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Priority setting
in healthcare

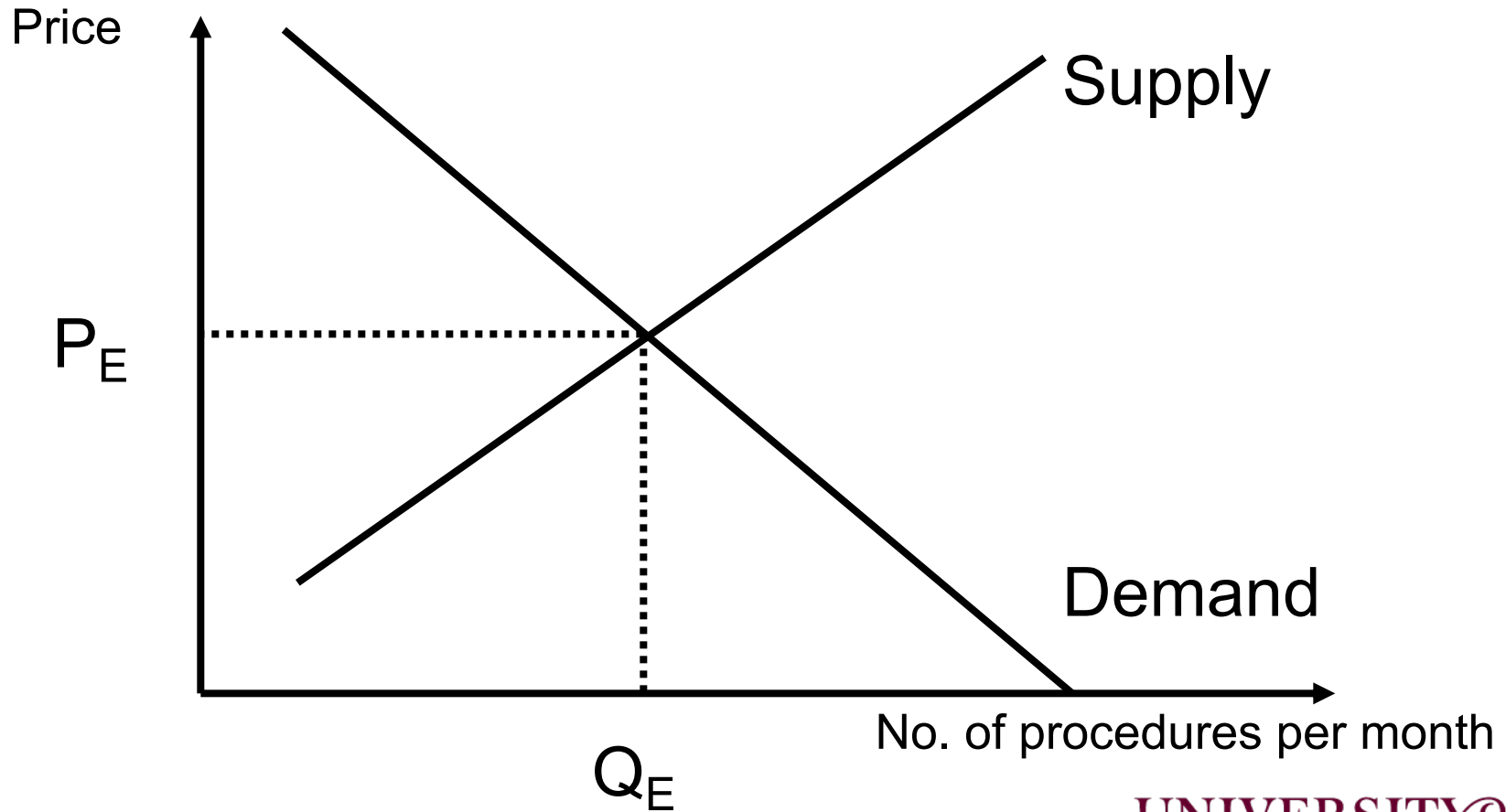
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Overview

