Is it time to ration access to acute secondary care health services to save the Aotearoa health system?

Saxon Connor

At face value, Aotearoa’s health system seems to provide “cradle to the grave” universal healthcare to all New Zealanders, with the aim of allowing individuals to lead healthy and fulfilling lives. By population metrics, Aotearoa seems to do well with an overall life expectancy of 83 years, with annual increase of 0.18%. On the global happiness index, of which health contributes a significant component, Aotearoa is ranked within the top ten countries in the world.

The Aotearoa health system is facing increasing pressures due to unprecedented demand. In secondary care, active decisions to ration infrastructure investment, workforce training and budget spend have been made. Yet no coordinated approach to explicitly ration acute secondary care demand to match available resources has been implemented. The workforce would appear to be at breaking point. We must consider some important principles, issues and barriers if explicit rationing were to be implemented in a just and fair way.

Aotearoa’s health system is required to operate within the principles of several important legal documents, including: Te Tiriti o Waitangi, article 25 of Universal Declaration of Human Rights (1948), Right 8 of the New Zealand Bill of Rights Act (1990), the New Zealand Public Health and Disability Act (2000) and the Code of Health and Disability Services Consumers’ Rights. Importantly, these state that all people have rights to good health and access to necessary resources, and that no one individual should be deprived of life unlawfully or inconsistently with principles of fundamental justice. Such principles are to be pursued to the extent that they are reasonably achievable within the funding provided. District health boards (DHBs) are expected to operate in a financially responsible manner and endeavour to cover all annual costs. In addition, each DHB is required to be a good employer, which includes providing a good and safe working environment for its staff. However, there is no mention in these documents on the process or principles to apply should underlying resources not be able to meet the previously stated requirements. Although the concept of fundamental justice is incorporated in the New Zealand Bill of Rights, a clear and concise definition remains elusive.

Secondary care health services within Aotearoa would seem to be in crisis. The collective draft deficit of the country’s district health boards for the 2019–2020 financial year was reported to be $885 million. Fit-for-purpose functional infrastructure remains a major problem. Numbers entering the lengthy training programmes required to produce highly specialised healthcare workforces are tightly controlled at a national level, and projections are estimating a significant shortfall of medical staff. The average numbers of hours worked by medical staff are decreasing. These constraints are surfacing as major workforce issues. A provisional improvement notice has been served on at least three emergency departments by nursing staff this year alone, alongside nationwide industrial action. A study of Senior Medical Officers in Aotearoa reported up to 50% prevalence of burnout. Burnout is an important issue in health workforce due to its association with an increase in medical errors, reduced quality of care and withdrawal of individuals from the health workforce. Loss of health professionals from the public workforce leads to more pressure on those remaining and becomes a vicious cycle.

It seems clear there is a burning platform. Is it acceptable to continue to have unrestricted access to a hospital or service that has exceeded sustainable working conditions?

Active decisions have been made to ration the fiscal, infrastructure and workforce pillars required for a functioning secondary care health system. Yet there is not an explicit coordinated approach to rationing demand. The attempt to...
meet all healthcare needs would overwhelm any country’s resources, including the need for other social goods, such as education or law and order. Therefore, rationing in the public healthcare system is necessary to ensure a balance of social goods can be provided to optimise the overall wellbeing rather than just the underlying health of a society.

Rationing has long been part of Aotearoa’s health system. Widely publicised and respected examples include PHARMAC, access to solid organ transplantation and surgical waiting lists. There have also been efforts to prioritise health funding. However, the current workforce pressures in secondary care are being created by the acute demand. Patients presenting acutely currently benefit from a passive approach to rationing using a combination of the principles “first in, first out” or “sickest first” (Table). Yet resources in secondary care are in the main shared by elective services and in most public hospitals elective service means urgent and cancer-based conditions. Thus, those classified as “elective patients” are having their care rationed without following ethical process for scarce resource allocation. The current passive approach exacerbates waste and current inequities of the health system through lost opportunity and by favouring those with streamlined access to the system.

