Very high cost treatment for a single individual

Sirs,

Wight and Richards\(^1\) describe a case where a Health Authority was requested to fund a high-cost treatment for a single individual. There have been previous cases which became high profile because of intense media interest, such as the case of ‘Child B’.\(^2\)

In Norfolk, six Primary Care Trusts (PCTs) now exist in the area covered by the former Norfolk Health Authority (population 795,144). All six work under a risk-sharing agreement, with PCTs being recharged on a weighted capitation basis, so as to share risk in the event of occurrences such as that described by the authors.

Of note, however, are two recent developments in Norfolk: a Panel set up to consider requests for non-routine/exceptional treatments in individual cases on behalf of all Norfolk PCTs, and a Health Technology Assessment and Advisory Group (HTAG) to advise the Norfolk health economy on new health technologies. A Therapeutics Advisory Group already exists in Norfolk to advise on medicines.

The Panel consists of a general practitioner, a nurse, a commissioner, a public health doctor and a librarian, and meets on a monthly basis to consider requests arising during the intervening period. The HTAG comprises representatives of all PCTs and Provider Trusts in Norfolk (public health doctors, commissioners, finance experts, clinical governance and clinical effectiveness managers, clinical consultants), a health economist, a librarian and two representatives of the public. The Group meets every 2 months.

Both groups are accountable to the Board of the Norfolk Public Health Network, which includes chief executives and directors of public health of all six Norfolk PCTs. Both have defined terms of reference, agreed principles for working, and apart from eliminating problems such as those described by Wight and Richards, also prevent (funding) inequalities surfacing within Norfolk as a result of differences in prioritization between PCTs.

References


Yours faithfully
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Reply

Sirs,

The risk-sharing arrangement between the six Norfolk Primary Care Trusts (PCTs) as described by Dr Rodrigues would undoubtedly be helpful in handling the financial consequences of any case similar to that we described if it should happen in that county. This is as we advocated, and no doubt other groups of PCTs will be taking similar steps. However, I fear that the claim that the Panel and the Health Technology Assessment and Advisory Group will eliminate problems such as those we described is unfounded. The difficulties associated with making judgements about funding where evidence is inevitably non-conclusive, and competing ethical principles lead to different conclusions, still remain. The locus of decision-making would simply be transferred to a different body.

Furthermore, one might suspect that requiring the Panel to make a judgement in a case with such enormous financial consequences might test the extent of delegated authority and the process of accountability. Ultimately, it is the individual PCT Boards that are responsible for financial balance, and they may not be content that this should be jeopardized by decisions made by a separate body.

Yours faithfully
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A CLAS act?

Sirs,

Since publication of our paper\(^1\) it has become apparent that an important reference concerning data on the CLAS programme was inadvertently omitted from both the CLAS programme and the Evaluation section. We would like to acknowledge and correct this oversight. We would be grateful if you could publish a correction, drawing readers’ attention to: