National Ethics Advisory Committee
Kāhui Matatika o te Motu

ETHICAL ISSUES IN ELECTIVE SERVICES: NEAC REPORT TO THE MINISTER OF HEALTH, 15 SEPTEMBER 2006

EXECUTIVE SUMMARY

The National Ethics Advisory Committee (NEAC, the Committee) has been working on ethical issues in elective services and would like to meet with you to discuss this work.

NEAC is well positioned to provide an independent view on ethical issues in elective services. The development of the Committee's work draws upon the credibility and expertise of NEAC members and is strengthened by the Committee's collaborative relationships with stakeholders, including the Ministry of Health.

The Committee has taken a whole-of-system approach to this work, considering the overall design of the electives pathway and its interaction with other parts of the New Zealand health system. This has resulted in the identification and discussion of a number of ethical issues in elective services. These are presented below with the intention of informing policy development and motivating further examination.

In NEAC's view, the ongoing development of elective services should be more explicitly built around the patient-centred idea of the 'electives pathway'.

Adoption of this idea would highlight the full set of steps at which things must work well for patients.

NEAC has not identified any ethical issues with the overall concept of a 'booking system' approach within the electives pathway and considers that there are potential ethical advantages.

The Ministry of Health currently addresses ethical issues as part of its ongoing work on elective services. NEAC endorses this approach and suggests that the Ministry use NEAC's findings to inform its work in the following areas:

- equity of access issues
- quality and national consistency
- centrality of the health professional-patient relationship
- the basis of prioritisation for elective services.

NEAC considers that there are some issues about the overall design of the electives pathway, and its interaction with other parts of the New Zealand health system, that merit further examination. There would be value in having these issues considered through a process that includes wide health sector and public input. This wider project could be introduced alongside specific initiatives being planned for elective

services, and could be carried out over a longer time frame. The following issues could be included in this work:

- the 'first specialist assessment' step
- relations between elective services and acute services
- relations between public and private sectors.

BACKGROUND INFORMATION

1. The National Ethics Advisory Committee (NEAC, the Committee) began work on elective services following a letter from the Canterbury Ethics Committee that expressed concerns about implementation of the 'booking system' approach in its region. NEAC replied to this letter that ethical issues were addressed in the process that led to introduction of the 'booking' approach to elective services. The Committee also undertook to examine ethical issues identified in written work completed since that time.

2. In July 2003, the Hon Annette King noted that NEAC was taking the limited steps outlined above.

3. In February 2005, NEAC completed a scan of literature reporting research and developments relating to New Zealand's booking system approach to elective services. The Committee copied this report to the Ministry of Health. The Ministry has been using the findings to inform its work on further development of elective services.

4. NEAC informed you about its work on elective services in November 2005 (Committee Report 20059145). You discussed this work briefly in a follow-up meeting with the NEAC Chair in February 2006. In particular, the idea of the patient-centred 'electives pathway' was raised.

5. As you agreed (Committee Report 20061467), NEAC presented the direction of its thinking on elective services at a Multi-specialty Forum on elective services hosted by the Ministry of Health in July 2006.

6. NEAC outlined its elective services project to a meeting of District Health Board (DHB) Chief Medical Advisors in July 2006. In August 2006, NEAC also presented the direction of its thinking on elective services to a meeting of the National Health Committee, of which the NEAC Chair is a member.

7. NEAC has liaised with the Ministry's elective services group throughout conduct of its project.

8. In conducting its work on elective services, NEAC has not consulted with patients, health sector stakeholders beyond those stated above, or the wider public. The Committee consequently regards its findings as indicative rather than definitive. Wider sector and public input would be valuable for the further work suggested by NEAC on the electives pathway and its interaction with other parts of the health system.

COMMENT

9. This section of the report introduces the concept of the patient-centred 'electives pathway'; comments on issues of resource limitation in elective services; addresses the 'booking system' approach within the electives pathway; notes some ethical issues within elective services that can be addressed by the Ministry of Health as part of its ongoing development work; and raises a number of wider issues that could be further examined through a process that includes health sector and public input.