So why is acute demand not being explicitly rationed and whose responsibility is this? For individual health professionals, the fear of being vulnerable to criticism from society, colleagues or regulatory bodies means many take the path of erring on the side of intervention. Within the medical fraternity there is wide variation in acceptance of rationing. Some perceive a conflict with the Hippocratic oath. Individual clinicians may feel conflicted: should they advocate for the individual patient or the sustainability of the health system? Thus, a collective approach from society is required to tackle this issue. Even with a collective approach from society, the process itself may still fail, as participating individuals may remain uncomfortable with the moral responsibility of the role and prefer the decisions to remain implicit or have the appearance of randomness. Such an approach allows for unwanted variation and bias resulting in increased inefficiency and waste within the health system, further exacerbating the underlying problem. It leaves individuals within the workforce vulnerable to being held accountable for the expected outcomes of a flawed system.

There are several principles (Table) that have been suggested as ways of rationing healthcare, each with its own strengths and weaknesses. Mostly these have been applied as individual principles or in descending order to break stalemates between equivalent patients. There seems to be little literature on a multi-principle-weighted approach to rationing across the spectrum of acute healthcare. Western cultural values are often at the forefront of discussions, and there is a need in the context of Aotearoa’s health system to incorporate the principles of Te Tiriti o Waitangi. Western societies often place the individual at the centre of decision-making, whereas other cultures may centre decision-making around extended family or societal relationships.

If principles considering prognosis are to be included, consideration as to which metric should be used. Frailty scores may help provide estimates of remaining life expectancy and, potentially, may help ration by more than simply age. However, careful consideration would be needed if this were applied to the Aotearoa population, given the delayed presentation and potential worse prognosis at presentation of Māori and Pacifica populations. How to risk adjust or incorporate this into the decision-making would need to be addressed to avoid systemic bias. In a multi-principle-weighted model, a weighting for potential resources consumed either by time, cost or workforce should be considered.

Rationing has recently received increased attention due to the COVID-19 pandemic. Whether this refocused attention can subsequently be translated to help health systems beyond the pandemic is yet to be seen. Removing the taboo around such discussions in healthcare are critical if we are to achieve a fair, just and sustainable system. In terms of the principles of implementation, several authors stress the importance of following fair processes in such high stakes decisions. These include the need for a legitimate institution, transparent decision-making, reasoning according to information available, a plurality of principles that help address differing stakeholders’ values, a process for appeals and meaningful public engagement.

In terms of a legitimate institution, it would seem important for this to be independent of political, lobbyist or interest group interference. Consideration should also be given to a body that oversees resource use within the health sector specifically aiming to identify areas of “waste” within either system processes or medical interventions.
Table: Principles of rationing that could be applied to healthcare.

