LONGER-TERM OPTIONS FOR THE NHS

Note by the Cabinet Office

1. At its last meeting the Group commissioned a paper on the longer-term options for radical reform in the NHS. This is attached (HC 15).

FIVE BROAD APPROACHES

2. The paper illustrates five broad approaches.

   i. Patient as Buyer would aim to put the main responsibility for arranging health care on to individuals, who would buy what they wanted in the market place. The Government's role would be primarily to regulate the market and finance health care for those who could not look after themselves.

   ii. Local Health Funds introduces the idea of free-standing bodies which in return for an annual subscription from members of the public would negotiate on their behalf with providers of health services - whether public or private - to secure a package of health cover which would meet their needs.

   iii. Independent Hospitals switches attention to the providers of health care and outlines in particular the possibility of putting hospitals on to an independent footing (eg by management buy-outs, selling them or giving them to charities). Public bodies such as health authorities would be responsible for buying health care for people in their areas, and the hospitals would compete for business from them.

   iv. Opting out would be a major innovation in the financing of health care which would allow individuals to choose to finance some parts of their health care themselves (eg through private insurance or belonging to a local health fund) rather than through the State, in return for a rebate on, say, their National Insurance contributions.

   v. NHS refurbished is the present system with organisational improvements designed to improve cost control and efficiency and to encourage trading both within the health service and between the NHS and the private sector, with the money following the patient. These improvements could be seen both as an end in themselves and as stepping stones to longer-term reform.

3. These approaches are not necessarily alternatives. It would be possible to combine elements of all of them in any final package of reforms. The following paragraphs show how they tie in with some of the ideas explored at the Group's last meeting.

CONTINUED NEED FOR GOVERNMENT FUNDING

4. First, one feature common to all approaches is the need for the Government to continue to finance - though not necessarily provide - certain basic forms of health care which would be available to anyone who needed them. This covers in particular those illnesses and conditions which private individuals cannot insure against at reasonable cost and cannot reasonably be expected to afford to pay for themselves: for instance accidents and emergencies, mental illness, mental handicaps and other long-stay conditions, chronic diseases, and geriatric conditions. There is no precise definition of what such essential health care covers, but paper HC 16 sets out in crude form some of the main headings, together with public expenditure on them.

5. Central Government is also likely to continue to have responsibility for financing measures directed at the health of the community generally including preventive care, the control of certain infectious diseases and community health care.

6. On any basis therefore there is likely to be substantial continuing expenditure by Government. But even within this category of Government-financed health care, there is scope for important reforms.

a. There could still be greater independence for hospitals. Although the Government may finance essential health care it does not necessarily have to provide it. Such care could be seen as a baseload of work for independent hospitals. They would carry it out to a required standard under long-term contracts in return for a guaranteed annual payment, while still competing against other hospitals to carry out other types of health care on a repayment basis.

b. There could still be a drive for greater consumer choice, eg for those who wished to buy privacy or other facilities, financed either by private insurance 'topping up' or out of their own pockets.

c. More generally, there could still be organisational reforms on the lines suggested in 'The NHS Refurbished', designed to secure greater efficiency and cost consciousness in the provision of essential services.

HEALTH CARE FINANCED BY THE INDIVIDUAL

7. At the other extreme there may be some forms of health care which the Group considers should not normally be available at the taxpayers' expense. Here again paper HC 16 lists possible headings, together with present expenditure on them. There are two particular points to note.

8. First, there is an important distinction between the NHS not financing certain kinds of health care, and not providing them. It may well be reasonable, or indeed necessary, for the NHS to be able to provide a particular treatment without necessarily being required to do so free of charge. In some cases (eg some forms of cosmetic plastic surgery) the expertise may be needed within the NHS for other purposes but the individual should be asked to pay because the treatment is a matter of personal choice, not a medical necessity. In other cases (eg sports injuries) it could be argued that there should be compulsory private insurance to finance particular types of treatment, even though the actual provision of that treatment might best be carried out within the NHS.

9. Second, although this category is relatively small in financial terms, it is a potential source of controversy. There can be cases under almost any heading where the doctors would advise that treatment is a medical necessity and where the patient is for one reason or another unable to pay. This suggests that there needs to be some form of medical discretion, carefully defined and regulated, to cater for the financing of such cases.

