

Helen Barratt explores the ethical dilemmas facing Clinician-Commissioners

AT WHAT COST?

STEWARDSHIP AND COMMISSIONING

key points

A key element of the NHS reforms will be the transfer of commissioning from Primary Care Trusts to the new Clinical Commissioning Groups (CCGs).

The author explores the ethical dilemmas that clinician commissioners will inevitably face due to the conflict of interest between commissioning for a local population and seeking the best treatment possible for an individual.

A reminder that good palliative care provides an alternative approach to high-cost drugs (with limited effects) raises the question over which is preferable in the light of the biblical mandate for good stewardship. Many complexities remain and discernment will be required when making decisions that impact individuals and whole communities.

Brian comes to see you in your Monday morning surgery. His wife Carol has colorectal cancer with hepatic metastases. All other treatments have failed, but her oncologist has recommended a monoclonal antibody therapy that costs over £10,000. Although the National Institute of Health and Clinical Excellence (NICE) is unable to recommend the use of this medication in these circumstances,¹ the oncologist feels it might extend Carol's life by two or three months. The application for funding is currently being considered by your local Primary Care Trust (PCT) and Brian asks you to chase up the request. They have read about a patient in another part of the country for whom the drug was funded, and Brian argues that surely Carol therefore also 'has a right' to receive it.

One of the key goals of the coalition government's NHS reforms is to shift the power for healthcare decision-making to frontline clinicians. Following the listening exercise and recommendations from the NHS Future Forum, clinical commissioning groups (CCGs) will take on the current responsibility of PCTs to purchase care on behalf of their local populations. CCGs will be composed largely of representatives from groups of GP practices, working alongside patient representatives and other healthcare professionals.

The future of commissioning

Although greater clinical involvement in commissioning has been welcomed by many, the new arrangements pose novel questions for the doctor-patient relationship, as the hypothetical case study about Carol and Brian illustrates. In the past, hospitals have received payment from the PCT for most of the care they provide, according to a national tariff that sets prices for services rendered by the NHS. Requests for treatments which are excluded from the tariff were submitted for consideration to the PCT. Examples include high cost drugs - specialist therapies whose use is often concentrated in a relatively small number of centres. If the use of a treatment was approved by NICE, PCTs would typically approve the request automatically. If, however, the drug did not have the approval of NICE, the request would be considered by a panel of PCT staff including, for example, representatives from commissioning, primary care, public health and pharmacy. The panel would consider evidence relating to the efficacy, safety and cost-effectiveness of the drug as well as the 'exceptionality' of the patient - are they significantly different from the average patient? Are they likely to gain significantly more benefit than the average patient?

Alongside the proposed changes to the way care is commissioned, a Cancer Drugs Fund was intro-

duced in April 2011 'to help cancer patients get greater access to cancer drugs that their doctors recommend.'² £200 million will be available annually for cancer patients in England from April 2011 to the end of 2013, following a pre-election pledge from the Conservatives that patients would be able to gain access to treatments that had been denied to them by NICE. Concern has been raised that such a system could lead to 'postcode lotteries', or geographical variations in care.³ The fund only applies to cancer drugs, but it is questionable whether or not it represents a good use of NHS funding, if the data about the clinical and cost-effectiveness of the drugs is limited.

At the same time, the government has also stripped NICE of its powers to decide whether or not patients should be given high cost treatments. It seems likely that, in the absence of NICE, CCGs will have to decide for themselves whether other drugs represent good value for money for their patients. The change in NICE's role was welcomed by the *Daily Mail*, with the headline "'penny-pinching" NICE stripped of power to ban life-saving drugs.'⁴ In contrast, Polly Toynbee noted in *The Guardian* that 'GPs struggling with the new tensions of distributing a shrinking budget between all patients and conditions will now find it impossible to refuse monumentally expensive drugs that preserve one person's painful last few weeks at the cost of many other lives that could be greatly improved... Will GPs take the flak in their local press if they spend where it works – or cave in to public pressure?'⁵

Future challenges

High cost treatments represent only a small part of NHS care, but they raise particular difficulties. As in the case of Carol, many are therapies for cancer which offer sufferers the possibility of prolonging life. The circumstances are therefore often highly emotive. However, many of the conditions are rare and consequently it is difficult to perform large scale trials, so the evidence base is limited. At the heart of this also lies the tension that Toynbee describes. Commissioners are tasked with doing the best they can for their community as a whole, with a limited pot of money. In contrast, for clinicians, the patient in front of them is paramount. Going forward, clinician commissioners will have to seek to resolve this and communicate the decision to patients and their families, like Carol and Brian.

The ethicists Beauchamp and Childress propose that ethical challenges should be considered in light of their impact on autonomy, justice, beneficence ('doing good') and non-maleficence ('not doing harm').⁶ Prescribing a high cost drug for Carol may be respecting her autonomy and right to choose, but at what price to the local healthcare economy? The prescription may also be considered to be just for her and her family, doing them good. However, is spending the money this way equally just and good for the community as a whole, particularly when resources are stretched? Finally, is prescribing

a drug for which there's limited evidence really in the patient's best interests? Or is it creating false expectations, when a pragmatic discussion about palliative care options may be more appropriate?

Biblical stewardship

The Bible is clear about our role as stewards of God's creation.⁷ With this comes a responsibility to be good stewards of the resources we have been given, and – by extension – a responsibility for those commissioning healthcare to use the funds entrusted to them wisely. We are also charged with a particular responsibility to support disadvantaged groups.⁸ Paul's teaching in 1 Timothy 5 offers a guide for allocating scarce resources. In this passage the apostle discusses the distribution of resources to widows. Paul urges the church to 'give proper recognition to those widows who are really in need.'⁹ He goes on to argue that the church should give priority to those widows with no other means of support available to them¹⁰ and those with a past record of responsible behaviour and service to others.¹¹ However, how should CCGs define need? Would Carol be more 'in need' if she cared for an elderly relative? If she were a former intravenous drug user with hepatocellular carcinoma secondary to Hepatitis C, would there be grounds for not funding her treatment? Restricting treatments only to those who have no other means of support risks further marginalising those in society who are already disadvantaged, unless careful thought is given to the definition of 'no support'.

Decisions about whether to fund high cost drugs will form only part of the work of commissioning groups. However, they provide a useful illustration of the tensions that may be involved in making difficult decisions about which forms of care to fund. Many questions remain unanswered, but being good stewards of the resources God has entrusted to us will involve hard choices about how to simultaneously do the best for individual patients on the one hand and the whole community on the other.

Helen Barratt is a specialist registrar in public health in London currently completing a PhD at University College London



Clinical Commissioning Groups will have to decide for themselves whether drugs represent good value for money

references

1. guidance.nice.org.uk/TA150 (Accessed 2 September 2011)
2. dh.gov.uk/en/MediaCentre/Pressreleases/DH_120941 (Accessed 2 September 2011)
3. Beckford M. Fears of postcode lottery in £200m Cancer Drugs Fund. *Daily Telegraph* 1 April 2011
4. Martin D. Drug victory for patients: 'penny-pinching' NICE stripped of power to ban life-saving drugs. *Daily Mail* 2010, 1 November.
5. Toynbee P. Forget patients - Andrew Lansley is the servant of big pharma. *The Guardian* 2010, 1 November.
6. Beauchamp T, Childress J. *Principles of Biomedical Ethics (5th edition)*. Oxford: Oxford University Press, 2001.
7. Genesis 1:28
8. Deuteronomy 14:29
9. 1 Timothy 5:3
10. 1 Timothy 5:4,8
11. 1 Timothy 5:9-10