www.cmf.org.uk

CMF files no:43

Christian Medical Fellowship

Christmas 2010

rationing of healthcare

By Peter Selby

In 2002 *CMF File* 17 considered *Resource allocation* from a Christian philosophical and ethical perspective. The societal debate about rationing is now more intense, and a clinician who sits on a NICE technology appraisal committee revisits it. Demand for healthcare outstrips the resources available, and several possible solutions are considered. Managed supply is seen as closest to biblical principles of distributive justice, and Christians are encouraged to be closely involved.

The problem

The problem, quite simply, is that demand for healthcare outstrips the resources available. At the inception of the UK's National Health Service in 1948 it was thought that making personal and public health services funded by the state widely available would lead to such an improvement in the health of the population that the need for health expenditure would diminish in the future. Bitter experience over the intervening 60 years has shown that this is far from the case.

Increasing health demands from the population, coupled with the availability of ever more sophisticated drugs and technologies, have led to an inexorable rise in the cost of the NHS. In 1949 the total NHS cost was £447 million (£11 billion at 2007 prices); [1] by 2008 this had risen tenfold to £114 billion. [1] These changes have occurred at a time of growing prosperity, but even so this represents a more than doubling of the proportion of gross domestic product (GDP) spent on healthcare. The proportion has risen from 3.5% at the inception of the NHS to 8.7% in 2008. [2]

Similar changes have been seen across the developed world, with the average health expenditure across the OECD (Organisation for Economic Co-operation and Development) amounting to 9.0% of GDP. In the European Union expenditure ranged from 7.0% in Poland to 11.2% in France. [2] However, in the United States health expenditure accounted for 16% of their GDP at the same time.

The proposed solutions

Much of the disease burden in developed nations is now due to so-called 'lifestyle diseases'. Prevention being better than cure, everything possible should be done to curb smoking, alcohol consumption, and obesity, for example. But need, real and perceived, will not go away.

In theory, political choices could be such that health expenditure continued to rise, but clearly, such an increase in healthcare expenditure with time is unsustainable. Different approaches have been used in different economies over time:

The 'market'

This is best typified by the situation in the United States of America where despite a large national investment in the Medicare and Medicaid programmes (for the elderly and the 'indigent' respectively), healthcare is primarily financed by private insurance. Having a substantial proportion of this paid by the employer is often a benefit of employment. Until recently this system has resulted in those who had insurance being able to demand, and get, extensive and expensive investigation and treatment.

At the same time, up to a quarter of the population who have no access to insurance, either because they cannot afford it or because they are deemed uninsurable, have only patchy or no meaningful access to healthcare. Despite the obvious inequities in this system, the distrust of anything organised by the state so prevalent within the American psyche, and perhaps the political influence of the insurance companies, have led to great resistance to any change. Conversely, many Americans point to the perceived shortcomings of the NHS as evidence of the failures of 'socialised medicine'.

Rationing by availability

Until about ten years ago this was the situation which applied within the NHS. By and large, patients in need of emergency treatment were able to access high quality care in a timely manner. However, patients with less acute problems were made to wait on a waiting list, which in some circumstances could delay treatment for months if not years. As a result of this, there were many stories of patients deteriorating while awaiting treatment or dying while on the waiting list for procedures such as coronary artery bypass grafting.

Managing supply

This is the approach which has recently been applied within most European countries. It generally involves some central body deciding on healthcare priorities, and determining on that basis the availability of different treatments within the nationally funded service. Most European countries achieve this by determining whether or not a particular treatment or investigation will be paid for or reimbursed by the healthcare authorities. Although treatments which are not so funded might be available on the basis of individual payment, failure of approval for funding effectively excludes the particular health technology from the national system.

NICE

Perhaps the most sophisticated approach towards this has been taken in the UK, with the development of the National Institute for Health and Clinical Excellence (NICE). This was established in 1999 by Frank Dobson who was then Secretary of State for Health. At the time he expressed two aims for the new organisation. The first was to identify those new developments which most improved patient care, thereby spreading good practice and new treatments quickly across the NHS. In addition it was hoped that NICE would protect patients from outdated and inefficient treatments, and thereby ensure that the NHS got the best possible value for money.

In order to achieve these objects the Institute provides a variety of advice to the NHS. The best known, and most controversial, aspect is technology appraisal in which a new treatment or procedure is examined and, on the basis of cost-utility analysis (where a calculation of the cost of 'Quality Adjusted Life Years' – QALYs – is made), a recommendation is made as to whether this new treatment or procedure should, or should not, be available within the NHS. Such recommendations are binding on healthcare commissioners who purchase treatments.