HEALTH CARE FINANCED BY THE TAXPAYER OR THE INDIVIDUAL

10. In between these two extremes there is a wide range of health care where treatment for the sick and injured must be available but its financing could be a matter either for the taxpayer or for the individual, and its provision might in principle be in the public sector or the private sector. Here again paper HC 16 indicates the main headings and their costs. In essence, they cover some 'acute' cases and most 'elective' treatment (that is, conditions with no medical need for immediate treatment).

11. This is the area where the private sector and private insurance are most active. It is also the area where the range of options is widest. The Group may in particular wish to consider three aspects.

12. First, waiting lists. Almost all treatments subject to long waiting times fall under this heading. Paper HC 17 describes the action now in hand to tackle the problem of waiting times and suggests two options for improving the position, which could be explored further if the Group wished:

i. compulsory insurance funding for all elective surgery, with the Government paying the premiums for those who could not afford to pay; or

ii. requiring health authorities to give guaranteed maximum waiting times, backed by vouchers where the waiting times could not be observed.

The Group may wish to commission further work on these options.

13. Second, the concept of opting-out is primarily of relevance in this area. It would be possible to switch the funding of health care to a national insurance (or a separate social insurance) system, and to allow individuals to opt out of that system in favour of private insurance cover for a range of acute and elective treatments. Paper HC 15 outlines some of the main factors - not least the costs - which would need to be assessed. The Group may wish to commission further work on this option as a priority.

14. Third, the introduction of Local Health Funds is also relevant in this area. One of the main concerns about allowing greater consumer choice in the present structure of health care, which is largely monopolistic, is that it would lead to a spiralling of costs. One of the main attractions of Local Health Funds is that they would have the bargaining power to help hold down costs and encourage competition between different providers of health care. They are a flexible concept which could be used with either private or public sector providers of health care. Here again the Group may wish to commission further work as a priority.

15. There are many ways in which these concepts might be developed and explored. One possibility, for instance, would be to combine opting out with Local Health Funds as one of the approved procurers of health care. Individuals who wished to opt out would be allowed a rebate on their national insurance contributions which reflected their age and, perhaps, medical history; and these rebates would be calculated so as to enable them to buy a health care package from a Health Fund or private health insurance. Tailoring rebates in this way would help counter the risk of Health Funds and private insurance creaming off only the most profitable and healthy sector of the public.

CONCLUSIONS

16. These papers are intended to develop the main lines of thinking which have emerged from the Group's work so far. Much more detailed work is needed on the public expenditure and other implications of the options. As a next step the Group may in particular wish to commission papers on:

a. opting out;

and b. Local Health Funds.

Cabinet Office
18 March 1988

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HC 16

CATEGORIES OF TREATMENT

At the Group's meeting on 29 February it was suggested that, in considering methods of financing health care, it might be helpful to think in terms of three categories of treatment:

*category 1: services which, it could be argued, were always reasonably likely to be financed by the taxpayer. These were primarily those forms of treatment which could not be insured against and which the individual could not reasonably be expected to afford.

*category 2: conditions requiring treatment which people might wish to choose to provide for themselves.

*category 3: forms of treatment which individuals were not normally entitled to expect from the NHS.

2. The attached Annex lists some of the main headings which might fall within such categories, together with the associated revenue expenditure.

3. The dividing line between the categories is not easy to draw and a lot more work would be needed before it could be used for any practical purposes. At this stage its main value is as an aid to policy formulation with particular reference to Category 2 and the scope for opting out. There may well be a case for letting the insurance market itself help to determine the scope of category 2. In the case of category 3, some services are already only partly funded by the taxpayer and expenditure is relatively small.

4. The Annex only covers that part of Hospital and Community Health Services which is directly related to the treatment of illness: a total of £8 billion out of £9.7 billion. It does not for instance cover expenditure directed at the health of the community such as:

Preventive care £45m.
Community health services £756m.

