

Priority Setting and Elective Surgery – the Health Care Manager's Perspective

Allan Cumming

Clinical Practice Group Manager, Healthcare Otago

Introduction

The debate over the introduction of booking systems and priority setting within health has often been portrayed as one affecting health policy, or one that should be within the realm of the medical practitioner. Debates over rationing have focused on the ethics of rationing health (the political policy view) or of the particulars of specific assessment systems and how they affect specific patients (the medical practitioner view). One view not commonly espoused is that of the health care manager, caught between the apparently conflicting views of health policy and the individual practices of the clinicians working within the public health system.

What is the Role of the Manager in the Public Health Sector?

Management is often seen as a (possibly) necessary evil by both the medical profession and the public. Alistair Mant talks about the binary and ternary views held by both management and clinicians¹ where the clinicians see themselves as holding to the higher purpose of the Hippocratic Oath, while the manager is solely interested in balancing budgets. The public frequently see management as the 'villain' in the health sector, restricting access to services and preventing the clinicians from providing much needed services to the patients.

The reality of management in the public hospital sector is not so simple. The health manager's self-perceived ternary role is that of the moderator, ensuring that both policy needs and the needs of the patient are met as best as is possible given the limited resources available.

The balancing role of management is not new. Prior to the purchaser/provider split introduced by the 1990 National Government, Area Health Boards had the job of determining, within Health Department guidelines, how resources would be allocated. Prior to that, Hospital Boards had a

similar role in respect to the amount of money allocated to the secondary sector. The health reforms introduced in the Health And Disability Services Act of 1993 gave the role of resource allocation to the Regional Health Authorities while Crown Health Enterprises determined how to use these resources efficiently. The more recent reforms following the formation of the National/New Zealand First Coalition Government changed the emphasis to one of funder/provider, but maintained a split between determining service level and provision of services.²

The allocation of resources does not stop at the level of contracts between the Health Funding Authority and the Hospital and Health Services. In any situation where there are limited funds (and that includes virtually every health system world wide) determining whether health dollars are spent on health promotion or elective surgery, on cataract extractions or on total hip replacements, is not the last decision to be made. With the exception of a few limited cases, there is insufficient resource allocated to allow all cataracts, all total hip replacements, or all totally effective health promotion strategies to be completed. The Health Funding Authority has a role in determining how many cataract operations are performed, but who decides, when there is insufficient money to perform every operation, which patient receives treatment and which patient does not?

In the New Zealand health sector, there are two choices as to how this allocation of resources can be done once the level of service is determined. Either the clinician can ration the available 'slots' for surgery, often on a 'first-come, first served' basis or, as has happened in the current debate, management has taken a role in promoting the development of priority access criteria to make the rationing process explicit and transparent.

There has always been rationing in

health. It may be officially denied (as is currently the case in England). It may be ignored but tacitly accepted (as in the United States). Until recently in New Zealand there was implicit rationing, which was not discussed within the sector or among the general public. Rationing can be done through the restriction of specific procedures (as in the Oregon experiment), through economic restrictions (such as in the United States where access to surgery is largely restricted to those with the means to purchase insurance) or through the quiet back door of waiting lists.³ But rationing is rationing, by whatever means it is done, and the role of the manager in health is to ensure that rationing is done fairly and impartially.

Why are Traditional Waiting Lists Unfair?

Few would argue that the previous system of waiting lists was a fair and reasonable way of determining access to health care. The experience of HealthCare Otago in developing booking systems showed that, with either of the two systems used to determine need, waiting lists performed poorly.⁴ People with low levels of clinical and social need waited very short periods of time between referral and surgery, while others with extreme levels of disability waited long periods. Major determinants for rapid access to surgery were: which clinician the patient was referred to (variations in average wait of three months versus three years); the tendency for the patient to complain (to the Department, their GP, MP or the media); and in some cases, the ease or difficulty of the case. In any fair system, none of these factors should determine speed of access to surgery.

Priority systems were introduced into this environment to reduce the level of inequality that had been apparent for several years. Their introduction was clearly successful. Within three years of introduction, using the same measures of need previously used, there was

a direct relationship between priority assessed at time of referral, and time spent waiting for surgery.

The exercise also highlighted another failing of waiting lists, unrelated to funding constraints but central to any initiative that aims to reduce waiting lists. It was found that in the case of the clinician with the shortest waiting time, the number of points needed to gain access to surgery was significantly lower than was the norm for other clinicians. Furthermore, many of the patients had scores lower than the level that most clinicians accepted as the clinical threshold, that is the level of disability at which surgery is desirable. Why was that? It appears that where there was little need for a specific clinician to ration, intervention criteria dropped so as to keep surgical volumes constant.

