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EDITORIAL

Surgical waiting lists are inevitable: time to focus on work undertaken

Waiting lists are a feature of all countries with a publicly funded health system, such as Spain, Australia, New Zealand, Canada, The Netherlands, Ireland and the UK. Despite countless well-meaning initiatives in all countries to eliminate them, their persistence continues to infuriate and frustrate governments and other public payers. But should it? Can waiting lists be eliminated?

Before addressing that question, it is important to recognize that, while prolonged waiting (say, over six months) is clearly undesirable, not only for humanitarian and economic reasons but also because clinical outcomes may be worse, benefits can result from a well-managed waiting list.[1] It maximizes efficiency by ensuring a steady demand for precious resources such as staff, theatres and beds. It also enhances staff satisfaction and morale by ensuring theatre lists have an interesting mix of cases, and enables training needs to be met. From the point of view of some diseases (such as otitis media with effusion or benign prostatic hyperplasia), waiting for surgery provides a period for spontaneous resolution of symptoms and, therefore, the avoidance of unnecessary surgery. And for those whose condition does not improve, it allows them time to either reconsider their decision or prepare, both practically and psychologically, for their operation.

Even if such positive attributes of waiting lists are ignored, it would not be possible to eliminate lists for three principal reasons. First, surgeons desire to operate and patients desire, or at least accept, being operated on. Healthcare systems are homoeostatic—there are feedback loops such that, the faster surgeons operate, the faster patients can join the queue (irrespective of whether or not surgeons induce demand for their services).[2,3] One consequence is that an expansion in the number of surgeons will inevitably lead to an increase in the number of patients waiting for surgery as each surgeon needs to have a waiting list, for the commendable reasons outlined above.

Second, new technologies offer new opportunities for surgical interventions. These may be procedures for previously inoperable conditions, such as hip prostheses for osteoarthrosis, or procedures permitting surgery in patients previously considered too risky to treat, such as transurethral prostatectomy in elderly infirm men. The impact of technological developments can be dramatic: the introduction of laparoscopic surgery for cholecystectomy led to a 25% increase in intervention rates.[4] Despite, or perhaps because of, progressively healthier populations, the demand for surgery grows inexorably.

Third, in publicly funded systems that permit surgeons to practise privately in parallel (such as the UK), there is a financial incentive for surgeons to maintain a waiting list. The principal reason people opt for private care is to avoid excessive waiting. Despite the steady increase in the number of publicly funded operations conducted in England during the 1970s and 1980s, the number privately funded rose in tandem, maintaining a steady 13–15% of all procedures.[5] This suggests that the average surgeon chose to spend about 14% of his or her time operating privately and this proportion did not change over two decades, despite major increases in the number of public sector operations.

So, rather than attempt to eliminate waiting lists, public healthcare systems should seek to improve the management of surgical services and payers should focus on the numbers of patients treated rather than the number awaiting treatment, which, as has been demonstrated, will remain resistant to change. Around the world several enterprising approaches to improving publicly funded services by altering the way services are organized and delivered have produced encouraging results. These include the use of priority scoring systems,[6] staff substitution,[7] better management of theatre time, pooled or shared waiting lists,[8] greater use of day care, shifting care from inpatient to outpatient settings and from hospitals to primary care, establishing elective-only surgery facilities, pre-admission assessment clinics,[9] issuing reminders to reduce non-attendance rates[10] and specialized, single-procedure surgical centres. While some of these are new initiatives, the benefits of others, such as pre-admission clinics, have been clear for several decades.

While none of these is a panacea, each can contribute to better management of services, greater efficiency and the maintenance of acceptable waiting times. While this may help to reduce their frustration, payers will never be at

peace until they start judging the performance of their health services on the amount and quality of the work undertaken rather than the numbers awaiting treatment.

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