Chapter 5
Ethical Commissioning of Emergency Ambulance Services

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Introduction

Commissioning is one of those things that is now talked about a lot in health care, but believe it or not, it is a relatively new concept in the UK. In 1988, there were only 12 mentions of the word in the UK parliament, but by 2012 there were thousands of mentions of commissioning in both chambers, and indeed, in 2011 there was a whole parliamentary Health Committee meeting to specifically investigate ambulance commissioning (House of Commons 2011). So something has changed in the last 25 years to make ambulance commissioning such an interesting subject—why is this? The answer lies in how we define ambulance commissioning, because unlike the process of contracting, the process of ambulance commissioning is a cycle that begins much earlier by identifying the urgent and emergency health needs of our population or community and designing the pathways of care provided by an ambulance service that will meet the needs of those people. By specifying and procuring ambulance services within the resources available, commissioning ensures that people get good care in the context of appropriate models and frameworks, and this also needs to take account of ethical considerations.

Ambulance commissioning therefore will involve a process of priority setting, which may involve deciding how best to make future investments, or in some cases may involve deciding which services are no longer being provided.

For the ambulance service in the UK, demand has generally gone up by around 5 % a year for the last 20 years, and although some of this increase can be explained by the population demographics (e.g. an increasing elderly population), this does not explain the total increase, and some of the rise may simply be that people expect

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to be able to call for an ambulance whatever health need they have. Ambulance commissioners therefore have a difficult task of ensuring there is the right amount of resource to meet the population needs for this service against the wider challenges of ensuring that any spend on health care maximises the population health. This can be a hugely difficult thing to do and probably explains why commissioning gets so much attention at the highest level. Each day, there are numerous ethical dilemmas that we face, and this chapter looks at ways in which we can ensure that ambulance commissioning is set in the context of being ethical, and some of the principles and processes that move this from an impossible to a manageable process.

Ethical Ambulance Commissioning

All healthcare commissioning involves allocating resources, and this becomes particularly challenging as resources become more limited. Challenging ethical dilemmas arise when trying to prioritise which services get funded compared to others. Ambulance commissioning occurs in this complex environment of competing priorities and ethical dilemmas, so let us think what some of those situations might be:

- *Should we fund services for people who do not need them?* If we know that a large number of people use an ambulance service for health needs that are not life-threatening or for which there are other services available, should we still provide an ambulance for them? What if there is no ambulance available to attend to somebody in cardiac arrest because the ambulance is attending somebody that does not have a life-threatening or urgent health need?
- *How do we measure the impact of investment in ambulance services?* If we can understand the health outcome delivered by an emergency ambulance service, then we can compare the investment against other health interventions. For example, where a person has major trauma, we know that an emergency ambulance getting to them quickly with a skilled paramedic able to deliver life-saving interventions before rapidly transferring the patient to a major trauma centre has significant health benefits that justify investment in this type of service. On the other hand, it is likely that a young person with a cough who calls an ambulance service to take them to hospital because they have no transport is unlikely to result in a significant return on the health investment in the ambulance service, and it may be argued that this service should not be provided.
- *How do we prioritise investment in ambulance services against other investment priorities?* Even where a service is clinically effective, there are still decisions that have to be made to prioritise investment. For example, if we think that we need to invest money to improve the emergency ambulance service for people with mental health crisis, how do we make the case against the investment needed to improve care for premature babies?

The decisions and priorities that need to be made by ambulance commissioners and providers of ambulance services can be complex. In addition, we have the added political dimension of services that are in the public eye; who, for example, wants to see an elderly lady who has fallen in the street wait for an ambulance even if arguably the wait may not result in further harm to her condition. In this case, an economic evaluation would not come up with the right answer because public opinion would simply not support a slow response to such need.

