

Can the English NHS meet the 18-week waiting list target?

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Waiting lists for hospital treatment are often viewed as a peculiarly British disease. While it is erroneous to think that other developed countries do not suffer waiting lists,¹ there is little doubt that long waits for hospital treatment have dogged the National Health Service for many years and are a source of dissatisfaction among patients.

Waiting lists for treatment have grown steadily since the inception of the NHS. Only since 1999 has there been a sustained decline in the numbers of people waiting. Waiting times for treatment, perhaps a better measure of system performance, have waxed and waned over the last decade as various initiatives by governments of all political hues have sought to tackle the problem of service access.

Successive governments have tended to focus on reducing the maximum waiting times for outpatient appointments and inpatient treatments. The current Labour government has now raised the stakes further. It has pledged that by 2008 there will be a maximum wait of only 18 weeks from any referral of a patient by a general practitioner to treatment in hospital if required. Such a target represents a large step up in expected performance. Current targets are that by the end of this year, no patient will wait more than 3 months for an outpatient appointment and a further 3 months for any inpatient or day-case treatment. Meeting the new target will require a massive effort, and despite considerable success to date, could it be a target too far? And, moreover, is there now a case for a change in focus on waiting times to address broader issues such as equity of access?

THE LABOUR GOVERNMENT'S 'WAR ON WAITING'

The attempt by successive Labour governments since 1997 to reduce hospital waiting has been described as a 'war' of three phases.² In the first phase (from 1997 to 2000) the focus was on achieving a reduction in the total number of patients waiting for treatment, while continuing at the same time to abolish any waits in excess of 18 months. An election manifesto commitment to reduce the total waiting list for inpatient treatment by 100 000 was achieved by early 2000. Key weapons in this phase of the war included targeted investment in specific waiting list initiatives and the

sharing of good practice in waiting list management through agencies such as the National Patient Action Team.

Phase two (between 2000 and 2004) shifted the focus from the size of the waiting list to the maximum waiting times experienced by patients and in addition introduced specific targets for certain diseases, in particular cancer and waits in other parts of the system, such as accident and emergency. The maximum wait for inpatient and day-case treatment was reduced from 18 to 6 months during this period, while the maximum wait for an outpatient appointment reduced from 6 to 3 months. The key interventions to achieve these reduced waiting times included the introduction of treatment centres (centres for elective surgery managerially and clinically separate to the provision of emergency and other treatment) together with targeted initiatives to reduce waiting in orthopaedics and ophthalmology, the introduction of patient choice and tighter performance management of hospital care through independent assessment and the 'star rating' system.

The current phase of the 'war on waiting' (from 2005 to 2008) is designed to tackle the combined waits that exist at different points along a care pathway. These include, for example, time spent waiting for an initial consultant appointment following referral by a general practitioner, for any diagnostic tests ordered by a hospital consultant, and finally for any treatment that may be necessary following the confirmation of diagnosis.

WHAT TOOLS ARE AVAILABLE TO MEET THE NEW TARGET?

The government's approach to reducing waiting times for treatment is based on three distinct strategies: the use of central targets backed up by firm performance management to concentrate the minds of managers and, to a lesser extent, clinicians; the procurement, through national contracts, of additional NHS capacity from independent sector providers; and the introduction of a quasi-market in the form of guaranteed choices of provider for patients ('patient choice') and new financial incentives ('payment by results') that are designed to spur greater efficiency and responsiveness within health care providers.

The first two strategies were both relatively well tested in the first two phases and therefore can be expected to contribute positively to the current waiting list campaign. Interestingly, notwithstanding recent government claims

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that competition has played an essential role in reducing waiting times,³ most of the current successes have been achieved before new independent sector or joint public–private treatment centres had made a significant contribution.

