Inform

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Resource Prioritisation: Lessons from Sweden

By now everyone must understand that rationing is an inevitable feature of all healthcare systems and the current distribution of health outcomes is inherently unfair. In an environment where demand will always exceed supply, prioritising the delivery of healthcare is a continual challenge for us. The question is, can we prioritise better and is there a model we can use to improve on what we are doing now? David Sage anaesthetist at Auckland City Hospital and Chief Medical Officer for Auckland District Health Board set out to find out. David shared his findings with branch members at our February seminar, held for the first time in Auckland City Hospital's new learning centre.

As part of his sabbatical leave in 2004 David joined a "Learning Set" organised by Anthea Penny. The 2004 group was: Chris Mules from Counties-Manukau, David Rankin from ACC, Carol Searle, then a Deputy Director General of Health, and Hayden Wano, the chair of the Taranaki District Health Board.

The Learning Set group is still working through their 18 month programme. In 2004 they had a partnering with CEOs and CMOs from the NHS. Two from an Acute Trust and two from a Primary Care Trust. David notes that the learning set worked very well for him. "We met half way in Singapore and worked out what we wanted to learn and they reversed. Then we looked at the Singaporean Health system while we were there and compared what it is like to have a 4-5% GDP spend on your health system compared with what we and the UK have.

David Sage

Those from the UK visited New Zealand in February 2004. The New Zealand group visited there in September and also went on to Holland and Sweden because there were things they wanted to see there. One of them was prioritisation. The Swedish centre for prioritisation is located in Östergötland so they went there and looked at prioritisation in the Östergötland county.

David first offered a little background to the prioritisation area because when making prioritisation decisions it is important to know the different prioritisation methods and the level at which you are working . If you have that level of understanding, you have the moral high ground – without it you don't.

David commented, "Coming from a hospital background I had little knowledge of primary and public health and the theory of prioritisation. The health economists have taught me a lot. Everyone would understand why prioritisation has to occur- it is not just because you have a finite resource – there is also a redistributive function in it to balance everything out. The interesting part is how you do it."

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David was taught by the health economists that most of the ways you use to prioritise the use of health dollars don't actually do that. Few take into account opportunity costs. Typically you use the historical method and just add on 2 percent; even if you do a needs assessment on a group or take the core services approach and say this is the basic core we supply to everyone. While you may do an economic evaluation on the cost of liver transplants against the cost savings on the cost of drugs and hospitalisation if you don't do it on that

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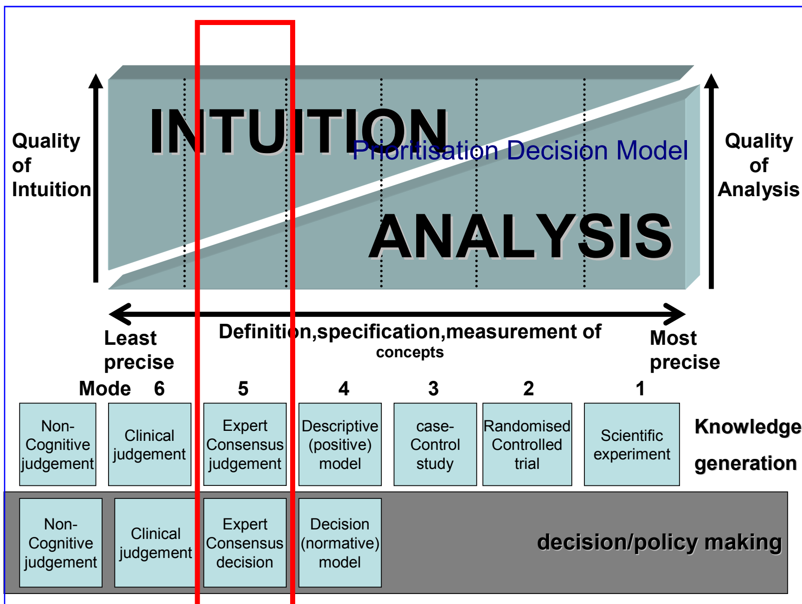
patient and the 50 patients who would get it, and then factor in quality of life – DALYS and QALYS and so on, you are not necessarily actually comparing the strategy for that piece of "health dollar" with the opportunities to spend it somewhere else.

