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Rationing within Healthcare

Obesity and rationing within the NHS: Joint replacement surgery

This paper addresses the problem of whether or not obese people should be blamed for their condition and its clinical consequences — should their obesity affect access to scarce resources within the NHS, including joint replacement surgery? General facts about obesity will be taken as read.[1] For example, we know that:

- large percentages of populations in developed countries are obese;
- obesity is defined in relation to Body Mass Index (BMI), along with other measures, and is linked to a variety of diseases;
- the clinical management of these diseases costs enormous sums of money;
- in the absence of specific genetic orders — it is usually possible for individuals to lose enough weight to lessen the risk of associated disease; and
- there are demands by doctors that life style should play a part in rationing scarce health care resources.[2]

Should people who are obese get less treatment or wait longer for the same treatments as the non-obese? Or should some treatments like joint replacement surgery not be made available until these patients lose an amount of weight dictated by their clinician?

The general moral debate about obesity is polarized.[3–4] Some argue that obese people are irresponsible and can and should lose weight. Conversely, representatives of those who are obese argue that they should not be blamed for their condition but that the food industry is responsible for creating an environment — especially of cheap fast food — that motivates poor choice through deceptive and manipulative advertising. These same moral themes play out in debates about the allocation of scarce resources within the NHS.[5] Should the apparent choice of a life style associated with obesity, including an unwillingness to adhere to clinical advice about its control, lead to unequal access to health care? Those who argue in the affirmative maintain that we all have an equal choice to protect our health. People who make unhealthy choices about diet should receive less care when in competition with those who are responsible. Alternatively, those who oppose such discrimination argue that within the NHS, medical care is a right that should be respected on the basis of need alone and that doctors should not assume the role of 'life-style police'.

That the argument should shape up in this way is hardly surprising for it involves the contentious issue of justice. A well rehearsed definition of justice was formulated by Aristotle: equals should be treated equally. But what should this mean in the context of scarce resources? Moral common sense seems to dictate that personal choice should certainly play a role: 'Since you have already chosen to eat most, your greed precludes your right to more.' Here, greed creates the inequality which justifies unequal treatment. Similarly, concepts of justice and fairness are also linked: 'It's not fair that he's getting the same amount as me since he's chosen to eat more already.' Examples such as these suggest that it is both just and fair for the greedy to get fewer scarce resources than those who make the appropriate moral choices. This paper will challenge the application of such arguments to discriminating against obese people in rationing health care.

The obese should receive less than the non-obese or nothing

Many regard the issue of choice as central to the acceptability of such discrimination: individuals can choose to lose but do not do so. To this degree, they do not behave as responsibly as those who maintain a medically acceptable BMI and hence are not entitled to be treated equally in the face of competition for scarce medical resources (e.g. joint replacement surgery). This argument faces serious problems.[6] To reward those who make good life style choices and adhere to clinical treatment presupposes that everyone has the same capacity to make such choices. But people are

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not equal in their ability to choose how well they look after themselves: they have varying capacities for such choice that are determined by factors upon which they have little or no impact. These include their understanding of relevant clinical information, their levels of self-control in relation to prevention and treatment, the degree to which their social environment reinforces such self-control and their genetic background. If for these reasons, some people are better able than others to make good choices about their weight, it is wrong to penalise those who are not simply because of what appear to be their bad choices. It is like saying: 'You are unfortunate enough to be unable to control your weight for reasons that were out of your control to begin with and now we are going to punish you by giving you less for having been so unfortunate!' Let us examine further these dimensions in the inability of individuals to control their weight.

Understanding

Poor levels of understanding about the reasons and treatments for obesity correlate highly with its occurrence.[7] If obese people have no clear comprehension of the causes and remedies of their condition, it is hardly surprising that they will find it harder to lose weight than those who possess this understanding. There are many factors relevant to such inequality of understanding — particularly the degree and quality of formal and informal educations and individual experience of the clinical relationship. High levels of respect and trust will promote greater levels of understanding and adherence to clinical advice. People who are obese have little control over the quality of the information they receive about their obesity or of the quality of their primary or secondary care. Hence they should not be blamed for their obesity and their access to appropriate NHS care should remain based on need alone.

Emotionality

Equally clear is the high correlation between obesity and low self-esteem.[8] Even when they understand why it is clinically important to lose weight and how this might in principle be done, obese people may still lack the emotional ability to act accordingly. Usually, such lack of confidence will not be confined to one area of their life and will dominate their feelings about themselves and their relationships with others, especially in the context of the stigma that obesity often engenders. Such feelings are deeply rooted in the early formation of their personalities over which they had little or no choice. Emotional confidence leading to weight loss may be improved by good counselling and therapeutic support. But, again, individuals may have little access to such care. They may be less able to lose weight or to avoid gaining it than others who have not been disadvantaged in these emotional ways. To the degree that this is so, to hold them responsible for their obesity makes no sense. To expect them to lose and sustain weight loss before they receive appropriate NHS treatment is therefore to expect the impossible. They should not be discriminated against.