18 March 1988

CATEGORY OF TREATMENT

Nature of Treatment	Expenditure 1985-86 figures	Possible Category
Elderly+	867	1
Physical/Mental Handicap	497	1
Mental Illness+	1,078	1
Chronic Illnesses	n.a.	1
Alcoholism/Drug Addiction	124	1
AIDS*	[100]	1
Accidents and Emergencies	454	1 (or 2 since accidents can be insurable)
Blood transfusion	54	1
Emergency Patient Transport	129	1
Maternity	562	1 or 2
Acute (less accidents and elective surgery)	2,781	Some 1, most 2. Information not available to break down.
Elective surgery	1,196	2
Non-emergency public transport	125	2
Aids for disabled	73	1, 2 or 3?
Sports injuries	n.a.	1, 2 or 3
Family Planning**	75	3?
Chiropody (under age 60)	5	3?
Sex change	1	3
"Aesthetic" cosmetic plastic surgery	–	3

+ Includes chronic diseases, defined as conditions which cannot be cured, but can be alleviated, by medical intervention.

* In 1985/86 expenditure on AIDS was nominal. In 1988/89 it is expected to be in excess of £100 million.

** Family planning has been defined in its widest sense to include routine family planning services in family planning clinics, infertility treatment, sterilisation and reversals and abortion (other than for foetal handicap).

HC 17

HOSPITAL WAITING LISTS AND TIMES - OPTIONS FOR PROGRESS

Introduction

After considering Paper HC(3) which sets out details of the composition of waiting lists and their distribution, the Ministerial Group asked for a further paper on waiting lists and times. In this paper:-

- Part I — sets out the nature of the problem (developed further in the Annex), the action now in hand to tackle it, and its limitations;
- Part II — suggests a range of means of intensifying the current initiative within the current structure of the NHS;
- Part III — sets out two more radical options that could flow from the current Review.

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PART I

Basics

2. The problem is waiting time. The size of the list would be irrelevant if it did not contain anyone waiting longer than desired for treatment. Nearly all waiting lists are for elective (cold) surgery.

3. Over time the number of patients referred for hospital treatment has increased broadly in line with the number of patients treated. This has allowed waiting time to remain constant. If a significant and lasting reduction in waiting lists is to be made the rate at which patients are treated has to rise faster than patients come forward. That means either increasing activity (without increasing demand) or reducing demand. ("Demand" in this case is however expressed through the decisions of doctors, themselves the suppliers, about the patients' medical needs).

4. Increasing the amount of surgery carried out (whether in the NHS or privately) the better to meet levels of demand, seems the obvious step. But any action, including the provision of any additional resources, needs to be directed in ways that encourage the successful and efficient, and produce permanent reductions in waiting times. Waiting lists can be cut by surgeons carrying out more operations: but the increase in activity needs to be dramatic, and the effort needs to be sustained over time if the impact on the waiting list is not to be a temporary improvement. Modest increases in activity may simply encourage more patients to come forward for treatment, and doctors to increase their waiting lists. When the short term effects of industrial action in the NHS at various times are discounted, there is a long-term consistent trend for waiting lists to grow, in step with the rising number of treatments given.

5. The other side of the equation, demand, in fact tends to rise because, inter alia:-

(a) trends in the population and in medical technology are increasing the scope for surgery;

(b) by international standards our rates of surgery per 000 population are low, and there is undoubtedly a large reservoir of untreated but operable illness in the community;

(c) doctors, especially surgeons, rather than managers (or even patients) are necessarily the arbiters of whether and when treatment should be given, what form it should take and how it should be handled.

6. Most patients on the waiting list are (medically) non-urgent. By definition they represent for the doctors concerned a lower priority than many other patients. Attempts to treat non-urgent cases ahead of cases they consider more urgent are unlikely to succeed.

Current policy

7. Since July 1986 making improvements in the time patients wait for treatment has been a high priority. The policy behind the current initiative is to try to increase the amount of surgery done by:-

(a) modest injection of additional funds to permit more operations to be done;

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(b) particular concentration on "blackspots" where waiting times are especially bad;

(c) setting local targets for waiting time and standards of service;

(d) agreements between managers and surgeons aimed at reducing waiting times; and

(e) providing information to GPs and the public about waiting lists to encourage referral to those places with the shortest lists.

8. This policy will not lead to markedly increased rates of treatment and is essentially long term. It can by no means be certain that it will produce early dramatic results, because:-

(a) the acute sector generally is under considerable pressure and constraints and when something has to give it is non-urgent (waiting list) work that suffers; but also

(b) as particular waiting list problems are solved that stimulates additional referrals from GPs.

