Are trust and security relevant to health service priority setting?

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Priority Setting and Objectives

priority setting affects the distribution of health benefits and burdens in society

(Kassich et al 2016)

“decisions on priorities for expenditure on health speak to the question of the purpose(s) which health systems serve within a given society”

(Syrett 2016)

“Present methods for priority setting are poorly adopted to address the full range of health system objectives”

(Norheim 2014)

But...

Some implications of pursuit of Health Gain Maximisation

- Life-saving or life-prolonging treatment may be denied, even where no alternative exists
- Some people or groups are deemed too expensive to treat
- Violates Equity?
  - Equal cost treatments, different gain

Larger Gain dominates regardless of severity of illness

<table>
<thead>
<tr>
<th>Existing Health State</th>
<th>Gain = 4 QALYs</th>
<th>Gain = 3 QALYs</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 years</td>
<td>64</td>
<td>60</td>
</tr>
</tbody>
</table>

Some implications of pursuit of Health Gain Maximisation

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  - Equal cost treatments, different gain
  - Treatment for A costs more than B – but same Gain?
  - Double Jeopardy for those already disadvantaged

There is widespread recognition that there is no single ‘correct’ approach to priority setting in healthcare. Nevertheless, cost-effectiveness, with the aim of maximising health gain, remains central to many approaches. This is based on the assumption, implicit or explicit, that health is the primary, or even sole, objective of healthcare systems. However, health-gain maximisation (QALY maximisation) can have a number of undesirable consequences, including reinforcement of inequalities and discrimination against those with rare diseases, those with pre-existing disabilities and those needing more costly interventions. As a result, modifications have been proposed, for example, weighting QALYs or adjusting funding thresholds, but without questioning the underlying assumptions of the pursuit of health-gain maximisation. After critically examining those approaches, this paper proposes that there should be a clearer distinction between the objectives of health-related interventions and the objectives of healthcare systems. In particular, in the case of healthcare systems, it is argued that trust and security are under-recognised as important, and possibly primary, objectives. The implications of this for healthcare priority setting, at all levels, are explored.
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  - Double Jeopardy for those already disadvantaged
- Sacrifice of the Individual to the Collective?
  - Small Gain to many > large gain to few

<table>
<thead>
<tr>
<th>Disease A</th>
<th>Disease B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing Treatment</td>
<td>Existing Treatment</td>
</tr>
<tr>
<td>Gain 0.25 QALYs Cost/QALY £40K</td>
<td>Gain 0.5 QALYs Cost/QALY £40K</td>
</tr>
<tr>
<td>New Treatment £20k/year</td>
<td>New Treatment £10k/year</td>
</tr>
<tr>
<td>(Gain 0.5 QALYs Cost/QALY £40K)</td>
<td>(Gain 0.25 QALYs Cost/QALY £20K)</td>
</tr>
<tr>
<td>ICER = £5k/0.25 = £20k</td>
<td>ICER = £10k/0.25 = £40k</td>
</tr>
</tbody>
</table>

Attempts to mitigate undesirable consequences

- Use of language –
  - Soft terms eg ‘Value for Money’
  - ‘Loaded’ phrases eg ‘Low Value Treatments’, ‘High Cost, Limited Clinical Effectiveness’

- Weighting QALYs and/or adjusting funding thresholds
  - Severity of Disease
  - End-of-life treatments
  - Rare diseases/Orphan drugs
  - No alternative treatment
  - Age, gender, deprivation, disadvantage
  - ‘Calibrating QALYs to Respect Equality of Persons’ (Franklin 2016)
  [to take account of different levels of maximum achievable health]

QALY maximisation with ‘knobs on’
Guidance for Priority Setting in Health Care (GPS-Health)

Priority-setting criteria to be considered in conjunction with cost-effectiveness results

**Group 1: disease and intervention criteria**
- Severity
- Realization of potential
- Past health loss

**Group 2: criteria related to characteristics of social groups**
- Socioeconomic status
- Area of living
- Gender
- Race, ethnicity, religion and sexual orientation

**Group 3: criteria related to protection against the financial and social effects of ill health**
- Economic productivity
- Care for others
- Catastrophic health expenditures

(Netheim 2014)

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- Cost-effectiveness +
- Multi-criteria approaches (MCDA)

Mapping of multiple priority setting criteria for use in MCDA

[(Tromp & Baltussen 2012)]

Possible Objectives for a health service (Mullen 2009)

- To relieve suffering and promote health and security of individuals
- To minimize (catastrophic) risk – especially HC costs
- To promote trust and provide security and certainty healthcare will be there when needed
- To ensure equity and fairness in access to healthcare
- To be responsive (in terms of quality)

“...a system of universal coverage, free at the point of use, is good for individual health even if no one takes advantage of it.”

