NHS Rationing and the Law

Warwick Heale
Devon STP Delivery Director

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MA Medical Ethics

Interest in legal and ethical issues in treatment funding decisions

What are you trying to achieve?

- Optimise patients for surgery.
- Avoid the need for surgery.
- Longer term health.

- Save money and/or improve RTT performance by delaying treatment.

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Key Principles

- The NHS does not have to provide a comprehensive health service, but it does have to provide one that is as comprehensive as possible within its budget.
- Patients do not have a right to any particular treatment (hence IFR processes).
- Patients do have a right to access NHS treatment on an equivalent basis to other patients.

Administrative Law

"*NHS England, clinical commissioning groups, NHS trusts and NHS foundation trusts must act in accordance with administrative law, i.e. their policies and decisions must be in accordance with their statutory duties, be reasonable and procedurally fair. In addition to the legislation on discrimination, therefore, it would be unlawful for those bodies to refuse access on unreasonable grounds*."

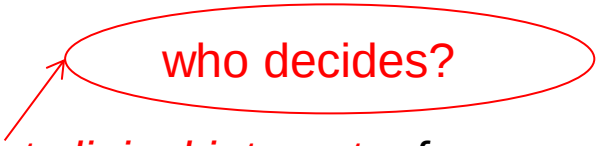
(NHS Constitution Handbook)

Legal cases suggest that refusal to offer a patient (or a group) specific treatment is only defensible if:

- The decision takes account of all relevant factors
- The decision doesn't take account of irrelevant factors
- The decision is transparent
- The process is sound

NHS Constitution

- *"You have the right to access NHS services. You will not be refused access on unreasonable grounds.*
- *You have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible.*
- *The right to treatment is subject to various exceptions. In particular, the right to treatment within 18 weeks from referral will cease to apply in circumstances where:*
  - *you choose to wait longer;*
  - *delaying the start of your treatment is in your best clinical interests, for example where smoking cessation or weight management is likely to improve the outcome of the treatment;*
  - *it is clinically appropriate for your condition to be actively monitored in secondary care without clinical intervention or diagnostic procedures at that stage…"*



It must be OK because others have done it!

- Public accept what the NHS tells them and are reluctant to take legal action.
- Smokers and the obese are sometimes regarded as unworthy:

Daily Mail (21/04/2015)

> **“Smokers and heavy drinkers should pay for treatment of 'self-inflicted' illnesses rather than expect NHS to foot the bill”**

The Guardian (28/04/2012)

> **“Doctors.net.uk, a professional networking site, found that 593 (54%) of the 1,096 doctors who took part in the self-selecting survey answered yes when asked: "*Should the NHS be allowed to refuse non-emergency treatments to patients unless they lose weight or stop smoking*?”**

- NHSE and Government are careful to rely upon adequacy of local processes and the local assessment of clinical evidence (or sometimes ‘clinical opinion’).
- Support of NHSE may be necessary, but is not sufficient. NHSE has been legally challenged in other areas of its responsibility.
- Legal action will fail if it is poorly focused.

Where does this leave us?

- It may be easier to refuse a treatment for everyone (on grounds of relative or absolute cost) than to restrict access for a sub-group.
- Patient autonomy and (informed) consent are fundamental.
- Decisions must be rationally supported.
  - What is level of evidence?
  - How relevant is it? (e.g. crash dieting may reduce BMI, but not improve fitness for surgery).
  - Are we extending it too far?
  - Reliance on clinical opinion is often cited at the individual doctor-patient level, but *evidence* is required in relation to formal policies.
- Compromises between what is lawful and what is not lawful don't work.
- Breaching a right (to access treatment) sets a high bar:
  - A patient has a right to access treatment on the same basis as other patients and cannot be refused treatment on unreasonable grounds.
  - It is not sufficient to show that risks of non-treatment have been mitigated if the right to access treatment has been breached.
  - Contrast:
    - We will not provide treatment to a particular patient unless there are sufficient reasons to provide it.
    - We must provide treatment to a particular patient unless there are sufficient reasons to not provide it.
- A delay in treatment breaches this right (not just a ban on treatment).
- If a delay is justified, nothing obvious on length of delay (but must meet other tests).

Passing the ‘not unreasonable’ test

1. Ensure a sound process.
2. Ensure a comprehensive rather than selective evidence review.
3. Include risks of deterioration with extended waits.
4. Don’t overextend or overgeneralise the evidence.
5. Address gaps in the evidence ‘reasonably’:
   - Evidence that ‘*lower BMI is associated with lower complication rates*’ is not the same as evidence that ‘*reducing BMI prior to surgery reduces complication rates*’, but still might be viewed as a reasonable judgement.
6. Understand all possible pathways and ensure that all are reasonable, e.g.
   - Patient quits smoking for 8 weeks or achieves target BMI, but has access to treatment further delayed.
   - Patient loses weight by crash dieting, reduces BMI but does not improve lung function or muscle mass (i.e. does not improve fitness for surgery).
   - Quit services not available in reasonable time.
7. Don’t focus solely on the ‘unworthy’ patient, think of the ‘worthy’ smoker or obese patient.
8. Recognise the status of the opinion of the patient’s doctor.

How to Respond?

1. Challenge this analysis of the legal position (but simply not liking it doesn't make it wrong).
2. Shape proposals to ensure that they comply with the law (focusing on specific evidence and informed consent).
3. Accept the risk that you might be acting unlawfully and continue in that knowledge.

4. Realign your objectives and stay true to them:
   - Optimise patients for surgery.
   - Avoid the need for surgery.
   - Longer term health.

Other recommendations

1. All CCGs should ensure that their managers and clinicians are familiar with the law on rationing in the NHS.
2. All CCGs should ensure that their Governing Body members are familiar with the law on rationing in the NHS.
3. Guidance for CCGs should be produced.

Useful reading

- NHS Constitution (updated 2015) https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england
- NHS Constitution Handbook (updated 2015) https://www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england
- J Herring, *Medical Law and Ethics,* OUP Oxford 2010
- R Klein & J Maybin, *Thinking About Rationing*, The King's Fund 2012 https://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Thinking-about-rationing-the-kings-fund-may-2012.pdf
- D Lock, *GPs and the Law on Commissioning NHS Services,* GP Law 2014 http://www.gplaw.co.uk/chapter-5-gps-and-the-law-on-commissioning-nhs-services
- M Smith, *Decision Making by Public Bodies: How to Avoid Legal Challenge,* Practical Law Dec 2008 http://www.fieldfisher.com/publications/2008/12/decision-making-by-public-bodies-how-to-avoid-legal-challenge#sthash.ixyEdv2j.dpbs
- A Ford, *The concept of exceptionality: a legal farce?* Med Law Rev 2012;20(3): 304-336.