When the figures for September 1987 become available next month they will need careful interpretation because of changes in the basis on which the data is now being collected. It is probably as the result of the present initiative that they will show a slight reduction in the numbers waiting for inpatient treatment. But for that, increasing demand and present constraints would probably have led to an increase in the waiting list. Nevertheless, the visible impact will be small.

9. To achieve more impact the existing initiative could be reinforced. Part II of this paper sets out suggestions - some of them fairly radical - for strengthening our attack on waiting lists within the existing framework of financing and management. But none of these ideas is likely to shorten waiting times to the extent that the problem is removed. For that more radical options need to be considered in the context of the review as a whole. These options raise questions about the methods of financing health care which are discussed more generally in the paper on "Options for Change (HC 15). The options also have the advantage of providing a practical illustration of how changes on a broader front might affect current NHS problems. Two such possibilities are considered for illustrative purposes in Part III

* funding elective surgery through insurance

* guaranteeing a maximum waiting time, backed by vouchers.

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PART II

INTENSIFYING THE WAITING LIST INITIATIVE

10. The present waiting list initiative looks likely to be effective in its limited objective of treating an additional 100,000 waiting list cases. It has:

- been useful for managers by giving them an entry into discussions of clinical practice;

- fostered cost effective forms of care;

- probably prevented waiting lists increasing further.

It could, in time, turn the trend but is, at best, a long term solution and is unlikely to change the nature of the problem. There are however a number of ways in which the present initiative might be intensified as discussed below.

General practitioners

11. The present initiative has concentrated on the supply side - additional patients treated by hospitals. The Primary Care White Paper made it clear that the Government intends to introduce an incentive into the remuneration system to encourage general practitioners, with the appropriate training, to carry out minor surgical operations, and this could take some pressure (though limited) off hospitals.

12. The rates of referral of patients to hospitals by GPs vary very widely. Just as with the prescribing of drugs, GPs could be provided with information about their referral rates to hospitals, and, in appropriate cases, counselled by an independent doctor. The Primary Care White Paper proposes that Family Practitioner Committees should use independent medical advisers to encourage good practice in the referral of patients to hospital. This could lead to an easement of the problem - particularly for long waits for out patient appointment and diagnosis.

13. The present initiative encourages provision of better information to GPs and patients about waiting lists and times. Most regions have reacted well to this aspect of the initiative. Several are using information technology and are evolving local systems. Experience so far shows that better information does enable some GPs to make better referrals but the benefit is marginal. Waiting lists change only slowly and GPs appear to be more interested in details of the names and special interests of consultants. Patients are not usually keen to travel far, especially when they are elderly. With tighter budgets, hospitals and doctors are not keen to receive other districts' patients without any additional funding.

14. Many GPs would nevertheless welcome better information for them to make appropriate referrals for a few difficult cases. It would be feasible to develop a regional or national network to provide each general practitioner with a VDU capable of displaying waiting list and time information as an aid to decisions on referrals. This could be done in a number of ways. The better systems would allow other information to be presented to GPs including:

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- prescribing rates and costs;
- adverse reactions to drugs;
- relative costs of drugs;
- specialties of consultants;
- private sector availability.

The more flexible the system the higher the costs are likely to be. Using existing Prestel systems (not itself recommended) would mean an initial capital cost, for giving some 24,000 GPs and 500 hospitals a basic terminal, of some £7m. The annual revenue cost would be some £6m. There is scope for private sector co-operation which could reduce costs. However in terms of significant improvements in waiting times this option alone is unlikely to be cost effective. The extent of its effectiveness could be tested on a pilot basis.

Incentives for consultants

15. It would be possible to give consultants financial incentives to do more waiting list cases, eg by payments related to the volume of work done or by altering or adding to the distinction award system so as to reward high activity rates. Such systems might well prove very costly; they could lead to distorted priorities and to problems with other groups of staff not so favoured; and the outcome could be to push up activity levels through unnecessary surgery but not to reduce the waiting list. Payments to consultants linked to short waiting lists unless firmly linked to high activity rates might well be represented as an incentive to idleness.

16. It is sometimes said that the possibilities of private practice give consultants a wrong incentive, ie to have a long waiting list. It has been suggested that any consultant with a long waiting list (say over three months) should be precluded from undertaking private practice. Alternatively, such consultants might be precluded from treating as private patients any patient whom they had previously seen or treated under the NHS. Both options would be extremely contentious with the medical profession. Disincentives rather than positive encouragement might actually retard the development of a 'mixed economy' in which the private sector played an increasing role.