Social and economic opportunities

Obese patients should also have equal access to health care because of the high correlation between obesity and socio-economic environment.[9] Healthy low fat food with low energy output is more expensive than high fat food with high-energy output. Therefore, a bad diet can be a rational choice for obese people on low income. Further, some social environments are less supportive of weight loss. For example, families where obesity is prevalent may be much less able or willing to provide emotional and practical supports to members who need to lose weight, especially when this entails a change of family diet. Therefore, it is morally wrong that individuals from a supportive environment which helps them to maintain a healthy BMI should receive preferential treatment over those who have not been so fortunate.

Genetics

Thus obese and non-obese people may be unequal with respect to their cognitive, emotional and social abilities to maintain a healthy BMI. The same argument obviously applies to inequalities within the population of obese people themselves. Some will be much more able to lose weight — and to sustain that loss —than others. These existing inequalities may be further reinforced by widely differing genetic dispositions favouring weight gain.[10] In this context, to deny those with such dispositions equal access to appropriate care is clearly unfair and unjust — the moral equivalent of abusing a machine for not doing things for which it is not designed.

Principle of equal irresponsibility

We have seen that there are many good reasons to believe that obese patients may not be equal to non-obese patients or to each other in their capacity to maintain a healthy weight. To this degree, it makes sense to believe that such inequality in capacity represents a corresponding inequality in responsibility. Returning to Aristotle, if justice is treating equals equally then it must follow that in the face of such inequalities, it is wrong to discriminate against obese patients in the rationing of health care. However, it would be just as wrong to ignore the moral danger inherent in such an argument: the suggestion that obese people have no choice about or responsibility for their obesity.

It has been shown that proper educational, therapeutic and social supports can help obese people to lose weight and to assume more responsibility for their well-being. Indeed, to deny that obese people have any responsibility for their condition constitutes a denial of their human dignity since this is inextricably linked to the capacity for choice. It might therefore be argued that it is still feasible to ration NHS care on the basis of the *degree* to which obese people are able to make choices about their health related problems. Health care providers will have to be very careful in establishing such degrees of responsibility but when irresponsibility can be identified then discrimination on this basis remains morally justified.

If other patients did not present similar degrees of irresponsibility then this argument might make some sense. However, choices of unhealthy life styles and non-adherence to prescribed care exist in abundance. Thus while it is true that some patients are to some degree irresponsible in specific ways (e.g. obesity), the same can be said of a wide variety of other types of irresponsibility that patients find difficult to control (e.g. alcohol abuse, dangerous pleasure sports, and sexual promiscuity). It is equally true that such irresponsibility can lead to less clinical benefit for those in need of treatment than for those who have exhibited more responsible behaviour. However, lower projected benefit cannot in itself be a reason for discriminatory rationing. Otherwise, calculations about inequality of benefit would justify reducing or stopping treatments at the very times when they were most needed. One can only imagine the impact on daily surgical ward rounds! For both reasons, the most appropriate approach to rationing within the NHS is simply to accept that we are all equal. We all find it difficult or impossible to lead healthy lives at some time and sometimes we all behave irresponsibly. It follows that health care should be rationed on the basis of need and need alone and that obese patients have the same right to appropriate health care as that of any non-obese patient with the same level of need.

Obesity and joint replacement surgery

There is no doubt that obesity increases the probability of orthopaedic problems, especially in later life. When particular joints — especially hips and knees — become compromised, obesity both increases long-term severity and reduces the potential success of orthopaedic intervention. Therefore, just as with smoking and other potentially hazardous activities, the question arises of whether or not those people who remain obese should have equal access to such interventions in the context of scarcity. Some agree with the arguments already developed in this paper. In a recent collection of comments on the topic, Dr. Hector Spiteri states, 'Most illness can be deemed to be self-inflicted or related to things we have or have not done. A caring society must continue to accept the fact that as humans, we all err and will do things to our detriment. If we judge the obese, the smokers and the drinkers as unworthy of our care, how about the socially inept, those who do not contribute to the common good, criminals and all others deemed a burden.'[11]

Others, however, continue to disagree. Arguing in favour of discriminating against the obese, Professor John Wood maintains, 'In our clinic, all decisions on treatment are made on clinical, not financial, grounds. However, running a clinic like this costs money and it needs to be financed by the relevant PCT.'[12] Wood highlights the increased risks that obesity entails both for surgical complications and the long-term success of surgery (earlier failure of joint replacement due to increased load and area of contact).[13,14] On these grounds he implies that it may not be fair to allow obese patients to undergo joint replacement surgery because they will not sufficiently benefit. Wood suggests that obese patients can earn access to treatment though losing weight from appropriate exercise programmes and trips to local swimming pools to engage in 'aqua-aerobics or similar classes.' He rejects the argument that it is arbitrary and unfair to discriminate against the obese on the grounds of life style and not to do the same for, say, rugby players. This is because 'Even if these rugby players required a knee replacement they would be unlikely to get one, not because of their BMI but because of their age.' So what is to be made of views like Professor Wood's?

