

Rationing in Healthcare: whether we know it or not. The Case for Explicit Prioritization.

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What would you want your family to do?

- You collapsed at work today— you are now in a coma at POSGH.
- Your prognosis is not good: an experimental drug can be brought in which can give a 5% chance of partial recovery when administered within 8-10 days in ICU.
- The Minister of Health spoke about your case on the news tonight saying that the health system is very capable of delivering modern treatments, and that the M-O-H is able to pay the \$340,000 for the drug and the \$220,000 for the ICU, so there will be no cost to your family.
- Your physician has asked your family to make a decision as to whether to proceed with the treatment.

To fund this treatment, some other initiatives will have to be put on hold. These include:



Shalini is in Standard 3 and has come first in her class. She wants to be a teacher like her mom. She suffers from an aggressive childhood leukaemia which must be treated abroad. Treatment costs US\$90,000 and the success rate is 95%.



Shaquil lives in Bonasse (South Trinidad). He suffers with ILD (a sometimes fatal illness) and needs to take a special drug that costs \$800 per dose twice per week. The ministry of health can scale the provision of these high cost/infrequently used drugs back.

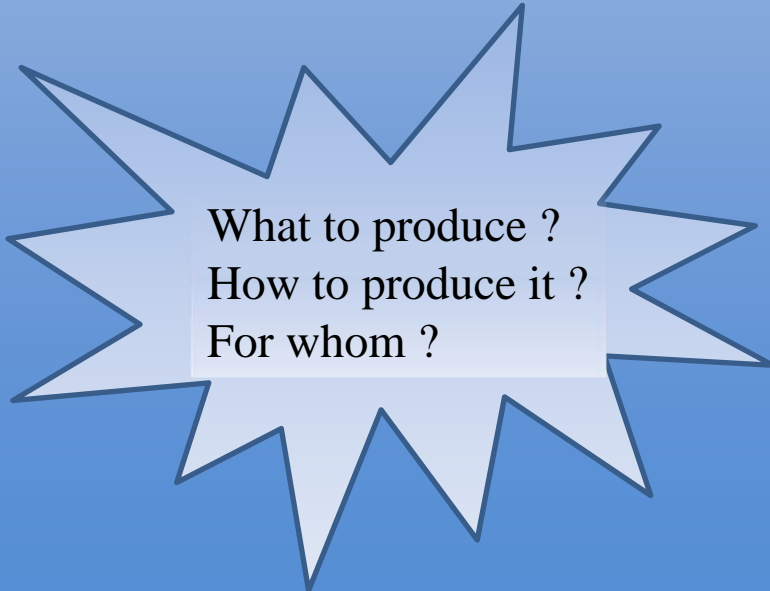
Now, what would you want your family to do? Does this new information change your decision?

Background: The Fundamental Economic Problem in Health.

- Health needs are infinite
- Resources available to health are finite

→ Scarcity

→ Choice



What to produce ?
How to produce it ?
For whom ?

Implicit Rationing based on:
Historical Line Item Budgeting
Epidemiological Data
Policy Decisions: M-O-H, MLAs

Unmet Need in T&T: 6 Clinical Areas

| | Patients Per Year | | | Est Average Cost (US\$ k) per case | Est cost of current throughput (US\$ k)/yr | Est cost of providing unmet need(US\$ k)/yr |
|-----------------------------------|-------------------|-------------------|--------------|--|--|---|
| | Needed | Actually Provided | 'Unmet' Need | | | |
| <u>Cardiology</u> | | | | | | |
| Stenting | 975 | 200 | 775 | 15 | 3,000 | 11,625 |
| CABG | 975 | 180 | 795 | 19 | 3,420 | 15,105 |
| Pharmaceuticals | 1800 | 1600 | 200 | 2(per pt/yr) | 3,200 | 400 |
| | | | | | 9,620 | 27,130 |
| <u>Renal Failure</u> | | | | | | |
| Dialysis | 1100 | 730 | 370 | 40(per pt/yr) | 30,000 | 14,800 |
| <u>Morbid Obesity</u> | | | | | | |
| Gastric Bypass | 250 | 30 | 220 | 15 | 450 | 3,300 |
| <u>HIV</u> | | | | | | |
| ARV | 30000 | 20000 | 10000 | 0.4(per pt/yr) | 8,000 | 4,000 |
| <u>Orthopaedic Surgery</u> | | | | | | |
| Hip Replacement | 150 | 70 | 80 | 13 | 910 | 1,040 |
| Knee Replacement | 350 | 220 | 130 | 9 | 1,980 | 1,170 |
| | | | | | 2,890 | 2,210 |
| <u>Diabetes</u> | | | | | | |
| Self Monitoring of Blood Glucose | 140,000 | 20,000 | 120,000 | 0.06 (per pt/yr) | 1,200 | 7,200 |