The 'electives pathway' for patients

10. Elective services are those not immediately needed to prevent death or other serious harm. They contrast with acute services, which are immediately needed to prevent death or other serious harm. In both policy and practice, however, it can sometimes be difficult to distinguish sharply between elective and acute services.

11. For a patient with a health concern, the first step toward receiving an elective service is typically a general practitioner (GP) appointment. Patients must also take further steps. They consequently need their overall electives pathway, and each of the steps within it, to work well for them.

12. The electives pathway includes the following steps (the diagram attached as appendix one presents these steps with further contextual detail):

    - Consult GP
    - GP referral prioritised
    - Have first specialist assessment (FSA)
    - Scored for priority
    - Booked for elective service
    - Have publicly funded elective procedure
    - Have any follow-up

13. NEAC considers that elective service developments should be structured explicitly around the patient-centred idea of the 'electives pathway'. This will parallel patient-centred developments in chronic care (e.g., current Ministry of Health work on 'Leading for Outcomes, chronic condition management'), in screening (e.g., the 'screening pathway' described by the National Screening Unit), in acute care (e.g., Improving the Patient Journey Project, Canterbury District Health Board); and also in disability support (e.g., the National Health Committee report, *To Have an 'Ordinary' Life*).

14. In your recent speech 'Cost-effectiveness in the New Zealand Health System', you noted further examples where "improvement is secured by viewing processes through the eyes of a patient".

The fact of limited resources

15. NEAC considers that the potential benefit to patients from elective services will always outrun the publicly funded resources available to deliver these services. This is the fact that there are limited resources for publicly funded elective services.

16. The Committee considers that there will also always be debate about what is the appropriate level of resources to make available for elective services, alongside debate about resources for other public priorities.

17. NEAC notes and endorses the leading work on practice issues in this context by the Medical Council of New Zealand: *Statement on safe practice in an environment of resource limitation*, October 2005.

18. Where there are limited public resources, NEAC considers it is a health professional responsibility to determine, on nationally consistent, fair, and open grounds, which patients should be given priority to be offered services.

19. When patients have been prioritised relative to one another, they are entitled to know whether or not they will be offered an elective service in a timely way from within the available publicly funded resources. In general, health professionals do not determine what level of resources will be made available for these services. This means that others – in particular, policy-makers and health service managers – share with health professionals the responsibility for whether or not patients will be offered publicly funded elective services.

20. Maximising cost-effectiveness is an important part of minimising the impact of resource limitation. For example, it is part of meeting the obligation to maximise the care provided within limited resources.

The concept of a 'booking system' approach

21. Since the mid-1990s, New Zealand has been implementing an internationally distinctive 'booking system' approach within its electives pathway. Key principles underlying the 'booking system' are clarity, timeliness and fairness.

22. NEAC has not identified any ethical issues with the overall concept of a 'booking system' approach within the electives pathway and considers that there are potential ethical advantages.

23. The 'booking system' approach has two key features. The first is the development of tools to 'score' patients for their priority to receive a publicly funded elective service. Informed by this 'priority scoring' step, the second key feature is a 'booking step', to inform patients whether or not they will be offered the service, and, for those who accept such an offer, to book the service for delivery to them within a defined period.

24. NEAC considers that the 'priority scoring' step has potential ethical advantages over alternative approaches, because it emphasises explicit rather than implicit

bases for prioritisation, and it aims to prioritise amongst patients on nationally consistent grounds.

25. NEAC considers that the 'booking' step also has potential ethical advantages over alternative approaches, especially in terms of patients' rights to know whether or not they will be offered a publicly funded elective service, the grounds for this decision, and that any such service will be delivered in a timely way.

26. NEAC considers, however, that it is more difficult than many recognised in the mid-1990s to achieve in practice the ethical advantages of the 'booking system' approach. The Committee comments further below about ongoing challenges to be addressed at the 'priority scoring' and 'booking' steps in the electives pathway.

27. Since the mid-1990s, development of New Zealand's electives pathway has tended to focus on this country's distinctive 'priority scoring' and 'booking' steps. The electives pathway also includes other steps that are equally deserving of sustained attention.

Ethical issues within the electives pathway

28. NEAC notes that the Ministry of Health addresses ethical issues as part of its ongoing work on elective services. The Committee endorses this approach. It also states its findings on such issues below, and recommends that the Ministry use these to inform its ongoing work.

