Severity of illness and priority setting in Norway

Summary of a report from a working group, November 2015.

Severity of illness has been a criterion for priority setting in the health care sector in Norway since 1987. The selection and weighting of prioritisation criteria have been discussed in three Norwegian Official Reports (NOU 1987: 23, NOU 1997:18, NOU 2014:12). In 2015, the Government appointed a working group with the specific task of determining how to assess severity of illness in practical priority setting in the health care sector. The working group submitted its report to the Ministry of Health in November 2015. Below is a summary of the working group's report.

Priority setting is one of several policy tools to ensure equity in the access to health care services, and thus concerns the distribution of health care services. The key concepts employed by the working group in its approach to the discussion of principles for distribution are *equity* and *need*. The challenge in practice is to define these concepts in a manner that makes them applicable to the design of practical principles for resource allocation.

Priority setting in health care takes place at various levels. There are four types of decisions for which prioritisation is relevant: i) decisions in clinical practice, i.e. decisions that will normally arise in the meeting between the individual patient and the health care services; ii) decisions regarding distribution of a limited budget between different types of health care services; iii) decisions regarding the introduction of new medications, treatment options, diagnostic techniques, public health programmes, and the like, i.e. decisions relating to changes in capacity; iv) political decisions at the societal level regarding allocation of resources among various types of public services, among various types of health care services, and the like.

Assessment of severity is relevant for priority setting at all levels in the health care sector, and the working group concludes that the severity criterion should be provided in two forms: a broad *textual description* primarily for use in clinical practice, and a targeted *operationalised form* for use in decision-making at the group level, such as when introducing new methods, new medications or larger-scale public health measures.

Up to now there has been no precise definition of severity, and the term has been employed in diverse ways. The working group has conducted a simple survey among clinicians, decision-makers and patient organisations to get an idea of how the concept is understood and used in various segments of the health care services. The responses reveal that there is no universal understanding of what severity entails, and no clearly designated usage of the term. Rather, severity is described by means of many elements and these elements are weighted differently. According to the working group, it is important to define a criterion for severity that reflects this range of meaning. A criterion with too narrow a scope will not adequately encompass the full range of relevant intuitions about what makes an illness severe, which will ultimately make the criterion less attractive.

Thus, the working group is proposing two different versions of the severity criterion for use in priority setting in the Norwegian health care services. The *textual version* describes the elements that the working group believes should be included in a severity assessment. The following description is proposed:

> *The priority of an intervention increases in keeping with the severity of the condition. The severity of the condition is to be assessed on the basis of:*
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> - *risk of death or loss of function;*
> - *the degree of loss of physical and mental function;*
> - *pain, physical or mental distress.*
>
> *The present health situation, the duration and the future loss of healthy life years are all of significance for determining the degree of severity. The more urgent the need to start the medical intervention, the higher the degree of severity.*

This textual description will be particularly suitable for priority setting in clinical practice, i.e. in the patient's meeting with the health care services. The working group additionally proposes a more targeted version of the term for use in decision-making at the group level. This version builds on and is in keeping with the textual version, but can also be operationalised to a degree that makes it more suitable for group-level decision-making. This version will be especially applicable to the assessment of new medications, new diagnostic procedures, new treatment methods and larger-scale public health measures.

The working group describes and discusses four different approaches to this more targeted description of severity. The term "healthy life years" is used to describe health gains and health losses in a manner that takes into account both increased life expectancy and improved quality of life with medical intervention. Severity can thus be potentially operationalised through:

i) *Prognosis:* The number of healthy life years remaining before a person dies.
ii) *Absolute shortfall:* The number of healthy life years lost as a result of premature death and reduced quality of life during the period of illness. Absolute shortfall is equivalent to future loss of healthy life years.
iii) *Proportional shortfall:* The number of healthy life years lost as a result of premature death and/or reduced quality of life during the period of illness, as a proportion of the potential number of remaining healthy life years in the absence of the disease.
iv) *Absolute shortfall from birth:* The sum of the number of healthy life years lost as a result of premature death and/or reduced quality of life during the period of illness plus the number of healthy life years lost earlier in life.

In all four alternatives, severity is measured in relation to the treatment options currently available to the patient groups. In its consideration of these alternatives, the working group has attached particular importance to:

Absolute shortfall from birth