SECRET

10.

PRIME MINISTER

THE NHS CRISIS: A PRIORITIES APPROACH

The NHS already operates a system of priorities. Accidents, emergencies and dangerous acute conditions will all receive immediate treatment. 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 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.

Making priorities explicit leads to a proposal 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.

The above table is included for purely illustrative purposes. It would require a committee of doctors to draw up such a list in reality.

Consequences

A system which combines priorities and cash limits must have a "residual" category of treatments which loses resources to the priority treatments when they run up against the limits of their budgets. In the above list 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 an earlier 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 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.

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. To decide such matters, there would need to be a Standing Committee on Medical Priorities.

People's knowledge that they might have to wait three months, six months or for an indefinite period would markedly increase the incentive to take out "topping-up" insurance for such conditions. It would also induce private insurance companies to offer and market low-cost insurance schemes targeted to those same conditions. (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 for a low premium.)

It is, finally, worth noting that a system of priorities is compatible with <u>any</u> 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".

<u>Advantages</u>

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

(i) It reconciles patient choice 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. It also gives DHA managers an incentive to "place" their patients with another authority before the guarantee expire and they have an obligation to fund an operation in the private sector.

(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. 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.

JOHN O'SULLIVAN