-complexity and the money available for purchasing surgical procedures. Patients with CPAC scores at, or above, the financial threshold would be provided with a booked date for surgery within six months of their assessment at the outpatient clinic. Patients with scores beneath the financial threshold would be returned to their GP for ongoing care.

Specialists at most hospitals agreed, or at least implemented, clinical thresholds: the level at which they thought surgery ought to be offered to patients – where the benefits were believed to outweigh the risks of surgery. As it transpired, the resources available to the booking system meant financial thresholds were situated well above the clinical thresholds. This meant many people were denied access to publicly funded elective surgery despite having an identified need for surgery. In 1998 the Health Funding Authority addressed this problem by requiring patients above the clinical threshold, but beneath the financial threshold, to be

placed on residual waiting lists (RWLs). These patients were told they may receive surgery within the next 12 months if additional funding became available. The RWL meant that only patients with scores beneath the clinical threshold became completely invisible to the booking system. However, over time, the numbers of patients on RWLs grew and certainty about surgical status could not be provided to these patients.

Aspects of the booking system, such as the CPAC tools, have been evaluated in relation to clinical judgement and extreme patient morbidity and mortality (Jackson *et al.*, 1999; Seddon *et al.*, 1999; Dennett *et al.*, 1998), however, there has been limited research into the performance of the booking system from the perspectives of patients. Nevertheless, a new system (referred to in this article as the AC&R system) was recently introduced, changing the management of patients beneath the financial threshold and the mechanisms for prioritising and rationing access.

The New System

Regarding the management of patients, patients prioritised for surgery are now to be: 1) provided with a booked date to receive surgery within six months of their outpatient appointment, 2) given certainty that they will receive treatment within the next six months, 3) placed on an active care and review list (for six-monthly review by the hospital) if they have priority scores beneath the financial threshold or have to meet some other requirement such as stopping smoking before receiving surgery, 4) provided with planned or staged treatment (as in the case of children awaiting certain types of cardiac surgery), 5) returned to the care of their GP or simply removed from the hospital records (Ministry of Health, 2001). These revised categories aim to improve certainty about surgical status provided to patients who meet the financial threshold for surgery as the RWL, with its inherent uncertainties, is to be removed and replaced by a much shorter AC&R list.

Rather than CPAC tools to prioritise (and ration) access to surgery new Integrated Scoring Systems (ISS) have been introduced throughout New Zealand for some surgical specialities: orthopaedics; and ear, nose and throat (ENT) surgery; plastic surgery, and some ophthalmology. ISS are founded upon clinical judgement of the relative need for access to elective surgery. Instead of being diagnosed by a

specialist and then prioritised for surgery according to a number of explicit dimensions within CPAC tools, each individual specialist compares each patient with a particular condition with all other patients the specialist has seen previously with the same condition on a 1-5 point linear scale of clinically judged priority of need. In conjunction with the 1-5 priority of need scale specialists have developed score ranges for different surgical procedures within the one service on a 0-100 point scale. For example on the ENT ISS, adenotonsillectomy has a score range of 20-70 points whereas tympanotomy has a range of 30-90 points. On the orthopaedic ISS, a knee joint replacement has a score range of 40-90 points whereas a finger amputation has a range of 30-75 points. The 1-5 linear score of priority of need for each individual patient is then computed into these score ranges to derive a final score. A patient diagnosed to be in need of a knee replacement with a linear priority of need score of 4 would have an overall final score of 77 points. A patient requiring a finger amputation also with a linear priority of need score of 4 would end up with an overall final score of 64. The ISS system thereby permits the prioritisation of patients with very different conditions alongside each other. This prioritisation is confined to particular specialties: a patient requiring heart surgery cannot be prioritised alongside a patient requiring a knee joint replacement.

There were considerable concerns raised by specialists about the introduction of the booking system. Some of these concerns were related to concerns that the thresholds were set too high and were thereby denying surgery to many patients with clinically defined need for treatment, and some were about the perceived erosion of clinical autonomy and discretion (Adams, 1998; Hadorn and Holmes, 1997; Wiles, 1998). While the CPAC tools were intended to be aids to clinical judgement it seems that in practice, many specialists felt the tools over-rode their judgement. There has been remarkably little comment from specialists (or others) about the national implementation of ISS in large surgical specialties, and anecdotally there has been a great deal of support for the changes. Some perceive the ISS to be fairer than CPAC which tended to prioritise within a few discrete surgical procedures: not among all the surgical treatments offered within each specialty.

A return to an emphasis on clinical judgement in the

prioritisation of access to surgery by ISS may well result in greater specialist support for the system (and less subversion of it), yet still permits prioritisation and rationing of services within tight financial parameters; thereby meeting requirements of managers, purchasers and government. However, the changes merit far greater consideration, for while they may meet the needs of specialists and purchasers of health care services, they may well not meet the needs of patients.

Out of Sight Out of Mind?