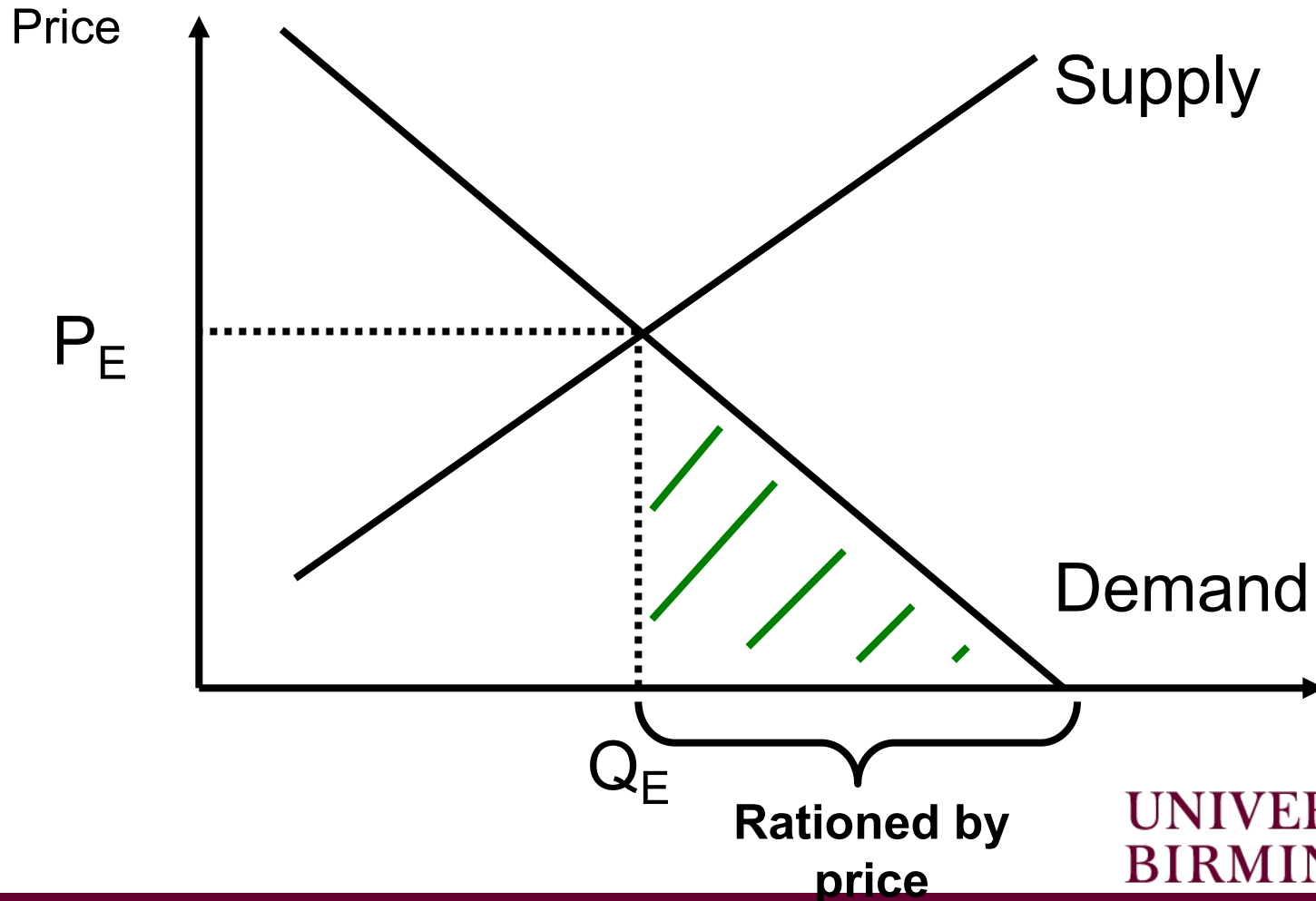
- Rationing in healthcare
- Economic approach to setting priorities
- Equity & fair innings