QALY

The difficult to define concept of 'quality of life' was taken one step further by some health economists who developed the idea of the Quality Adjusted Life Year (QALY). This enables the outcomes (or technically speaking, the *cost-utility ratios*) of different treatments to be compared quantitatively. To do this the quality of life is assigned a value between zero (a life that has no quality) and 1.0 (a life of 'perfect' quality).

If a medical intervention is successful, the assumption is that the person's quality of life will increase. The QALY for a given intervention is then the quality of life experienced after the intervention, multiplied by the number of years that this benefit lasts, which is often the person's remaining lifespan. [3]

In addition, the Institute also develops clinical guidelines in which more complicated clinical pathways are examined; this advice is developmental in nature and is therefore not binding on commissioners or doctors. The Institute also produces public health guidance, and guidance on the safety and efficacy of new interventional procedures.

Criticisms of NICE

The main criticisms of NICE have been in situations where a recommendation has been made that a certain treatment should not be available on the NHS. In most cases this has occurred in respect of expensive drugs for treating cancer, but it has also occurred in the case of medication for common conditions such as dementia and osteoporosis. In most of these the criticism has usually taken the form that NICE has failed to consider all the particular circumstances of the condition in question. [4]

However, criticisms have also been made of the basic approach employed, especially the use of quality adjusted life years. From the time of Hippocrates, doctors have always been concerned to maximise the welfare and wellbeing of their patients, but the idea that each human life can be assigned a 'quality' is a recent innovation, the concept not entering medical practice until the 1970s. [3]

Although it might be presumed that having an independent organisation such as NICE could take criticism about healthcare decisions away from the government, this does not appear to be the case in practice. Politicians still come under intense pressure when a technology has been denied to the NHS, and as a result allocation of healthcare resources remains a deeply political issue.

The current government have announced their intention to alter the way in which NICE advice is implemented. Although the full details of this are not yet available, it is likely that NICE will continue as an advisory body only and that local procurement decisions about provision will be passed to new commissioners, at the time of publication thought to be 'Consortia' of general practitioners.

One potential danger of this approach is that a treatment may become available in one area of the country but not in another. It was the existence of such 'postcode prescribing' that was one of the driving forces for the establishment of NICE in the first instance, so it remains to be seen whether the proposed changes will settle public anxiety or merely deflect anger and criticism in another direction, perhaps towards GPs.

the idea that each human life can be assigned a 'quality' is a recent innovation, the concept not entering medical practice until the 1970s

A Christian response

Death and disease are clearly not part of God's design for his creation but came about as a result of the Fall. Furthermore, we are assured that in his new creation 'there will be no more death or mourning or crying or pain'. [5] However, the passage goes on to say that this will occur as a result of God establishing his kingdom – 'for the old order of things has passed away'. It could therefore be considered an indication of human pride and arrogance that we could even contemplate the possibility of abolishing disease as a result of our own efforts.

The optimism and over-confidence of the authors of our NHS might even be compared to the hubris of the men of Babel. [6] It is therefore incumbent upon Christians working in healthcare, and indeed in politics, to offer a well thought out, biblically-based approach to the allocation of healthcare resources. At the current time, when the size of the public purse will inevitably shrink as a result of the recent recession, it is even more important that Christian voices are prepared to enter this debate.

In the past the most audible Christian response has frequently been one released

in criticism of a particular decision of NICE. Such criticisms have frequently been prompted by compassion for a particular group of patients who were felt likely to have been disadvantaged by a particular decision. These responses are typified by an article in *Triple Helix* some years ago, where it was argued strongly that if a doctor identified a patient who may benefit from an 'affordable treatment' we should prescribe that treatment even if it was not supported by NICE. [7] In doing this the author argued that we should be prepared to risk criticism and even disciplinary action.

While this might appear to represent a superficially attractive way in which we can demonstrate God's love for the individual patient in front of us, the adoption of such an approach could ultimately be counter-productive. Indeed it may actually result in the diversion of resources away from other patients for whom we are caring, and to whom we owe an equal duty of concern. It is inevitable that if we divert limited healthcare resources to one group of patients, these will not be available to treat other patients. Even if we are able to ensure that patients under our own care have adequate access to the treatment we believe appropriate for them, this will inevitably mean that we are depriving patients of treatment elsewhere in the NHS. Christians have a particular responsibility for stewardship of resources. [8]

Furthermore, such an attitude directly contradicts the instruction from the apostle Paul that we should all be 'subject to the governing authorities'. [9] At the time when Paul was writing, the authorities would have been very hostile to Christianity but nonetheless he was able to recognise that ultimately even pagans derive their authority from God. In our post-Christian, increasingly secular society surely the same considerations need to be applied, so that, unless an organisation like NICE is recommending a course of action which is clearly in contradiction of God's will as revealed in Scripture, we should obey their instructions.

