

# The ethics of resource allocation: a case study

The Right Revd John Habgood *Bishop of Durham*

## Author's abstract

*The paper analyses the factors involved in a series of decisions by the Newcastle Area Health Authority concerning the future of one of its hospitals, as an illustration of the way in which choices about priorities in the health service are actually made. There is no easy way to resolve the various conflicts of interest, notably in this case the competing demands of acute and chronic medicine. Difficult decisions are made more difficult, however, by the over-rigid division of medicine into compartments, by mistrust between the medical profession and administrators, and by the inordinately long time-scale of the decision-making process. It is suggested that there might be value in acknowledging explicitly that occasional examples of 'heroic medicine' must not be allowed too much influence in shaping public expectations.*

*The paper results from the deliberations of a working group on current medical-ethical problems, set up under the auspices of the Northern Regional Health Authority (1).*

*(A commentary follows on page 25)*

The purpose of the National Health Service Act of 1946 was to ensure the provision of health services to everyone in the population regardless of financial means, age, sex, employment or area. An implicit assumption was that the provision of such a service would improve health through treatment and prevention, and ultimately diminish the demands on it.

Many of the original aims of the service appear to have been achieved. Higher expectations of health on the part of the population and expanding possibilities for intervention on the part of the professions, however, have led to continually increasing expenditure, and not to the economy expected.

It is often stated that the problems of the National Health Service could be resolved by the allocation of additional monies. Indeed, in the past, this has frequently been the case, at least superficially. The reality now is that the rising costs of health care are of concern to governments throughout the Western world, and produce similar problems no matter how the system is

funded or how much is already spent. In a declining economy the problems are especially acute, and are compounded by the rigidity often imposed on systems when they are under financial constraint.

There is no simple way of deciding, when the demand exceeds the supply, how available resources ought to be allocated. In the past allocations appear to have been made on the basis of tradition, evolution, emotion and optimism.

The traditional basis of medicine is that of saving life. The so-called 'acute' specialties have therefore been awarded priority. Many of the problems with which they currently cope, however, are less than acute and many lives incapable of being saved.

Services have evolved largely as a result of technical developments in investigation and treatment. These have concentrated care in hospitals and have led to an expansion in the concept of routine investigation. While much of this expansion has been of considerable value, some confers doubtful benefit and even possible harm. New techniques have created a demand for universal adoption often with major resource implications.

Emotion affects the decision-making process. Each doctor does the best he or she can for his or her individual patients, but some specialists are in practice able to do more than others. This difference is reflected in the hierarchy of prestige in the medical profession, as well as in the distribution of resources. Physical and mental handicap, mental illness and old age, though regarded with sympathy, have generally not had the same emotional appeal nor invited the same commitment of resources as conditions more amenable to active intervention, for example by cardiac surgery.

Optimism influences decision-making by suggesting that technical advance will achieve therapeutic success. Sometimes this happens. But at other times technical advance in one field, whether or not it is valuable in itself, is achieved at the expense of patients suffering from other conditions, who might have been helped by simpler, less expensive, treatments.

A valuable study, *The Ethics of Resource Allocation in Health Care*, edited by K M Boyd, reveals the complex inter-relationship between these and other factors and the many levels of decision-making involved in the determination of priorities. While stressing that there

## Key words

Ethics of resource allocations; medical ethics; hospital manning; acute and chronic medicine; geriatrics.

can be no general solution to the problems of resource allocation, it encourages the investigation of particular decisions as one way of exposing the actual values being expressed within them. This way of considering ethical issues, by exposing values rather than by arguing from principles, is still relatively unfamiliar. What follows is an attempt to apply the method to a decision made by the Newcastle Area Health Authority concerning the proposed temporary closure of Walkergate Hospital. The example has been chosen not in any critical spirit, but simply because it illustrates some of the complexity of the interactions in a matter which aroused considerable public interest.

The fact that the problem was eventually rendered much less acute by an unexpected injection of new finance does not diminish its significance as a case study. Value-decisions may be highlighted by financial stringency, but this does not mean that they are not implicit when money is more plentiful.