Health economists taught David the principles of ***programme budgeting marginal analysis,*** which is really a complicated way of looking at what we already do – budgeting for a programme and then applying marginal analysis on pieces of the programme against what else you might spend the money on. It is a method that is very attractive to health economists and it was the element used in the Swedish model, although not in this formal way that health economists would apply it.

PBMA has been used in Canada for budgeting a provincial budget of Alberta. There is an example in Australia in their cancer strategy whereby they take the opportunity costs and benefit of pieces of the programme, like the cost saving of increasing the age of cervical screening from 25 to 35 years, versus the cost benefit of a smoking programme – which is something we don't generally do. You can apply strict economic principles once you know the budget of the programme and do it quite systematically right through the provincial health budget if you wish and it is along the lines of what the Swedes are doing, which is why the Group went there.



What particularly interested David was, at what level of knowledge do you make prioritisation decisions? If you look at the psychology and the whole history of decision making, in medical terms, we are very used to the evidence based approach where you take a long look at the quality of the evidence and rank it – and there are some standard ranking methods for evidence and quality, from the most precise to the least precise. When we bring in clinical guidelines we are working way down at the level of mostly intuition and you would like to think that somewhere in the area of expert clinical consensus judgement is the area you are working in when you make decisions.

Level 5 is the kind of level of analysis and intuition where you like to think guidelines are developed and so the whole guidelines movement relies on operating at expert consensus level – evaluating the available evidence, which generally is not that great. If you look at all the national guidelines that come out, the amount of level I evidence within them is not high. In decision and policy making the same thing applies. You hope that you are making policy and prioritisation decisions at this expert consensus level but often you are not. For example, "last year's budget prioritisation" is purely non cognitive – there is no evidence in there what-so-ever. If you look at whole pieces of our DHB budgets, they are in that category – they are just rolled over.

The other question which underlies any prioritisation system is the ethical basis for it. Fundamentally there are two approaches to this.

Ethical principles		
	human dignity	All people equally valuable Same rights
	need	Resources shall be invested in areas (operations, individuals) where need is greatest
	cost efficiency	Reasonable relationship between cost and Q of health and life ought to be sought when choosing

One is to have an ethical framework to start with; the other is not to – that is to do your prioritisation and hold it up against an ethical check list. That is the approach of some American HMOs who first prioritise and then check to make sure what they are doing is ethical. The Swedes developed their ethical framework first and begin with that and David has a slight preference for that approach.

Sweden is a country with a population of just under 10 million (most of whom live in the south) divided into 21 counties to whom the health budgets are devolved. The group went there because the Swedish GDP spend on health from a taxpayer funded universal access system is not too different from New Zealand's. Ironically, while health services in Sweden are free, they have more part charging in hospitals than we do. Ninety percent of the health budget, raised by local taxes, is held by the county council. The other ten percent comes from the Federal budget and this is designed to top up poor counties where the tax base is inequitable and to pay for national programmes. Although the country is divided into 21 counties, it is grouped into eight regions for tertiary services.

Östergötland is a county with a population of about 500,000 – not much bigger than a DHB. They have three hospitals in three small cities. The largest hospital is a 700 bed teaching hospital very similar to Auckland City Hospital in size – not quite so much quaternaryness but it is a regional centre for burns and has the usual tertiary clinics and services. In addition to that, general practices across the county are located in 43 health centres owned and operated by the county.

