

MAKING CHOICES ABOUT RATIONING – SEEING THE COMMUNITY PERSPECTIVE

A. INDIVIDUAL-PROCEDURAL RIGHTS APPROACH

NHS Constitution

The NHS is committed to providing best value for taxpayers' money and the most effective use of finite resources.¹

“Like all public authorities, PCTs are required to operate within finite budgets and, therefore, have to prioritise some treatments over others according to the needs of local communities... Disinvestments should be considered along with investments.”²

You have the right to expect local decisions on funding of ... drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you.³

NHS Constitution Directions

...each PCT must have in place arrangements for making decisions and adopting policies on whether particular healthcare interventions are to be made available for patients for which the PCT is responsible... Each PCT must compile and publish clear written information outlining the arrangements specified...⁴

Where a PCT makes a decision to refuse a request for the funding of a healthcare intervention, where the PCT's general policy is not to fund that intervention, the PCT must provide that individual with a written statement of its reasons for that decision.⁵

South Central Ethical Framework

<http://www.berkshire.nhs.uk/priorities/tools/policy-display.asp>

- (a) evidence of clinical and cost effectiveness of the treatment,
- (b) equity and the principle of equal access for equal need,
- (c) the health care needs of the patient and their capacity to benefit from the treatment,
- (d) the cost of the treatment and its opportunity costs,
- (e) the sometimes countervailing needs of the community and
- (f) guidance from national institutions such as NICE, or the government.

¹ NHS Constitution, Principle 1(6).

² *Defining Guiding Principles for Processes Supporting Local Decision Making About Medicines*, 3 and 14.

³ NHS Constitution, Principle 2a.

⁴ *Directions to PCTs and NHS trusts concerning decisions about drugs and other treatments* 2009

⁵ *Direction to PCTs and NHS trusts concerning decisions about drugs and other treatments* 2009

B. PUBLIC HEALTH AND THE COMMUNITY PERSPECTIVE

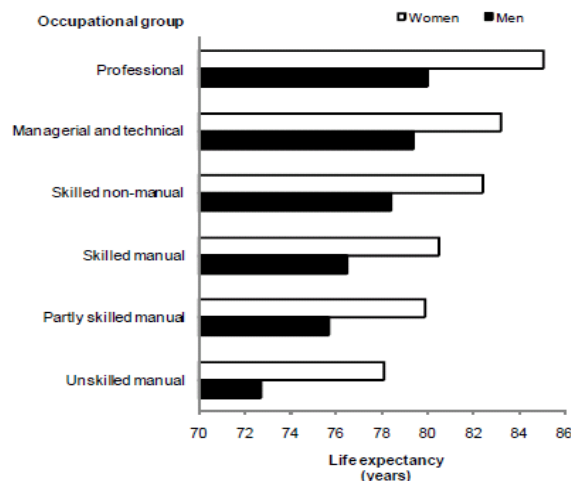
We are likely to have more people living in poorer health and this presents a significant challenge for health services and wider society. Firstly, we have an ageing population, which partly reflects the huge progress that has been made in reducing mortality and extending lives. Many health conditions increase markedly with age, which will mean a considerable rise in age-related chronic conditions such as diabetes, dementia, blindness and arthritis. . . It is expected that the number of people who have three or more long-standing illnesses will rise by 60% over the next 10 years.