Rationing in healthcare

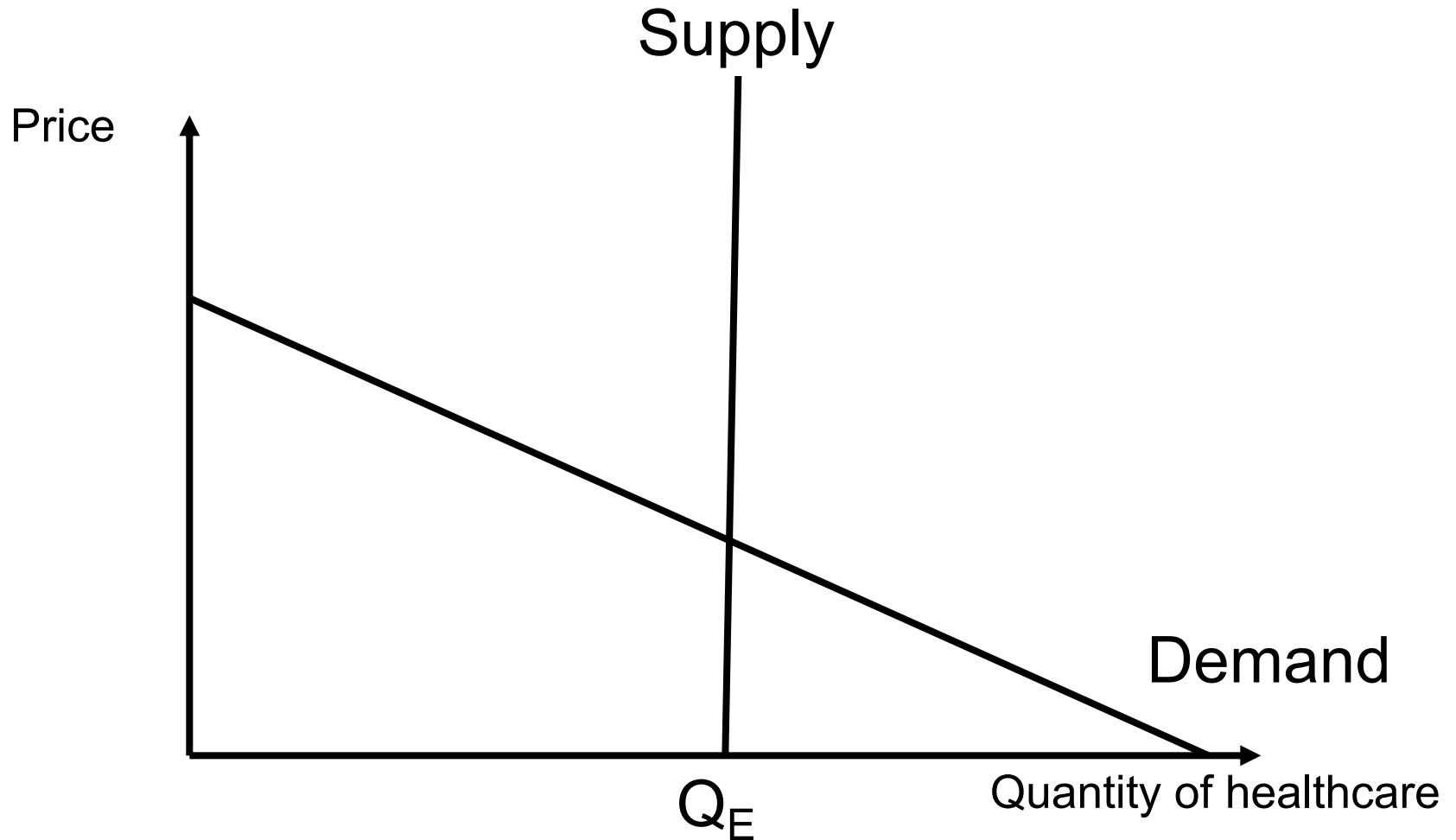
Rationing of care in a market system: the demand and supply of liposuction I