A similar phenomenon is seen where waiting lists are reduced through one-off funding initiatives (such as the Waiting Times Fund, set up to eliminate waiting lists in New Zealand in 1997, or the current Waiting Times Initiative in the UK). As waiting lists are reduced, the criteria for placing patients on the lists are relaxed and the number of patients referred increases, so that despite considerable increases in surgery volume, the waiting list size does not significantly reduce.

All these factors suggest that clinicians alone are not able to fairly monitor and control waiting lists. One reason for this may be that clinicians have a primary duty of care to the patient that they are treating. While intellectually accepting that there is a need to determine that those in greatest need have first access to services, and that some disciplines have greater need for resources than others, many clinicians either explicitly or implicitly give priority to the patient that sits before them in a one to one relationship. This means that as waiting lists reduce, the clinician is more likely to place a patient for surgery. As the likely waiting time reduces, access to surgery is easier, and the clinician, weighing up all the factors including the need for rationing of services, is more likely to operate than in a time when waiting times are long.

Managers and their Role in Rationing

Managers are, by their nature, one step removed from the direct patient clinician relationship. They have no ex-

PLICIT duty of care to the individual patient, indeed their role, as seen above, is to determine fair and equitable distribution of the allocated resources. This dual concept of care is similar to the 'Type One and Type Two' care model proposed by Fitzgerald.⁵ If the manager has a duty of care to the patient population, the manager is in the ideal role to be a partner with the clinician in the development and implementation of a fair rationing system.

At HealthCare Otago, the implementation of priority access criteria and booking systems has been a partnership in some cases and a management directive in others. There is no doubt that the partnership approach is not only preferable, but that it has the greatest hope of long-term success. Managers must accept that the success of priority setting is dependent on the support of clinicians, and that involvement of clinicians in the implementation is the first and necessary step in gaining that support. Clinicians on the other hand must accept that management has a legitimate role in the distribution of resources, and in determining that limited resources are used efficiently and fairly.

It is important to gain clinician support for the concept of explicit rationing. This is not hard, because most clinicians have a much more realistic appreciation of the level of rationing in the public health sector than either managers or politicians, as they live with rationing decisions every day. More difficult is gaining support for a specific rationing tool, largely because of the diversity of views as to what should be included in the scoring process. However a consensus process, with full consultation, can also resolve this dilemma, and in New Zealand priority tools are slowly being developed in this way.

This leaves the issue of duty of care to be addressed. How can we gain clinician support for a decision in an individual case which goes against their belief that their patient requires surgery? Management can make this easier by separating the clinician's duty of care to the individual from the population-based rationing decision. At HealthCare Otago this has been achieved by explicitly not asking the clinician to determine whether or not an individual patient receives surgery. The clinician is asked, through the development of the tool, to determine

on what basis priority will be assigned. The clinician will also use the tool to determine what level of priority an individual patient has. Used like this, the tool is simply an *aid* to decision making, a way for the clinician to maintain consistency from day to day. It is then the role of the manager to determine, on the basis of data gathered from all assessments and contract volumes agreed between the HFA and the HHS, what level of service can be provided and thus what score will determine access to surgery.

It is the role of Government advised by the Ministry of Health to determine nationally how much money should be made available to purchase elective surgery. It is the role of the Health Funding Authority to determine, in consultation with the public and the health providers, how and where that money should be spent. It is the role of the clinician to determine whether or not an individual patient requires a clinical intervention. However once all these decisions are made, it is the role of management to ensure that the money allocated to a particular service is spent efficiently and fairly.

Equitable use of resources can be achieved only if management works in partnership with clinicians to ensure that patients are allocated the limited resources in a fair and transparent fashion. Priority access systems are a way to ensure that that process occurs, and compared to rationing systems based on either waiting lists or on access to money, they are better, fairer, explicit, and above all, transparent.

Notes

- ¹ Mant, Alistair. *Intelligent Leadership*, Sydney: Allen & Unwin, 1997, p8.
- ² Ministry of Health. *Implementing the Coalition Agreement on Health*, Wellington, 1997.
- ³ New, Bill (ed). *Rationing; Talk and Action in Health Care*. London: BMJ Publishing Group, 1997.
- ⁴ Cumming, Allan. *Waiting List Management in Ophthalmology*. Internal HealthCare Otago report, 1994.
- ⁵ Fitzgerald, Ruth. *Who Cares? An Ethnographic Investigation of the Meaning of Care*. Thesis submitted for the degree of Doctor of Philosophy, University of Otago 1998.

Allan Cumming is the manager of a number of surgical services at HealthCare Otago. In 1994 he developed the first priority access system and booking system within a major surgical speciality in the New Zealand public health system.