Equity of access

29. NEAC's work on elective services has identified some equity issues in the electives pathway that merit ongoing attention. Detail on these issues is contained in the NEAC literature scan copied to the Ministry of Health in February 2005.

30. There is evidence that access to some elective services (e.g., cardiac surgery) has been relatively low for Māori and Pacific people. In general, these levels of access should instead be relatively high, due to the higher prevalence of disease in Māori and Pacific populations. Some recent evidence suggests this situation may be improving. Further work in this area is also appropriate.

Quality and national consistency

31. NEAC considers that those who develop 'priority scoring' tools should assess the capability of these tools to predict beneficial treatment outcome (predictive validity). Such assessment would further enhance the quality and consistency of tool use.

32. Implementation of some elective services developments has been variable across regions. In some cases, for example, different 'priority scoring' tools have been implemented in different places for the same condition. The level of resource available for particular elective services can also vary across district

health boards. Such variations can make it difficult to monitor and improve equity and access to services.

Centrality of the health professional-patient relationship

33. The health professional-patient relationship is crucial to quality elective services. NEAC considers that the 'booking system' approach within the electives pathway must be carefully managed to ensure it does not compromise the health professional-patient relationship and good outcomes for patients.

34. At first specialist assessment (FSA), it is important that the health professional and patient discuss the risks and benefits of any options involving publicly funded elective services, and also the risk-benefit of any other options. Where relevant to the patient's situation, 'priority scoring' should generally be part of these discussions. If priority scoring is instead done later, or by a third party (e.g., by a consultant's secretary or a booking system administrator), this can harm the health professional-patient relationship and compromise good outcomes for the patient. One risk is that the 'priority scoring' tool then becomes the decision-maker, instead of being the *aid* to health professional and patient decision-making that it should be. There is also a related risk of compromising informed health professional-patient discussion of all the available options and their risks and benefits.

35. To improve each step within the electives pathway, and to assist nationally consistent implementation of these improvements, it is important that health professionals and their national organisations continue to play leading roles (e.g., by leading development of 'priority scoring' tools, by acknowledging that prioritisation is a professional responsibility, and by endorsing validated tools for nationwide use).

The basis of prioritisation for elective services

36. The two established bases of prioritisation for elective services are need and benefit. NEAC endorses both of these. There is a 'need requirement' because it is inappropriate to offer a publicly funded elective service to a patient who would benefit but does not *need* it. Some 'enhancement' surgery may be of this sort. There is a 'benefit requirement' because it is inappropriate to offer a publicly funded elective service to a patient who has no real prospect of significant benefit from it.

37. NEAC's work has identified that the 'need' and 'benefit' bases for prioritisation are often closely aligned. For conditions that include cataracts and prostate enlargement, there is evidence that measures of need before the procedure (in particular, measures of patient-experienced health status) are the best predictors of patient benefit from the procedure. The Committee also acknowledges, however, that 'need' and 'benefit' are likely not to be aligned in this way for all conditions.

38. Within the 'benefit' basis for prioritisation, NEAC considers that a focus on 'patient-experienced' measures of benefit is appropriate to the patient-centred nature of the electives pathway. The Ministry has been taking up this point by

emphasising 'impact on life' measures of benefit. NEAC endorses this Ministry move.

Design issues about the electives pathway

39. NEAC considers that there are some issues about the overall design of the electives pathway, and its interaction with other parts of the New Zealand health system, that merit further examination. There would be value in having these issues considered through a process that includes wide sector and public input. This would provide the opportunity to involve sector groups in constructive engagement on the development of elective services. This wider project could be introduced alongside specific initiatives being planned for elective services, and could be carried out over a longer time frame. Outlined below are three issues that could be included in such a project.

The 'first specialist assessment' step

40. New Zealand's current definition of first specialist assessment (FSA) is: "The first assessment by a registered medical practitioner or nurse practitioner for a particular referral (or, with self-referral, for a discrete episode). The healthcare user receives treatment, therapy, advice, diagnostic or investigatory procedures at a health care facility and leaves within 3 hours of the start of the consultation. Excludes Emergency Department attendances and outpatient attendance for pre-admission assessment/screening." (Cited in: *Addressing Disincentives Working Party Report*, 10 May 2006).