Rationing of care in a market system: the demand and supply of liposuction II

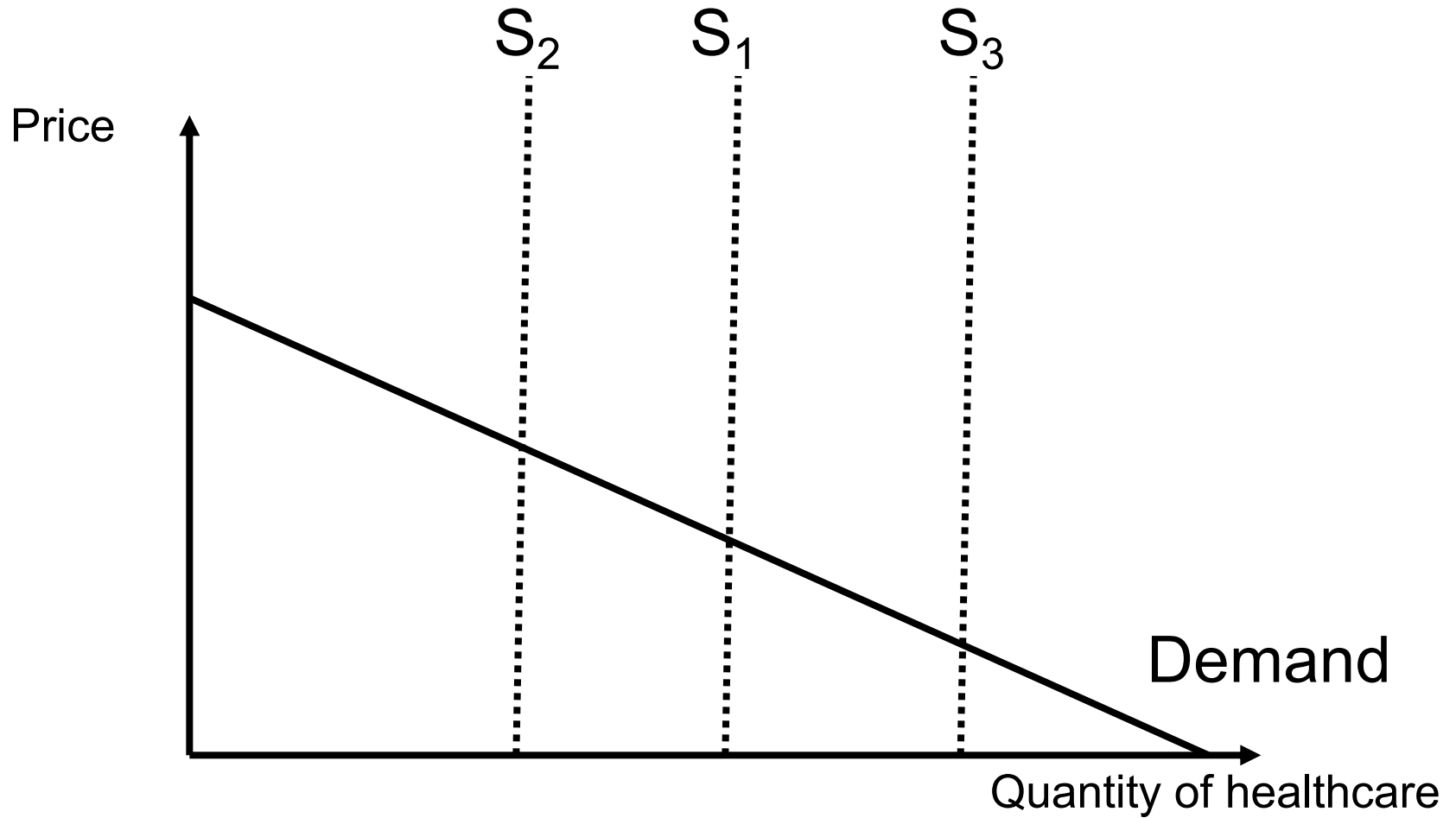


Rationing of care in a public system I

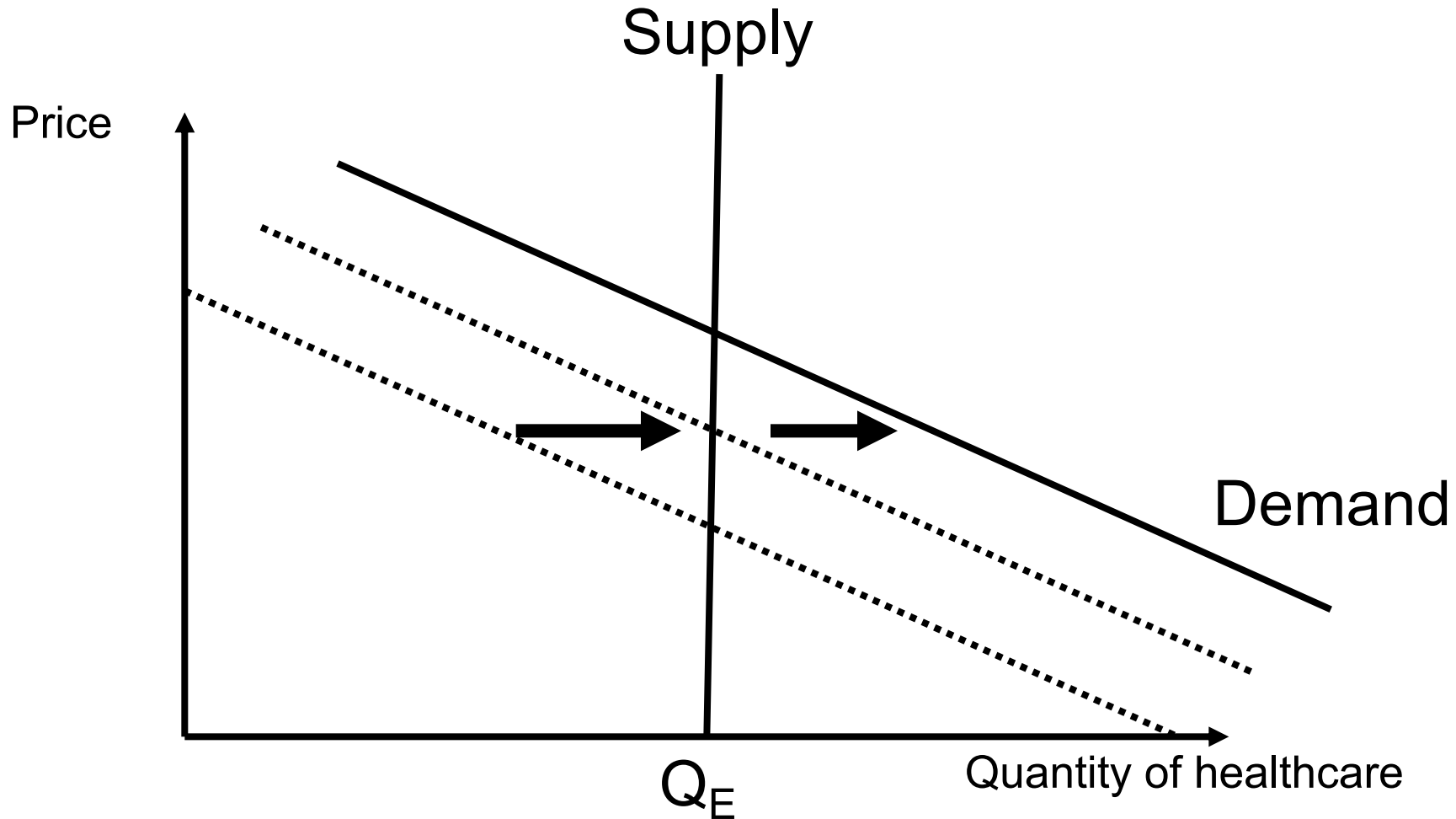


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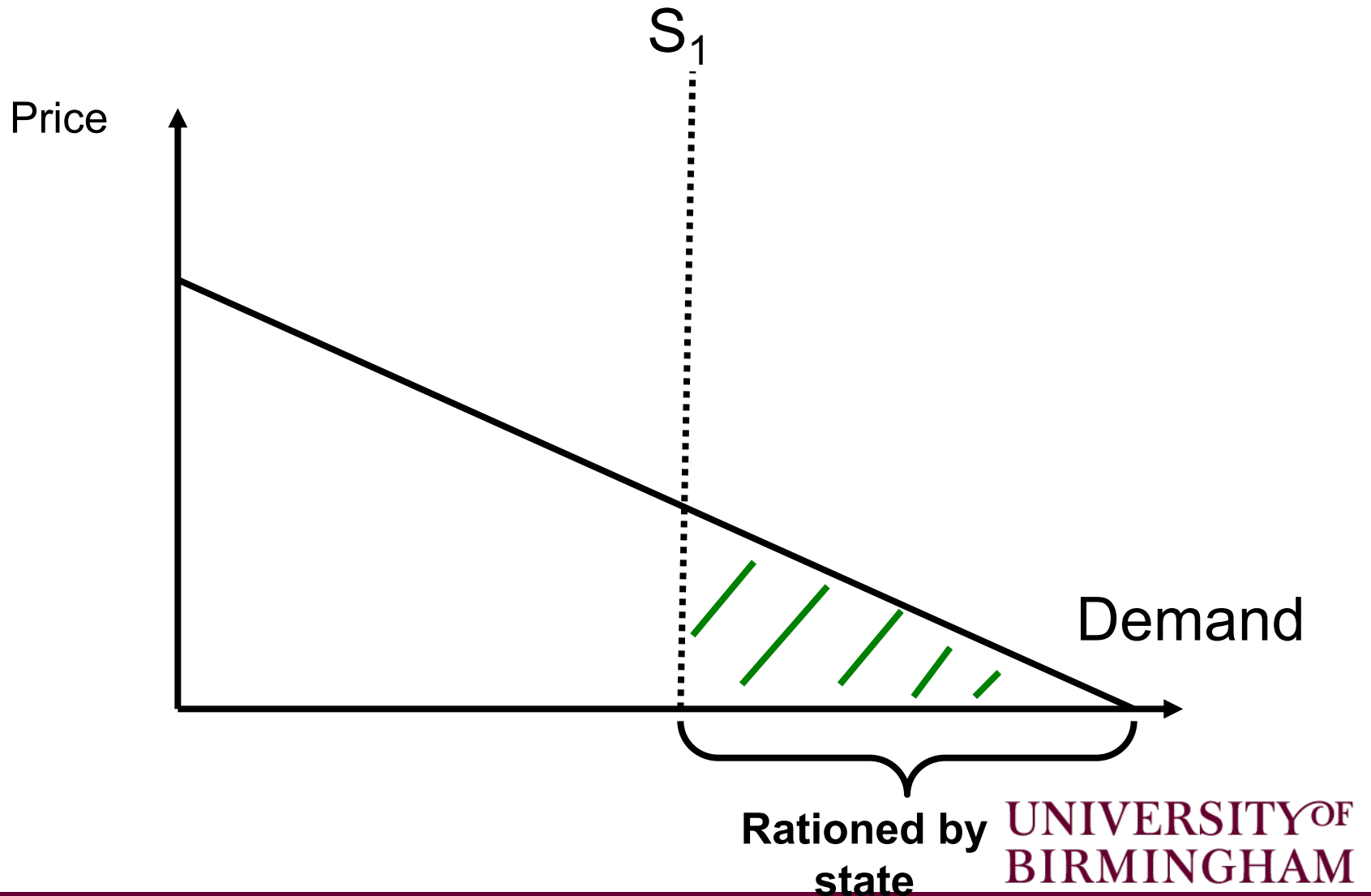
Rationing of care in a public system II



Rationing of care in a public system III



Rationing of care in a public system III



Seven forms of rationing I

- By Denial:
 - Patients denied care they need, for example, deemed unsuitable or not urgent enough

- By Selection:
 - Patients selected because of characteristics, for example, most likely to benefit from treatment