It is therefore important for us to consider whether the decisions reached by bodies such as NICE are so clearly counter to God's revealed will that, as Christians, we have no option but to resist them. In order to determine this we need to look both at the rules underlying the way in which NICE undertakes its appraisals, and also the way in which it reaches decisions on individual topics.

Scientific judgments

In formulating its guidance NICE needs to make two different forms of judgment. The first are scientific judgments: although these are often made in the absence of complete information and therefore depend upon many assumptions being made, it is unlikely they would be a major cause of concern for any Christian working in the healthcare field as they are likely to be arrived at using the same sort of analytical approach as is applied to most professional problems. Of course, there may be disagreement regarding the assumptions that have been made, but these are unlikely to trespass on ethical or moral concerns.

Social value judgments

Of more concern are the social value judgments made by NICE during the course of its deliberations. These are now made with the benefit of a policy on *Social Value Judgements* which was initially developed in 2005 and revised in 2008. [10] This makes it clear that NICE works on the basis of the widely accepted moral principles of:

- respect for autonomy
- non-maleficence
- beneficence
- distributive justice

These principles are in line with an earlier *CMF File* by a clinical ethicist which examined the principles of resource allocation from a Christian point of view, [11] though a formal CMF Submission to a NICE consultation on their draft guidelines on Social Value Judgements was somewhat more expansive. [12] NICE acknowledges that there is a tension between a utilitarian approach to justice in which the aim is to maximise the health of the community as a whole, and the egalitarian approach which aims to be as fair to individuals as possible. Therefore, it seeks to ensure that its decisions are undertaken in a transparent manner and that the reasons for those decisions are made explicit.

In reaching any individual decision NICE undertakes a wide ranging consultation, and most decisions are subject to challenge through an appeals process.

Distributive justice

Although none of these policies was developed from a specifically Christian viewpoint, many of the underlying principles would sit comfortably in a Christian worldview. In particular, the concept of distributive justice bears a remarkable similarity to the attitude towards the poor which is demanded by God in the Old Testament and demonstrated by Jesus in the New. God's people were commanded to be generous in maintaining those who could not maintain themselves [13] and to use their tithes to support disadvantaged groups such as aliens, orphans and widows. [14] These were the very groups in Jewish society who were unable to speak up for themselves, yet it is clear that God maintains his concern for them and, in particular, does not wish to see them being downtrodden by groups with greater social standing or economic power.

From CMF File 17, Resource Allocation, by Katie Wasson:
…the two occasions when Jesus fed thousands of people using meagre resources indicate that when a Christian sets out in obedience to God's call to serve, he or she can look to God to provide resources. Many people, like the founder of the Barnardo homes, Dr Thomas Barnardo (1845-1905), and the founder of the hospice movement, Dame Cicely Saunders (1918-2005), have discovered that even though their resources were tiny, God enabled them to achieve much.

It is easy to view resource allocation as a process of basic accounting, but Christians should expect that when they serve God great things happen. None of this, of course, detracts from the responsibility of being good stewards with the resources we have.

In the New Testament we see Jesus emphasising the needs of the poor and powerless over against the rich and powerful. [15] The way in which NICE is constituted ensures that NHS healthcare is available irrespective of economic standing and, equally importantly, is not preferentially targeted at the most articulate who shout the loudest or at victims of diseases which have a greater call on the heartstrings of the public, such as childhood cancers, to the detriment of sufferers of diseases such as dementia who are not able to plead their cause strongly. Surely, these latter groups are a modern day equivalent of aliens, widows and orphans.

The managed approach towards allocation of healthcare resources typified by NICE can therefore be seen as concordant with the basic principles of justice commanded by God and spelled out throughout the Bible. However, before adopting this as the most appropriate way forward to be embraced by Christians concerned with the allocation of healthcare, it is important to consider the alternatives.

Review of the other possible solutions

As can be seen from the large number of people denied adequate healthcare in the United States, where a market model of healthcare delivery applies, it is difficult to see how that particular system answers the challenges of justice demanded in both the Old and New Testaments. Under that system it would appear to be the poor who are denied the healthcare they might otherwise expect (and are possibly more likely to need) and that would seem to be precisely analogous to the situation railed against by the Old Testament prophets. [16] As Christians we should seek a more equitable distribution of healthcare resource.

Although limiting availability through the use of waiting lists does appear, on the surface, rather more equitable there are still problems with this approach. These relate to the facts that it is likely to be the more expensive therapies which are less readily available under this system, and that the main determinant of waiting lists is the availability of resource rather than the actual needs of the individual. This can be an example of 'postcode lottery'.