It has already been argued that the idea that health care should be rationed on the basis of benefit alone calls standard clinical procedure into question. At any given time, there is a wide spectrum of potential benefit among patients all of whom continue to be treated equally. It is true that a threshold of clinical need must be crossed before admission and that this will hinge upon the potential for disability to be meaningfully reduced or eliminated. Yet provided that treatment can lead to such a reduction then a health care system that prioritises justice will allocate treatment on this basis alone. It does not follow from their greater risk of complications and earlier likelihood of failure of joint replacement that obese people will not benefit from surgery in the shorter term. Hence they should not have less access to beneficial treatment than non-obese people. No doubt, there must be some variations of benefit among Professor Wood's own non-obese patients, caused perhaps by other pre-existing morbidity or surgical complications. It is doubtful that retrospectively, he would have provided care only to those whom he now knows would have had the best outcome!

Professor Wood also appears to underestimate the difficulty for some obese people of participating in weight loss programmes. His argument presumes that all obese people have an equal choice about whether or not to participate. Yet for the reasons already examined in this paper, we have seen that this is not correct. Some may have little cognitive ability to understand the importance of exercise; others may understand but still be emotionally unable to act accordingly; still others may understand and be emotionally confident but may not have the money and/or mobility to access the activities to which Wood refers. It is for these reasons that clinicians should not discriminate against obese people who can benefit from joint replacement any more than they should discriminate against rugby players. Professor Wood adds little clarity to this matter through suggesting that rugby players may also be discriminated against because of their age.

Conclusion

This paper has argued that if obese patients can benefit from medical care then they should receive it. They should do so irrespective of their adherence to treatment or to other choices about their life style. It has been shown that such choices are morally complex and that education, counselling and integrated social care should reflect this.[15] A morally wise use of NHS resources calls for a more coherent approach to the recognition and resolution of this complexity rather than the pretence that the best way to save money is through the penalisation of individual patients. Indeed, such a view makes little economic sense

since obese people who are more mobile are more likely to be able to lose weight and avoid even further NHS expenditure on related morbidity. Probably the least likely route to such clinical success is for the trust of obese patients in their doctors to be compromised by fears of unjust discrimination in the provision of their care. In short, we are all equal in that we have greater or lesser abilities to look after ourselves in specific ways. It is this equality that is one of the moral foundations for clinical need continuing to determine who should get what in the NHS. Long may it be so.

Yet it must also be said that the debate about rationing health care should not stop with questions about how the size of the NHS cake should be divided. It should also focus on ways in which to increase the cake itself, always ensuring that resources are properly administered. This means that the debate concerning rationing is not just about health care; it is about politics and political determination. To this extent, there is little to disagree with the way in which Professor Wood closes his analysis: 'If the NHS is going to be forced into rationing secondary to financial constraints imposed by the Department of Health and central government then the BMA should be asking these two bodies to make all decisions regarding who should be getting treatment and those where treatment should be withheld. It should not be doctors doing the DH's or Labour's dirty work.' Indeed!

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Read about obesity and how it can seriously affect your health. Ways to lose weight safely include eating a healthy, reduced-calorie diet and exercising regularly.Â Cookies on the NHS website. We've put some small files called cookies on your device to make our site work. We'd also like to use analytics cookies. These send information about how our site is used to services called Adobe Analytics, Hotjar and Google Analytics. We use this information to improve our site. Let us know if this is OK. We'll use a cookie to save your choice. How rational is rationing? BMA News; 4 Feb, 2006:10e1. The quality of health care rationing. Jan 1995. Qual Health Care. 273-83. L Doyal.Â Many health disparities in the United States are linked to inequalities in education and income. This review focuses on the relation between obesity and diet quality, dietary energy density, and energy costs. Evidence is provided to support the following points. First, the highest rates of obesity occur among population groups with the highest poverty rates and the least education. Second, there is an inverse relation between energy density (MJ/kg) and energy cost (US dollars/MJ), such that energy-dense foods composed of refined grains, added sugars, or fats may represent the lowest-cost option to the consumer. The impact of obesity and increasing age on the outcome of joint replacement surgery remains controversial. The current difficult financial climate has led to an increasing drive towards reducing costs within the UK National Health Service (NHS) and, in a. SC. future where we are facing the use of Patient Reported Outcome Measures (PROMs) data to reimburse Trusts on a Payment by results Basis (PbR), it is important that the. NU.Â It is well recognised that arthroplasty surgery within the United States in obese. MA. patients is associated with increased use of hospital resources and therefore higher financial costs13,14.Â 6. Coombes R. Rationing of joint replacements raises fears of further cuts. BMJ. 2005 Dec 3;331(7528):1290.