Secondly, several major diseases are expected to become more common in all age groups, reflecting changes in people’s lifestyles. For example, higher rates of obesity will result in a higher incidence of chronic conditions such as arthritis and type 2 diabetes. There were an estimated 3 million people with diabetes in England in 2009; estimates suggest that the number of people with diabetes could rise to 4.6 million by 2030. There has also been a rapid rise in gastrointestinal diseases, particularly chronic liver disease where the under-65 mortality rate has increased 5-fold since 1970. Liver disease is strongly linked to the harmful use of alcohol and rising levels of obesity.⁶

	Cost/year (£ billion)			
	2007	2015	2025	2050
Diabetes	2.00	2.20	2.60	3.50
Coronary Heart Disease	3.90	4.70	5.50	6.10
Stroke	4.70	5.20	5.60	5.50
Colorectal cancer	0.45	0.50	0.53	0.50
Breast cancer	0.27	0.29	0.32	0.31
NHS cost (all related diseases)	17.40	19.50	21.50	22.90

Source: Foresight ‘Tackling Obesity: Future Choices’

Figure 2: Occupational group differences in life expectancy, England and Wales, 2002–2005



Source: ONS Longitudinal Study, 2007.

If everyone in England had the same death rates as the most advantaged, a total of between 1.3 and 2.5 million extra years of life would be enjoyed by those dying prematurely each year as a result of health inequalities. . . The estimated costs of these illnesses accounts, per year, for productivity losses of £31-

⁶ *Our Health and Wellbeing Today* (HM Government, 2010), para 3.6-7

33 billion and lost taxes and higher welfare payments in the range of £20-32 billion. The additional NHS healthcare costs in England are well in excess of £5.5 billion.⁷

C. COMMUNITY INTERESTS AND THE POLITICS OF INDIVIDUALISM

Department of Health politics

Otley v Barking and Dagenham PCT (2007)

[Mrs Otley] was relatively fit. She was young by comparison with the cohort of patients suffering from this condition. Her reactions to other treatment... had been adverse. Her specific clinical history suggested that her reaction to a combination of chemotherapy and Avastin had been of benefit to her. ...Unlike many of those the subject of the studies, [she] had suffered no significant side-effects from a cocktail which included Avastin. All of those points are fairly made by Professor Sikora.⁸

Hierarchy of evidence:

(a) well-conducted meta-analysis of several, similar, large, well-designed randomized controlled trials (RCTs), (b) large well-designed RCT, (c) meta-analysis of smaller RCTs, (d) case-control and cohort studies (e) case reports and case series, (f) consensus from expert panels, (g) individual opinion.⁹

Watts v Bedfordshire PCT (2005)

Commission v France (2010)

If persons insured under the French system could obtain at the expense of the competent institution treatment involving the use of major medical equipment corresponding to that listed exhaustively in the Public Health Code [ie “Scintillation camera, magnetic resonance imaging, medical scanner, hyperbaric chamber, cyclotron], the planning endeavours of the national authorities and the financial balance of the supply of up-to-date treatment would as a result be jeopardised [41]. That possibility could lead to under-use of the major medical equipment installed in the Member State of affiliation and subscribed by it or yet a disproportionate burden on the Member State’s social security budget.¹⁰

D. POPULATION-BASED OBJECTIVES AND THE TYRANNY OF TARGETS

Annual Health Check – waiting times for referral, A&E and cancer

Rationing by *delay*, replaced by rationing by *dilution*

Targets, league tables and *choice* (and Foundation trusts status)

Bristol Eye Hospital (2003)

Mid Staffordshire NHS Foundation trust (2009)

The trust stabilised its finances and successfully focused on becoming a foundation trust. However, it lost sight of what should have been its main priority: to provide high quality care to all of its patients. It took a decision to significantly reduce staff without properly assessing the consequences. Its strategic focus was on financial and business matters at a time when the quality of care of its patients admitted as emergencies was well below acceptable standards...

Stoke Mandeville NHS Trust (2006)

Maidstone and Tonbridge Wells NHS Trust (2007)

⁷ *Fair Society, Healthy Lives* (The Marmot Review, 2010), 38.

⁸ *Otley v Barking and Dagenham PCT* [2007] EWHC Admin 1927; [2007] LS Law 593, para 20.

⁹ See eg, *Supporting rational local decision-making about medicines (and treatments)* (National Prescribing Centre, 2008), 42.

¹⁰ *Commission v France* (2010) ECJ, C-512/08.