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Explicit rationing of elective services: implementing the New Zealand reforms

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Abstract

In an attempt to make rationing of elective surgery in the publicly funded health system more explicit, New Zealand has developed a booking system for surgery using clinical priority assessment criteria (CPAC). This paper is based on research undertaken to evaluate the use of CPAC. To explore whether the goals of explicit rationing were being met 69 interviews were undertaken with policy advisors, administrators and clinicians in six localities throughout New Zealand. The aims of reforming policy for access to elective surgery included improving equity, providing clarity for patients, and achieving a paradigm shift by relating likely benefit from surgery to the available resources. The research suggests that there have been changes in the way in which patients access elective surgery and that in many ways rationing has become more explicit. However, there is also some resistance to the use of CPAC, in part due to confusion over whether the tools are decision-aids or protocols, what role the tools play in achieving equity and differences between financial thresholds for access to surgery and clinical thresholds for benefit from surgery. For many surgical specialties implicit rationing will continue to play a major part in determining access to surgery unless validated and reliable CPAC tools can be developed.

Keywords: Rationing; Prioritisation; Elective surgery; Protocols; Primary–secondary care interface; Waiting lists

1. Introduction

New Zealand has been identified as a developed country with exceptionally long waiting times for elective health services, with many people waiting over a year for operations [1–3]. Waiting lists have been a serious political issue, with significant media attention paid to the length of waiting lists, the times people wait for care and the consequence of waiting on physical and mental health.

Considerable effort has been made in New Zealand in recent years to move away from a system of implicit rationing, where discretionary decisions were made

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within fixed budgets, to a system of explicit rationing, where the rules of allocation are more transparent [4]. Other countries and states have pursued the same objective, examples including the Oregon Medicaid Initiative where limits were placed on which treatments would be provided [5], and the Western Canada Waiting List project where tools have been developed to manage waiting lists [6].

In relation to waiting lists in New Zealand, the Core Services Committee (CSC, later known as the National Health Committee or NHC) began this process by commissioning a report in 1993 on the management of waiting lists. The report noted that different approaches were being used to decide which patients to put on a waiting list; that some patients were more able to "work the system" to obtain care earlier than others; and that patients (and their GPs) were not clear about when or even whether they may get treatment. There was also no clarity about whether patients getting care were those with the most to gain from treatment [7]. The report recommended that waiting lists be replaced by booking systems; and that criteria for accessing elective care be developed, based on need and ability to benefit ("likely outcome from this procedure in this patient at this time") [8].

The CSC commissioned a number of national working groups to begin to develop tools for assessing need, ability to benefit and likely outcomes from care, to support a more explicit approach. Conditions initially covered were cataract surgery, coronary bypass surgery and angioplasty, hip and knee joint replacements and prostate surgery [9–11]. Some research was undertaken in an attempt to establish reliability and validity during the early stages of tool development [12–17]. Work then continued over the next few years on the development of priority assessment criteria to assess patients and on the implementation of a booking system to replace waiting lists [9,10].

In the 1994/1995 policy guidelines from the Minister of Health to New Zealand's four regional health authorities (RHAs),[1] RHAs were asked to consider recommendations to move from waiting lists to booking systems and to develop priority assessment criteria. RHAs were to report back to the Ministry of Health on how these might be achieved [18]. Policy guidelines for the 1995/1996 year recorded the progress some RHAs had made in relation to joint projects with the Core Services Committee, and noted that:

> The government wants to build on these initiatives. Appropriate management of waiting lists means that clear priority criteria are established so that the most urgent patients are treated first and that patients know their relative priority and time for treatment [19].

Policy guidelines for the 1996/1997 year stressed the importance of reducing waiting times and implementing patient booking systems based on priority assessment criteria. The government noted that a long-term goal was achieving consistency in the criteria used to assess and prioritise patients for elective surgery. The date for implementation of the system was set for June 1998, by when all patients eligible would be booked for surgery to occur within 6 months of assessment [20]. Urgent cases would continue to be treated immediately.

Additional funding was provided over a number of years to clear the backlog of people waiting for care and to facilitate the introduction of the system. Additional funding was only available where clinical priority assessment criteria (CPAC) and booking systems were in place, where audits of waiting lists were completed, and where financially sustainable thresholds were established to determine access [10].

A single national purchaser, the Health Funding Authority (HFA), was established in 1997, bringing together the work of the four RHAs on waiting times into one project (the National Waiting Time Project, later the Elective Services Group). Although it was recognised that wide variation existed across the country with respect to tool development [21], a national framework for waiting times was developed [22]. An Elective Services Policy Unit was also formed in the Ministry of Health in 1998. Regular reporting on progress implementing the policy began in 1999 [23].

Despite changes of government, the elective services policy continues [24]. There are now CPAC for 31 surgical and medical procedures available on the Ministry of Health website[2] and developed through the Elective Services Group. Different early approaches taken to surgical prioritisation by various regions has led to the development of different tools for the same

[1] Regional health care purchasers.

[2] http://www.electiveservices.govt.nz/.