Some Indicators:

| Life Exp | At Birth | | At Age 60 | |
|----------|----------|------|-----------|------|
| | 1990 | 2009 | 1990 | 2009 |
| T&T | 69 | 70 | 17 | 19 |
| Americas | 71 | 76 | 20 | 22 |

| IMR | 1990 | 2010 |
|--------------|------|------|
| T&T | 28 | 24 |
| World Median | 27 | 18 |
| Americas | 23 | 14 |
| St. Kitts | 13 | 7 |

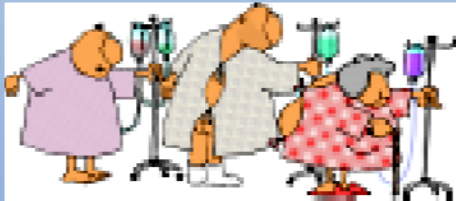
| T&T Spending | 2002 | 2011 |
|--------------|------|------|
| US\$ THE/Cap | 331 | 956 |
| US\$ GHE/Cap | 169 | 506 |

Explicit vs Implicit

- Prioritization = Rationing !
- Explicit Prioritization:
 - based on clear criteria that guide prioritization decisions, and these criteria are well understood by all involved parties.
- Implicit Prioritization:
 - No such clear criteria.

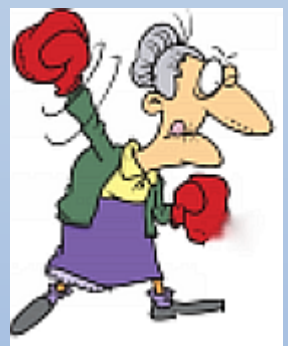
CHOICES:

Drugs
Programmes
Interventions
Equipment
Patients
Hospitals
Computers
Doctors
Nurses
Supplies
.....

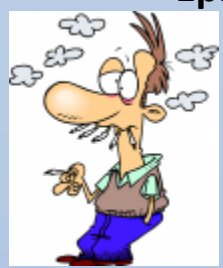


INFLUENCES

Demographic Changes

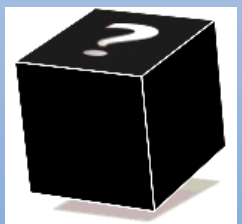


Epidemiological Changes

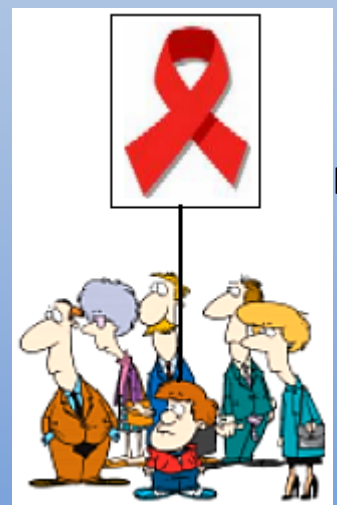


Producers of Inputs

'Other Influences'



