Briefing

Rationing of health care in the NHS

Governments like to pretend that health care rationing does not exist. However, rationing decisions are necessary to ensure that the NHS provides only treatments that will truly benefit patients. Whether called ‘rationing’, or ‘resource allocation’, or ‘sustainability’, the fact is that when the NHS is when faced with reasonable requests for extra funding to fund something new, something else has to be sacrificed. There is simply not enough money for all patients to receive the best treatment.

A Right to health?

Central to the debate about access to health care and the role of resources is the notion of a right to health. Several sources strongly suggest that such a right does exist. The WHO’s commitment to human rights in health care was reinforced with the publication in 1995 of Promotion of Rights of Patients in Europe, which reaffirmed that: “everyone has the right to such protection of health as is afforded by appropriate measures for disease prevention and health care, and to the opportunity to pursue his or her own highest attainable level of health”.

Patients are encouraged to demand a quality service by documents such as the NHS Patient’s Charter telling them that they have a “right to receive health care on the basis of clinical need, not ability to pay, lifestyle of any other factors.” The European Social Chapter also states in Article 13 that a person “without adequate resources is entitled to the care necessitated by his condition.” A further source is Article 2 of the European Convention Of Human Rights (now incorporated in the Human Rights Act 1998) which states that “everyone’s right to life shall be protected in law. No one shall be deprived of his life intentionally.” In addition, Article 25 of the Universal Declaration of Human Rights asserts that “everyone has the right to a standard of living adequate for health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services.”. The UN Convention on the Rights of the Child recognises their right to the highest attainable standard of health and to treatment of illness ¹.

Treating rights to health care as basic human rights is very persuasive but raises questions as to how attainable these rights actually are in practice.

Legal Framework of the NHS

The legal framework of the NHS is contained in the National Health Service Act 1977 (the 1977 Act) which imposes on the Secretary of State a broad general duty to continue the promotion in England and Wales of a comprehensive health service to secure improvement in the physical and mental health of people and in prevention, diagnosis and treatment of illness (Section 1)².


² The comprehensive nature and standard of this commitment has been the cornerstone of the NHS legislation since the original legislation in 1946 and was expressed in the 1944 White Paper: “Everybody, irrespective of means, age, sex or occupation shall have equal opportunity to benefit from the best and most up-to-date medical and allied services available.”
Furthermore, services must be provided ‘free of charge’ unless the law expressly allows charges to be made.

Other sections impose more detailed duties, in particular, to provide facilities for the care of young children; the prevention of illness and care of those who have been ill (Section 3); the medical and dental examination and treatment of state school children (Section 5).

Section 2 grants the Secretary of State power to provide “such services as he considers appropriate” for the purpose of discharge of his duties and to do “any other thing whatsoever which is calculated to facilitate, or conducive to, or incidental to, the discharge of such duty.”

Under the same section the Secretary of State is to provide “facilities for the prevention of illness, the care of persons suffering from illness and such other services as required for the diagnosis and treatment of illness.”

Section 41 of the 1977 Act imposes upon the Secretary of State a statutory obligation to provide general medical services in accordance with the principles of the Act and ancillary to this to ensure that patients would be treated with “proper and sufficient drugs and medicines.” Nowhere in the Act does it talk in terms of priorities or rationing.

Significantly, as subsequent case law has emphasised, the duties of the Secretary of State are qualified by the requirement of Section 3 that such provision is “to such extent as he considers necessary to meet all reasonable requirements.”

In England and Wales, general practitioners, along with other health professionals and local health authorities, work together in commissioning groups (Primary Care Groups or Trusts) to decide the best health services for their communities. They work within defined budgets, and must take account of local health plans.

The role of NHS trusts is to provide hospital and community health services and in the past they received the majority of the NHS budget. This is being reversed in favour of primary care as the government carries out its stated aim of devolving more power to the frontline services. The New NHS Modern Dependable Secretary of State for Health. The New NHS: modern, dependable (CM 3807). London: The Stationery Office, 1997

**Clinical Freedom of doctors to Prescribe**

One of the principles underlying the NHS was that of clinical freedom of doctors to prescribe whatever medication he considered, in his clinical judgement, was needed for treatment of his patient. Since the 1970's, successive governments have sought to reduce the spending on medicines; through controls on what could be defined as a medicinal product; limiting prescribing freedom through the Selected List Scheme; Clinical Freedom of doctors to Prescribe

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3. The Advisory Committee on Borderline Substances had its terms of reference extended in 1992 to allow it to take into account comparative cost as well as therapeutic use when deciding whether a product was a drug appropriate for prescribing.

