

The Postcode Lottery

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INTRODUCTION

As an Intensive Care Foundation Year Doctor, I have cared for many patients that are critically unwell. Resuscitation of these patients is stressful and rewarding as I work as part of a team to stabilise and diagnose the underlying condition. The case I will be discussing is unusual in that we had a diagnosis and a plan but the patient was refused access to the optimal treatment. I believe this was due to the 'Postcode Lottery'.¹ This essay explores this phenomenon and how I sought to reason with the rationale behind it.

The NHS is under financial constraint, requiring difficult decisions regarding funding allocation. This reflective essay will explore the problems which arise when resource allocation decisions affect an acutely deteriorating patient with a potentially reversible cause. I will provide an analysis of the salient ethical considerations and their legal implications, and reflect on the emotional strain of these issues on frontline healthcare professionals.

THE CASE

A 70-year-old female was admitted with an upper-gastrointestinal bleed to a district general hospital (DGH). Initial endoscopy identified that there had been a bleed from the patient's small intestine. The patient was haemodynamically stable and admitted to the intensive care unit for monitoring. A repeat endoscopy the following day identified an active source of bleeding; unfortunately, this was uncontrollable. In some centres, urgent interventional radiology (IR) is available for uncontrollable upper-gastrointestinal bleeds.² This was not available. The alternative treatment option is a high-risk emergency laparotomy (the local policy), where the risk to life is considerably greater. The final option is conservative management with the most likely outcome being death. After a significant delay and multi-disciplinary discussions, the patient was transferred to the local tertiary centre and received IR. In this case, it was unsuccessful and the patient refused a laparotomy. The patient passed away peacefully a short time later.

THE 'POSTCODE LOTTERY'

The 'Postcode Lottery' refers to the variation in availability of services within the National Health Service (NHS) dependant on your geographical location in the United Kingdom (UK).¹ The issues arise because there are not national policies on the provision of all services. Instead regional commissioning groups (CCGs), run by General Practitioners, retain the ability to commission services at a local level.¹ As in this case, your location in the UK could mean that there is a discrepancy in the treatments available.

The NHS has a finite budget in which to deliver care. Ultimately as the number of interventions and their costs continue to rise exponentially, while the NHS budget does not follow the same trajectory, there will be an ever-increasing discrepancy between demand and availability. The decision on how to allocate this budget is hotly debated, with regular reshuffling of the organisational pyramid and the development of numerous cost-effective analysis tools.

Cost-effective analysis tools are used by healthcare decision makers to assist funding decisions. These provide a quantitative figure on the efficacy and utility of the intervention in comparison to its cost. The cost-effective analysis tool used in the UK is the quality-adjusted life year (QALY). Those interventions that are deemed to be cost effective by the National Institute for Health and Care Excellence (NICE), are then to be commissioned by CCGs.³ However, it can be more difficult to assess the cost-effectiveness of emergency interventions. There is no QALY data for interventional radiology regarding upper-gastrointestinal bleeds. Decisions regarding the funding of treatment is therefore based upon clinical trial data, where interventional radiology shows superiority over alternative therapy.

Allowing local CCGs some autonomy with their allocation of the budget allows for a community to react to its own needs. Autonomy is defined as the ability for one to be directed in action and thought by one's own considerations, desires and conditions, and not influenced or directed by an external force.⁴ CCGs and NHS England face difficult decisions and have reduced the availability of some non-essential care. Funding of expensive new therapies adds additional strain, which means that services, such as interventional radiology, are not commissioned.

Although the current organisation of the NHS allows a community to allocate funds to those that are in greatest need, it does not fulfil the mandate of the NHS. The current delivery of service has greater appeal to a more consequentialist principle, yet the NHS was founded on egalitarian principles. The current approach to NHS budgeting would appear to refute its foundations.

Total consequentialism explains that:

*moral rightness depends on the consequences for all people or sentient beings.*⁵

For the action to be morally right depends upon the net good from the action outweighing the net bad. Let us test this case; interventional radiology is an expensive service to provide, requiring many highly skilled healthcare professions and specialised equipment. Given the finite budget, this service has been amalgamated into a tertiary centre providing a limited service to surrounding DGHs. Thereby providing the most cost-effective service to the largest population.

