Very high cost treatment for a single individual

Sirs,

Wight and Richards 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’.

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

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 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:


Yours faithfully

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Although only a slightly higher proportion of south-east Asian have decreased if respondents had an active job. We note that at work was related to socio-economic group, as risk factors may significantly, thus confounding the results.

With regard to facilities or health promotion could have changed Asian one, and between 1993 and 1997 the situation in Newcastle earlier and over a shorter period of time than the south-east Asian population was significantly less active than a comparable European one although this difference did not have a significant effect on its cardiovascular risk factors. It seems appropriate that the paper recognizes that health promotion needs to be culturally relevant and there should be further work into the issue of health promotion amongst ethnic minorities in the United Kingdom. We wondered whether there are any plans for qualitative research into health promotion initiatives in Newcastle?

The authors discussed several possible reasons why this difference in exercise should exist but we question why they do not appear to have taken more account of socio-economic influences. It is now well documented that the burden of disease falls more on the poorer than the richer population, and as Hayes et al. point out, many from the south-east Asian community are in the lower income bracket. The Newcastle Heart Project questionnaire might have contained some questions about occupation and we wondered whether occupation could have been used as a proxy for socio-economic grouping at least to see if the ‘European’ and ‘south-east Asian’ populations were comparable? Instead, the authors noted that ‘socio-economic factors … might exert an independent influence on participation in physical activity’.

We also have some concerns about the timeframe over which the study was performed. The European population was studied earlier and over a shorter period of time than the south-east Asian one, and between 1993 and 1997 the situation in Newcastle with regard to facilities or health promotion could have changed significantly, thus confounding the results.

There may also be confounding introduced if physical activity at work was related to socio-economic group, as risk factors may have decreased if respondents had an active job. We note that although only a slightly higher proportion of south-east Asian males had a very active job compared with the Europeans, this could have been enough to skew results in their favour, so reducing the difference between the two populations. This may have also affected leisure activities of south-east Asian males, as their energy levels may have been considerably depleted by heavy work thus they could not be more active in their leisure time.

Finally, we would be interested to know how the authors selected the ‘south-east Asian sounding’ names, and whether there was any effort made to confirm the representativeness of this sampling method.

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