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No such thing as fair shares in the NHS

Alan Nathan reports on the ethical and legal issues surrounding the allocation of NHS resources

Not a day passes without news reports of the constraints of a cash-limited NHS, with headlines like: "Paying for the cancer drug Herceptin means other cancer patients will lose out, doctors warn"; "NICE denies access to Aricept for early stage Alzheimer's"; and "Do smokers and heavy drinkers have the right to scarce health care resources?". To what extent does the law set boundaries between the rights of the individual and the wider interests of local and national populations? On the ground, how do health care professionals, including prescribing adviser pharmacists, square their ethical obligations to individual patients with their mandate to stay within budgets or meet government priority targets?

Christopher Newdick, Professor in Health Law at the University of Reading, spoke about rationing, the law and government policy. When it came into office in 1997, the New Labour government committed itself anew to the historic principle of the NHS of providing for everyone whatever treatment was required, based on need and need alone. But it soon became clear that, like its predecessors, the administration was making claims that could not be met from the resources available, Professor Newdick said. The NHS was represented as a comprehensive service that met all the public's needs but patently did not do so, and NHS clinical and managerial staff were caught between the growing disillusion of the public and the tendency of governments to point to them as scapegoats for a failing service. Under the NHS Act, the Secretary of State for Health has a statutory duty to promote (but not necessarily provide) a comprehensive health service. And it has been established through case law that rationing of health services is lawful because a comprehensive service, for resource reasons, may never be achievable.

The Secretary of State delegates his NHS functions to primary care trusts and health boards in England and Wales, and the NHS Acts require them to carry these out within their budgets. The Government established the National Institute for Health and Clinical Excellence with the aim of reducing inequities in access to expensive new treatments, by making expert assessments and issuing technical assistance guidance (TAGs) on whether treatments can be recommended for routine use in the NHS. TAGs must be implemented by local trusts within three months of issue. However, several court cases have established that PCTs have reasonable discretion in the allocation and weighting of priorities. For example, an authority may decide that treatment of cancer or heart disease merits higher priority than treatment for transsexualism, and different PCTs may have different priorities. However, blanket bans are unreasonable and exceptions to policy might have to be made.

A rationing case study

In November 2005, North Stoke Primary Care Trust decided not to fund Herceptin (trastuzumab) which, at that time, was not licensed for the early treatment of breast cancer, for a patient with that indication. Following negative publicity, the PCT reversed its decision. In April 2006, Swindon PCT's decision not to fund the drug was overturned in the Court of Appeal. In May 2006, Herceptin was licensed for use in early breast cancer and, in August, NICE issued guidance on supplying the drug. The cost of treatment is £20,000 per patient per annum (by comparison, treatment for chronic heart failure is £300 per patient per year). The case attracted much media interest and it was suggested that the initial decision to supply resulted from government pressure, overriding its own policy, on the PCT because of the critical media coverage.

Practical pointers for making difficult resource allocation decisions

Rationing brings ethical dilemmas. It is broadly recognised that health need is greater than the available resources and, despite increased investment, not all need can be met, said Julian Sheather, senior ethics adviser at the British Medical Association. There is, therefore, a requirement to find morally acceptable methods of distributing these scarce resources, but it must first be acknowledged that where resources are scarce some legitimate need will not be met, he added.

The dilemma lies in choosing whose needs will be prioritised. There are several possible approaches:

- Absolute equality, where an equal amount is given to all
- A rights based approach, founded on a morally justifiable respect for people's rights
- A distribution in proportion to need (ie, the greater the need the greater the resources provided) based on morally relevant differences

This last approach is intuitively attractive, particularly among health professionals, but its obverse is the concept of "just desserts", which contends that, for example, a heavy smoker's health problems may be self-inflicted and, therefore, less deserving of the allocation of scarce resources.

The meaning of needs and the hierarchies within them — survival, growth, fulfilment — must also be taken into account, Dr Sheather said. However, there is no universal measure by which needs can be evaluated and compared. For example, how can hip replacements be compared with cancer treatment or gender realignment surgery? They are, in reality, incommensurables that cannot be compared but, in the allocation of NHS resources, they have to be.

One method used for weighting incommensurables is quality adjusted life years (QALYs), which compares the cost of interventions for different conditions against the improvement in quality and additional length of life they provide. QALYs are a measure of benefit and, rather than assessing allocation of scarce resources in terms of meeting need, it might be morally preferable to allocate resources to provide the greatest benefit to the greatest number.

In practice, the competing forces of needs and benefits have to be weighed up. In the situation of two patients with the same high need but with one having a higher probability of benefit, should preference for treatment be given to the latter if there is not sufficient resource for both? Also, can a need be distinguished from a want, Dr Sheather asked. For example, should everyone thinking that they need cosmetic surgery or infertility treatment be told to pay for it themselves?

There are some practical pointers to help guide health care professionals who have to make difficult resource allocation decisions. Giving thought to efficiency and avoiding waste will maximise the benefit that can be provided, as will use of treatments for which there is evidence of efficacy, and ensuring that the least expensive of comparable options is chosen. The moral values that should be engaged include: responding to need in proportion to it; distributing benefit as widely as possible; providing maximum choice; and respecting people's autonomy.

In making these morally difficult decisions transparency is essential: decision makers should be explicit about how decisions are made, who makes them and what balancing methods are used. Decisions should be accountable to democratic process and should be open to public scrutiny, Dr Sheather concluded.

The annual seminar of the **Pharmacy Law and Ethics Association** was held in London on 16 May