Because the public highly value an emergency service and will generally want a rapid response if they need it, politicians see this as an important issue to address and apply arbitrary targets for emergency ambulances to respond to a person in need. In the National Health Service (NHS) in England, for example, there is a target for the time taken for an ambulance to arrive at a person who is deemed to have a life-threatening (red 1) or potentially life-threatening (red 2) condition; the current target states that in 75 % of these cases, an emergency ambulance should arrive at the patient within 8 min. This creates some interesting discussion, as 8 min is an arbitrary target that would be of little benefit in a situation of cardiac arrest where the patient would almost certainly have died if they waited that long; and even where a quick response is needed, why is a target set at 75 % (what about the other 25 % of patients)? The reality is that many of the people that fall into this category of urgency do not end up being this severely unwell or injured, but in England this single measure of performance has become the political target that determines whether an ambulance provider is successful or not. The fact that some of the target measures are of dubious scientific rigour creates a dilemma for ambulance commissioners who often invest large amounts of resource to hit the targets, often at the expense of other interventions. But even if these targets are not clinically necessary, the public tell us often that equally they do not like waiting a long time for an ambulance to arrive. So even if these targets are arbitrarily set and create as many dilemmas as they solve and consume huge amounts of resource without being clear on how this benefits patient outcomes, patients often just would not accept a slower response, and this creates a dilemma.

Ensuring Ethical Priority Setting and Resource Allocation

Because healthcare resources are diminishing on a relative basis in most countries in the world, this means that not everybody can have what they need and want all of the time, so we need to find ethical ways to help us decide what services get funded and which ones do not. Much of the research and the rationale for priority setting is set in the context of acute medicine where some of the measures and evidence are at a much greater state of maturity. Hospitals, for example, have been measuring patient outcomes for many years, but the application of these methods to the commissioning of an emergency ambulance service can be more complicated because the information may simply not be available.

There are two fundamental ethical principles that should be applied to the commissioning of an ambulance service in all situations (adapted from Dworkin 2002). The first is that every person's life has intrinsic value and should be considered with equal concern, where every life matters irrespective of any other factor that is present. The second is that people have responsibility for their own life, but in delivering an ambulance service, we should not be judgemental about the life choices that a person has made, and care should be delivered equally to all people. Assuming we can accept the above principles, then there are initially three things that need to be considered in an ethical sense when making decisions about the commissioning of an emergency ambulance service:

1. *Doing good (utility)*—cost-effective analysis is a way in which we identify priorities for investment, and health commissioners will often look to maximise the effect of their investment, and this is referred to as allocative efficiency (allocative efficiency is a term used to describe a system where there is an effort to maximise health-related utility per unit cost).
   Health economists would advocate a mechanism of ensuring the greatest return on investment. A quality-adjusted life year (QALY) is an example of this approach and is used by the National Institute for Health and Care Excellence (NICE) in the UK. Where QALY is used as the only mechanism of prioritising resource allocation, this can disadvantage people with a limited life expectancy, such as those who are elderly or who have a long-term condition. It is also unfair for those people who have less to gain from particular interventions, such as people with disabilities. This approach can be applied to many ambulance interventions—for example, a service that is able to effectively treat people with stroke, myocardial infarction and trauma is likely to score high on this measure. It is more difficult to apply this type of methodology to an elderly person with dementia who has fallen, for example, as the ambulance intervention on its own is unlikely to increase the person's life expectancy or quality of life.
   When considering 'doing good', it is also important to consider the wider benefits of an intervention. In the UK, for example, a review of major trauma care was undertaken, resulting in the development of improved pre-hospital care by ambulance services and the introduction of specialist major trauma centres. When evaluating the impact of the resource allocation, whilst QALYs were used, a wider impact assessment was undertaken, including the extent to which a person became independent and contributed to economic self-sufficiency. So when we assess the benefit of an ambulance service in economic terms, we need to consider the impact on patient survival and the impact on their quality of life and other benefits that patients may consider important. We also consider how an ambulance service contributes to the overall efficiency of health care; and in the UK ambulance services are increasingly the first point of contact for people who have urgent care needs, making the service a critical part of a system to ensure that people get to the right place of care and treatment in a timely manner.
2. *Being fair*—because of the inherent problems of resource allocation being based on utility (doing good) alone, in ambulance commissioning we often focus atten-

tion as much on the issue of the process of allocation being fair (referred to in the literature as 'distributive justice'). Being fair is important to people and our evidence would suggest that members of the public are satisfied that we may do less good overall, so long as we deliver in a fair way. An example of this would be the delivery of an emergency ambulance service to urban and rural areas. The speed of an ambulance response is important where a person has a life-threatening condition, but should the time that a person has to wait for a response differ in urban and rural areas? Those people that advocate a fair system of delivery might suggest that the speed of response should not be affected by the urban or rural nature of where the emergency situation is, even if providing the same speed of response requires a relatively more expensive resource allocation in the rural areas. Other people might argue that it is fair for people to wait longer in areas where population density is sparse but might argue that clinical outcomes should not be adversely affected, so this might require a different response model in order to maintain the highest level of care whilst awaiting the arrival of an emergency ambulance.