Participating in decision making

Therefore, if it is accepted that some form of management of scarce healthcare resources is necessary as part of our God-commanded stewardship, it becomes incumbent on any individual Christian in the healthcare system to ask how they should participate in such structures as may exist in their health economy. The response put forward in reaction to the guidance on dementia drugs might not be the most appropriate. On the other hand, it is quite clear from the example given to us by the apostles [17] that we should not mindlessly follow the instructions of a pagan government when they are at variance with the will of God.

I conclude that, in most circumstances, the approaches taken by organisations such as NICE are the closest to offering the justice demanded by our God that we are able to reach within our current healthcare systems. However, these decisions are currently being made in a secular environment without reference to God, and so are bound to be imperfect.

As Christian health professionals we should therefore be supporting the work of bodies such as NICE in our prayers, as well as being prepared to support them in their work by being involved in consultations where relevant, and even by putting ourselves forward to participate in their decision making. Such input may arise from our professional expertise in particular areas of healthcare, but equally might relate to more general policies such as revision of statements like the *Social Values Judgement* document.

Peter Selby *is a consultant physician and Honorary Senior Lecturer in Manchester. He is a member of a NICE technology appraisal committee*

References

1. Office of Health Economics. Sixty years of NHS expenditure and workforce. *www.ohe.org/object/download.cfm?lib=liDownload&id=613*. Accessed 20 November 2010
2. Organisation for Economic Co-operation and Development. *www.oecd.org/dataoecd/46/4/38980557.pdf* Accessed 20 November 2010
3. Adapted from Wyatt J. Quality of Life. *CMF File* 30 (2005)
4. See, for instance, my own comments in respect of osteoporosis: Kanis JA, Adams J, Borgström F, Cooper C, Jönsson B, Preedy D, Selby P, Compston J. The cost-effectiveness of alendronate in the management of osteoporosis. *Bone* 2008; Jan, 42(1):4-15
5. Revelation 21:4
6. Genesis 11:1-9
7. Treloar A. A nasty challenge from NICE. *Triple Helix* 2007; Winter: 5
8. Genesis 1:28
9. Romans 13:1
10. National Institute for Health and Clinical Excellence. Social Value Judgements 2e 2008. *www.nice.org.uk/media/C18/30/SVJ2PUBLICATION2008.pdf* Accessed 20 November 2010
11. Wasson K. Resource Allocation. *CMF File* 17 (2002)
12. Response from CMF to NICE on their draft guidelines on Social Value Judgements. 2005 *www.cmf.org.uk/publicpolicy/submissions/?id=38*
13. Deuteronomy 15:11
14. Deuteronomy 14:29
15. See for example Luke 12:33, 14:12-14
16. See for example Amos
17. Acts 5:29

Past titles in the CMF Files series:

No. 12 *Therapeutic Cloning and Stem Cells*
No. 13 *Do Not Resuscitate Dilemmas*
No. 14 *Genes and Behaviour*
No. 15 *Human Experiments*
No. 16 *Reproductive Cloning*
No. 17 *Resource Allocation*
No. 18 *The Mind-Body Problem*
No. 19 *Advance Directives*
No. 20 *Homosexuality*
No. 21 *Sex Selection*
No. 22 *Euthanasia*
No. 23 *Abortion*
No. 24 *Globalisation and Health*
No. 25 *Gender Identity Disorder*
No. 26 *Speciesism*
No. 27 *Neonatal Ethics*
No. 28 *Saviour Siblings*
No. 29 *Autonomy - who chooses?*
No. 30 *Quality of Life*
No. 31 *Transhumanism*
No. 32 *Human Suffering*
No. 33 *World Population - challenge or crisis?*
No. 34 *Chimeras, Hybrids and 'Cybrids'*
No. 35 *Consequences of Abortion*
No. 36 *Organ Transplantation*
No. 37 *Teenage Sex*
No. 38 *The Family and Bioethics*
No. 39 *The Doctor's Conscience*
No. 40 *The Doctor's Worldview*
No. 41 *Climate Change*
No. 42 *Christians and Medical Research*

This series arose out of discussions within the Medical Study Group of the Christian Medical Fellowship. ©CMF 2010
The views expressed in these papers are not necessarily those of the publisher

Visit *www.cmf.org.uk* to download all the *Files* in pdf format and for more information about medical ethics

Christian Medical Fellowship. A company limited by guarantee.
Registered in England no. 6949436. Registered Charity no. 1131658. Registered office: 6 Marshalsea Road, London SE1 1HL