### **The story in outline**

Walkergate Hospital is a small, partly acute hospital, sited in the East End of the City of Newcastle upon Tyne, North East England. Its grounds also house the headquarters of the Northern Regional Health Authority. The hospital has 195 beds for Dermatology, Geriatrics, Ear, Nose and Throat, Ophthalmology, and dental patients. The patients attending the acute specialties are drawn from neighbouring area health authorities as well as Newcastle.

The hospital was first identified as a possible target for closure and redevelopment in 1977, when financial projections by the Newcastle Area Health Authority revealed a probable future shortfall in income of £1.3m. By closing Walkergate as a general hospital and subsequently rebuilding it as an 'old people's village' in partnership with the Local Authority, the Area Health Authority hoped to reduce its current expenditure, while at the same time fulfilling two other objectives. The first of these was the eventual provision of more, badly needed, geriatric accommodation. The second was the completion of the commissioning of a new district general hospital, Freeman Hospital, a matter of particular concern to the Department of Health and Social Security, in view of its intended role as a leading centre for cardiothoracic surgery and urology.

The Area Health Authority's operational plan for 1979/80 stressed the need to reduce stock and plant and to rationalise its services. It pointed out that Newcastle had three major acute hospitals, and the closure of Walkergate would provide an opportunity for redistribution of some of the acute services. Furthermore, it was claimed that Walkergate was old and under-used, and that capital for rebuilding it as a geriatric centre would be easier to find than the income needed to keep it open.

Most of those working in the specialties due to be transferred elsewhere accepted the plan after some initial opposition. However, since at different stages in the discussion different specialties stood to lose most

beds, the focus of opposition tended to shift. The division of medicine, which originally supported the plan on the grounds that it would eventually increase the number of geriatric beds, later withdrew its support through lack of confidence that Walkergate would be rebuilt in the five years proposed. The plan was to transfer 60 geriatric beds permanently to a smaller local hospital, which had previously been closed. When Walkergate was rebuilt, its beds would eventually produce a considerable net gain, as well as allowing greater flexibility in the kind of provision for old people. But doubts were expressed about whether in a period of increasing financial stringency this would ever happen. Despite the assurance given in a subsequent planning document that 'the Authority was resolved that [the plan] should not proceed unless, at the time of the closure, there was clear evidence that the hospital could be brought back into use within 5 years', it is in the nature of such cases that guarantees are not possible.

Meanwhile, in September 1979, a local newspaper revealed the plan before the process of public consultation had been started. Its story began: 'A confidential report calls for the closure of NE hospital units because of the Health Service's chronic cash troubles . . .'. Later, in 1980 and early in 1981, the media gave prominence to the proposals with such headlines as 'Fury over hospital closure threat': 'Councillors issue stern warning': 'Hospital cuts may force old to move'. There was talk about creating an 'old people's ghetto'. The key issue picked out by the media was the threat to Walkergate Hospital itself, as representing the loss of a local amenity even though the hospital does not in fact serve the local community. There was also a lot of emphasis on 'the old folks', with little attention given to other aspects of the operational plan.

There was immediate opposition to closure from some of the trade unions, and the Community Health Council, which did its best to sound public opinion, also reported opposition from those who took the trouble to react. The council itself was worried by the implication of the original plan that there would be no increase in geriatric beds during the five years of redevelopment, and proposed a compromise whereby two of the better equipped wards would be kept open until new accommodation had been built.

In a discussion document issued in April 1981, the Area Health Authority pointed out that a compromise solution could lead to greater capital expenditure while failing to generate the proposed revenue savings anticipated during the period of closure. However, by September of the same year it was clear that more money could be made available from central and regional sources, and the compromise of keeping part of Walkergate Hospital open was adopted as the best way forward. The discussion had thus come full circle, with the original stimulus of financial crisis removed and with two of the objectives, the fuller utilisation of the Freeman Hospital and the promise of 60 extra geriatric beds, attained. The objective of controlling expendi-

ture and providing a more efficient service has not been attained, and it remains to be seen whether the remaining part of the Walkergate site will in fact be developed. A potentially difficult problem, with strong ethical overtones concerning the proper distribution and use of limited resources, was solved (or rather, evaded) in the classic way – by producing yet more money.

### Decision-making

The story, even in brief outline, illustrates the complex balance of factors – political, professional, administrative and psychological which, as well as public opinion, impinge on a decision of this nature.