4. The terms of reference of the Advisory Committee on NHS Drugs are “To advise the UK Health
and more recently through various initiatives encouraging ‘rational prescribing’. Theses have been viewed by many as a euphemism for restricting access of patients to particular medicines and particularly the more innovative and expensive products. Following the Health Act 1999, the National Institute for Clinical Excellence (NICE) is now charged with the task of undertaking a cost-effective assessment for new drugs and treatments before they are available under the NHS, and the Commission for Healthcare Audit and Inspection (CHAI) (formerly Commission for Health Improvement (CHI)) oversees and monitors adherence to NICE guidelines.

The existence of language in the 1977 Act suggesting that Ministers have a wide discretion in determining what medicines it is necessary to supply under the NHS to meet “all reasonable requirements” indicates the difficulty any patient would face in challenging the refusal of a health authority or NHS Trust to provide a particular drug or treatment.

In R v Secretary of State for SS ex p Hincks (1980) the Court of Appeal made it clear that the Government’s obligation to provide services under the NHS could not be viewed as absolute and in reality it was cash limited. In this regard, no distinction is made between drug and non-drug treatment: “It cannot be supposed that the Secretary of State has to provide all the latest equipment.. all the kidney machines …or heart transplants in every case where people would benefit from them … it cannot be said that [he] has to provide everything that is asked for in the changed circumstances, which have come about. That includes the numerous pills that people take nowadays: it cannot be said that he has to provide all these free for everybody.” Lord Denning MR.

A similar decision was reached in R v Central Birmingham HA ex p Walker (1987) where the Court of appeal refused a mother’s claim that heart surgery, which had been postponed due to nursing shortages, should be carried out on her child. Again the court would not substitute its own judgement for the judgment of those responsible for the allocation of resources unless they acted unreasonably (which they had not).

The both these cases, the patient's lives had not been at immediate risk and this raised the question of whether the court would reach a different decision if that were the situation. This occurred in R v Central Birmingham HA ex p Collier (1988), and the court refused to order ‘life-saving’ surgery on a 4 year-old, postponed because of lack of intensive care beds, despite being in ‘desperate need and would probably die without it’. Stephen Brown LJ said: “… the courts of this country cannot arrange the list in the hospital .. and should not be asked to

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5 R v Secretary of State for SS ex p Hincks (1980) 1 BLMR 93
6 R v Central Birmingham HA ex p Walker (1987) 3 BLMR 32
"intervene" and Ralph Gibson LJ added that the courts: “have no role of general investigation of social policy and of allocation of resources”.

Even in wardship cases where the judges must be particularly protective of the childwards whose fates must be decided, there has been unfailing insistence that resource allocation is not within the scope of the Court's jurisdiction. In Re J (1990) 8, Lord Donaldson MR, giving judgement in the Court of Appeal as to appropriate medical treatment for a severely handicapped baby stated that: “in an imperfect world resources will always be limited and on occasion agonising choices will have to be made in allocating those resources to particular patients.” In re J (1992) 9 concerning the withholding of life-saving treatment for a 16-month-old baby, the court accepted that resource allocation formed a proper part of medical decision-making. Balcombe LJ said: “...The sad fact of life is that health authorities may on occasion find that they have too few resources, either human or material or both, to treat all patients whom they would like to treat in the way in which they would like to treat them. It is their duty to make choices.”

This did raise the question as to whether futility was being used to disguise arbitrary rationing of resources, an issue which arose most acutely in R v Cambridge HA ex p B (1995) 10. Here the health authority refused to fund treatment on the basis that it was not in B’s best interests and was not an appropriate use of the authority’s limited resources. At first instance, Laws J decided that the health authority should reconsider their decision. Affidavit evidence before the court had indicated that one of the reasons for the refusal was the issue of where to allocate scant resources. Laws J stated: “merely to point to the fact of finite resources tells us nothing about the wisdom, or ... the legality of the decision to withhold funding in the particular case. Where a question is whether the life of a 10-year-old child might be saved, by however slim a chance, the responsible Authority ... must do more than toll the bell of tight resources. They must explain the priorities that have led them to decline to fund the treatment.”