Östergötland county found that they were over budget, so they needed to have approaches for reducing the health budget and developed a prioritisation process to enable

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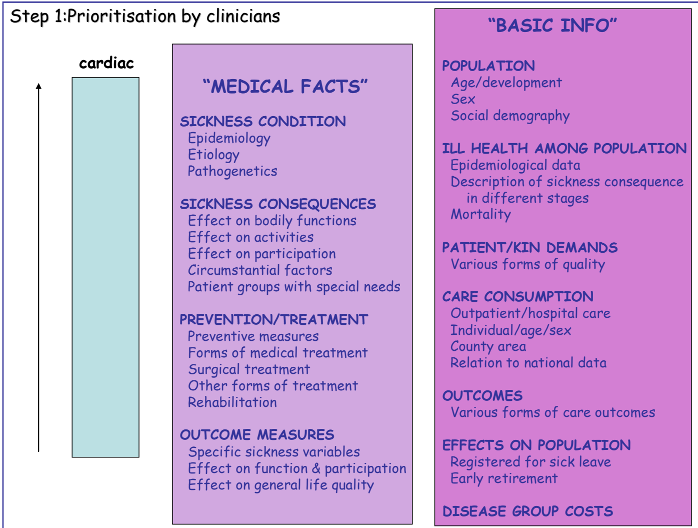
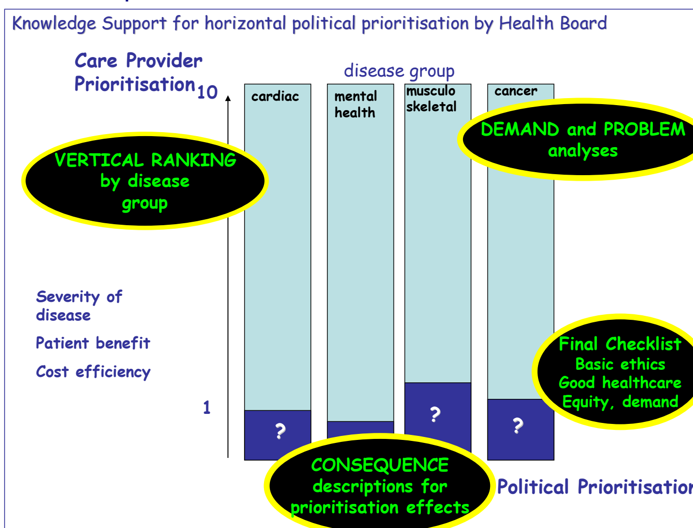
them to do this. They had finished the process and were going into round two when the group arrived for their visit.

They set out the ethical principles in some detail and have a complex and systematic matrix for applying ethical principles to diagnosis and treatment at the beginning of the process rather than at the end. They started off by dividing services into fifteen areas and asking clinicians to prioritise for their specialist area on a scale of 1 to 10 for all their activities. This took a long time - the first part of the process took nine months.



The next step was to decide what to do with the procedures that had low rankings. If they were going to remove procedures for budgetary reasons, how were they going to do this equitably across the fifteen disease group streams? This is traditionally where clinicians quite reasonably say, "I have done my bit, you do that bit." The County Council health sub committee, which is entirely elected and equates to our DHB, recognised that this was their job so the prioritisation across the specialities became the "political prioritisation process.



They realised that they needed more information than just what the clinicians had told them so they asked for consequence descriptions of prioritisation effects. In other words, what does it mean for me (the politician) when we say we are not going to do that? And that is reasonable, given that you are asking politicians to make a social decision, they should be aware of the consequences of their decision, so there was a huge consequence checklist.

In addition to that they wanted to know about the things that were not on the list – the things the clinicians were currently not doing – what about the other population requirements you know about but are currently not doing, or have come up some other way, or have come up through social services? They wanted problem and demand analysis to weigh up against the consequence list for the current stuff. Finally, to make sure they had considered all the issues they had an elaborate check list to weigh up those things they proposed to add or remove from the funding budget.

The target was to take 10% out of the secondary care budget. Using their prioritisation process, over one year they took 2% out of the budget and by having some major structural changes, some of which were quite far reaching – for example, over the whole county they amalgamated all departments in the secondary sector. Such as, having one orthopaedic department delivering in three hospitals and in clinics across the county. They put general medicine, primary care and mental health together into one administrative directorate.

The CEO of the County Health Department recognised that she could only take the 10% out of the budget by doing the standard things. One was by improving the technical efficiency of health delivery and mechanisms and the second by structural change. But she also needed to consider whether they were doing things they did not need to be doing and to tackle that logically she invoked the one year prioritisation process.