Offering patients the right to go elsewhere/common pooling

17. Some GPs and patients prefer particular consultants despite their long waiting lists because of high clinical reputation. However most patients have little option. It would be possible to introduce a standard practice whereby patients who have:-

- already waited a set period; or
- were likely to wait a considerable time,

were automatically offered an alternative. This could either be referral to another consultant with a shorter list or entry to a common pool. Patients entering the common pool would be given a high priority for treatment and all consultants in the specialty would be expected to treat a proportion of "pool"

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patients each month. This option would probably be unpopular with the medical profession though it would increase consumer choice. It would have only a limited effect on waiting times.

Targeting funds to deal with waiting lists

18. The present waiting list initiative has provided £25m (£30m in 1988/89) for targeted action to reduce waiting lists. In principle this technique could be used more extensively, even to the point of hypothecated district budgets for agreed rates of elective surgery. In practice the protection, by earmarked funding, of waiting list work at the expense of other work which is probably of higher medical priority would be difficult - and in extreme cases impossible - to justify.

19. A variant could be to make use of under-used capacity in the NHS and private sector to stimulate expansion for selected, high priority treatments of proven health benefit. A defined list of cold surgical procedures could attract direct central government funding, based upon marginal costs. Such a scheme could be piloted for a narrow range of defined procedures. Overall costs would be likely to rise.

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PART III

20. Within the context of the review the Group will consider more radical options for the structure and funding of the NHS. It is possible, however, to limit the coverage of a change in the structure of funding. Elective surgery is not entirely separate from other surgical and medical treatment but it is possible to consider options for change limited to this category of treatment. It accounts for some 2 million NHS inpatients a year (one third of all in patients) and almost 1 million day patients. The options set out in Part III are examples. Others can also be explored by the Group members.

Option 1: Insurance funding for elective surgery

21. The NHS does not have a monopoly of elective surgery, particularly for routine procedures. The private sector already does over 13 per cent of elective surgery and this is rather higher for some procedures (25 per cent of hip replacements are done by the private sector). However the private sector is mostly used by the insured population, which does include very few of the elderly, the major users of the NHS. It would be possible to remove most elective surgery, say, 80 common surgical procedures, from tax-funded provision. There would need to be a requirement for compulsory insurance. Those who could not afford to pay would be bought in by the Government. The cost of premiums would not be very high for those of working age, since cover would fall short of full BUPA type cover*. The cost to Government of insuring the elderly and others unable to pay the premiums would be much higher but there would be significant offset to Government through a reduction in health authorities' allocations since these would no longer bear the cost of elective surgery. Overall control of public expenditure costs would be through control of rates of subsidy for insurance premiums.

22. This proposal would enable NHS and private sector hospitals to compete for elective surgical work. The private sector would not have the capacity at least initially to carry it all out. NHS hospitals would continue to carry out elective surgery to the extent that they could attract the business. Funding would go with the patient. The NHS would continue to provide all other medical services, including emergency acute care, psychiatric and geriatric services, free of charge as it now does.

23. **Some pros and cons**

Pros	Cons
(a) Amount of elective surgery would rise sharply - probably to the point at which waiting lists ceased to be a problem.	(a) Some of the surgery done would be of doubtful value. Shortages of surgeons and support staff might either frustrate growth of elective surgery or lead to problems in coping adequately with more urgent work
(b) Money would travel with the patient, enhancing consumer choice.	(b) Defining the procedures to be covered and fixing the rates would be new bones of contention with hospitals and doctors.

*BUPA are about to market a cut rate scheme for elective surgery at markedly less than normal premium rates.

(c) Payment of premiums and billing for individual procedures would make costs visible to all.	(c) Total costs to the community would almost certainly be higher, and probably much higher.
(d) NHS and private hospitals would compete for business.	(d) The necessary financial administration and insurance enforcement would mean extra costs.
	(e) If NHS hospitals lost large amounts of work the viability of individual hospitals could be impaired (eg trauma work, which the NHS would continue to do, depends on routine orthopaedic work to be economic). This is unlikely in early years. However the best staff may no longer be there to do emergency work.

The system could result in large increases in earnings for surgeons and private sector attractions could force up NHS salary rates. A new form of contract would be needed, at least for some groups of consultants.