3. *Doing the right thing*—initially this might be encompassed by the principles of 'doing good' or 'being fair', but there is a slightly different perspective that ambulance services need to consider from an ethical perspective. If a service cannot be justified on the basis of 'doing good' or 'being fair', it can often be considered on the basis of 'doing the right thing'. Consider, for example, a person who is injured whilst committing a crime, but whose injury is not life-threatening. We could argue that treating them takes resource away from people who are genuinely sick, but ambulance services need to treat people in a way that is non-judgemental by 'doing the right thing'.

   There are other situations where it is clearly not cost-effective to provide a service, but some situations or services conflict the need to assess purely on the grounds of 'doing good' and 'being fair', and this is particularly the case for emergency services where there is a legitimate view that civilised societies should fund services to save lives despite the cost. This concept often causes some professionals working in pre-hospital emergency care a dilemma, as clearly in a cash limited healthcare system this creates an imbalance between 'doing good' and 'being fair'. If massive amounts of resource were allocated to services that delivered to a more than likely futile outcome then it is likely that people would question the rationale for this.

So the three factors that we have to consider when prioritising investment in our ambulance services are often creating opposing tensions and differing priorities or ethical dilemmas, but there is a fourth consideration for emergency services that I describe as 'being seen to be doing the right thing'. There are some emergency situations where you have to provide help irrespective of whether it is cost-effective, fair, or the right thing to do. For example, think of a situation where a person has been trapped in a collapsed building; ambulance services will often commit large amounts of resource to the safe recovery of a single person, and often at huge risk to the people involved in the rescue, and this continues even where the chances of

a person's survival become increasingly low. Jonsen (1986) refers to this as the 'Rules of Rescue', where the public expect a significant response as there are often identifiable people in tragic circumstances.

'Being seen to be doing the right thing' doesn't always conflict with the other principles, as the cost of saving an identifiable person from death in many instances may be minimal; for example, where an ambulance service provides cardio-pulmonary resuscitation to a person in cardiac arrest, the benefit of saving a life is so great and the cost of doing so low, that the action dictated by the 'Rules of Rescue' happens also to be the most cost-effective one, but the measure is undertaken initially without immediate consideration for the cost-effectiveness. Let us then consider a different example where a person has jumped from a high building and is still alive on the road below. We know that the likelihood of survival is low, but the principle of the 'Rules of Rescue' is that despite this, we are likely to mobilise significant resource to try and help the person who is severely injured. There is therefore a human mindset that suggests that the logical and rational approach implied in the cost-effectiveness analysis is disregarded when a person's life is threatened, and in certain situations there is a duty to help a person irrespective of the cost-effectiveness ratio, or the likely chances of the person's survival.

'Being seen to be doing the right thing' provides an added dimension to the principles of ethical commissioning. Think, for example, of the resources that are put in place for severe emergencies, such as major trauma teams, and the Helicopter Emergency Medical Services (HEMS). These services are often provided at great cost, and albeit they are not always universally funded through public money, arguably have a cost that might not be supported if a pure cost-effectiveness case were to be applied. The fact that people are willing and keen to support services that are not the highest priority when assessed by a cost-effective analysis suggests that human nature must be taken into account in order for any proposals to be seen to be ethical and be acceptable to the public.

When delivering ambulance services, people can take the view that all services should be provided in all situations regardless of cost; however, in a cash-limited healthcare system, it can be difficult to reconcile this public pressure of being seen to be doing the right thing, against the reality of maximising health benefit from limited resources. Ambulance service providers and commissioners should consider this from the context of a 'prudent person' (Dworkin 2002) who would spend money on health care throughout their life, but would generally set this against other things that they value, such as education and housing. Ambulance commissioners, acting as an Agency for a 'rational person', might forego some heroic treatment of dubious value in return for more certain benefits of other ambulance interventions.