Nevertheless, there are a number of issues that will need to be addressed if the 18-week waiting time target is to be met. In particular, bottlenecks in access to diagnostic tests have been acknowledged as a serious problem by the Chief Executive of the NHS.⁴ As discussed above, these waits have hitherto been excluded from the waiting time formula. Moreover, these problems with access exist despite significant historical investments in diagnostic services. Between 1996/1997 and 2003/2004 the number of diagnostic scans has increased by almost 4 million (14%) within the NHS in England, including major rises in the number of magnetic resonance imaging (MRI) and radio-isotope scans (37%) and computer tomography (CT) scans (47%).¹

To address the persistent deficit in diagnostic support the government earlier this year announced that £1 Billion worth of additional diagnostic scans will be procured from the independent sector to bolster NHS capacity.⁵ In addition, from November 2005 patients waiting more than 20 weeks for MRI and CT scans will be offered the choice of a scan at another hospital.⁶

However, the third strategy to reduce waiting times, the creation of a quasi market, is rather more speculative. This relies on the market forces to improve efficiency and to equalize demand for services across the NHS. In theory, patients with accurate and ‘real time’ information on the relative waiting times at different providers will select the provider offering the shortest wait at any given level of quality. This should have the effect of equalizing waiting times across hospitals and reducing long waits to the length of the average. This should help hospitals meet the 18-week target so long as there is sufficient total capacity within the entire health system (the second strategy). Any gains in efficiency as a result of competitive forces should also contribute to meeting the target.

However, there may be doubts as to whether such a strategy will be effective in practice. In particular, will patients use their new found powers to choose? The biggest experiments in patient choice so far have been the London patient choice initiative (where patients waiting 6 months for treatment were offered a choice of four alternative providers) and the national choice pilot for coronary heart disease (where patients waiting more than 6 months were offered a choice of provider of cardiac surgery). Here, 62% and 57% of patients, respectively, took their opportunity to select a different provider. However, Department of Health statistics for all patient choice suggest that a much lower

proportion (only 21%) of eligible patients selected an alternative provider.⁷

Moreover, it might be expected that patients who had already waited for six months might face particular incentives to select a new provider. From December 2005, the ‘choice at six months’ initiative will give way to ‘choice at the point of referral’. Under this scheme, patients will select their provider at the time that they are first referred and, by definition, will not have waited at all for treatment. Early evaluation suggested that an overwhelming majority of patients opted to use their local hospital.⁸

Other research has also examined patient preferences when offered a choice of provider. Evaluation by the King’s Fund, RAND (Europe) and City University of the London Patients Choice Project (LPCP) found, for instance, that while waiting times were an important consideration for patients about to choose a hospital, they were also prepared to sacrifice quicker access for longer waits at more ‘reputable’ hospitals.⁹ This finding is perhaps not surprising, but as waiting times reduce in pursuit of the 18-week target, this sort of trade off will become more dominant in patients’ choices.

There is therefore no guarantee that patient choice will either act as an effective mechanism to efficiently match demand for care to supply or provide a significant competitive stimulus that will spur (and, importantly, sustain) improvements in waiting times among providers.

The likely impact of Payment by Results (PbR) on hospitals’ ability to reduce waiting times is similarly uncertain. PbR introduces payments directly linked to levels of activity performed, paid at a price that reflects current average hospital costs (subject to a regional variation). It is hoped that this incentive structure will both encourage extra activity to be performed and relatively high cost providers to reduce their costs to the average, thus allowing more care to be purchased within existing budgets.

However, it is equally feasible that at least some providers currently above the average NHS cost will simply seek to reduce the extent to which they provide those services rather than seeking to drive down costs. This will reduce the extent to which the NHS may expect any additional activity within its limited budget. Indeed, the effect may be to cause additional capacity problems in some specialties or in some geographical areas.

However, the key aspect of the financial incentives embodied by PbR is not so much whether trusts’ costs are above or below the national tariff, but whether their *marginal* costs are higher or lower than the tariff. Even hospitals with below-tariff costs may find that the costs of carrying out more activity—their marginal costs—exceed the income they would receive. Whether PbR will

inevitably lead to an expansion in activity across the NHS, and, in particular, an expansion in just those activities which will help to reduce waiting times, is not guaranteed (even assuming that simply doing more work is the solution to reducing waiting lists and times).

