Waiting in the NHS: Part 1—a diagnosis

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The denial of potentially beneficial treatment is a characteristic of all health systems. In a tax-funded cash-limited health system providing services irrespective of ability to pay—such as the NHS—waiting lists are a key means of rationing access to treatment. Understanding this is critical to the design and implementation of policies concerning waiting lists. A commentary on UK waiting-list management in the 1980s and 1990s stated:

> 'None of the policy initiatives have been based on an adequate account of the nature of the problem to be tackled. The simple view . . . that the waiting list is a backlog, which extra resources and better management could clear, was never fully dispelled'[1].

The notion of infinite demand for elective surgery is questionable[2]. Nevertheless, the view that demand for surgery is both static and completely unresponsive to changes in waiting time is an inadequate basis for policy, for two reasons. First, the wait faced by patients is a determinant of their demand for taxpayer-funded treatment[3]. Second, potential patients can substitute privately funded treatment for publicly funded treatment at high waits (and *vice versa*). Demand for publicly funded elective surgery is more usefully characterized as being neither infinite nor fixed but responsive, to some degree, to waiting times and other factors.

Despite a range of new initiatives since publication of the *NHS Plan*[4], including a massive injection of funding to increase capacity, strategies for better waiting-list information and management[5] and new waiting-time targets, the Government is unlikely to 'solve' the waiting-list problem. We go on to argue, in part 2, that a more explicit and comprehensive strategy is required to prioritize patients for treatment in a manner consistent with NHS aims.

APPROACHES TO WAITING IN THE NHS

The NHS has a long and undistinguished history of attempts to manage the gap between demand and supply[1,6]. In the 1950s there was a 'concerted effort' to reduce the length of lists and in the early 1960s the Ministry of Health issued guidance to general practitioners (GPs) on gaining admissions for their patients, basic requirements for administering waiting lists and practical measures for managing, for example, theatre time. Numbers waiting increased. In 1975 attention was given to practical management of lists and additional funding was made available to tackle supply bottlenecks. Numbers waiting increased further. A Royal Commission in 1979 emphasized the importance of length of wait, rather than numbers waiting, but offered no instant solutions. In 1986 the Waiting List (later, Waiting Time) Initiative was launched. By its end in 1995, £252 million had been spent, and the longest waits (over two years) had virtually disappeared, thereby honouring the Patient's Charter. However, total numbers waiting were again higher.

The Conservatives believed that the introduction of the internal market would help to reduce waiting times. Waiting times and numbers were known to vary around the country. By encouraging patients and GPs to choose hospitals offering lower waiting times it was hoped that the length of lists would be equalized. Competition was also expected to provide incentives for hospitals to reduce waiting lists. In practice, although there was some 'shopping around', regional variations persisted and both waiting times and numbers climbed[1].

In summary, policy before 1997 included: increasing spending, encouraging patient choice and between-provider competition, better list administration and better management of existing hospital capacity. The outcomes were higher numbers waiting, reductions in only the longest waiting times and persistent regional variations in both.

The Labour Government came to power pledging to reduce numbers waiting for inpatient treatment by 100 000. This target was achieved in early 2000[7], although the total has changed very little since and at a local level success was patchy: 60% of local authorities failed to reduce lists by the average target reduction of 9.5%, and 20% actually increased their lists[8]. When Labour was re-elected, the *NHS Plan* announced a new set of targets focusing on inpatient and outpatient waiting times.

To achieve these targets the Labour Government has put in place a range of measures. On the supply side, it has made a series of earmarked cash injections—over £737 m between 1998/9 and 2000/1[8]. It has also committed itself to using the private sector in the UK and European Union

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countries[9]. As well as addressing supply bottlenecks, this is part of a broader plan to improve patient choice of where they receive treatment[10].

Measures to boost NHS capacity have been accompanied by redesigned care pathways aimed at reducing delays, improved systems for waiting-list management and a booked admissions programme offering patients greater certainty about the time of assessment or treatment[11]. Finally, as providers struggle to reconcile constrained funding with seemingly unconstrained demand, localized attempts at patient prioritization have arisen, involving the use of various 'scoring' systems, although these are uncoordinated and largely unevaluated[12].

Some initiatives appear to have been successful[8,13]. However, the number recorded as waiting for outpatient appointments is now higher than in 1997[14]. While there has been progress towards lowering maximum waits[15], average waiting times have scarcely changed[8]. Growth in the level of inpatient and daycase activity is surprisingly low—around 2% per year. Statistics on the source of admissions show the numbers of patients admitted from the waiting list or as booked admissions *fell* between 1997 and 2001, increases in admissions over this period coming largely from planned (non-waiting-list) cases[8]. It seems increasingly unlikely that the *NHS Plan* targets will be achieved within the time-scale envisaged.

The Government might argue that it is too soon to judge the effectiveness of the new policies. However, there are fundamental and inherent problems with the use of the targets as the central means of managing waiting in the NHS.

TARGETS: A HIT OR MISS AFFAIR?

Targets may be missed because of feedback effects. As waiting times or numbers fall there are changes in the demand for treatment[1,16–20]. Patients may be more likely to seek publicly funded care and less likely to pay for private surgery, GPs more likely to refer to consultants, and consultants more likely to place patients onto lists. These changes in behaviour can undermine the successful meeting of targets.