[Wolf 2012]

Provides Security
Health Security

Wolff (2012)

"Universal health care can improve the quality of people's lives: improvements in health may be only part of that improvement."

"Universal health care not only confers benefits to particular individuals, but also improves population health by providing health security."

"Security...is the inverse of risk or vulnerability...how exposure to risk can make people worse off... [is useful] in thinking about health."

Not WHO definition

Health Security

Wolff (2012)

"More to health security than health...four dimensions: vulnerability, control, resilience, and anxiety."

1) Vulnerability or the probability of falling ill
2) Control - cost & difficulty of mitigation strategies to reduce health risk...cast individuals [face] to try to control their risks.
3) Resilience - people's ability to "bounce back" after an adverse health event...[both]...the consequences of ill health & the costs and difficulties of...[mitigating]. Those consequences medical aspects include one's ability to access care and to take advantage of it.
4) Fear or Anxiety - people fear or become anxious about falling ill. Fear or anxiety attaches to the illness [eg cancer]...its adverse consequences...[including]...its potentially ruinous financial consequences.

"Hence a system of universal coverage, free at the point of use, is good for individual health even if no one takes advantage of it."

Physical Safety

(John 2009)

"Health is not the most useful concept for understanding the value of public health policy...[overlooks] important benefits"

"I define an individual's level of 'physical safety' in terms of threats to her continued achievement of a minimal level of normal physical functioning."

"Distinction between being healthy and being physically safe: someone might be healthy but physically vulnerable (for example, she is in full health but must cross a busy road every day), unhealthy but physically safe (for example, she has malaria, but is undergoing an effective treatment)."

Physical Security

(John 2011)

"To say that an individual enjoys physical security is to say that her future enjoyment of normal human physical functioning is protected against some range of threats."

"Security not (just) 'absence of fear'."

"An agent enjoys complete physical security if and only if there is warrant for her to believe that she will continue to achieve normal human physical functioning across the range of plausible futures, and this belief would be true."

"Whether or not we possess warrant for this belief depends on the reliability of the mechanisms by which we meet our needs."

"Our level of security varies with the reliability of the mechanisms by which we meet our needs."

Security?

Many types of security, including...

National/International Security
Global Health Security
Public Health Security
Individual/Personal Health Security

"Economic security, environmental security, identity security, social security, and military security are different forms of security, not fundamentally different concepts."

(Baldwin 1997)

"Building individual and global health security."

(UNDP Human Development Report 1994)

"A feeling of insecurity arises more from worries about daily life than from the dread of a cataclysmic world event. Job security, income security, health security, environmental security, security from crime-these are the emerging concerns of human security all over the world. Most people instinctively understand what security means. It means safety from the constant threats of hunger, disease, crime and repression. It also means protection from sudden and hurtful disruptions in the pattern of our daily lives-whether in our homes, in our jobs, in our communities or in our environment."

Human Security

- Economic security
- Food security
- Health security
- Environmental Security
- Personal security
- Community security
- Political security.
But is (Individual) Health Security
simply
Security against
Risk of Catastrophic Expenditure?

*Do the very rich have total health security?*

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**Possible Objectives for a health service** *(Mullen 2009)*

- To relieve suffering and promote health and security of individuals
- To minimize (catastrophic) risk – especially HC costs
- To promote trust and provide security and certainty healthcare will be there when needed
- To ensure equity and fairness in access to healthcare
- To be responsive (in terms of quality)

  - Security from catastrophic health care costs
  - Security that health care will be there when needed
  - Security against risk of becoming ill

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**Strengthening health systems to promote security**

“The notion of health security (understood as the health components of human security) offers a useful approach by identifying the risks that challenge the health of individuals and populations, along three dimensions: epidemiological risks that determine disease, safety risks associated with poor quality of health-related goods and services, and financial risks derived from paying for care.” *(Frenk 2009)*

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Patients’ fears highlight the enduring marvel of a free NHS

“If you couldn’t pay for treatment, illness was once a death sentence – as I learned as a young doctor in a former mining town” *(Freya Ackroyd Parkin Guardian 9.6.16)*

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**How?**

*In Place of Fear*

A Free Health Service
(Bevan 1952)
Security Measurement?

HASU
Health Assurance and Security Unit

Could HASUs be the new QALYs?

Need Security because of......

Fear/Risk of (getting)
Illness/Disease/Accident

Uncertainty/Fear/Risk of not
getting treatment when ill/injured

Reasons why might not get treatment when ill/injured?