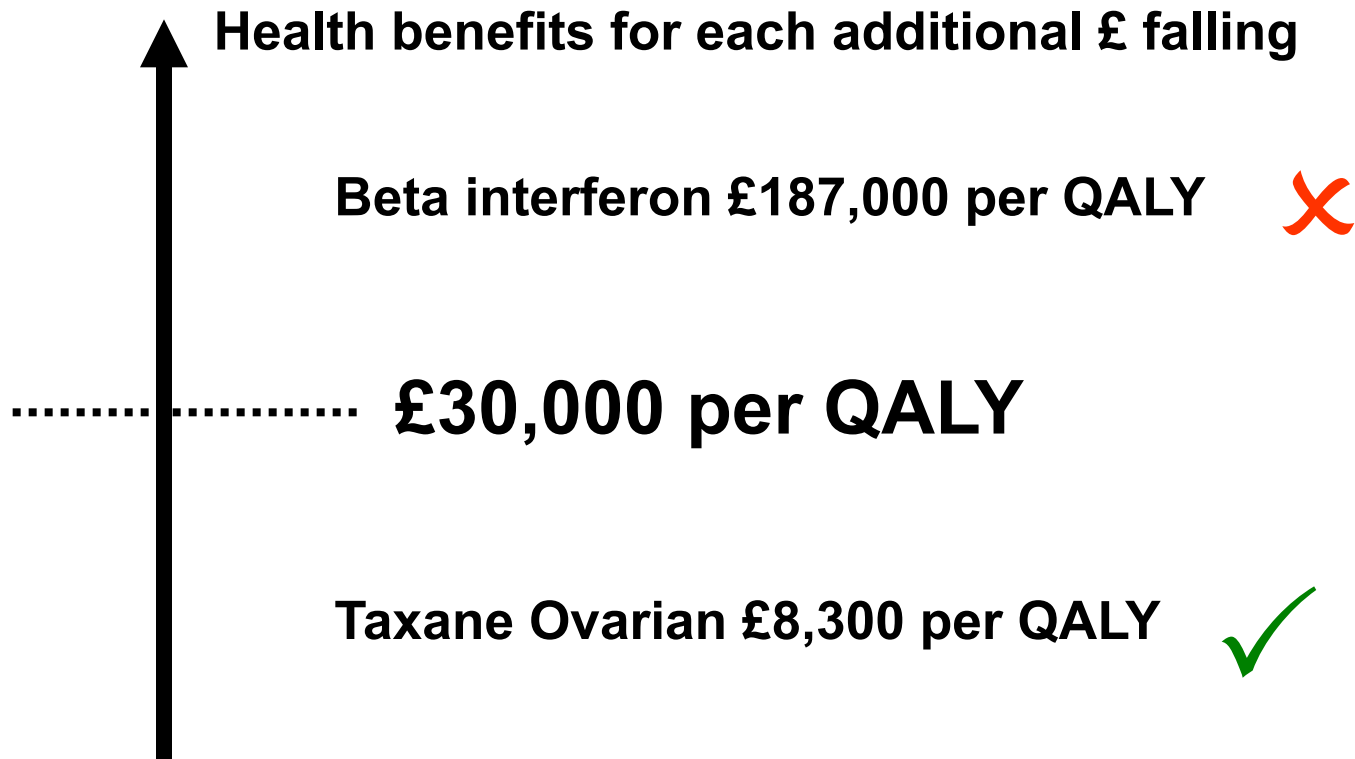
- By Deflection:
 - Patients encouraged or turned towards another service, for example, private care

Seven forms of rationing II

- By Deterrence:
 - Patients deterred from seeking care, for example, barriers or costs put in place or not removed.
- By Delay:
 - Needs not met immediately, for example, wait for appointments or waiting-lists.
- By Dilution:
 - Services given to all but amount given reduced, for example, general practitioner consultants.
- By Termination:
 - System no longer treats certain patients, for example, cessation of cancer treatment

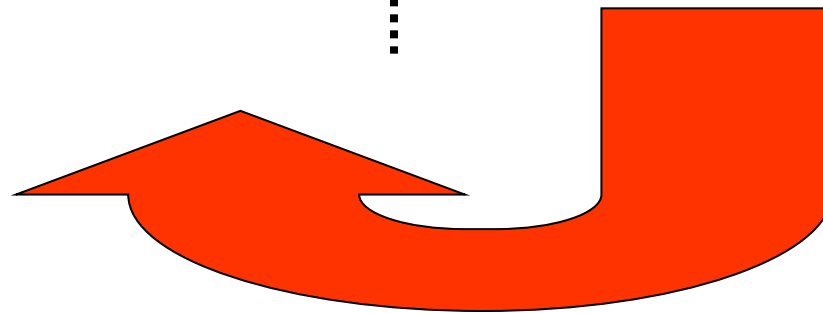
Economic approaches to priority setting

Threshold approach to priority setting



PBMA approach to priority setting

Rank	Service devt area	Score	Rank	Resource release area	Score
1	Special needs	866	1	School health service	1323
2	Comm. liaison	702	2	Health visitors	568
3	Respite care	653	3	Child devt centre	527



Resources

Health economics

- Health economists use an *economic framework* in order to make *recommendations* about how health care should be rationed *efficiently*.
- The promotion of *efficiency* (as defined by most health economists) leads to the production of more health.

Utilitarianism I

- The QALY approach adopts a utilitarian framework:
 - that is, it attempts to maximise the benefits to society from health care spending.
- The approach makes the (naïve) assumption that the appropriate benefit is ‘health gain’:
 - that is, the intervention that maximises health gain per £ spent is the preferred option.

Utilitarianism II

- The QALY approach requires that limited health care resources should be allocated to those individuals that will produce the greatest QALY gain, regardless of:
 - age
 - sex
 - ethnicity
 - class
 - income
 - anything else, except ability to benefit from health care.

Utilitarianism III

The QALY methodology could, therefore, said to be fair as it treats all patients the same.

