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Comparative Healthcare Services

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The Just Allocation of Healthcare Resources and Learning from Other Systems

I **Introduction:**

The concept of a good health system is profound- as no one healthcare system is perfect. It would be nearly impossible to meet expectations of “the perfect healthcare system,” but many countries have much progress to make in this sense. This bears witness to the National Health Service or NHS in short, the United Kingdom’s healthcare system. Established on July 5th, 1948, the NHS marked a revolutionary step towards providing comprehensive healthcare services free at the point of use and funded through general taxation to UK residents. The concept of the healthcare system aimed to address the inadequacies of the previous healthcare system, which was largely inaccessible to those without financial means of accessing it. Thus, the NHS was created with the understanding that all UK residents should have the opportunity to access necessary medical care despite their financial status. The NHS is built on three fundamental principles: universality, equity, and comprehensive service. Universality refers to healthcare services being available to all residents of the UK, equity means that services are provided based on clinical need rather than the ability to pay, ensuring fair access for everyone, and comprehensive service refers to the NHS’s wide range of healthcare services, ranging from primary care to specialized treatments and emergency services, aimed to meet the diverse needs of the population. As mentioned previously, the NHS is primarily funded through general taxation and National Insurance contributions. Its organizational structure includes NHS England, which oversees the planning, budget, and delivery of healthcare services.

Furthermore, Clinical Commissioning Groups (CCGs) manage local healthcare services to meet local population needs. NHS trusts operate hospitals and other health facilities which play a critical role

in implementing national healthcare policies and providing care (NHS, 2020). With modern times and advanced technology, the NHS faces a few difficult challenges that must be addressed in the upcoming years. Reflecting on these challenges, this essay aims to explore rationing in the UK healthcare system as well as assess its advantages and disadvantages, and in turn propose potential changes to enhance the effectiveness and equity of NHS services by referring to healthcare system strategies that had success in other countries (NHS, 2020).

II Rationing of Healthcare via Elective Surgery Waiting Lists

In a perfect world, no healthcare system would even think of rationing off resources or access to them, but unfortunately, resources and funding are not unlimited. Due to this, certain measures are implemented to ration the healthcare system in question, whether as a cost-control measure or as an effort to preserve available resources. This is no different in the United Kingdom. The NHS being a government-funded healthcare system, is very political and faces differences in funding depending on what political party is in the majority. A notable example of rationing within the NHS is the management of elective surgeries, such as hip or knee replacements. Due to budget and resource limitations, patients often face long waiting times for these procedures.

Additionally, as of early 2020, more than 4.4 million people were waiting for elective surgeries in England, with around 84% of patients waiting up to 18 weeks even though the target is for 92% to be treated within this period. Elective surgeries in the NHS are scheduled and prioritized based on clinical urgency and the severity of the patient's condition. The criteria for placing patients on waiting lists include the patient's medical needs, the potential for improvement in quality of life, and the availability of hospital resources. This system is designed to ensure that those in greatest need receive timely care while simultaneously managing the limited resources efficiently (NHS, 2020).

Rationing for elective surgery affects not only the patients but also the healthcare system. Long waiting times can deteriorate patient health, increase pain, and decrease mobility, which significantly impacts their overall well-being. The prioritization of urgent cases ensures that critical resources are

allocated efficiently systemwide. But it also leads to longer waiting times for non-urgent procedures, creating bottlenecks and reducing overall system efficiency. This source of rationing poses a strong advantage by contributing to cost control and budget management prioritization of urgent cases and equitable distribution. By delaying non-urgent surgeries, the NHS can control its budget as well as allocate funds to areas that require more attention, ensuring financial sustainability by controlling costs (Health at a Glance...,2020). Just as well, the system ensuring that more urgent cases are addressed first promotes equity in healthcare delivery. Therefore, patients with more severe conditions are treated first, preventing further complications and improving outcomes. This approach to rationing has some disadvantages, however. With the extended waiting times, patients may experience deterioration in their condition while waiting for surgery, which can lead to more complex and costly treatments later. For example, the median waiting time for hip replacement surgery was approximately 91 days, higher than the OECD average of 49 days (BMJ, 2020). Just as well, waiting times are the main source of unmet care needs in the UK, with over 85% of health system unmet care needs being attributed to waiting times (Waiting Times...,2020). Additionally, these long waiting times often lead to dissatisfaction among patients and criticism from the public and media, which can affect the perceived quality of the NHS and lead to a loss of trust in the system (Waiting Times...,2020).