Treatment doesn't exist

- None
- Known but no provision
- Absolute Scarcity

Treatment known and exists

- Known
- Insurer/NHS denies provision
- Can't afford to pay
- Logistics denies provision

Reduce Risk of Illness/Disease/Accident
(Assure the conditions for health
Reduce risk of needing health care)

Clean Water & Air
Safe Food
Shelter
Road Safety
Work H&S
Control of
Epidemics
Vaccinations
e tc
Screening and
Prevention

Smoking Cessation etc

Screening and
Prevention

'Leisure' & Sports Safety

Some Headlines

She supported the NHS - then it let her down

Independent on Sunday 31/8/08

Age-related macular degeneration

It's usually wrong that when she needs help it's not there
Alzheimer's

Independent on Sunday 12/10/08

It's like having a death sentence hanging over me

When Nics decided the drug wasn't cost effective, I was devastated.
The fact it could be taken away is
Pulmonary hypertension

Independent on Sunday 12/10/08

It's like having a death sentence hanging over me.
Rescue?

"The mission of health care is to rescue individuals from the suffering caused by disease."

(Wells 2012)

"Failure to rescue is a critical systems failure because it results in increased morbidity and mortality. When bioethicists plan not to rescue someone because the condition she has is too expensive, they are accepting a preplanned, critical system failure."  

(Wells 2012)

Guaranteed ‘basket’ of interventions/services

What goes in?  ?  What is left out?

- Commodification/Fragmentation
- Condition/treatment pairs
- (Rigid) guidelines
- Inflexibility
- Distort Medical Judgement
- Disregard Patient Differences
- Problems with Multi-morbidity
- Risk of over-treatment
- Could Stifle Innovation and Progress
- Process for introducing ‘new’ items?
- Process for removing ‘old’ items?
- (Criteria, timing, speed, methods)

Health (care) Systems v Health-Related Interventions

"...a system of universal coverage, free at the point of use, is good for individual health even if no one takes advantage of it."

(Wolf 2012)

Health (Care) System ≠ Σ Health-Related Interventions

The Objectives of Healthcare Systems

The Objectives of Health-related Interventions

What are the implications for evaluation and priority setting?

Epidemics/Pandemics

- SARS
- Ebola
- Bird Flu
- Zika Virus

‘Classic’ Health Security Problems

"Pandemics more than any other kind of disease have a virtual existence apart from having any actual existence. This means that preventive measures are taken against a threat that is unknown. Precaution and preparation are carried out on the basis of forecasts, anticipations and modelling and therefore a good deal of policy-making concerning pandemics takes place in circumstances of great uncertainty, in which risks and benefits are highly hypothetical."

(De Grandis & Littmann 2011 p7)
Security, but no apparent outcome

- Process utility – eg unsuccessful IVF, “futile” care at end-of-life
  Assurance of having tried everything
- Having a diagnosis – even if nothing can be done about it.
- Redundancy – Patient Safety?

Example from Thailand – Kieslich et al (2016)

- First-line drug treatment for epilepsy and neuropathic pain causes severe adverse reaction for small % of patients
- Can screen to identify those at high risk of severe adverse reactions
  Alternative treatments more expensive
- Screening cost-effective for neuropathic pain
  Screening not cost-effective for epilepsy
- “cost-effectiveness is a major criterion for coverage decisions”
  **but…**
- For “ethical reasons, inc. treating similar cases in the same way” coverage has been approved for both. **Equity**
- “omitting the screening test can be seen as leaving the patients to face the preventable life-threatening drug reactions” **Security**

Do we want absolute security?

“No one ... is ever entirely secure. Death is inevitable.”
(Dahl & Lindblom 1953/1976)

“the pursuit of security necessitates the sacrifice of other values”
(Baldwin 1997)

‘probably most people do not really want “absolute” security, if such a state is imaginable; “optimum” security would probably still leave an area of challenge, risk, doubt, danger, hazard, and anxiety. Men are not lotus-eaters’
(Dahl & Lindblom 1953/1976)
Does Security require Certainty?

Want certainty treatment will be available when needed

but

Cure

Death

1-p

p

Treatment

No Treatment

Ill-health

Standard Gamble

HASUs v QALYs

What would or could a focus on security mean for priority setting?

- Interventions being evaluated independently of health system objectives?
- Greater focus on need?

Possible example…?

- More priority for novel interventions (where no pre-existing treatment)
  &
  Less priority for ‘Me Toos’?

Competition for Security?

"Health care resource allocation decisions are population health decisions; funding one person’s health care means not funding someone else’s."

(McCabe 2012)

- Does this apply to security?
  - do we have to trade one person’s security for another’s?

- What are the implications for equity?

- If we attempted to maximise HASUs is there a danger of/from utilitarianism?

Security and Trust are the missing dimensions in Priority Setting

Thank you