The three principles of *'doing good', 'being fair' and 'doing the right thing',* set against the context of 'being seen to be doing the right thing' highlight the challenges that commissioners have and the fact that it is unreasonable to procure an ambulance service on the basis of a single principle. For example, if resources are allocated on the basis of identified need, then other principles such as cost-effectiveness may be ignored, but if we allocate resource simply on the basis of 'doing good', then a large proportion of ambulance resource will be allocated to those incidents

where we know there is a positive health benefit and would fail to consider how the allocation of this resource negatively impacts on those people with less immediate needs. 'Doing good', 'being fair' and 'doing the right thing' are often priorities that pull in opposite directions, so the challenge for ambulance services and commissioners is to ensure that there is a balance between the three and to consider other principle of 'being seen to be doing the right thing' in order to reach a decision.

Ensure Fair Decision-Making: Involving Clinicians, Patients and the Public

When we commission an ambulance service whilst recognising the need to 'be fair', it is also important 'to be seen to be fair', and whilst this may seem pedantic, the process of fair decision-making is probably as important as the principle of 'being fair' and is probably harder to achieve than might appear at first sight.

There have been many attempts in the UK and around the world to provide principles and rules to support decision-making. In the UK, for example, we have a number of strategic documents that set out the direction of travel for the delivery of an effective ambulance service, but these are often fairly abstract in nature and on their own are unlikely to result in effective action. Work undertaken around the world by Sabik and Lie (2008) suggests that strategy needs to be interpreted by expert national bodies to consider how it would be implemented in specific interventions, and in the UK we have a number of expert bodies providing the necessary expertise in translating policy, such as the Association of Air Ambulances (AAA), the Association of Ambulance Chief Executives (AACE) and the Ambulance Commissioners Network (ACN).

Even where due process is followed to reach a decision when we are commissioning emergency services, the result is often that we are faced with irreconcilable conflicts that are not easily resolved, and we need to consider how these irreconcilable decisions can be managed. Recent moves in the NHS in England have been to involve clinicians in the commissioning process for emergency ambulance services through clinical commissioning groups (CCGs). Clinicians often view conflicts in a different way to administrators as they are used to these difficult dilemmas in their everyday practice, and Heath (1999) refers to this as the 'oscillating gaze' where the seemingly impossible scenario is managed to a successful conclusion by considering all aspects of the dilemma. Experienced paramedics are often faced with logically irreconcilable conflicts in everyday practice, for example, incidents that require them to prioritise treating one patient before another, or in major disaster situations possibly not treating some patients at all. Whilst commissioning an emergency ambulance service might be slightly different in the focus (e.g. the needs of a particular patient vs. the needs of society in general), clinicians often cope well in these seemingly impossible situations where mysteriously all aspects of the dilemma are considered to ensure that where possible, a satisfactory decision or compromise is reached. Clinical commissioning is a concept that is relatively new in

the UK, but having experienced clinicians involved in decision-making and priority setting is crucial to a successful outcome and recognising and nurturing people with such skills is critical to a successful outcome.

Clinicians are integral to both the formulation of commissioning policy and the implementation of it. This creates something of a double-edge sword, where on the one hand, the patient needs to be assured that the paramedic will take the best decisions on behalf of an individual patient, but on the other hand, it will need to consider scarcity in considering that decision.

Priority setting will always be liable to ethical dilemmas; so, systems need to be robust to be sure that where there is likely to be some challenge of the decision or there is no universal consensus, there are systems that legitimise the decisions or give legitimacy to the outcome. Because not all decision-making will be taking place in a perfect world, and there is a potential for decisions to be tainted by value judgements or indeed conflicts of interest, then it is important that any decisions on prioritisation or disinvestment are taken in a fair way, with 'procedural justice'; that is to say, that even if somebody does not agree with the decision that has been taken, they are able to see that it has been undertaken in a fair and just way.

Resource scarcity creates problems for emergency services, particularly in the context of reducing resource, increasing demand, and increasing expectations from service users and the public. Funding reductions for publically funded emergency services are a reality in many countries around the world during the current global recession. In previous years, informal mechanisms of priority setting were the norm and went largely unchallenged, but due to the size of the current fiscal challenge in many areas, politicians are supporting the concept of explicit priority setting (Sabik and Lie 2008).

Involving clinicians in priority setting can help align conflicting priorities, but involving the public and service users is an equally important priority for the delivery of effective ambulance services for a number of reasons:

1. It is a good thing to do—service users have a right to be consulted about their health services, and it enables them to be empowered and in control of the services they use. It is also a good way by which traditional ambulance services can be challenged to deliver more patient focused care.
2. It is socially and politically important—involvement of members of the community will help to support the proper use of ambulance services by invigorating the social and civic responsibilities of participants, and ensuring ambulance services have strong local voices back into the communities they serve.
3. It can ensure ambulance services focus on improvement of care and outcomes—service users can be used as a means to a better end and allow consideration of the patient voice in how the service is delivered.

