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NHS file.

PRIME MINISTER

THE NHS CRISIS: A PRIORITIES APPROACH

The language of socialism, said the founder of the National Health Service, is the language of priorities. What makes this relevant is that the NHS is a Socialist institution - but one without a clear, open and explicit set of priorities for treatment. It thus becomes the equivalent of a Full Employment Bill in India, making unlimited promises to all when only limited promises to some can be fulfilled.

The NHS, of course, has priorities. Accidents, emergencies and dangerous acute conditions will all receive immediate treatment. Some of the recent "heart baby" stories in the press have actually occurred because other cases were more urgent, namely because of priorities. But this is not widely known. Press coverage, shroud-waving consultants, management failures, the mal-distribution of resources have all combined to give the impression that the NHS is in a state of moral chaos in which people in urgent need of life-saving care do not receive it. This is a key influence on public opinion. If a patient who needs a new hip thinks that he and a heart patient are being kept waiting (and dying) because of a mean-spirited Government, he will be angry. But if he realises that he is waiting so that heart patients can be treated promptly, he will be pacified. As the founder of logotherapy, the psychologist Victor Adler has shown, people can accept and even welcome sacrifices that have a purpose. They are driven mad (sometimes literally so) by sacrifices that seem meaningless and arbitrary.

If priorities are to be open and above board in the NHS however, what kind of priorities are we talking of? There are essentially three:

(i) Priorities in treatment: these cover a spectrum from the life-threatening to the merely inconvenient, from the agonising to the irritating. We might ask in this section such questions as: is the condition painful? Does it threaten life? Does it disable some-one from their job or from every day life? And, of course, is it contagious?

(ii) Social priorities: here such unpleasant and unsettling questions arise as: how much should we be prepared to spend on keeping alive a 75 year old man for 10 years?

(iii) Research priorities: should we devote resources to, say, a new technique which is currently very expensive in the hope that we will find ways to reduce the cause and make it generally available. Renal transplants are a successful example of this.

Research priorities are already dealt with satisfactorily under the health service by a policy of central grants. Social priorities are dealt with, however, in a disguised and inevitably unsatisfactory way. In effect, consultants who face budgetary scarcity in a particular discipline may decide that anyone over 55 will not receive a heart by- pass operation in their district. Patients will simply be told: "Nothing can be done, I am afraid". (A comforting thought is that the age of eligibility tends to rise as consultants grow older.)

Ministers will not readily wish to let this genie out of the bottle marked "clinical freedom" without very good reason. But they have little alternative. It is already beginning to be raised in the public discussions of the NHS - and the investigative journalists will shortly be discovering fresh horror stories on these lines. Nothing could be politically worse than for Ministers to seem to be withholding necessary

treatment for budgetary reasons and yet placing the responsibility on doctors. Yet that is how it could appear if we do not publicly address the problem of priorities soon.

There is also a moral point at issue. If people are going to be deprived of the medical treatment that can give them 20 more years of life, they should know about it and be able to make alternative arrangements.

How to handle this problem, however, is still more difficult. Patients above a certain age might in future be asked if they wanted treatment and given the opportunity of counselling, etc. We cannot predict how elderly people, particularly widows and widowers, might react if offered a choice between living a normal but shorter life, and achieving a longer one at the cost of constant pain or dependency upon a machine. Such problems, however, are beyond the scope of this short paper.

The doctor's other dilemmas

It is priorities in treatment, however, which offer real scope for policy changes. Making such priorities explicit is allied to a proposal, advanced previously by Norman Blackwell and myself, to tackle the waiting list problem by giving guaranteed maximum waiting times for certain treatments. If a patient's District Health Authority had not given him treatment when that time expired, he would receive a voucher for full-cost treatment at any hospital, NHS or private, in the country. Categories would therefore be expressed in terms of the waiting time guarantee as follows:

(i) Treatments requiring immediate assistance: this might include accidents, emergency admissions, coronary thrombosis, deep-vein thrombosis, pulmonary embolism, strokes (of various types), perforated ulcers, acute pancreatitis, meningitis

and other infectious diseases, etc., etc.

(ii) Conditions requiring treatment within three weeks: e.g. all malignant disease, cancer of the colon, breast, stomach; etc., life-threatening diseases, e.g. investigation of haematuria; many forms of chronic heart disease, TB.

(iii) Conditions requiring treatment within three months: e.g. conditions which are either painful, or interfering with the patient's life, or produce insomnia; enlarged prostate, hysterectomy for severe menorrhagia, etc.

