



ISSUES IN MEDICINE

Clinical excellence and the NICETies of value-based priority setting

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In an environment where debates about tertiary care viability in South Africa are characterised more by stridency than logic, it is refreshing to encounter positive suggestions such as those from Kenyon *et al.*¹ They suggested that scrutiny of expensive new medications and technologies by a NICE-like body would lead to appropriate rationing. NICE refers to the UK's National Institute of Health and Clinical Excellence, a government-funded but politically independent body tasked with evaluating the clinical efficacy and cost-effectiveness of medicines and health devices. Its efficacy in improving quality of care and resource allocation is still unclear, and similar attempts in the United States have failed because of the political sensitivity of perceived rationing in that country.² The proposal to establish a similar unit in South Africa appeared unduly optimistic to Taylor,³ who observed correctly that setting cost-effectiveness thresholds is not a rationing strategy in the absence of a concurrent mechanism and commitment to forego established expenditure on other less cost-effective items. (This is an issue which has not yet been resolved by the United Kingdom's NICE.) She also observed that cost-effectiveness analysis is time-consuming, extremely resource-intensive, and arguably not easy to perform on a large scale in South Africa at present.

Further local debate on this matter has been reported recently in the *Journal of the Colleges of Medicine of South Africa*, where Price⁴ argues that there are many more societal advantages to tertiary care than those measured by cost per patient benefited. His example of society's assumed willingness to pay for the assurance of availability of renal replacement

therapy highlights the quandary faced by funders – while each individual tertiary component may seem a reasonable purchase, it is the composite of many such items that proves less easy to justify.

The South African Essential Drugs List committee has recently started reviewing medication used in the tertiary and quaternary setting and, while this venture cannot be equated with the depth and complexity of NICE, it has highlighted a number of fundamental issues. Attempts to confine decision-making to a matrix of efficacy, safety and cost are intuitively appealing but raise other problems besides the cost-effectiveness threshold conundrum; these include historical inequities due to the way tertiary care has evolved and is structured, societal values that require incorporation, and the views of clinicians concerned about restrictions to either scope or volume of practice.

The following considerations come to mind:

Tertiary care structure as a barrier to collaborative rationing

1. Collaborative engagement regarding resource allocation across disciplines is counter-intuitive – if you help another discipline get more funding within a fixed overall budget, there's less left over for yourself. Accommodating clinicians who are prepared to forego resources in such situations may actually disadvantage their own patients.
2. Cross-discipline allocative efficiency is hampered by the 'silo effect' – individual disciplines see little need to compare the efficacy and cost of their disciplines with others. Comparing an oncologist's percentage change in progression-free survival with a rheumatologist's percentage change in ACR50 is problematic. Resorting to cost-utility measures (the whole point of which is to provide a common comparator) results in immediate, and often valid, protestations that such indices fail to capture the subtleties of clinical benefit, or else that the use of these measures in a particular field is too immature for such comparisons to be fair.
3. Enthusiasm for new medications and technologies is often proportional to marketing push and novelty rather than a considered appraisal of true clinical benefit.⁵ Opinion leaders and even august societies may occasionally take a stand on a particular medication or technology that is

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not always borne out by careful review of the underlying literature.

4. The 'all or nothing' concept. There may be a level of rationing below which function is impossible in some sub-specialty disciplines such as cardiac transplantation. Units that were developed through a combination of need, clinical enthusiasm, historical accident and political expediency are easy targets for funding cuts. Any further cuts may render such units non-viable.

Societal values which may need consideration in collaborative rationing

The clinical outputs of health care at a tertiary level are often difficult to quantify. At very high levels of expenditure, as in the USA, spending at academic medical centres may vary by up to 60% without a corresponding measurable improvement in outcomes.⁶ Price's points about teaching, research and international economic attractiveness are well made, but such societal values are very difficult or impossible to measure. The 'rule of rescue' is another important consideration. Society may have an emotional need to 'gamble' resources on vulnerable members, such as children with certain malignancies, where therapy may not meet conventional criteria of cost-effectiveness, but where there is a widespread consensus that it is still a worthy expenditure.

Arguments other than cost-effectiveness that are used by clinicians

1. Academic training – an inability to train to cutting-edge First-World standards is seen as a teaching failure. The problem is that often the only place where this training can be applied is in the private sector or overseas. The corollary (to under-train so that clinicians remain in the public sector) is deeply concerning.
2. To be congruent with professional society guidelines (often industry-influenced). On occasion, it appears that local professional societies have adopted wholesale the guidelines of other countries or regions, without regard to local exigencies.
3. Tertiary comprehensiveness: any gaps render the whole system incomplete, and the appeal is 'If we don't look after the patient with this rare illness, then who will?'
4. Professional autonomy – 'We should be left to decide the scope of practice and appropriate resource needs. Only experts in our field can understand it.' This concept comes with the expectation of ability to self-regulate.
5. The need for tertiary care clinicians to be 'early adopters'. This carries the risk that implementing technologies with an immature evidence base sometimes causes more harm than good. It also creates a problem for funders, who prefer more robust evidence of the ratio of benefit to harm.

6. Older therapies and the 'grandfather clause' – rigorous evidence of efficacy is historic, unavailable and never likely to be found.
7. 'It's about standard of care.' This may camouflage one of two underlying arguments: either 'It has become accepted practice in other countries' (back to point 4) or 'We have always done it' (point 6), which begs the question of whether there was ever acceptable evidence for the original decision.
8. 'We have looked into it and it is cost-effective.' This often refers to suboptimally performed cost-minimisation exercises.
9. 'Failure to get/keep this medication or technology will make doctors want to leave.' Although this is an intuitively appealing argument, there's little evidence that clinicians make this sort of decision based on the new non-availability of a single item.
10. 'Clinicians at X have been using it unrestricted for ages' (issues of interprovincial equity).

Mechanisms of collaborative rationing

Tertiary care is probably too complex for rationing purely on the basis of cost-effectiveness to be acceptable to society. However, there is clearly a need to counter the perception (and occasional reality) that allocated resources are not always effectively spent. An attempt by tertiary care to redefine itself as an autonomous sector, capable of self-scrutiny and unprompted ability to identify and relinquish less effective modalities in favour of more effective ones, would probably be of interest to both public and private sector financial managers with neither the ability nor the inclination to venture into this area.

A pragmatic team approach, starting first with a rigorous scrutiny of the evidence, not only in terms of quality and statistical significance but also in terms of clinical effect size, usually allows a defensible judgement call on the appropriateness of inclusion of an intervention. This would only rarely need to be followed by a formal cost-effectiveness review. It may be reasonable to incorporate some or all of the arguments mentioned previously as variables in a decision matrix, provided that they are applied consistently and transparently.

Clinical excellence is about what one does with what one has, rather than perseverating about perceived deficiencies. A brief consensus document on each diagnostic and therapeutic item from a NICE-like body would be valuable in promoting equity and in setting an appropriate standard of clinical excellence in a resource-constrained environment.

Although limitations on tertiary care budgets are all too real, one could argue that optimism, clinical determination and credible leadership are equally important (albeit constrained)



resources. The desire to preserve the status quo could be replaced by optimism about the possibility of building a leaner, keener enterprise where it is the norm for resources to be allocated on the basis of proven clinical efficacy rather than stridency. Determined tertiary clinicians who are aware of the absolute benefits of the medications and technologies they wish funded would rise to the challenge of maximising delivery within a limited budget. The inertia generated among undergraduates by disgruntled tertiary physicians affects morale, willingness to stay and, most importantly of all, patient

care. A credible, united, academic leadership could inspire hope by finding innovative resource-appropriate African solutions.

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