Involving service users that are representative of all service users can be a challenging process. On average in the NHS in England, a person will have the need to phone 999 for an ambulance about once every 6 years, so many people have little experience or knowledge of the service until the point at which they need it, and at this point they may be unwell and experience the service for a relatively short

time in the overall pathway of their care. Even after experiencing the service, many people may not have a particularly strong view of the service, unless it has not met their expectations, so it can be challenging to involve the public in this process; however, even where people do not have much experience as a service user, it is still important that their views on fair decision-making processes are sought.

Some ambulance services have a concern that individual stakeholders may attempt to exert undue influence, but where stakeholders form into organised groups, they can be particularly useful in ensuring that the voice of people who are traditionally marginalised have their voice heard; London Ambulance Service, for example, has a very effective Patient's Forum that work closely with the service and commissioners to ensure a strong patient and public voice.

Whether it is patient involvement in ambulance service prioritisation or wider public involvement in decision-making, it is likely that a decision will have greater legitimacy if it has the patient and public acceptance of the fairness of the decision-making process. Patient and public involvement cannot simply be a token gesture as this would create mistrust and cynicism, and the following examples need to be avoided:

1. Agenda setting—the ambulance provider or commissioner controls the terms of the debate and may also prevent some issues being discussed. For example, service users are consulted about the closure of some ambulance bases, but are not given information on all viable options, or selectively include service users' views.
2. Preference shaping—the ambulance provider or commissioner influences people's thoughts, desires and perceptions. For example, they do not seek to influence a decision to close some ambulance bases because they believe that the only valid evidence for decision-making is the official or clinical view of the ambulance service provider.
3. Decision-making—the ambulance provider or commissioner informs people of a decision that has already been taken, but refers to this as consultation. For example, the ambulance provider or commissioner takes a decision to close an ambulance base and seeks simply to inform the service user.

For some services that people do not use very frequently, such as ambulance services, the public may not want to be involved in decision-making, and very often they would rather leave difficult decisions to professionals who have access to a wider range of information and are able to assimilate this more readily. For a service that is not used regularly by most people, there can be a tendency for more informed patients to come forward as user representatives, and this in itself can cause some difficulties as the regular service user becomes professionalised into the role, and this questions whether such people could be representative of the community as a whole.

Despite the challenges of involving service users and the public, it is important that there is a legitimate process through which their valuable input can be sought in a proactive and constructive way.

Conclusion

Urgent and emergency ambulance services are a critical part of the pre-hospital infrastructure and are held in high regard with service users and the public. These services are working in a challenging climate where decisions on priority setting have to be made within an ethically acceptable framework. Commissioners and ambulance service providers need to ensure that services that are in place are effective (do good) and that decisions on priority setting are fair. For ambulance services, however, there is an additional consideration of services that 'do the right thing', so service providers and commissioners need to take into account these three, often conflicting priority considerations when specifying the model of ambulance response.

Making decisions about the priorities for investment can be a difficult process, and although there are numerous scientific and rational approaches that can be used to reach a decision, the fact that ambulance services are in the public arena means that not only must the decisions be fair but also the process of decision-making needs to be transparent and accountable. For ambulance services, the principles of ethical commissioning using a scientific and rational approach will not always reach a conclusion on priority setting, and two additional factors need to be taken into account when reaching decisions.

Firstly, clinical engagement is critical. Paramedics and other clinicians are very skilled in clinical priority setting and have the ability to make decisions when there are competing clinical priorities. Involving paramedics and other clinicians in the wider health system will enable difficult priority setting decisions to be made in the context of ethical dilemmas.

Secondly, it is important to involve patients, service users, and the public to ensure that the patient voice is considered and to ensure that the decision-making process is seen to be fair, adding a greater legitimacy to any decisions that are proposed. Ensuring good levels of public and service user engagement ensures that difficult decisions made by commissioners of ambulance services have a legitimacy that justifies the reasonableness of the decision and the decision-making process.

A triangulated approach to ethical decision-making for urgent and emergency ambulance services will provide the most ethically robust process for priority setting. Using a rational and scientific approach, engaging paramedics and other clinicians, and involving service users and the public are critical to successful decision-making.

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