CONFIDENTIAL

PRIME MINISTER 27 July 1990

NHS : MANIFESTO
WAITING TIMES FOR ELECTIVE SURGERY - A THREE POINT PLAN

There is no doubt that waiting time - for outpatient appointments and in-patient surgery - is the greatest concern among patients.

In a confidential Gallup Poll conducted last September, 400 GPs were asked 'what, if anything, is the greatest concern expressed by your patients about the service they receive?' Over three-quarters mentioned waiting times. The next concern was a mere 2% (future of the NHS) and 2% (time available with the doctor).

And out of almost 300 hospital doctors, around 50% gave waiting time as the most worrying concern of their patients.

In the words of one doctor, who is a senior health authority manager in the Northern Region 'Although many, many surgeons work conscientiously and extremely hard to reduce delay for patients requiring care, the attitude and behaviour of a substantial minority of consultants is a major barrier to reducing waiting times. Unsatisfactory waiting times are a much greater concern to patients and the public generally than they seem to be to some clinicians and managers'.

There would be enormous benefits if we could address this problem head on. This paper proposes a three point plan, building on the NHS reforms which would guarantee a maximum waiting time for in-patient surgery.

Trends in waiting

Waiting lists are split into in-patient cases and day cases.

Unfortunately, day case totals go back only as far as 1987. Yet three points are clear:

First, September 1989's in-patient waiting list was about the same level as in 1979 (700,000 people). This disguises:

(positively) - a substantial increase in the numbers of in-patients treated since 1979 by one and a half million each year to a total of over eight million a year.

(positively) - a slight fall in the numbers of people waiting over a year for in-patient surgery, from 28% of the list in 1979 to 25% today.

(negatively) - this has been offset - to an uncertain extent- by a substantial rise in the waiting list for day cases (currently 180,000 people).

Second, of the total of 880,000 people waiting (in-patient and day cases), 220,000 people have been waiting for more than a year.

Third, if self-deferral cases are also added, there were about 920,000 patients waiting for surgery in September 1989.

The 220,000 long wait patients are the most significant, especially those in pain waiting for a hip replacement, or those struggling to see properly while they wait for a cataract operation.

And if we are not careful, there is a risk that the numbers of long wait patients could increase. This is because DHAs are being forced - quite sensibly - to eliminate any funding

deficits built up over the years. St Thomas's Hospital is an example. Waiting times for elective surgery could be the fall out.

Will the NHS Reforms make a difference?

In the long-run, the benefits will be enormous.

If hospitals continue to run outpatient clinics for the benefit of the consultants only, patients will leave in droves if there is a good alternative. People do not mind waiting if there is a good reason as long as they are kept informed. But many will not tolerate discourtesy. In the future, the principle of 'money following the patient' will encourage the introduction of better managed appointment systems.

In the same way, long delays in in-patient surgery for hips, cataracts and hernias should shorten considerably. The separation of the commissioning role of the DHA and the providing role of the hospital is a fundamental change. DHAs will want to maximise the amount and quality of care for the local resident population, wherever they are treated. If that means sending willing patients to another hospital, then so be it. And in the hospitals, poor performance will be far more transparent.

So the long-term picture looks promising. Indeed, in one London hospital's application for self-governance (North Middlesex), a commitment is given that 'No patient will be kept waiting for treatment under any circumstances for more than twelve months'. But past funding shortfalls and any teething problems created during the implementation of the reforms may well cause some lengthening of the queues in the next few years.

Why has the Department's Waiting Lists Initiative had little impact?

Since its introduction in 1986, the waiting list initiative has made little overall impact for two reasons: until recently there were no incentives built into the system of payments and the initiative has been poorly managed. In some cases, hospitals have artificially increased waiting lists to attract waiting list money, with no net benefit to the NHS.

This is changing. Early last year, the Department of Health set aside £5 million out of the £31 million initiative money, to enable John Yates, an acknowledged expert in this field, to tackle the 22 districts in England with the longest lists.

This time, before any money was allocated, waiting lists were properly validated by John Yates and his team; the baseline levels of surgical activity were agreed; performance targets were fixed and clawback penalties were set in the event of non-achievement of contract.

In a period of 15 months, the number of long-wait patients in those districts has fallen by over a third. While in the rest of the country, there was a small increase.

John Yates has now been given - quite rightly - responsibility for another 100 districts out of 191 in total.

John Yates' initiative has not had time to show through in the national figures which are only available up to September 1989. (This substantial delay typifies the poor management of the lists.) Yet I suspect they will be much the same in aggregate, when the March 1989 figures are available in September.

A three point plan

1. Every single district should have a waiting list based on an incentive system, from April 1991.

2. All district health authorities would be required to eliminate most long waits beyond a year before April 1993. This would include varicose veins, hernias, cataracts and hips but would exclude certain procedures such as minor plastic surgery or removal of tattoos.

3. After that date, districts would issue medical credits to any patient waiting for more than 12 months after the patient's name had been added to the waiting list. The cost of the medical credits would be met by the DHA out of existing budgets.

Other characteristics of the medical credits;

- not transferable to any other person;

- the medical credits would have to be used within a certain period, say three months;

- the medical credits scheme would not be open to those patients covered by a GP fund holder;

- the value placed on the medical credits could be set at the relevant average regional speciality cost for each surgical procedure;

- medical credits could be used in the NHS or in the private sector;

- patient choice (on where to spend the medical credits) could be encouraged by a new organisation called 'The

Medical Exchange (UK) plc'. This company will be operating as a clearing house between the DHAs and the GPs on the one hand, and the hospitals on the other.

Pros and cons

Pros:

- it would defuse public concern over the waiting list problem by enabling the public to see explicit priorities and be reassured that they need wait no longer than the guaranteed time for any urgent operation.

- cosy arrangements between districts and hospitals would be broken. If a district is inefficient at placing contracts, it would lose out financially. And the local hospital would lose income.

- such a proposal would show we are confident that the NHS reforms will give real benefit to patients. This change is merely an extension of the reforms.

Cons:

There are two main risks: financial and political. But both can be countered:

Financial. There is a risk that this proposal may lead to demands for more funds or a displacement of other services, such as community health services.

This would be true if there was no spare capacity in the health service. But in practice, there is often plenty of room to manoeuvre, particularly in improving the workload of some consultants who are not fulfilling their NHS contracts.

Few medical credits would be issued. The mere possibility of a voucher would encourage DHAs and hospitals to bring down waiting times.

Political. Some people would say we are still condoning waiting times of up to one year for in-patient surgery. We can counter this claim by saying we expect all DHAs to reduce waiting times to as low a level as possible. This proposal simply places a ceiling on waiting. In the future we could review progress and reduce the ceiling to nine months or lower.

Also some may say 'why do we need a medical credits scheme to replace a waiting list scheme that is beginning to work?' There are two good reasons:

(1) A central initiative is only necessary during the transitionary period, while the reforms are being phased in. Kenneth Clarke would prefer, quite understandably to transfer the waiting list initiative money to normal funding allocations to regions and districts. But now is not the time.

(2) But once waiting times are shorter, through a combination of the reforms and the waiting list scheme, the latter would be allowed to expire and vouchers issued to long-wait patients, if necessary. Such a commitment would be seen by patients as a tangible benefit of the reforms.

Conclusion

A three point plan (as above) should be initiated to achieve - by April 1993 - a system of guaranteed maximum waiting times for most elective surgical procedures. In particular:

- At your next bilateral with Kenneth Clarke after the recess, you would ask him to consider extending the waiting

list initiative to all districts managed along the lines of an incentive system.

- A medical credits scheme could be considered as a Manifesto commitment.

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