<table>
<thead>
<tr>
<th>Principle</th>
<th>Benefits or weakness</th>
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<tbody>
<tr>
<td><strong>Egalitarian: each person should have equal opportunity</strong></td>
<td></td>
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<tr>
<td>Lottery</td>
<td>This system is simple to administer and hard to corrupt but would be hard to consistently apply in emergency healthcare setting. Likely lead to some decisions that would be morally challenging to accept at an individual patient level.</td>
</tr>
<tr>
<td>First in, first out principle</td>
<td>Can occur passively in most systems but favours those with power and influence and can lead to corruption and inequities due to manipulation of the system. Can have flow on effects by creating inequity in other parts of the health system due to lost opportunity.</td>
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<tr>
<td><strong>Prioritarian: favouring those individuals with a specific health attribute</strong></td>
<td></td>
</tr>
<tr>
<td>Sickest first</td>
<td>This prioritises those who worst off right now but ignores potential prognosis or likely outcome. It finds favour in humans’ psychological responses to people near death in that they wish to intervene no matter how small the chance of success or likely benefit. It leads to ignoring those who may become sick but don’t yet qualify and hence may have worse prognosis when finally meet criteria for intervention.</td>
</tr>
<tr>
<td>Youngest first</td>
<td>Prioritises young over old to give all individuals equal opportunity to live a normal life span. Can be considered as prioritising those who likely to be most benefit to society in future.</td>
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<tr>
<td><strong>Utilitarian: maximising benefits</strong></td>
<td></td>
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<tr>
<td>Maximising total number lives saved</td>
<td>Aims to save the most lives, thus benefiting the greatest number but does not consider the quality or prognosis of those lives.</td>
</tr>
<tr>
<td>Maximising prognosis or total life years saved.</td>
<td>Maximises life years produced to the system, including accounting for quality or disability adjusted life years. Therefore, may sacrifice several people for benefit of one individual. Potentially biases against the elderly.</td>
</tr>
<tr>
<td><strong>Social value: based on past or potential future perceived social usefulness</strong></td>
<td></td>
</tr>
<tr>
<td>Instrumental value</td>
<td>Places preference or priority on those who have a perceived future value to society. Is open to manipulation and likely favours the powerful.</td>
</tr>
<tr>
<td>Reciprocity</td>
<td>Rewards those who are deemed to have added value to society in the past. This is open to manipulation and abuse.</td>
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Gaining consensus of the lay population, ethicists and medical professionals will be important. Although there is evidence of common ground, there is also evidence suggesting that these three groups may differ in their priorities of the guiding relevant principles. Building consensus and having a process that allows differences to be acknowledged while still finding a way forward will be important. A possible forum is the use of deliberative democracy in form of citizen juries, which were trialled during Aotearoa’s euthanasia debate. Potentially this is where the use of a multi-criteria decision-analysis support tool, such as 1000minds, could be advantageous. Such a tool allows patients to be prioritised according to defined criteria, with individual weightings, and for stakeholder preferences to be incorporated. It is possible lay stakeholders would engage in the above processes if there was a wider understanding of the extent of the total healthcare spend being used within the last 1,000 days of life. Currently, in the United Kingdom, one-third of the total healthcare cost is spent within the last 1,000 days of life. In Aotearoa, in-patient costs in the last year of life are eight-times higher in comparison to costs for age equivalent individuals who did not die in same time-period.

At a pragmatic level, understanding how this could be implemented in an acute inpatient setting is challenging. For example, could patients be pre-emptively categorised? Moosa et al proposed such a system for the use of dialysis in a middle-income country. Category 1 were patients eligible for full treatment. It was agreed the cap on dialysis would increase to meet this need. Patients in Category 3 were offered compassionate care alone. And patients in Category 2 were all patients in between. Category 2 patients were treated if resource was available at the time they required treatment. The cap, however, was not extended to enrol them in treatment. Could this be applied to a population such that predetermined Category 3 patients would not be admitted to secondary care but instead be offered compassionate care at home or in residential care. How such an approach could translate across a whole spectrum of emergency specialties and disorders is unknown.

The explicit and systematic application of rationing could better help Aotearoa society understand the limitations currently faced by the health system. It would allow people to think ahead and potentially reconsider how they plan to use their wealth as they age. It may stimulate the government to think about creating an equivalent of a “Cullen fund” for health. At a micro-allocation level, by pre-emptively and explicitly making these decisions at a population level, the burdens and bias associated with individuals making such decisions are removed. It would have the advantage of removing unwanted variation in clinical decision-making and reduce the frequency of futile treatment. Both of which are expensive hidden costs within the current health system.

These conversations would allow Aotearoa to reconsider the purpose of the health system. Is “cradle to the grave” philosophy still appropriate, sustainable or affordable? Should the purpose be to provide equity of healthcare access and outcomes to a certain point? For those individuals privileged enough to live beyond the agreed outcome, self-funding would be required. This is accepted with other social goods. Should health be any different?

These are challenging conversations that many don’t wish to have. However, by avoiding them unwanted variation and bias flourish within the AHS. Is it morally and ethically acceptable for a generation of health privileged individuals to leave a legacy of financial debt and a decimated workforce in pursuit of delaying an inevitable death at any cost?
COMPETING INTERESTS
Nil.

AUTHOR INFORMATION
Saxon Connor: Hepato-pancreato-biliary (HPB) Surgeon, Department of Surgery, Canterbury District Health Board, Christchurch.

CORRESPONDING AUTHOR
Dr Saxon Connor, Hepato-pancreato-biliary (HPB) Surgeon, Department of Surgery, Canterbury District Health Board, Christchurch, Private bag 4710, 03 3640640
saxon.connor@cdhb.health.nz

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