Mention has already been made of the Department of Health and Social Security pressure to complete the commissioning of the Freeman Hospital within current resources, and it can be argued that if from the start the money for this project had been allocated to other hospitals in the area the overall advantage to Newcastle in terms of efficient service might have been greater. Fashion plays a part in such decisions, just as in a cost-conscious era the relative cheapness of geriatric services has its attractions.

The Regional Health Authority is not directly involved in decision-making about particular hospitals, and endeavours to allocate its funds by the application of general objective criteria related mainly to population, patient flow etc. In this particular instance it decided to rescue the Area Health Authority, though the reasons for this have not been made clear. The fact that its headquarters are in Walkergate Hospital may have made it especially aware of some of the problems and perhaps more sensitive to public opinion.

The main onus of decision-making and pressures from external bodies fell on the Area Health Authority which also had to resolve internal competition between various specialties. It was claimed that the Area Health Authority was not affected by criticisms in the media. As mentioned previously, different specialties at different times criticised the plan and the latest in line, the paediatricians, were still vigorously opposed to it when rescue came. There was also strong pressure from the geriatricians to satisfy their demands for additional beds faster than the five years envisaged.

The Area Health Authority was engaged in a sensitive planning exercise in which the inevitable delays, and the number of specialties whose goodwill had to be won, allowed time for rumours to circulate, opposition to build up, and the least cost-effective solution to win the day. Its difficulties prompt the question: How far are developments controllable in such a diversified field as medicine with so many individual centres of decision-making? The system moreover, has to be open to unpredictable advances in technique as well as to sudden changes in demand. An Area Health Authority's problems in long-term planning are further increased by the fact that unexpended revenue is difficult to accumulate.

The Community Health Council, though its positive proposals correctly anticipated the eventual outcome, was conscious of many pitfalls in its attempts to represent the public interest. Local opinion almost always resists closures, but is usually unaware of the wider ramifications of particular decisions.

The role played by the media in the whole affair is uncertain. Most people claimed to be uninfluenced by scare stories in the press. Such stories can nevertheless have an indirect effect by setting the terms in which issues are discussed. One geriatrician was of the opinion that the press had damaged the cause of the elderly by focusing attention on 'long stay homes for the old folks' rather than on the possibilities of active care.

### Underlying issues

The planners' dream of being able to employ an objective cost-benefit analysis to determine priorities bears little relationship to actual decision-making. Decisions emerge out of complicated interactions, and it is difficult to see how they could do otherwise in a democratic society. Behind these interactions, however, lie assumptions, often unexamined, which need to be brought out into the open, even if this does not make the decisions any easier.

There are, for example, inherent conflicts of interest between acute and chronic medicine. The role of the Freeman Hospital and its effects on the resources of the Newcastle area illustrate the conflict, but it is not a simple case of money for cardiac units versus money for geriatric wards. Developments in acute medicine, and the provision of more acute beds, may relieve pressure on geriatric facilities by allowing more elderly people to return to the community. On the other hand, there is the phenomenon of 'blocked beds' in acute wards, which reduces the overall flow of patients, and can cause frustration and discontent among the staff.

Behind such practical issues lurk major problems of definition, which limit all attempts to compartmentalise. Even the age criteria for 'geriatric' differ between two areas as close as Newcastle and Sunderland. Nor can provision for the elderly be confined to the National Health Service alone. Local Authority Social Services Departments and Housing Departments both have a part to play, not to mention the role of families and friends. The Walkergate Village project was conceived as an attempt to break down some of these compartments, but was criticised as creating a separate compartment for the elderly, and, as has been said, labelled a 'ghetto'.

It would seem from an ethical point of view that the requirement to treat patients as people, and to take account of their total circumstances, weighs against the demands of administrative tidiness. If the system is to be tolerable, though, for those who operate it, some degree of compartmenting is inevitable. Much then depends upon the relationship between the compartments. In a world of competing specialisms there is an incentive to maintain high standards and chalk up

'successes'. But unless competition is balanced by trust it can lead to a kind of defensiveness which in the end works against everybody's interest. Particularly in a time of financial stringency, when everyone wishes to defend his own, it becomes extremely difficult to make bold decisions. In a static system this would be bad enough. Medicine, however, suffers from 'creeping growth' – the gradual and largely uncontrollable accumulation of new ideas, techniques and possibilities of treatment, coupled with continually rising expectations among patients. Pruning what is already there is not easy. The result is that more and more layers are added to an already overloaded structure, while attempts to rationalise or rethink are resisted.

