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Prioritising: Is it the Way to Counter Today's Economic Crisis within the Healthcare System?

In response to the current economic constraints within healthcare systems, different action plans and reforms, including tax increases, have been deployed to decrease the se and to increase healthcare's effectiveness. It is, however, the time to realise that these measures are not enough and prioritisation might be the only way to cure this chronic condition.

Worldwide, healthcare systems have been struggling with higher costs and demands of becoming more cost-effective. The discrepancies between increased costs and an economic retrenchment can be handled in five different ways:

- 1) Increase resources financed by either the state or different individuals;
- 2) Supervision of either demands or access to healthcare (through dividing costs);
- 3) Elimination of ineffective activities or replacing them with cheaper alternatives;
- 4) Increase the effectiveness of the service provision; and
- 5) Create possibilities to prioritise.

Experiences from England and Germany show that none of the four first alternatives have proven to be sufficient or possible to carry out, but prioritising (rationing) (Abel-Smith et al. 1995; Smith 1993).

Priorities are about choosing how to use our public and private resources best. It is a process by which different operators on political, administrative or clinical level make well-aware or unconscious decisions about order of precedence between different activities or group of patients. The decision, in turn, leads to certain consequences for the resource distribution and the activity's performance and thereby the healthcare's direction and contents (Hope et al. 1996; Kohn 2000; Cho et al. 2005). Priority within healthcare services is either economic or non-economic. In the former, the healthcare budget is considered to be insufficient during longer time ahead. Thus, the production costs (e.g. technology, personnel) within the healthcare are, and remain costly. The non-economic priority is a process that happens irrespective of the economic access and is influenced by other factors e.g. medical factors (Harrison et al. 1997; New and the Rationing Agenda Group 1996). In such a setting the ethical stand and the guidelines for priorities are considered to constitute the ground for open and conscious priorities and should be available for everyone (Statens offentliga utredningar 2001). The priority can also be horizontal or vertical. The horizontal priority is mainly a political responsibility and deals with the resource distribution among different activities e.g. primary- vs. hospital-healthcare. The vertical priority is a medical affair and has long expressed itself through waiting lists and exclusion, where the patients are ranked due to their medical problems and other medicalrelated factors such as their general conditions. In such a system, exclusion deals with cases that cannot obtain a treatment due to the lack of resources as a result of horizontal priority. There are thus many contact points between these modalities when priorities are practically made (Carlsson et al. 2007; Statens offentliga utredningar 2001; Redwood 2000; Prioriteringar i hälso- och sjukvården 2007). The priority should therefore be carried out in a dialogue between politicians and medical professions.

There are some factors, that influence the priority-setting:

- 1) Patients' demand on type and quality of treatments are important today, but are socially conditioned and subjective and should not influence the way healthcare resources are distributed (Cho et al. 2005; Harrison et al. 1997; New and the Rationing Agenda Group). However, since the political priority- making aim for the benefit of the people it can be influenced by trends and extraneous requirement from the public (Läkarsällskapet 2001).
- 2) Politicians' quest for control of the healthcare system through priority may simply be clarified as New Public Management. These are control and management policies from early 1900, often renewals of what has been examined within other activities and unknown for large groups of managements and employees in the healthcare services (Statens offentliga utredningar 2001; Olson et al. 1998).
- 3) Although prioritising is actually nothing new or difficult for healthcare professionals, the ability of choosing between medical and economical benefits is; knowledge that should be offered by policy-makers.
- 4) Finally, there is too much territory-mindedness within the medical profession resulting in not taking command in the crucial medical questions, losing its credibility and making cooperation impossible (New and the Rationing Agenda Group 1996; Redwood 2000).

All these issues emphasise the need for an understanding and mutual leadership (Carlsson et al. 2005; Sandberg et al. 1998; Sahlin-Andersson 1999; Lind et al. 2007). In a desirable situation, there is a balance between demands and access based on evidencebased medicine, research, and economy in line with a healthy ethical standpoint. But, in reality that does not exist and political frustration has led to repeated catastrophic reorganisations and increasing mistrust between healthcare and political professionals.

Conclusions

Let us agree that certain changes in our welfare and healthcare system are necessary to finance the costly and demanding healthcare system. Prioritising and or increasing effectiveness are two alternative solutions that are not necessarily cheaper, but linked together (Socialstyrelsen 2007; Reeleder et al. 2005). Therefore these measures should be part of healthcare's future planning. It should, however, not be the responsibility of a single group. Politicians should not single- handedly take difficult priority decisions on ethical and medical grounds and the medical profession should not be left alone to choose between money and patients. Making such difficult decisions should not be based on political trends and historical materials. The healthcare professionals should be engaged earlier to practice their responsibilities and to contribute

with their knowledge, but also to become aware of the economical consequences of their decisions. Making priorities should be based on sound ethical grounds, national will and a political unity, complemented by higher influence of professionals and better engagement of those who eventually benefits all these efforts – the patients (Östergren et al. 1998; Daniels et al 1997).

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