As described above, the new system intends to remove RWLs. RWLs and the earlier waiting lists are politically unpalatable, as they are clear, if imperfect, indicators of the level of unmet need for treatment in the community. However, if the RWLs are removed as originally intended, and replaced by a shorter list of patients on Active Care and Review (Health Funding Authority, 2000), this will increase the invisibility of many more patients who fail to meet the threshold. Indeed, the concept of the clinical threshold disappears entirely with the new AC&R system – only the financial threshold remains. The potential for increased invisibility of patients who could benefit from surgery is concerning. Time will tell if the RWL can be successfully removed and not be replaced by an equally large group of patients on the Active Care and Review List. Already, it seems the number of people on the AC&R list is actually increasing (Electives Services Group, 2001). Such increases may well help protect against invisibility and permit appropriate targeting of resources.

There is also uncertainty over the best possible location of the financial thresholds for these new ISS. Before, under the booking system, when separate thresholds were set within each CPAC tool for discrete types of surgery, the thresholds often proved to be far from stable over time, instead thresholds tended to increase due to funding constraints. Now, with ISS, thresholds must be established across the entire range of surgical procedures within each specialty (the orthopaedic ISS prioritises more than 80 different procedures and the ENT ISS prioritises 70 procedures). Some maximum scores allocated to the ranges for certain surgical procedures are quite low. The government has identified the need for more elective surgical services; if resources remain inadequate then patients with certain conditions, even with a linear priority of need score of '5', may never reach the financial threshold for surgery.

National Consistency or Obfuscation?

We know that the booking system led to the development of many different CPAC tools for the same surgical procedures throughout the country, and also a range of often-increasing financial thresholds, determining access to treatment: unfortunately the old historical inequities of access remain within New Zealand. The new ISS promise, at face value, to enhance national consistency, yet could well prove to be a veneer of consistency placed over continuing between-clinician and between-region inequities for patients. Because the 1-5 priority of need scale asks each specialist to rate individual patients in relation to all other patients they have previously assessed with that patient's condition, it is easy to see how this could perpetuate regional inequities, rather than alleviate them. Under the ISS system a patient with a linear priority of need score of 3 in a region with a tradition of excellent access to surgery may in truth have less 'need' than a patient with a score of 3 in a region with a poor access tradition. Yet nationally it could be claimed with confidence that both regions are providing access to patients with a score of 3. This may help reduce adverse publicity surrounding inequitable access (as accompanied the death of Colin Morrison in Southland while waiting for cardiac surgery under the old booking system despite a CPAC score higher than the CPAC scores of patients receiving surgery in other regions of New Zealand), but it may not reduce present inequities of access.

Conclusion

The new AC&R system is attempting to improve the level of certainty about surgical status provided to patients above the financial threshold. This is laudable as uncertainty about when (or even if) patients were to be called for surgery was one of the most troublesome aspects of the earlier waiting list system in New Zealand (Derrett *et al.*, 1999). However, improved certainty is also attached to a potential for greater invisibility for those patients beneath the financial threshold and this necessarily returns us to debates about equity and fairness, and how best to care for people denied access. Further, at a national level the new ISS tools introduce changes permitting national and between-clinician consistency to be asserted where inequity and variability remain.

The new ISS, and the overall AC&R system, have been implemented, as was the earlier booking system, without

prior evaluation of its effect on patients. Health status burdens, remediable by surgery, will be (and have been) borne by many patients sitting invisibly in the community who fail to meet a financial threshold of uncertain credibility or durability. Systems of health care ought not be implemented because they meet the needs of clinicians, managers and purchasers (although meeting these needs may well be a good thing), they ought to first and foremost be implemented to improve the performance of the health sector in addressing the needs of patients, and beyond patients, the general public who fund the health sector.

The Ministry of Health is now, five years after the booking system was first introduced, funding a national research programme evaluating the prioritisation and rationing of certain types of elective surgery. However, this programme of research is several years away from being able to provide results about the patients' perspectives of, and outcomes from, the recent changes to the system. There are acknowledged difficulties in evaluating systems as they are implemented. There are also tensions between the desire to quickly improve and change systems and waiting years for the results of research to inform policy decisions. However, contemporaneous research programmes evaluating health sector change from the patients' perspectives may help engender public confidence that the motivation for change is indeed to improve the process and outcomes of care for patients, and, at the very least will provide baselines permitting reasoned consideration of future change – to enhance the mechanisms for honestly prioritising and rationing patient care. In the meantime, while we wait for results from the national research programme, we ought to engage in debate about the ethical issues accompanying the present round of changes to the system: issues of access, fairness, equity and the involvement of patients (and the general public) in decision-making about access to treatment in New Zealand.

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Note

1. Separate CPAC were developed for a range of different treatments. For example, there was a CPAC tool prioritising patients diagnosed in need of cataract surgery, and a CPAC tool prioritising patients for hip or knee joint replacement, but the tools did not tend to prioritise across the range of surgical procedures, even within specialities. It must also be said that a characteristic of the booking system and its accompanying CPAC was the diversity of instruments in use throughout New Zealand: many hospitals elected to develop their own tools rather than adopt the tools developed by the national consensus working parties.

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