Targets may be missed because of perverse-incentive effects. Where consultants work in both the public and the private sector, reductions in waiting numbers or times in the public sector may have the effect of reducing demand for the services they offer in the private sector. This direct conflict of interest is claimed to reduce incentives to lower NHS waiting lists and times[21].

Targets themselves produce perverse effects. For example, as patients with less severe disease approach maximum target waiting time, they gain priority over patients with more severe disease who might benefit more from treatment. The National Audit Office (NAO)[14] found, from its own survey data, that over half of consultants reported such distortion in clinical priorities in order to meet targets.

Pressure on managers to meet targets can create incentives to misreport waiting, or subtly alter the way in which patient contacts are recorded. The NAO confirmed the existence of this kind of waiting-list manipulation; indeed it concluded that data supplied to the Department of Health by trusts could not be relied upon to provide a true picture[14]. Further analysis suggested that 'fiddling' of waiting lists occurred in 9 out of 50 health authorities investigated[23].

In addition to difficulties with target implementation and management, fundamental issues of equity and efficiency are not addressed by focusing on waiting-time and number targets. Where waiting times *have* been reduced in a sustained fashion—for example, Dorset—it remains unclear what mechanisms have been used to achieve that, what determines clinical priorities and patient access to treatment, and *where* and *how* exactly care is being denied (for example, is a greater share of funding allocated to elective surgery than in health economies that miss their targets? What is *less* being spent on?). Given that the demand for healthcare commonly outstrips supply, close

Box 1 **Is a waiting list like a supermarket queue?**

Challenged to explain the Government's shifting focus from targets on *numbers* waiting to *time* waited, the Health Secretary, Alan Milburn, has argued that the two are directly correlated[29]. Drawing an analogy with supermarket queues, he explains that the number of people waiting at the till is closely related to the amount of time waited: achieving one goal will also lead to success on the other.

This is not entirely correct: there could be thousands of people waiting for flights at Heathrow Airport, but so long as the flights leave on time, the time each waited would not be of concern[30].

Leaving that aside, the analogy itself illustrates problems with current thinking about waiting-list management. Everyone in a supermarket queue has an equal claim on the attention of the till operator. However, an objective of the NHS is to ensure that those in the surgery queue who get 'served' first are those with the greatest need and capacity to benefit (and that the speed with which you get served, given your condition, should not depend on whether you happen to be queuing in Dorset or Croydon).

Further, while the presence of someone in a supermarket queue indicates the availability of means of payment, access to surgery depends on the availability of NHS resources which are not unlimited. One person in the queue can only be treated by sacrificing the treatment of another in that queue, or of someone in a *different* queue altogether. The resources required to increase activity in order to reduce time or numbers waiting for elective surgery might, conceivably, be better used to increase health (or reduce inequalities in health) elsewhere.

scrutiny of waiting-times performance may simply make rationing occur elsewhere, in a less overt fashion.

Targets for waiting times and numbers mean that targets become the focus of measurement. These are important indicators; however, they do not ensure that patients with illnesses of similar severity have similar access to treatment. Currently, in the UK, priorities between patients, even within the same specialty, are determined implicity (urgent, soon, routine) on a list-by-list basis. Decisions behind this prioritization process are invisible, hiding variation in access between different areas and between patients. Consequently, opportunities to address horizontal equity (the equal treatment of equals) are missed. Furthermore, implicit clinically judged priority has been shown to relate poorly to patient-acceptable waiting times for surgery and health status severity and to the personal preferences of patients for treatment[23–28].

Finally, a focus on targets obfuscates decision-making about the resources allocated to treatment. Setting a target creates an imperative in terms of resource allocation—which may or may not reflect the best use of NHS resources. In fact, the Government has never set out, in the *NHS Plan* or in subsequent policy papers, what the total budget for elective care should be or how much the new proposals might cost. It is assumed that the extra resources being allocated to the NHS will be enough to reach the plan targets. As we have seen, they are unlikely to be sufficient; and, even if they were, they would deny resources eleswhere (such as emergency care) which might offer greater benefits.

CONCLUSIONS

Waiting in the NHS has received considerable public, political and policy attention—most of which fails to recognize the role of waiting in a non-price healthcare system. Consequently, policy has tended to focus on achieving targets by improved management and increased spending. This is doomed to failure, for two reasons.

First, targets still reflect too simple a view of waiting in the NHS. Setting targets creates incentives to meet those targets. This can be attempted by increasing supply, but also by not 'counting' some demands in the system (for example, deferred decision to operate) and by perverse effects on patient priorities. Spending more money improves capacity and may reduce waiting times—but this can feed back into increased demand and be at least partly self-defeating.

Secondly, it is never clear, with this approach, when we have arrived at the 'right' level of spending on elective surgery. Increased elective surgery has an opportunity cost—the health gain that could have been enjoyed by using NHS resources on different services. Crucially, waiting-time or number-waiting targets cannot guarantee equity between people with the same condition in different areas and with different conditions in the same area. This would be true even if waiting were almost abolished.

Thus the key questions are: how much should we be spending on each treatment (given that spending more on treating one set of patients denies the use of those resources to treat others)? Who should receive priority for accessing treatment quickly? And what are the patient-experienced process issues and outcomes of treatment—or no treatment? In Part 2, to appear next month (Waiting in the NHS: a prescription) we argue that careful and explicit priority setting may provide a better means of ordering access, and of ensuring that efficacy and equity objectives are being met—or are at least more visible.

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