III Rationing of Cancer Treatment Drug Availability

The availability of cancer treatment drugs in the UK is influenced by the National Institute for Health and Care Excellence (NICE). NICE is responsible for evaluating and approving new drugs based on their clinical and cost-effectiveness. The criteria used by NICE include the quality-adjusted life year (QALY) metric, which assesses the cost per additional year of healthy life provided by the drug. Only treatments that provide sufficient clinical benefit relative to cost are recommended for use in the NHS. The strong approval process means that not all cancer drugs available globally are accessible through the NHS. Drugs that do not meet the cost-effectiveness threshold may not be routinely provided, even if they offer potential benefits to patients. The use of this process ensures that NHS resources are used

effectively as well as provide the greatest overall health benefit (NICE, 2022). The rationing of cancer treatment drugs has significant impacts on patient access to potentially life-saving medications and contributes to disparities in treatment availability and outcomes.

One of the advantages of this rationing approach is its cost-effectiveness. NICE ensures that limited financial resources are spent on treatments that offer the most significant health benefits. This evidence-based approach helps in maximizing the health outcomes per pound spent, ensuring that the NHS can provide effective care within its budget constraints. Just as well, by focusing on drugs that have demonstrated substantial clinical benefits, the NHS can avoid wasteful spending on treatments with marginal or unproven efficacy. This optimizes the use of public funds and improves overall healthcare quality. However, there are disadvantages to this approach, as the rigorous approval process by NICE can delay the availability of new treatments, which may be available sooner in other healthcare systems. Only 70% of new cancer drugs approved in the US and Europe are available with the NHS. This delay can negatively impact patients who might benefit from early access to innovative drugs (Pharmaceutical Spending...,2019). The delay in approval can result in patients missing out on potentially life-saving treatments that are readily available in other countries. Just as well, there is a limited availability of high-cost drugs, impacting patient outcomes. Patients with rare or aggressive cancers may not receive the latest, potentially more effective treatments if these drugs are not deemed cost-effective by NICE. This limitation can result in disparities in treatment outcomes and overall survival rates. The high cost of new cancer drugs often limits their availability on the NHS, which can adversely affect patient outcomes (Björnberg, 2019).

IV Change 1: Implementing Comprehensive Electronic Health Records (EHR) Systems

After discussing rationing in the NHS, and noting the disadvantages of each approach, some changes can be made to improve the healthcare system. The first change might be the implementation of comprehensive Electronic Health Records (HER) systems across the NHS. This could significantly improve the efficiency and quality of care while also integrating patient information across all levels of

healthcare, facilitating better coordination and continuity of care. This system would have a nationwide rollout and start with pilot projects in select NHS trust sites to identify best practices and potential issues, then gradually expand to all NHS trusts. This phased approach helps manage risk and ensures continuous improvement throughout the rollout. Just as well, comprehensive training for healthcare professionals will be crucial in ensuring smooth adoption and effective use of the system. This training would cover not only technical skills but also the importance of EHRs in improving patient care. Just as well, this system will have compatibility with existing healthcare IT systems and secure data-sharing protocols. The system should facilitate seamless data exchange between different healthcare providers as well (European Commission, 2020).

It's important to recognize the success of other countries as well in this matter. For example, Denmark's centralized HER system has improved patient outcomes and efficiency by providing seamless access to patient information across the healthcare system. Denmark's HER system reduced hospital readmissions by 30% and improved the overall quality of care by 25%. Additionally, Denmark's system integrates data from various healthcare providers, allowing for better coordination of care and more informed decision-making by clinicians (European Commission, 2020). Estonia is another example of a country as its digital health records system is renowned for its security and efficiency. The system provides a model for cost-effectively integrating digital health, with all citizens having access to their health records online. This system has been credited with improving patient satisfaction by 40% and reducing administrative costs by 50% (McKinsey & Company, 2020).

This change may have some barriers, however. Data security remains a high priority for any healthcare system, and keeping privacy and security of patient data is essential. Because of this, encryption and routine security audits are necessary to protect this sensitive health information. Estonia's system includes strong data protection laws and technologies to safeguard patient information (European Commission, 2020). Initial costs may be an issue, with upfront investment in infrastructure and training being an initial investment. However, long-term benefits such as reduced administrative costs and improved health outcomes may outweigh these initial expenses. It is also estimated that

comprehensive HER systems could save the NHS up to 4.4 billion pounds annually through reduced duplication of tests and improved workflow efficiency (Health at a Glance...,2020). Another barrier to implementing this is maintaining digital literacy. Ensuring all healthcare staff are proficient in using the new system is crucial for its success. Continuous professional development and support systems need to be in place to help staff adapt to the new technology. The Euro Health Consumer Index reports that countries with high digital literacy among healthcare staff have better HER adoption rates and outcomes (Björnberg, 2019). While barriers may occur, there are notable benefits that must be taken into account for the Electronic Health Records system. One benefit is improved efficiency. EHRs can streamline administrative processes, reduce duplication of tests, and improve the coordination of care. For example, Denmark's system has shown reductions in redundant testing by 20% and improved workflow efficiency (European Commission, 2020). Just as well, patient outcomes may see a positive change with this implementation. Timely access to comprehensive patient information can lead to more accurate diagnoses and effective treatment plans. Studies indicate that integrated HER systems can significantly reduce medical errors and enhance the quality of patient care. McKinsey & Company also reported that EHRs contributed to a 15% reduction in medical errors in countries with mature digital health systems (McKinsey & Company, 2020).