Option 2: Give guaranteed maximum waiting times, backed by vouchers

24. Under this option the existing arrangements for financing and providing elective surgery would stay intact, except that health authorities would be required:

(a) to give a guaranteed minimum level of service to patients in their catchment area, eg no one need wait more than six months for any of a centrally determined set of procedures; and

(b) to offer a voucher, equal to the cost of obtaining the procedure he needs, to any patient who does not get treated within the guaranteed period. The patient could then, if he chose, obtain treatment elsewhere, using the voucher to pay for it.

25. It is impossible to judge precisely what impact such a scheme would have on waiting lists and times. On the assumption that NHS hospitals would have to finance the vouchers from within present budgets, these hospitals would have a strong incentive to cut out long waiting at least for those treatments for which maximum waits had been set. However this could be done in ways that did not necessarily benefit patients eg by simply refusing to accept GP referrals or by accepting them but then distorting priorities so that all or nearly all patients got treated within (say) 6 months but urgent patients waited longer than before (say on average 2 months rather than one month). If the set procedures for which maximum waits were prescribed were few, the health authority would need to look for reductions in other elective surgery - with consequential increased waiting for low priority treatment.

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26. **Some pros and cons**

Pros	Cons
(a) Takes some of the political sting out of waiting lists, and puts pressure on hospitals and doctors to ensure waiting times at least for high priority treatment are reasonable.	(a) Impact on waiting lists and times problematical: might be cosmetic rather than real.
(b) Gives guaranteed level of service and strengthens patient's rights.	(b) Budgetary control very difficult: doubtful if compatible with a cash limit system.
(c) In some cases money travels with patient, enhancing consumer choice.	(c) Would probably require significant additional funding to ensure vouchers did not erode hospital budgets unacceptably.
(d) Voucher system makes costs visible to all.	(d) Increased administrative costs.
(e) To a limited extent encourages competition between NHS and private sector.	(e) Very difficult within present structure for management to achieve savings in low priority treatment to achieve short waits for high priority procedures.

Further work

27. The detail of the options could be readily adapted if necessary: for example, funding of elective surgery could be through social insurance with provision for reduced contributions if private health care arrangements are made instead.

28. The options need to be worked up in more detail in the context of the review as a whole, if Ministers are attracted by either of them. Officials could do this in the light of Ministers' response to the general options paper (HC 15) and any further work put in hand as a result of this paper.

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WHY THERE ARE WAITING LISTS

Introduction

1. This annex discusses:-

- the significance of waiting lists;
- their relationship to numbers of patients treated;
- their function; and
- some of the reasons why some patients wait excessively.

A measure of unmet demand?

2. Waiting lists have been a feature of the NHS since it began. By 1949 they stood at around 500,000 and they have not been significantly below that figure since. The public regard the waiting list as the measure of the gap between supply and demand in the health service and so focus on movement up and down as an indication of success or otherwise. The Korner statistics from June 1987 will do this better by comparing numbers of patients treated in a quarter with patients entering the list. Up to April 1987, however the waiting list had severe limitations as a measure of this sort. These include:-

(a) It is a snapshot at a census point. Within the total list it does not distinguish between people who have been waiting a very few weeks (quite acceptable) and those waiting many months (probably less so, but it depends what they are waiting for);

(b) It overstates the problem. At any census point people waiting a long time are likely to be disproportionately represented. A patient's expectation of early treatment when entering the list is far better than the 25 per cent on the list for more than a year suggests;

(c) It is inaccurate. Experience has shown that lists - particularly long lists - contain many people who no longer require treatment. They may have moved, changed their minds, been treated already elsewhere or as emergencies. They may have died, normally of other conditions. Experts believe this inflation could be as high as 10% though health authorities are now strongly encouraged to keep lists accurate;

(d) They do not actually reflect need. There are two clinical decisions before a patient reaches a waiting list - the GP's decision to refer, and the consultants to treat. Different clinicians reach different decisions, taking account of clinical factors but also, to varying degrees, of priorities and available resources. This level of expressed demand is likely to be quite distinct from underlying need. It will differ markedly geographically.

At best the waiting list is an indication of the number of commitments to treatment entered into by the NHS which at given date had not been met. The vast majority will be honoured within a very few weeks of the census date.

A queue?

