Advance care planning:

an unsuitable subject for QOF?

INTRODUCTION

Allowing individuals to retain control over their health care even after losing mental capacity, advance care planning (ACP) can be seen as the ultimate expression of patient choice and empowerment. Evidence of the extent to which medicine has turned its back on paternalism, ACP has proved an attractive concept for healthcare policy makers, and recent years have seen increasing development of related professional guidance. Recognition in UK legislation in the Mental Capacity Act 2005 has further strengthened interest.

Promotional initiatives for ACP, particularly in primary care, have focused on increasing its use, with one guideline advocating integration into the Quality and Outcomes Framework (QOF) as a means of establishing ACP as a 'routine' part of care.¹ The suggestion that something as complex and sensitive as ACP could be dealt with in a similarly routine and structured way to blood pressure monitoring or cardiovascular risk assessment seems surprising; certainly the possibility should lead to detailed examination of the implications of incentivisation of this process, as well as perhaps to a degree of re-examination of the concept itself.

INCREASING ACP IN PRIMARY CARE

Undoubtedly there is evidence for significant benefits of ACP. It gives patients a feeling of control over their future care,² reduces the burden of decision making on relatives³ and healthcare professionals,⁴ and improves care, especially end-of-life-care.⁵ ACP may also have the potential to ease financial burden on health care by reducing inappropriate hospital admissions and unwanted interventions.⁶ While relatively little evidence is derived from primary care, this is likely to be an ideal environment for its use, with the ability to develop close working relationships with patients over time, and unrivalled opportunity for follow-up.

Consequently, making more use of ACP as a 'normal' part of primary care, may well seem a laudable aim. However, while establishing ACP as part of QOF, or as Directed or Local Enhanced Services, may well increase its use in primary care, strong arguments exist against such directed or incentivised use of ACP not only in primary care but in any environment. Seen alongside important practical and

ethical concerns, these approaches at best seem premature and at worst risk being significantly detrimental to public perception of the process.

PRACTICAL AND CONCEPTUAL DIFFICULTIES

Central to ACP is the assumption that healthy individuals can anticipate their reaction to future health conditions in order to make reliable choices about future care and treatment. Some commentators,⁷ supported by a body of research on 'affective forecasting',⁸ argue that this assumption is demonstrably false, with evidence of extreme difficulty in accurate prediction of future wishes calling into question the validity of ACP as a concept. Where such key doubts remain, making ACP a routine part of care may seem unwise, at least until these issues have been further explored.

ACP will inevitably involve difficult discussions with patients, often about end-of-life care, including necessary recognition of a time when they may not be able to make decisions for themselves. Clearly this will be a sensitive process, with some patients simply not being of a temperament to participate fully; many healthcare professionals will also find this a difficult subject. In addition to being personally sensitive, complex variation in attitudes and understanding of ACP may exist across diverse populations, with cultural differences,⁹ as well as varying educational levels,¹⁰ having significant impact on patients' ability and desire to establish anticipatory decisions of this kind.

The fact that individuals appreciate ACP in very different ways makes it likely to be most effective when carried out in an individualised manner, tailored to particular patients' needs. Directed approaches to its implementation, therefore, with their potential to lead to an impersonal and methodical 'tick box' approach, would be

expected to be less successful, inadequately addressing patients' real needs and failing to achieve useful anticipatory decision making.

Furthermore, in order for increased use of ACP to be of value, it must be possible actually to implement patients' wishes. Commentators¹¹ have highlighted how rationing can seriously compromise the choices available to patients in reality; ACP will certainly be subject to the same criticism. With many patients likely to choose to remain at home at the end of life, for example, it will be essential that appropriate funding and staffing of community services exist to ensure that this is possible.

Finally, the likely focus on documentation of future wishes of large numbers of patients involved in directed approaches to ACP may well be missing the point. Evidence of benefits of ACP in terms of achievement of psychosocial goals of preparing for death and opening up communication with loved ones,² has suggested that some patients feel documentation to be unnecessary once the process of open discussion with healthcare professionals and families has been established.¹²

COSTS AND FINANCIAL INCENTIVES

Population-wide directed approaches to ACP may also have significant financial implications for patients. While there is no requirement to seek legal advice, patients will often wish to, and indeed many doctors may suggest this, with consequent financial cost. In addition, some elements of ACP involve unavoidable costs: in order to be used, Lasting Powers of Attorney must be registered with the Court of Protection, currently incurring a £110 fee. This raises questions about the ethics of promotion of a process likely to result in personal expenditure for patients and, perhaps, where ACP is actively encouraged by

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healthcare professionals and considered an important part of patients' care, such costs should be borne by the NHS.

Evidence of ACP's potential to reduce healthcare costs⁶ may support its promotion as an ethically valuable means of reducing the financial burden of unwanted and inappropriate interventions, particularly towards the end of life. However, equally this may lead to significant concerns about drivers of ACP, which, when coupled with apparent financial incentivisation of its use in the form of QOF targets for example, could result in unfortunate conclusions being drawn. One of the most concerning aspects of the Liverpool Care Pathway controversy was the possibility that financial incentives had been provided to increase its use. Alongside beliefs that the pathway might be used as a means of deliberately hastening the death of patients, the suggestion that payments could have been made for use of the pathway as a means of saving costs in end-of-life care had dramatic implications in the eyes of the public and media. If ACP is to continue to be acceptable to patients, it will be vital that any controversial association with 'reward payments' be avoided.

CONCLUSION

ACP unquestionably has much to recommend it, with the potential to be highly beneficial both for patients and healthcare professionals, and effective use of ACP will in many situations reflect good quality care. However, it is clear that it must be used appropriately, with the ideal being an individualised approach, as part of a personalised therapeutic relationship, to patients who are likely to benefit: a directed approach leading to a box-ticking exercise for all will not sit well with this aim.

Furthermore, recent experience with the Liverpool Care Pathway would suggest that great care will be needed to ensure that promotion and use of ACP is carried out in a considered and sensitive manner to ensure appropriate increase in use of patient centred ACP while avoiding negative associations or misinterpretation both by the general public and by health professionals themselves.

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Competing interests

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