Interest Groups



Clinical Professionals



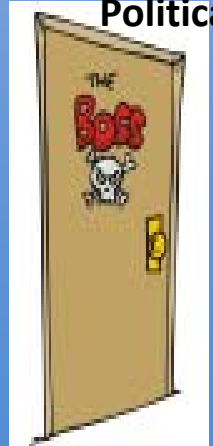
Donors; MLA's



Bureaucrats



Political Agenda



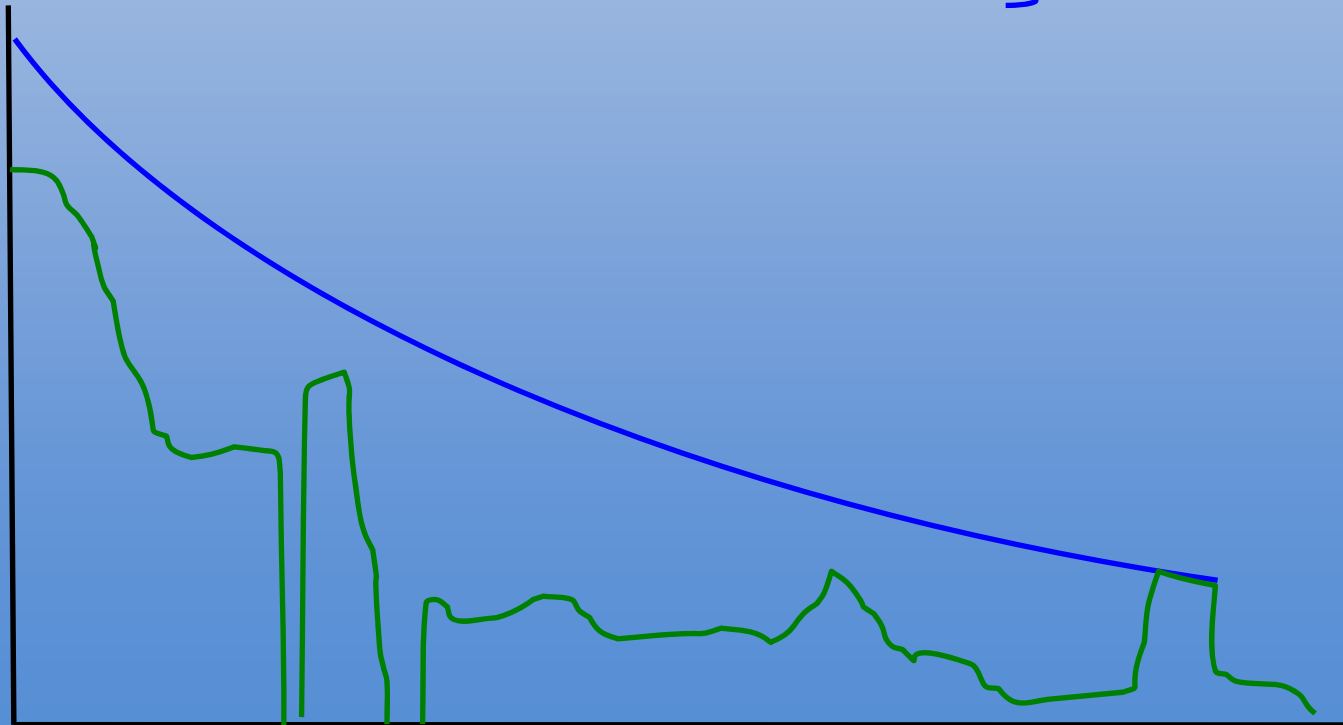
Gains from E-P:

- The least effective HIV interventions produce less than 0.1% of the 'health' produced by the most effective HIV interventions.
- Reallocation can result in a 1000x increase in DALYs produced (Glassman & Chalkidou 2012)

Explicit Prioritization

- Objectives of the health system:
 - Maximize Population Health
 - Minimize Differences in health

Set of Rules



Prioritization Approaches:

- Prioritization Category
 - What we are prioritizing *between*
 - Examples?
- Prioritization Criteria
 - What we are prioritizing *by*
 - Efficiency
 - Equity
 - Other

Explicit Prioritization

- Challenges:
 - The ‘set of rules’.
 - Measuring health
 - Dealing with equity
 - Identifying the scope
 - Implementation
 - Political, social reality
 - Resource & data requirement
 - Complex problem

Explicit Prioritization

- Lessons from International Experience:
 - Start small & develop agenda
 - Methods to inform –not replace- decision making
 - HTA Agency
 - Careful involvement of the public
 - Clinical Guidelines vs service exclusion.
 - Marginal Decision making
- Recommendation for T&T:
 - PBMA

Thank You!