A number of services, including vasectomy and caesarean section without a medical reason, were cut. The one that attracted a public and media uproar was the removal of a second hearing aid for the elderly. When they looked at the evidence they found that a hearing aid in both ears was a marginal improvement to one and only increased hearing by 5% at the best. But that was a 'red rag to a bull' to the population and spawned headlines like "Östergötland denies hearing to the elderly." One of the outcomes of this exercise was the adoption of a new PR approach for announcing these cuts and engaging the local population.

They were put under a bit of pressure from central government to be more transparent with how they arrived at their decisions and once they did that and re-published it with the reasons why, it was accepted by the public and there was very little media coverage of the revised publication.

The county has gained a huge planning base for future budgeting. Although this exercise was done for the 'burning bridge' financial problem they had and was done in a slightly compressed way, it will be of huge benefit in outer years and it really suits itself to a 3 or 4 year planning process. Ideally it requires more involvement from the public as well, especially at the later stages of the horizontal prioritisation."

The theory behind this process was developed by the Prioritisation Centre in the University of Linkoping. So they have academic input into the process – in fact it originated with the Centre who said, "look you have got a problem,

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we will help you." They have health economists in that department and they had quite a lot of help from medical advisors – the County had six medical advisors of one sort or another and they ran a lot of the process, particularly the clinical prioritisation, getting the buy-in of the clinicians along the way.

For the first round the politicians agreed that they would not question the prioritisation ranking given by the clinicians. This potentially leaves an opportunity for the clinicians to just rank highly the things they want to keep. However, there was a lot of moderation and no evidence that this did happen. More political oversight of future rounds of the process is possible.

Östergötland :success factors for horizontal prioritization

- Humbleness when faced with a complicated and difficult task
- Dialogue
- Legitimacy and distinct delegation of responsibility
- Good data
- •Realistic schedule -12 months
- Substantial info to all health care personnel
- •Adequate info to general public
- Loyalty to decisions adopted

Primary Care

The Swedes thought that their primary care spending was about right so they did not think they could make savings by targeting that with the prioritisation process. In terms of primary – secondary integration, the 43 health centres are spread across the county each with an enrolled population in the circa of 5 -10,000 with a GP ratio of 1:2000 and quite a stack of nurses and nurse practitioners.

The centre the group visited was really impressive. They had a control room in the centre run by a practice nurse who would answer the phones using a 'tele-cue' system. With this system callers do not wait in an on-line cue to be answered. They are cued off-line and are told, "thank you for your inquiry, Nurse Ludquist will call you back at 10:30." It stacks up the patients who have phoned in and gives the nurse a half hour gap between phone calls. When she calls back she has the patient's chart on the screen and inquires what the problem is. The nurse has a number of options:

- she can put the patient into one of the 15 acute slots the doctor has each day;
- or to see a nurse practitioner;
- or a physiotherapist; or
- she can prescribe analgesics and stuff like that based on telephone inquiry;
- she can put them straight into the local ED;
- or she can bring them back in a week or so for a non urgent appointment.

The nurse answers about 120 calls a day from their enrolled population. At 6:00p.m. the medical centre control centre coalesced with several of the other control centres in the city until 10 or 12 o'clock and the same process happened using after hour GPs and nurses. After that they coalesced again to the hospital ED, where a nurse practitioner continued the same process where she could make appointments back in the primary care centres the next day. The Centre said that they were a year away from the ED control centre having the GP's notes on their screens.

The third component of the primary care system was the home care service. This is an advance on our district or community nursing in that there were doctors in the system. Their home care service had 70 nurses and 4 or 6 doctors. The doctors' background was either hospital or primary care, often with an interest in palliative care. They were rostered and worked in three teams.

Routinely, one of the rostered nurses would go to ED and identify anyone who had gone into ED between midnight and 8:00a.m. who did not need to be there. She would book them out and put them home with the advanced home care that was required. And the doctor from the service did the same thing – he went to the acute admitting ward of the hospital and pulled out anyone who had got through ED to the assessment ward and could be managed with home care. So the integration between secondary and primary care is superb.

