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Hearing on Priority Setting on 13 December 2004

List of questions

Against the background of considerable financial problems in the German health system, the Study Commission on the Ethics and Law of Modern Medicine is examining issues relating to the allocation of resources in health care. At the hearing, the Study Commission would like to deal with questions about how (scarce) resources can be distributed appropriately in health care.

Priority setting is of interest as a potential strategy for solving these issues. However, initial moves towards explicit priority setting, such as a paper produced in 2000 by the Central Ethics Commission of the German Medical Association entitled "Priorities in medical care in the statutory health insurance system: need we and can we decide?", have not yet had any impact on German health policy.

The Study Commission would like to draw on the experiences of other countries in its deliberations. It is thus interested in considerations about priority setting and its specific practical consequences on health care in other countries, with their various systems and conditions.

The political debate

1. What problems caused your country to begin a debate on explicit priority setting in health care, and what kind of health system structure existed at that time? When did this debate take place and who was involved?

   If there has been / is no debate in your country about priority setting in the health system: why has there not yet been such a debate, and what alternative issues relating to financing and resource allocation in the health system have been / are being debated?

   Response: In the UK over 90% of all healthcare is provided through the National Health Service (NHS) and funded from general taxation. There was never, since the inception of the service, been any formal or explicit mechanism for prioritising healthcare services. During the late 1980s and the early to mid 1990s, when the mismatch between demand for healthcare and the available resources was obvious to the medical profession, there was still no formal or explicit process for prioritisation. Indeed, the Thatcher and Major governments believed that resources for healthcare, in the UK, were adequate; and that efficiency savings could compensate for the increasing costs of medical care.

   Nevertheless, the professions considered that a formal mechanism for priority setting should be introduced. The Royal College of Physicians proposed, in the mid-1990s that a national priority-setting forum should be established; and, at about the same time, the British Medical Journal ran a series of articles on the need for, and possible approaches to, priority-setting. Nothing came of these initiatives at a governmental level.

The incoming Blair government, in 1997, realised that there was a mismatch between demand for healthcare and available resources. There were major problems in the NHS and substantial public disquiet. By any international comparison, per capita healthcare expenditure was lower than other comparable country; and there had been too little investment both in training doctors and nurses, and in the infrastructure of the health service itself. During the 1997 election, however, Tony Blair and Gordon Brown had committed themselves to honouring the expenditure plans of the Major government for its first two years of office. It was unable, therefore, to increase funding for healthcare until 2000. Since that time, resources for healthcare have increased annually at a rate of 7.3% (in real terms) and major efforts have been (and are being) undertaken to overturn the consequences of a long period of underinvestment.

In 1998, the Blair government published a plan for improving the quality of care for NHS patients entitled *A First Class Service".* Amongst other initiatives, it proposed the establishment of the National Institute for Clinical Excellence (NICE) with the responsibility to give health professionals guidance on providing their NHS patients with the highest attainable – not "possible" – standards of care. In doing so, NICE was expected to take account of both the clinical effectiveness, and the cost effectiveness, of health technologies and other forms of clinical care. So far as I am aware this was the first time, in the UK, that an explicit reference for the need to consider cost effectiveness in healthcare had been made by any government.

The stage of analysis of priority setting

2. In your country, which health services or medical and care services or service areas are to be provided as a priority? What can / will be given low priority? Are there groups of people, diseases and / or indications or indication areas which are to be given high or low priority? Which health aims or aims relating to the services provided are considered a high priority, and which low?

Response: In the UK, the incoming Blair government indicated its commitment to some areas by developing National Service Frameworks (NSFs) covering areas of either perceived need or historical neglect. Those produced so far include cancer, mental illness, cardiovascular disease, older people, diabetes, children, and renal disease. An NSF on long-term medical conditions is currently under development.

3. On the basis of which ethical values and criteria should priorities be set in your country? What hierarchies of values exist? What factors are not criteria in priority setting, or are deliberately ruled out as criteria?

Response: I am unaware of the existence of a formal set of ethical values or criteria specifically constructed for setting priorities in the NHS apart from those that were given to NICE, at the time it was established, by a legal "Direction" from the Secretary of State for Health (see below).

4. In your country, which institutions and groups are / were to deal with prioritisation and to set priorities? How are these actors legitimised? What role does public involvement play in priority setting in your country?

Response: Local priorities for the NHS are decided by Primary Care Trusts (PCTs) which commission care for their populations (covering 100,000 to 300,000 persons).

They are provided with resources, from central government, and have a considerable degree of flexibility on the use of funds. Nevertheless, central government imposes some priorities on PCTs, and may set "targets" for their implementation.

PCTs are established by law and the membership of the Boards includes non-executive directors (drawn from the local community) and executive directors (appointed by the non-executive directors).

PCTs attempt to involve the public in several ways. The Boards of PCTs are required to hold their meetings in public. Public consultation is accomplished, on major issues, by holding public meetings; and, in a very few instances, by convening "citizens juries". NHS hospitals and (very recently) general practices are also required to conduct surveys of their patients: the results of such surveys may lead to changes in the allocation of resources.

5. In what ways is / was priority setting to be introduced and implemented?

6.

Response: Priorities decided by central government may be enforced by imposing "targets" on PCTs (or hospitals). Whether such targets have been, or are being, met are generally assessed by the Healthcare Commission (HC). This body (previously known as the Commission for Healthcare Inspection or CHI) has a statutory obligation to evaluate the quality of care given to patients by PCTs, NHS hospitals, and general practice. Recently, the scope of its enquiries has been extended to cover the private sector. Failure to meet expected standards, without good cause, results in penalties being imposed on PCTs and their Boards. This occasionally includes the dismissal of some Board members from their positions.