FOUNDATIONS OF THE NHS

The NHS was founded on egalitarian principles; that everyone is an equal and deserves equal rights and opportunities.⁶ The principle objective of the NHS is to deliver "appropriate and necessary care" to equals. The necessity of treatment for an uncontrollable upper-gastrointestinal bleed is undisputable, it is life or death, requiring prompt treatment. The appropriateness of an intervention is often a point of dispute. NICE guidance recommends prompt interventional radiology as first line after failed endoscopy where available. Therefore, interventional radiology is both necessary and appropriate.

Interventional radiology was not promptly available so the local policy reflects national guidance; proceed to high risk laparotomy. This does not treat this patient as an equal to those individuals that live within the geographical

area covered by the tertiary centre where interventional radiology is available. Therefore, the allocation of a necessary and appropriate intervention is not equal.

BALANCING OF THE SCALES

One of the four pillars of ethics is justice; a just allocation of treatment within a finite resource. The pillars in this case are competing factors. Autonomy of a community to allocate the resources and commissioning of the most appropriate care, the beneficence of ensuring emergency care is available and the justice of a fair health service.

The distribution of funding is a balance between meeting the healthcare needs of a population and treating individual members of that population equally. The overall budget is broadly allocated proportionally to CCGs by NHS England per population demographics.¹ At this point individuals are treated equally. What each CCG then does with their funding is semi-autonomous, as it must still be in line with national guidance and policy.

A health service free at the point of need, providing an equal service to all is an unwavering foundation of the NHS. A compromise is sought to blend these conflicting and confounding factors. To treat all equally and fairly requires the equal distribution of the initial resources to the CCGs. This can be balanced with the autonomy of a community's decision makers. Agreements between neighbouring CCGs can allow for pooled resources to serve a wider population.

THE EFFECT ON STAFF

This was an incredibly difficult situation to confront as an Foundation Year Doctor, where I became emotionally invested in the patient. I was shocked and angered that interventional radiology was not available. I was aware of budget constraints but this was the first time that I had faced it regarding provision of emergency treatment. Emotions blurred a rational approach to the problem. From the perspective of the intensive care team, there was nothing more that could be done. The patient was adequately stabilised, while treatment was sought.

There was no legal requirement for interventional radiology. No-one had done anything wrong. There was an alternative treatment available. Although not legally wrong, it felt a morally compromised position. Through our own expertise, we were aware of a better treatment option but had no means of providing it initially.

My initial reaction was fight the system, harass seniors, chase the teams involved in the decision-making process, escalate the problem to those that have the power to 'do something'. I was not alone in my action, everyone involved in this case went the extra-mile.

The experience was mentally and physically exhausting. Through reflecting and reviewing the salient points I feel that I have developed a clearer understanding of some of the contributing factors. My understanding of policy has improved considerably. The most important outcome is that the patient received the required treatment, unfortunately it was unsuccessful. A patient safety incident was submitted to the trust regarding the local policy of upper-gastrointestinal bleeds to help future patients. A response is awaited.

CONCLUSION

The issues faced by this patient encompassed an ethical, legal and economic dilemma. Unfortunately, not all elements can be explored in this short essay. The NHS budget is under considerable strain, CCGs are struggling to commission all the treatments that the public demands. The founding principles of the NHS are being scrutinised, as we as healthcare professionals seek to ensure that all are treated equally and to the best of our ability, while decision makers must ration funds.

The patient in this case received the optimal treatment through the hard work of the healthcare team at the DGH and tertiary centre. I fear that as we move away from the egalitarian principles on which the NHS was founded, cases such as these will become more common. Future ethical dilemmas cannot be resolved by the 'good-will' of healthcare professions as this will only lead to a detrimental effect to all. Further research is required to explore these emotionally difficult cases from the perspective of healthcare professionals.

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