(iv) Conditions which require treatment within six months: e.g. gall stones, haemorrhoids, hip replacements; conditions which, if untreated, would produce disability; some cataracts.

(v) Conditions which will receive treatment, but with no promise about timing: e.g. cosmetic surgery which is recommended for psychological reasons; minor orthopaedic disabilities; removal of benign skin conditions; uncomplicated varicose veins; persistent disc lesions.

(vi) Conditions which should be treated outside the NHS altogether: e.g. vasectomy, or reverse vasectomy; tattoo removals; sub-mucosal re-section; cosmetic operations; health promotion; alcoholism; birth deliveries.

The above table is included for purely illustrative purposes. It would require a committee of doctors to draw up such a list in reality and, of course, their conclusions would reflect the fact that most minor medical condition can, in certain circumstances be life-threatening. Nonetheless, I would argue that the basic taxonomy is a sound one.

Consequences

Any system of priorities based on a guaranteed maximum

waiting time must have additional resources coming from somewhere. Category (vi) should offer an immediate, if modest, injection of funds; but they would soon be used up. In a system which combines priorities and cash limits, there must be a "residual" category of treatments which loses resources to the priority treatments when they run up against the limits of their pre-set budget. In the above lilst this is category (v). In effect, operations for categories (ii), (iii) and (iv) will continue all year round without let or hindrance - eliminating incidentally the damaging practice described in the DHSS paper in which specialist wards are closed and nurses let go because greater efficiency has resulted in budgets being exhausted before the end of the financial year. This would happen, of course, in category (v) where at some point operations might simply cease in order to leave fungible resources free for elsewhere. But the rationale that such resources were being transferred to patients suffering from more serious conditions would be widely known, and the transfer would accordingly arouse much less resentment.

A second problem is that new treatments emerge over time, often demanding more resources. These would have to be placed in one of the categories. They might also produce some knock-on effects such as pushing other treatments into different categories. For instance, a paliative drug might alleviate a painful and life-interfering condition sufficiently to push curative surgery for it from categories (ii), (iii) or (iv) into category (v). It is quite possible that, over time, category (v) would gradually expand. To decide such matters, there would therefore need to be a Standing Committee on Medical Priorities, based mainly of doctors but also including an accountant and a moral philosopher.

The knowledge of category (v) would markedly increase the incentive to take out "topping-up" insurance for conditions

with an indefinite time for treatment. It would also provide an inducement for private insurance companies to offer low-cost insurance schemes targeted to precisely those same conditions. That is not in the least far fetched. There is at present an insurance company which offers treatment directly linked to the waiting list. If a patient has been on a NHS waiting list for more than six weeks, he can obtain treatment under the scheme. And because of the restricted condition, the premium is low. If NHS priorities were to be introduced, as I suggest, such schemes would be given a considerable boost. Were that not to happen, consideration could then be given either to introducing charges for category (v) treatments, or making private "topping-up" insurance for them compulsory.

It is, finally, worth noting that a system of priorities is compatible with any organisation of health care. If the Government were to adopt a HMO-based system, for instance, this categorisation of priorities would then become the basis of the "NHS minimum package".

Advantages

We can therefore sum up the likely results of a NHS priority system as follows:

(i) It reconciles patient choice (with the GP as gate keeper or travel agent) with cash limits, and therefore makes a true internal market possible.

(ii) It re-assures the general public that life-threatening conditions will be promptly dealt with and that painful conditions will be dealt with in a reasonable specified time.

(iii) It makes the sacrifice of those queuing for category (v) treatments more acceptable to them by establishing clearly that it is the price for saving other people's lives.

(iv) It forces DHAs to face up to questions of allocating scarce resources, including the consultants' time, at the start of each financial year.

(v) It increases the incentive to take out "topping-up" insurance for conditions that either carry an indefinite time limit in the NHS or are not provided by it at all.

(vi) It provides Ministers with arguments - based on need and social justice - which Socialist opponents will find hard to counter. Throwing the Aneurin Bevan question about priorities at Mr. Kinnock and Mr. Foot is using an opponent's strength to defeat him, the political equivalent of ju-jitsu.

Recommendations

I therefore recommend that you establish a Committee of Inquiry, composed of two doctors and one health economist, with the clear brief to report back in not more than six months on (a) health priorities in general, and (b) the establishment of categories of urgency for treatment based upon guaranteed maximum waiting times outlined in this paper.

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