

Prioritization versus rationing of healthcare – elective surgery is not optional surgery

HOW SHOULD PRIORITY BE ASSESSED TO ENSURE EQUITY?



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The effect of COVID-19 on healthcare services has contributed to millions of patients waiting for planned hospital treatment; in England alone, more than six million are waiting, of whom more than 700,000 are orthopaedic patients.¹ It is estimated that those awaiting surgery will more than double to over 13 million by the end of 2022.² A healthcare system not meeting demand may not be considered an equitable healthcare system.

Patients deteriorate on waiting lists, with worsening health-related quality of life.³ Rationing is inevitable when demand exceeds capacity to deliver, and is always a difficult subject in universal healthcare systems such as the NHS.⁴ However, the need to restrict the allocation of resources during the initial wave of the COVID-19 pandemic was widely understood and accepted.⁵ An alternative concept to rationing would be the prioritization of services to those who are thought to benefit the most from the intervention.⁴ Prioritization does not withhold treatment from patients, but would result in those with a lower priority waiting longer.

Patients are currently prioritized according to time spent on the waiting list, or by subjective tools such as The Federation of Speciality Surgical Associations (FSSA) criteria (P1a < 24 hours, P1b < 72 hours, P2 < 1 month, P3 < 3 months, P4 > 3 months).⁶ Patient priority level P2 – surgery within one month – includes joint arthroplasty ‘where delay will prejudice outcome, however this is not defined. Patient priority level P3 – surgery within less than three months – includes revision joint arthroplasty, avascular necrosis, or patients going off their legs. Patient priority level P4

– surgery within more than three months – includes ‘joint arthroplasty’. However, these priority levels were devised early in the COVID-19 pandemic, and patients listed six to 12 months ago may have had symptom progression and clinical deterioration, and their priority may need to be reassessed. Furthermore, not all patients listed as P4 priority level will be equal, with varying degrees of impairment of both joint-specific and general health-related quality of life.^{7,8}

There is an urgent need to subdivide this last category, as many patients with a non-cancer diagnosis do not have a benign condition. Time and symptom severity are accounted for in the Federation of Surgical Speciality Associations (FSSA) prioritization document, according to level of clinical harm, where those patients felt to be at moderate risk (reduced functional status, severe pain, psychological harm) can be upgraded to a P3 or P2. The need for prioritization ‘tool kits’ has been identified as a key component for equitable delivery of healthcare in times of restricted resources.⁹

Patients are commonly prioritized according to the time they have spent on a waiting list and/or surgical factors.^{10–13} However, patients most in need of expeditious surgery may not receive it if this criterion is applied. Currently, surgical procedures are categorized as outlined above. Unfortunately, this system designates a large cohort as P4, who are destined to wait many months or years for treatment. Within this P4 cohort, there are patients whose baseline quality of life is so poor that they rate their health-related quality of life as ‘worse than death’. It also includes,

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without identifying them, patients who are steadily deteriorating while waiting for surgery. In general, for each six-month period spent on waiting for a hip or knee arthroplasty, there is a clinically significant deterioration in the patient's quality of life.³

Employing prioritization tools may result in the potential for 'gaming', with patients modifying their scores/symptoms to obtain their surgery at an earlier timepoint, but this is not consistent with patient opinion.¹⁴ There is also the question of how often patients should be reassessed and re-prioritized while on the waiting list, which may simply be down to resource allocation. However, in the knowledge that every six months waiting for surgery is associated with a clinically significant deterioration in quality of life,³ this would seem a potential regular timepoint for reassessment while awaiting surgery.

Resource management within universal healthcare systems such as the NHS is driven by prioritization, where acute life-threatening conditions and cancer are given priority. One option would be to provide the most cost-efficient procedures/interventions to ensure that the maximum benefit can be obtained from the limited resources available. Hip and knee arthroplasty are among the most cost-effective interventions available in medicine.¹⁵ The health-related quality of life of patients on waiting lists across the UK is, according to the EuroQol five-dimension (EQ-5D) utility index – where 1 is perfect health and < 0 is a health state worse than death – 0.24 for total hip arthroplasty and 0.34 for knee arthroplasty.³ This is a lower quality of life than that observed in other morbidities such as diabetes (0.78),¹⁶ heart failure (0.64),¹⁷ chronic obstructive pulmonary disease (0.52),¹⁸ or stroke (0.40).¹⁹ However, unlike these morbidities, the effect of arthritis on a patient's quality of life is reversible with surgery.¹⁵ There are also cost implications for long waits for arthroplasty surgery. Patients become deconditioned, continue to consume healthcare resources needed to manage pain and functional loss, lose independence, and their perioperative risks potentially increase with reduced fitness and increased opioid use.²⁰ Getting It Right First Time (GIRFT) is now a key enabler for healthcare systems working on the High-Volume Low Complexity programme, supporting elective recovery and the development of standardized patient pathways across regions to ensure maximal efficient use of the limited resources.²¹ However, operating on patients with the poorest health-related quality of life, such as those prioritized as P3 or P2, may reduce elective capacity with increased surgical complexity and lengths of stay for frailer individuals.

Prioritization tool kits are urgently needed in orthopaedics, and potentially across surgery, to help deliver healthcare to those patients who need it most. Elective surgery is important healthcare.

Before the pandemic, there was insufficient capacity for planned surgery with rising waiting lists in a number of administrations.²² COVID-19 has amplified a pre-existing crisis. There is a pressing need to permanently

increase the capacity to deliver year-round 'elective' surgery, which is not 'optional surgery' but simply means it can be scheduled. This would be good for patients and good economics. However, ahead of this, prioritization tools may be the most appropriate way of deciding how long an individual must wait for surgery. These should be based on the severity of the impact on quality of life, the rate of decline while waiting for treatment, and whether delay of the intervention impairs the outcome.

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