The decision was overturned by the Court of Appeal. The court would not interfere with a health authority’s funding decisions providing they were rational and fair: “... health authorities ... cannot provide all the treatment they would like...” and using utilitarian arguments as to the moral basis of their decision: “... difficult and agonising judgements have to be made as to how a limited resource is best allocated to the maximum advantage of the maximum number of patients. That is not a judgement which the court can make.” Sir Thomas Bingham.

The Court also adopted a strong line in R v East Lancashire Authority ex p B and

8 Re J (A Minor) (Wardship: Medical Treatment) (1990) 3 All ER 930
9 re J (A minor)(Medical Treatment) (1992) 4 All ER 614
10 R v Cambridge HA ex p B (1995) 2 All ER 129
others (1997) 11. Even though the treatment 12 was the preferred choice of their doctors due to its safety profile, the court refused to give the necessary leave required to bring an application for judicial review. However, the court did remark that the obligations to meet all reasonable requirements under the 1977 Act suggested that, even when a policy of not funding a particular treatment is adopted, there might be an obligation to consider whether individual cases exhibited special features that should cause them to be dealt with outside the basic policy. Litigation concerning the availability of expensive drug treatments for multiple sclerosis has re-opened the issue by focussing upon the relevance of guidelines for treatment issued centrally by the NHS and has indicated that the courts will intervene where financially driven rationing of expensive treatment is administered irrationally (R v North Derbyshire HA ex p Fisher (1997)) 13. Although the Direction letter from the Secretary of State 14 was found not to impose mandatory requirements, the court considered the decision to disregard its provisions and implement a different policy to be unlawful: “There should be no clinically effective treatment which a health authority decides as a matter of principle should not be provided. There will always be the exceptional case where treatment is clinically justified. To ban treatment in such circumstances would be inconsistent with the principles on which the NHS is established and I do not believe that they represent acceptable practice”. The court considered the submission of the authority that funds were insufficient to treat all patients and that to treat patients on a ‘first-come first-served basis’ would be unfair, to be an irrational reason for providing no patients at all with the drug.

Specific decisions involving resource allocation that have been made based on expert clinical assessment of the patient’s medical needs are most unlikely to be overturned. Decisions may be challenged if they discriminate against certain types of patients; operate blanket policies not to treat particular conditions 15; or break promises to provide particular services 16,17. Age-related denial of treatment would probably not in itself be considered to be Wednesbury unreasonable. This is due partly because the courts are reluctant to make orders they cannot supervise but also because of their unwillingness to be drawn into policy

11 R v East Lancashire Health Authority ex p B and others (Queens Bench Division 27th February 1997; COD 267 - through Kennedy & Grubb (2000)

12 Health authorities refused to fund recombinant Factor VIII on the grounds that cheaper alternatives existed.


14 Executive letters EL(94)72 and EL(95)97 concerning management of experimental drug therapy.

15 A, D and G v North West Lancashire HA (1999) Medical Law Monitor, 8 September

16 R v North Devon Health Authority ex p Pow and Ors; ex p Metcalfe (1998) BMLR 77

17 R v North and East Devon HA ex p Coughlan (1999) Lloyd’s Rep Med 306. Note: the withdrawal of treatment, or refusal once offered, could be considered by the courts as inequitable by defeating a patient’ legitimate expectation
questions about the distribution of finite resources which they regard as questions for Parliament and not the courts.

It is possible that a stronger type of duty may be owed to individuals where statutory duties are more specific such as the Mental Health Act 1983 \(^ {18}\); the Chronically Sick and Disabled Persons Act 1970 \(^ {19}\); and the NHS and Community Care Act 1990 \(^ {20}\). It is not possible to appreciate the full impact of the Human Rights Act 1998, but in as far as it recognises a right to life it is likely that a patient denied life-saving treatment might invoke it (Walters, 2000).

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**www.dh.gov.uk**

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\(^ {18}\) **R v London Borough of Richmond ex p Watson**


\(^ {19}\) **R v Gloucester County Council ex p Barry**

Times law Reports 12/7/96 CA; 21/3/97 HL (The cost of arrangements and resources were found by the House of Lords, on appeal, to be a proper consideration for the local authority to take)

\(^ {20}\) **Batontu v Islington Borough Council** QBD

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Web Sites

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