Could we apply the Swedish model of prioritisation to our DHB budgets? David's view is that it could be rather pointless, because DHB investment/disinvestment decisions are subject to veto by the government.

However, he said, "with central government approval and acceptance by the community and healthcare providers, it has enormous potential as a long term planning tool."

beyond evidence base:

MEDICINE IS A STOCHASTIC ART

Gallenic School

Alexandrine School

The answer will be found in the data

Impeccable science, but the practical application is fallible, because of patient variation

As science progresses, individual failures will be explained

Variability is an inherent property of medicine

An individual practitioner's experience cannot be relied on

If the answer is always uncertain then ensure that the process is acceptable

Chaos Theory

Large multi-centre trials

meta-analysis

VALUES BASED MEDICINE

Humanistic approach

As the evidence base increases, so do the options : there is always a subjective component.

New Zealand Institute of Health Management
A Branch of the Australian College of Health Service Executives

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Inform Editor Bruce Parkes

Seminar Programme

March 23rd

@ Cap Gemini, AXA Building, 41 Shortland Street, City

5:30p.m. for 6p.m.

Tsunami Banda Aceh: The hospital's story

Dr Charmaine Tate, N.Z. Army

Non Members Welcome

Cost

Members	Free
Non Members	$25

Eurest supports our seminar programme

Voluntary Guidelines Seek to Lower Nosocomial Infections

A key advisory committee to the Centers for Disease Control and Prevention (CDC) has issued new recommendations to help American states more accurately measure the rate of healthcare-associated infections (HAIs) and monitor healthcare providers' efforts to prevent them.

HAIs, also known as nosocomial infections, include sepsis, pneumonia, and infections after surgery. They are considered a major public health problem by the CDC. In the US they account for two million infections, 90,000 deaths, and $4.5 billion in excess healthcare costs each year.

The voluntary guidelines from the CDC's Healthcare Infection Control Practices Advisory Committee are intended to help policymakers, consumer groups, and other entities concerned about reducing HAIs establish effective monitoring and improvement programs.

Prompted by consumer advocates and major healthcare purchasers, the trend toward mandatory reporting of HAIs is in full swing. Already, four states (Illinois, Pennsylvania, Florida, and Michigan) have passed laws mandating that healthcare organizations publicly disclose their HAI rates, and similar efforts are under way in about 30 other states, according to the CDC.

Without recommending for or against mandatory reporting of HAIs, the CDC committee advised that monitoring programs take the following steps:

* use established public health surveillance methods;
* create multidisciplinary advisory panels, including persons with expertise in the prevention and control of HAIs;
* choose appropriate process and outcome measures based on facility type,
* and phase in measures so that facilities can adapt; and provide regular and confidential feedback of performance data to healthcare providers.

At a more specific level, the committee also recommended that states that decide to establish a public HAI reporting system select one or more process or outcome measures to determine an institutions' performance. They are:

* central-line insertion practices;
* surgical antimicrobial prophylaxis;
* influenza vaccination coverage among patients and healthcare personnel;
* central-line associated bloodstream infections; and
* surgical site infections after selected operations.

The guidance document is available on the CDC's Web site at **www.cdc.gov/ncidod/hip/default.htm**

Our March presenter, Charmaine Tate is currently working for the New Zealand Defence Force as a doctor. She was deployed with the Defence Force contingent to Banda Aceh after the Boxing Day Tsunami. She will cover the effect of the tsunami on hospital and medical services as a whole and then the issues faced as the hospital was transformed to a functioning facility

Contributions Welcome

1. The Auckland Branch welcomes contributions to **Inform** on subjects of interest to managers in the health and disability sector. Articles may be longer researched contributions, comments on current practice, or shorter notes and/or reviews. The range of possible subjects is very wide.
2. The maximum length is generally 3000 words. Shorter contributions are very welcome. Please include an e-mail address so authors can be contacted and a brief list of key points or an abstract.
3. Copy should be provided by e-mail or on a computer disk.
4. Contributions may be passed to the Editorial Committee for consideration.
5. Make submissions or contact the Editor for more information at admin@nzihm.org.nz