WILL THE 18-WEEK TARGET BE MET?

Despite the forgoing pessimism about the impact of choice and payment by results on waiting times, there are grounds to think that the NHS will substantially hit the 18-week target.

First, there is the evidence of recent history. Despite considerable scepticism from many in and outside the NHS that previous waiting times targets would not, indeed, could not be met, they have, in large part, been achieved. Second, as with previous targets, the new target carries considerable political weight and commitment; failure is an option, but it still carries a heavy price for management. Third, one upside of the recent single-minded focus on waiting times targets has been that a considerable amount of learning—about the nature of the phenomenon of waiting lists and the multi-pronged solutions needed to reduce waiting times—has taken place. Waiting lists are not simply a ‘backlog’ of work that can be cleared given enough healthcare resources. Clinical decisions—in particular, decisions to admit to a list, at what point to operate and so on—are crucial in determining success or failure in reducing waiting times. There is still more to be understood here, in particular understanding the reasons for variations in clinical decisions, but broadly, there is a better understanding of ways to tackle waiting times—streamlining administrative and operational systems, focusing on admitting patients in chronological order, being more sophisticated in deciding criteria to admit patients out of order and so on.

Perhaps the more fundamental question to ask is *should* the 18-week target be met? And, in particular, is the cost of achieving it worth the benefits? As the evaluation of the LPCP suggested, as waiting times reduce, the *value* patients place upon further reductions starts to diminish. The question is whether patients’ valuations of the benefits of reduced waiting will dip below the costs of achieving the 18-week target before it is met? In any case, as the NHS progresses towards this target, a more fundamental aspect of access (of which waiting times is but a part) is likely to increase in importance. We know, for example, that access to (and utilization of) healthcare generally is not equitably distributed across population groups or geographically according to need. Tackling this aspect of access is undoubtedly difficult, but goes to the heart of the reason for the existence of the NHS.

CONCLUSIONS

Central targets appear to be effective in marshalling the attention of the NHS around highly specific policy issues, providing that they are backed up by sufficiently powerful rewards and sanctions. In so far as excess waiting times were a legitimate public policy issue (and there is a broad consensus that they were), the use of targets in this area has been remarkably successful.

Of course, poorly conceptualized targets deliver poor or perverse outcomes as an unintended consequence. It would seem that the newly formulated waiting time target is an improvement on the targets that preceded it. The current 18-week target more accurately reflects patients’ experiences in that it accounts for total waits that may be experienced during a single episode of care. It may also serve to avoid some potentially perverse outcomes. In this case, hospitals will not be able to prioritize some parts of the care pathway (i.e. those parts that were previously subject to specific waiting time targets) at the expense of other parts (i.e. those parts that were not subject to specific targets).

Nevertheless, there are risks. The evidence as to whether or not waiting time targets distorted clinical priority setting is undeveloped and unclear.^{10,11} This issue persists as a theoretical danger at the very least and needs further monitoring.

As waiting times in the NHS reduce a further question is posed; should targets become ever more ambitious? Here there may be a case for restraint. As waiting time targets become more demanding, the room for hospitals to manoeuvre becomes limited and unanticipated variations in demand become more difficult to cope with. One consequence may be that providers increase surplus capacity in order to deal with these random fluctuations and costs could rise as a result.²

These additional costs for ensuring very rapid access may be out of proportion to the benefit gained. It is likely that the marginal benefit of extra reductions in waiting times will fall as the costs rise. A better strategy may be to set differential targets for diagnosis and treatment so that in future shorter waits are mandated for urgent compared to elective care. In the meantime, a wider debate about what ultimate length of waiting time for non-urgent care is ‘reasonable’ would be valuable.

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