3. The waiting list is not a simple queue. "Last come" is not "last served" - often quite the reverse. The waiting list is a pool. Patients are selected from the pool on grounds of:-

(a) clinical priority; and

(b) the special interests of the consultant; and

(c) available operating slots; and

(d) the training needs of junior medical staff.

In the main most patients treated will be at the high clinical priority end of the spectrum of need. High priority patients on the waiting list will have a rapid turnover. The extent to which low priority cases are also treated depends upon clinical practice which can differ. For instance, a balanced operating list for one consultant could be one major operation and two minor. For a second it could be two major cases. The second is likely to have a longer waiting list.

4. The fact that the rapid turnover from the waiting list can be limited to high priority cases means that for a given consultant there is no necessary link between increased numbers of patients treated and the size of the waiting list.

Categories of patient

5. High clinical priority depends on the patient not the condition. As explained in HC(3), already considered by the Group, the waiting list comprises, in the main, patients who do not wait excessively. Yet the urgency of an individual patient cannot simply be judged by the condition. For instance most patients with prostates or hernias are capable of waiting many months. But some become emergency admissions in a matter of hours. Some cancer treatments do not need "emergency" - that is immediate - admission. But their treatment is not in any real sense elective.

6. On the waiting lists, at least in theory, are life-threatening cases which need very early admission but also other urgent cases. In this latter category - which could include for instance glaucoma cases - the urgency is that there is a limited window for successful intervention. Once that window is missed, the patient lives but the resulting disability can no longer be treated. These are extreme examples of the high priority cases that will always be treated in favour of other "waiting list" cases.

Long waiting lists inevitable?

7. Some list and some waiting is inevitable within a health care system if facilities are going to be used efficiently. Yet there is no underlying reason of principle for excessive waiting time, even as a rationing device. Nor is the current size of the list necessary for efficiency. Different sizes of districts and different specialties will require different sizes of pool for efficiency but the regional and national totals would be far less than current levels.

8. Over time the total waiting list has increased in line with numbers of patients treated. In part this may be the effect of supply stimulating demand. Given that total potential demand greatly exceeds current levels of supply, such

a relationship could be expected. An analogy however can be made with an efficiency supermarket. As the supermarket increases numbers of customers each year, the number of customers in the shop before reaching the till at any time would be higher. Yet if the supermarket increases its efficiency then no individual customer waits longer. On a national level that is apparently what has been happening with waiting lists and patients treated.

9. Yet the analogy breaks down at regional level. Over the last four years several regions have experienced rapidly increasing rates of elective surgery which have allowed waiting lists to be reduced and waiting times reduced. There is, apparently, no necessary link between increased activity and increasing demand at least in the medium term. If clinical practice could be influenced to the extent that additional patients treated were at the low priority end of the spectrum, that is patients who had already waited excessively, this is likely to produce a slight stimulus to demand but there is no reason why the improvement once achieved could not be sustained.

10. Other than as a rationing device, long waiting lists are not inevitable. In countries such as Germany with far higher numbers of surgeons and beds, there are no waiting lists. The high cost paid is not just inefficient excess capacity but probably also unnecessary surgery. In England, the numbers of surgeons available in the foreseeable future would be a brake on any tendency towards unnecessary elective surgery.

Causes

11. Experience in analysing several of the longest lists in the country, has suggested to some experts that there is no single cause of excessive waiting time. The cause of each list needs local investigation. HC(3) listed some of the possible causes:-

- efficiency (a poor workrate, low throughput of beds, inadequate discharge or admission procedures);

- bottlenecks (anaesthetists, specialised nurses, beds, operating sessions etc);

- minor capital.

The cause could also be clinical practice (a consultant with a special interest) or even the condition in question (tonsils and adenoids represent 4% of the total waiting list and yet there is considerable clinical doubt as to its worth as an operation).

12. In the main, however, the waiting lists are their current size because they have been traditionally accepted as a necessary rationing device to enable high priority cases to be treated. Clinicians when seeing patients at out-patient clinics tend to decide not that every patient is a priority for treatment within available resources, nor that the patient can be treated within a reasonable time. Rather they decide that a patient can be aided by their clinical intervention. It is later, when operating theatre sessions are being planned, that decisions on relative priority are taken. This can leave patients capable of being aided but of low relative priority on the list for a long time. The cost of that approach is that hidden within the low priority cases are many with increasing disability or in pain and discomfort.