41. One key question is whether patients should be entitled to access timely FSA on GP request, or whether further conditions should also be met if patients are to access this step in the electives pathway.

42. If patients should be entitled to access timely FSA on GP request, this has potential resource implications that would need to be considered further alongside other priorities for the use of limited elective services resources.

43. If patients' access to timely FSA should also depend on the *clinical appropriateness* of the GP referral, it would be important to check that existing criteria for access to FSA are robust enough to enable GPs and specialists to decide whether referral of particular patients for FSA is clinically appropriate.

44. If patients' access to timely FSA should also depend on *availability of resources*, it would be important to check that existing criteria for access to FSA are robust enough to enable health professionals to determine, on nationally consistent, fair, and open grounds, which patients should be given priority to be offered FSA. Patients for whom a publicly funded FSA would be clinically appropriate, but who would not have enough priority to be offered it, might need to be offered an alternative step. This would parallel the 'active review' step that has been developed for patients who would benefit from, but do not have enough priority to be offered, a publicly funded elective service.

45. NEAC notes and endorses the Health and Disability Commissioner recent work on consultant, District Health Board and GP responsibilities in relation to the provision of FSA. (Case 04HDC13909).

46. The current definition of FSA (see paragraph 40 above) notes a range of important purposes that FSA can serve for patients. NEAC considers that further examination of this range of purposes would be valuable. For example, this might enable some innovations to be identified in how, where, and by whom FSA could be delivered in various clinical settings in future, within scopes of practice and quality requirements. Such innovations may extend the capacity of medical specialties to secure more services for patients from within available resources. This might be achievable in part through drawing on the specialist expertise of other health professionals to provide FSA services where appropriate.

47. Elective Services Performance Indicators (ESPIs) are used to monitor how patients are managed, and to assess system performance. There is at present no ESPI to report the number of patients who are referred from primary care, but to whom no offer of an FSA is made. NEAC considers that systematic collection of this information would provide important insights into equity of access, any unmet need, and quality of communication between primary and secondary services, at this key step in the electives pathway. These insights would be valuable whether or not patients should be entitled to access publicly funded FSA on GP request.

Relations between elective services and acute services

48. New Zealand's publicly funded health system embodies a commitment to the priority of acute care over elective care. This is reflected in many arrangements to enable re-allocation of resources from elective services to acute care when the need arises. There is also a current policy commitment to 'clarity of access' for electives, emphasising patients' entitlement to know whether and when they will be offered a publicly funded elective service. NEAC considers that there is potential for tension between these two commitments, and consequent potential for ongoing challenge in meeting them both. The scale of the challenge depends on the extent to which variations in demand for acute services are predictable and manageable, and on the rate of any growth in acute demand. There would be value in further examination of this question.

49. NEAC notes that in some areas of clinical specialty, relations between acute services and elective services are addressed in part by considering them together within prioritisation tools. For example, the most recent 'priority scoring' tool for coronary artery bypass grafts (CABG) addresses both in-hospital cases and new admissions.

50. NEAC considers that any general change from the established priority of acute services over elective services would need to involve wide sector and public discussion.

Relations between public and private sectors

51. Publicly funded hospitals interact with privately owned primary care practices at many points in New Zealand's electives pathway. These points include GP referral, active review, and patient follow-up. Quality public-private relationships at all these points are important to securing good outcomes for patients.

52. Some studies have highlighted issues of equity of access to FSA. In particular, New Zealand patients are permitted to pay to access FSA in the private sector or to have private insurance meet this cost, and then to re-enter the publicly funded hospital system to receive their elective service. Where waiting time to access the publicly funded system can differ in this way according to ability to pay or insurance status, NEAC considers this to be of significant ethical concern.

53. NEAC considers that New Zealand's system of allowing the 'dual practice' of medical specialists in both the publicly funded and privately funded sectors has systemic potential to generate conflicts of interest. The Committee considers that, alongside the potential benefits of dual practice, these risks for the publicly funded electives pathway should also be recognised and addressed.