A QALY is a QALY is a QALY, regardless of who receives it.

Implications of QALY maximisation – insensitivity to distribution of benefits

- An intervention that improves the life of one person by 1 QALY is valued the same as an intervention that improves the life of 100 individuals by 0.01 QALYs. (The distribution of the benefit)

Implications of QALY maximisation – insensitivity to culpability

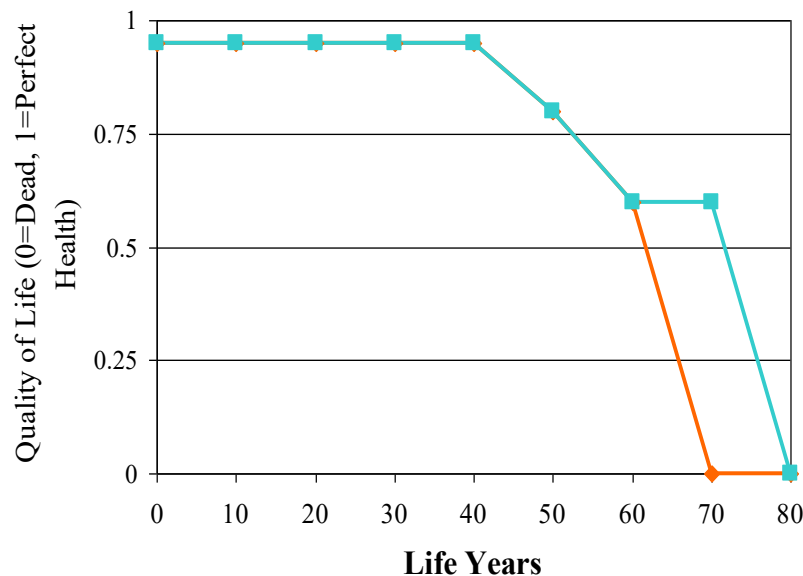
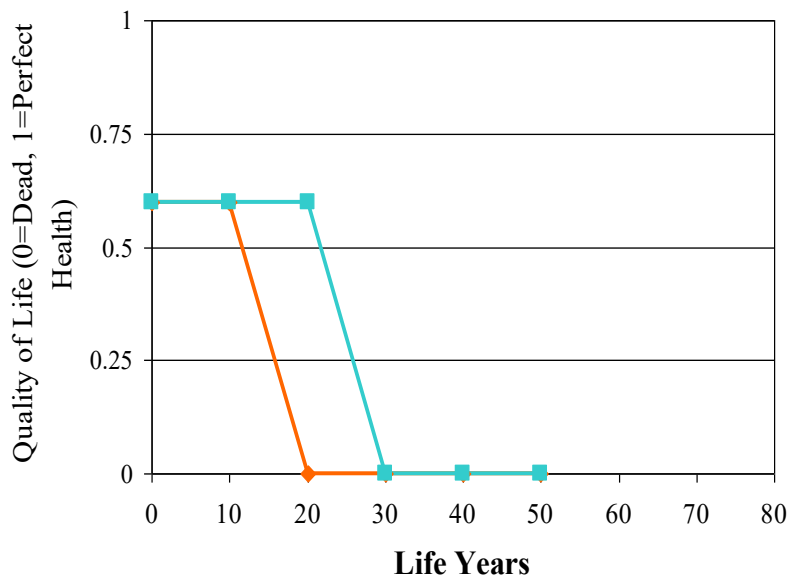
- An intervention that improves the quality of life in a smoking-related disease by 0.1 is valued the same as an intervention that improves the quality of life of a congenital disease by 0.1

Implications of QALY maximisation – insensitivity to severity

- An intervention that improves the quality of life of one severely ill patient from 0.1 to 0.2 for exactly 4 years is valued the same as an intervention that improves the quality of life of a generally healthy patient from 0.8 to 0.9 for 4 years.

Implications of QALY maximisation – insensitivity to age

- An intervention that extends the remaining life expectancy of a terminally ill infant from 10 to 20 years is valued the same as an intervention that extends the remaining life expectancy of a terminally ill pensioner from 10 to 20 years.



Equity and the 'fair innings' argument

Personal Characteristics

- Should we ration, in part, on the basis of personal characteristics?

- If yes, what are the relevant personal characteristics?
 - Desert: what we have and have not done in our lives
 - Life-cycle: age is important (young preferred to old)
 - Hard-life: two main types:
 - Rawls maxi-min: the focus should be on the worst-off
 - Double jeopardy argument: do not give more hardship to those who have already experienced it.

QUESTIONS

Should we ration, in part, on the basis of personal characteristics?

If yes, what are the relevant personal characteristics?

'Fair Innings' argument

- It is always a misfortune to die when one wants to go on living, but it is a *tragedy* and misfortune to die when young.
- Everyone is entitled to some 'normal' span of health (e.g. 'three score years and ten').

Characteristics of the argument

- Outcome-based.
- Concerns whole life-time experience.
- Reflects an aversion to inequality.
- Quantifiable.