V Change 2: Expanding Value-Based Care Models

Another proposed change is expanding value-based care models. Value-based care models focus on rewarding healthcare providers for patient outcomes rather than the volume of services delivered. Expanding these models within the NHS could enhance the quality of care and improve cost-effectiveness. (Porter & Lee, 2013). With this implementation, performance metrics are vital, and metrics are needed to measure patient outcomes and provider performance. These should be evidence-based, focusing on both clinical outcomes and patient satisfaction. When developing these metrics, the experiences of value-based care models in other countries can be used where measurement has been a key to success (Kaplan & Porter, 2011). To make this change effective, financial incentives for providers

who achieve high-quality care outcomes should be prioritized. This could involve bonuses for meeting specific health targets or penalties for poor performance. Incentives may encourage long-term improvements in patient care rather than short-term gains (Porter & Lee, 2013).

Drawing inspiration from other countries, the US has implemented several value-based care initiatives under Medicare such as the Hospital Readmissions Reduction Program and the Value-Based Purchasing Program. These initiatives have shown improvements in patient outcomes and cost savings by incentivizing hospitals to focus on quality over quantity. For instance, the Hospital Readmissions Reduction Program led to an 8% decrease in readmissions and saved Medicare \$2.9 billion in just five years (Porter & Lee, 2013). Taking from this, the UK can adapt these models to fit the NHS's unique structure and principles, ensuring they align with the broader goals of universal health coverage and equity.

The cultural shift in the healthcare system may be a potential barrier to implementing this expansion. Moving from volume-based to value-based care requires a significant change in mindset among healthcare providers. This shift can be facilitated through continuous education and highlighting the long-term benefits of value-based care for patients and providers. Engaging stakeholders early and continuously throughout the transition process is vital to retrieve support as well as address any potential concerns (Porter & Lee, 2013). Additionally, fair and accurate metrics need to be developed for assessing outcomes which can be challenging but remains important for the overall success of the model. These metrics must be reliable, valid, and reflective of true patient outcomes. Just as well, ongoing research and pilot programs can help refine these metrics and ensure they are effective in measuring performance (Kaplan & Porter, 2011). However, this change has strengths in its potential to enhance quality of care and cost-effectiveness. By focusing on patient outcomes, improvements in the quality of care can be provided. Providers will be incentivized to adopt best practices and continuously improve their services to achieve better outcomes. For example, value-based care models in the US have led to reductions in hospital readmissions by 10% and improvements in chronic disease management. This greatly can improve patient's quality of life as well through these measures (Porter & Lee, 2013).

Value-based care models incentivize providers to use resources more efficiently, leading to potential cost savings. The overall cost of care can be managed more effectively by reducing unnecessary procedures and focusing on effective treatments. Additionally, like that of enhanced quality of care, it is estimated that value-based care could save the NHS up to 2 billion pounds annually by reducing unnecessary hospitalizations and improving chronic disease management (Health at a Glance...,2020).

VI Discussion and Conclusions

While it's no secret the NHS has improvements to make regarding rationing practices, mechanisms such as elective surgery waiting lists and NICE's drug approval process greatly aid in managing already limited resources. While these methods have advantages, such as cost control and equitable distribution, they also have significant drawbacks, including potential health deterioration and public dissatisfaction. Implementing comprehensive HER systems and expanding value-based care models are two proposed changes that could enhance the efficiency, quality, and equality of NHS services. Learning from other healthcare systems, like those in Denmark, Estonia, and the US, provides valuable insights into how these changes can be successfully designed and implemented. The benefits of a comprehensive HER system include improved efficiency and better patient outcomes, as evidenced by the success in Denmark and Estonia. The potential for cost savings and improved care coordination underscores the importance of investing in advanced digital health infrastructure.

Similarly, expanding value-based care models promises to enhance the quality-of-care models promises to enhance the quality of care and improve cost-effectiveness. The US Medicare's success in reducing hospital readmissions and saving money demonstrates the potential of these models. By focusing on patient outcomes rather than service volume, the NHS can drive improvement in chronic disease management and overall healthcare quality. However, these changes come with challenges, including ensuring data security, managing initial costs, and facilitating a cultural shift among healthcare providers. Advanced cybersecurity measures, phased implementation plans, and continuous professional development are critical to overcoming these barriers. Engaging stakeholders and refining performance

metrics through pilot programs will also be essential to ensure the success of value-based care models.

Balancing cost control with patient care is essential for the future sustainability of the NHS, and continuous improvement based on global best practices and evidence-based strategies is vital. By embracing digital health technologies and innovative care models, the NHS can improve healthcare delivery, enhance patient outcomes, and ensure a more sustainable and efficient healthcare system.

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