Mistrust between the medical profession, the administration and the public, and between the Government, Health Regions and Health Areas, is exacerbated by the inordinately long timescale in the National Health Service planning process. In the present case a key factor was the original decision to build the Freeman Hospital in the early 1960's. Changes of policy within such a timescale become inevitable, but they give rise to doubts about the ability of the authorities to fulfil their long-term intentions. Such doubts, set within a more general context of competitive defensiveness, and allied with unexamined popular assumptions about the appropriate kind of provision for the 'old folks', appear to have been decisive features in the Walkergate story. A more explicit agreement on general principles might help to strengthen understanding between different sections of the Health Service as a *sine qua non* of successful planning.

## Conclusion

The moral of the story is a confused one. An individual doctor asked to decide between using limited resources for heart surgery or providing facilities for old people might find such a choice intolerable. Committees find it equally hard to make clear choices about priorities, and to stick to them, though they have the advantage of being further from the distressing personal and individual factors which weigh more heavily on those facing actual choices about particular patients. Concentration on more immediate but less personal matters, such as adjustments, costs and bargaining powers, enables decisions to be made, though in retrospect the process often looks messy and the eventual decisions less than ideal.

When the inherent difficulty of the process is compounded by lack of trust, in-fighting and the uncertainties of popular feeling, it is not surprising that a practical solution which avoids the main underlying issues, is grasped with relief.

Subsequent analysis, as in this paper, in allowing some of the underlying issues to come to the surface outside the immediate context of decision-making, might help to improve the quality of future decisions. A more general and widespread examination of basic principles might also help to create a climate of opinion

in which changes could be more readily accepted as part of a comprehensive vision.

A useful start might be made, for instance, by examining the way in which life-saving measures are held in balance with other less urgent goals, such as comfort and convenience, outside medicine. Decisions have to be made on a wide range of subjects from the design of cars to the price of cigarettes. Considerations of safety often have a surprisingly low priority.

There are occasions, though, when in the public mind the saving of a particular life becomes a matter of paramount interest and importance. Huge resources may be used in a single rescue operation, which if distributed more rationally might in the long run save more lives, though in a less dramatic way. It is as if popular feeling needs from time to time some visible symbolic reminder that no price is too high in matters of life and death, while at the same time it is recognised implicitly that most people's day-to-day actions belie this valuation.

Perhaps medicine, too, needs its dramatic and expensive symbols of 'total care'. Apart from their research value, occasional examples of 'heroic medicine' underline the imperative to spare no effort in saving life. No doubt each doctor will continue to think of his own patients as suitable recipients of such care. But administrators, with a more distant view, ought to be able to distinguish between what it is possible to maintain as a norm, and what belongs to the category of the exceptional. The resulting compromise may seem unfair. It is an unfairness which is commonly accepted in other areas of life, however, and there is no inherent reason why the public should not come to accept that the most advanced and expensive forms of medicine cannot be available to all. The fact that they are available to some expresses an intention and a hope, and may pave the way for others to share in them. But the norm has to be set at a lower level.

In planning terms, the explicit recognition that some forms of treatment have this symbolic character, might help to counter the pressure from each specialty to pursue its own interests to the limit. On some such principle as this it might then be possible to ensure better provision of basic medical care for all, while not neglecting the need for experimentation and the possibilities of advance.

## References and footnotes

- (1) Members of the working party were: The Rt Reverend J S Habgood, Lord Bishop of Durham, chairman; Mr S L Barron, consultant obstetrician; Mrs S Burrow, lay member; Professor A L Crombie, consultant ophthalmologist; Professor F T Farmer, former professor of medical physics, University of Newcastle upon Tyne; Reverend M O'Dowd, Ushaw College; Dr J Parkin, consultant paediatrician; Miss D Turnbull, regional nurse specialist (personnel); Professor J H Walker, Department of Family and Community Medicine, University of Newcastle upon Tyne; and Mr D Yare, administrative member.