Specific requirements

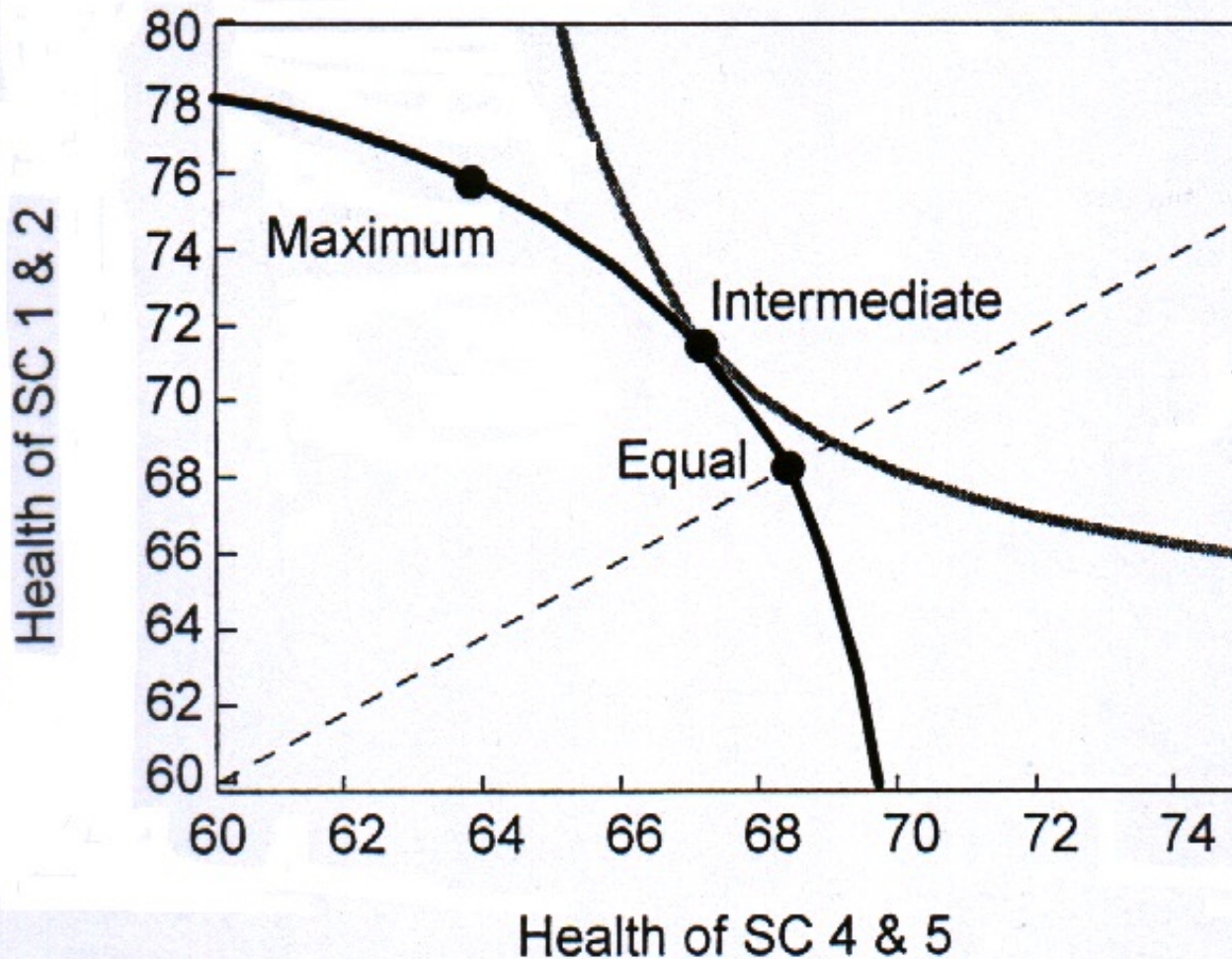
- How is health to be measured?
- How is health inequality to be measured?

'Fair innings' applied to life expectancy

- UK (male) survival rates:
 - social classes I / II (professional and managerial): 72 years
 - social classes IV / V (manual workers): 67 years.

- Reducing inequality of life expectancy:
 - would require changes in health/public policy
 - weighting additional life years gained (from health/public policies) according to social class of recipient.

Life expectancy at birth, males by social class



Key questions

- Is the 'fair innings' argument a good basis for making equity adjustments in health care?
- Fair innings of what?
- Are you willing to have the overall level of health of the community reduced in order to reduce inequalities in the distribution of health?

Fair Innings

- Average Life Expectancy at Birth
 - Combined: 74 years
 - Males: 71 years
 - Females: 77 years

- Quality Adjusted Life Expectancy at Birth in UK
 - Combined: 60 QALYs
 - Males: 57 QALYs
 - Females: 62 QALYs

Conclusions

- The role of the health economist is to use a *normative framework* to make *rational policy recommendations* about how health care should be rationed.
- Many other factors should be taken into account (it's not all about efficiency!)

References

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