Turning theory into practice: (stage of decision making and initial implementation)

7. What values and criteria are applied in prioritisation decisions? How does this happen? How are the values and criteria operationalised?

Response: When NICE was established, in 1999, the Institute was issued with a Direction from the Secretary of State for Health that, in advising whether technologies and techniques should be available in the NHS, the following matters should be taken into account:

- the broad clinical priorities of the Secretary of State and the National Assembly for Wales (as set out for instance in National Priorities Guidance and in National Service Frameworks, or any specific guidance on individual referrals);
- the degree of clinical need of patients with the condition or disease under consideration;
- the broad balance of benefits and costs;
- any guidance from the Secretary of State or the National Assembly for Wales on the resources likely to be available to the NHS and any guidance from the Secretary of State or the National Assembly for Wales on such other matters as they may think fit; and
- the effective use of available resources.

These criteria do not, of course, incorporate full the range of the social value judgments that the Institute may be required to make; and NICE has established a Citizens Council to assist it in a programme of development of such values. A description of the Institute's emerging approach to cost effectiveness can be found in Annex 1.

8. Who implements, or which institutions implement, prioritisation decisions in your health system? At what levels does this take place, and how binding is it? What are / were the consequences (including structural consequences) of explicit priority setting on health care in your country?

Response: PCTs, NHS hospitals and general practices have a legal obligation to make available funding for those health technologies that are recommended by NICE. Although there is no legal impediment the NHS is very unlikely to adopt, as a routine treatment, a technology that has been rejected by the Institute. There is an expectation that NICE's guidelines will be implemented over a reasonable period of time. The adherence of NICE guidance within the NHS will, in the future, be subjected to scrutiny by the Healthcare Commission. A brief description of the work of NICE can be found in Annex 2.

9. Which mechanisms are best suited to identifying and achieving priorities? Which mechanisms have in practice proven to be unsuitable? In your country, how significant in this process are the concepts and methods of evidence-based medicine, demands from the area of alternative or complementary medicine and of care, the political interests of the various actors, and cultural factors (concept of health / illness)? What conflicts have come to light?

Response: NICE guidance is developed from four fundamental principles:

- All NICE guidance is based on a full systematic review of the relevant literature.
- NICE involves all the relevant stakeholders in the formulation of its guidance. These include relevant professional organisations, relevant industries, and relevant patients and/or patient advocates.
- NICE's processes, and the evidential basis, is as transparent as is humanly possible.
- NICE guidance is constructed by independent advisory bodies. Although the Board of the Institute has powers to over-rule their decisions it has not, to date, done so.

The topics on which NICE develops guidance are, ultimately, decided by health ministers. This means that central government makes priority-setting decisions since, once a topic is referred to NICE, government has no further input. This approach to topic selection was originally the subject of considerable criticism. The fact that the final decision as to which topics should be placed before ministers is made by a committee, which I jointly chair with the deputy chief medical officer, has led to its general acceptance.

10. How is priority setting evaluated and, if necessary, adjusted?

Response: The priorities of central government, and local PCTs, are inevitably adjusted in the light of prevailing circumstances and health needs.

Maintaining explicit priority setting in the long term

11. Has the priority-setting procedure developed in your country been able to take root?

Response: NICE, at the start, was a controversial "experiment". Although it had the support of most of the professions (who recognised the need for an organisation, such as NICE, to be developed) there was hostility from the pharmaceutical industry and the opposition parties in parliament. This has changed. Industry is now largely supportive and all the main political parties see NICE as an essential component of UK healthcare. There is public support too: an opinion poll in March 2004 showed that 27% of the population knew about NICE; and that 72% of those aware of NICE's existance thought it was doing a "good" or "very" good job. NICE is no longer an experiment although its decisions will always be controversial.

12. Which approaches have proven to be helpful, and which have had to be discarded?

Response: When NICE was first established we attempted to keep our provisional conclusions "confidential". This proved to be impossible and we changed our processes so that our emerging conclusions could be seen, and commented on, by anyone. This transparency, and the opportunity to challenge our emerging findings, has proved to be extraordinarily helpful in gaining the confidence of our stakeholders.

13. What long-term efforts exist to deal with the challenge of allocating resources in health care fairly?

Response: The real challenge is developing an appropriate balance between efficiency and equity. The tension between a utilitarian approach to prioritisation, and a Rawlsian approach, is inherent in all healthcare systems based on a principle of social solidarity. Where the balance of interest lies is, in part, a bioethical issue; but needs to take account (especially in a system funded by general taxation) the priorities of the public. How best to ascertain these latter views is uncertain: we, at NICE, have established a Citizens Council to assist in this but other approaches may work as well or better.

Recommendation

14. What recommendations can you give Germany as regards explicit priority setting in health care.

Response: It would be inappropriate, impertinent and misleading for a UK citizen to recommend an approach to healthcare priority-setting in another country! The differences in culture, political systems, and values make translation of the experience we have gained with NICE, to Germany, impossible. It may also be helpful to point out that NICE was established at the start of an unprecedented growth in UK healthcare expenditure. It would have had to face a very different challenge if it had to work within a retracting financial environment for healthcare.

I suggest is that Germany examines the approaches used in the UK and decides for itself what aspects do, and do not, meet its own needs. I and my colleagues at the Institute remain available to give advice and help, at any time, to the German government and its people.