SUPPLEMENT

TALKING POINT

Waiting for surgery

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There has been much public comment about the size of waiting lists and the length of waiting times for surgery in the NHS. Hospital Activity Analysis (HAA) data include the date on which a patient is placed on a waiting list for surgery and the date of admission. This paper considers waiting times between these dates in Avon in 1977 in six specialties: general surgery, urology, ENT, orthopaedics, ophthalmology, and gynaecology.

Results

In the six specialties there were 42 013 discharges and deaths. Of this number, 76.4% patients had at least one operation. A quarter of the surgical patients admitted did not have an operation; others had more than one—some a second principal operation. The average number of operations on patients who had an operation was 1.44. A total of 36 268 principal operations were carried out in the six specialties; 15 950 (44%) were urgent cases and 20 318 (56%) waiting-list patients. Tables I, II, and III give the times waited by waiting-list patients who were admitted for and received a principal operation.

Table I gives the cumulative percentages of cases admitted within one, three, six, and 12 months for all six specialties. Table II gives figures for general surgery according to five diagnostic categories, the first four of which were selected because most of the patients were put on the waiting list rather than admitted as urgent cases. Table III gives similar figures for

ophthalmology; in Avon in 1977 this was the specialty with the longest waiting times. The tables show that from 71.8% of patients (in ophthalmology) to 83.9% (in gynaecology) waited less than six months and from 56.4% (in urology) to 72.3% (in gynaecology) less than three months. For the six specialties taken together a total of 8.6% of patients had waited more than a year for admission, 11.9% between six and 12 months, 17.1% between three and six months, and 62.4% less than three months.

Discussion

Are waiting times too long and, if so, by what criteria is this value judgment to be made? Avery Jones and McCarthy[1] quote figures from a study by Yates[2] of average waiting times for surgery of 14 weeks and 20 weeks in 1972 (with which the Avon figures are comparable) to suggest that performance may be better "than suggested by the official figures." They point out that delay in admitting a patient may be for medical, social, or personal reasons and that a manageable waiting list is desirable for the efficient use of resources.

Certainly, compression of waiting times would be likely to cause logistical problems for surgical services, since urgent admissions comprised 44% of all admissions. This means that 80% of all operations were on patients admitted either immediately or within three months of being put on the waiting list.

TABLE I—*Number of cases admitted, by source, and cumulative percentages of waiting-list patients having operations, by waiting times, Avon AHA, 1977**

	Number from waiting list	Number not on waiting list	Percentages admitted from waiting list within			
			One month	Three months	Six months	12 months
	%	%	%	%	%	%
General surgery	6300 (52.1)	5794 (47.9)	34.5	60.7	77.8	91.1
ENT surgery	3543 (77.0)	1058 (23.0)	18.1	59.0	80.5	91.8
Orthopaedic surgery	2470 (42.8)	3296 (57.2)	22.1	57.9	79.0	94.7
Ophthalmology	1442 (64.2)	803 (35.8)	25.1	58.1	71.8	84.7
Urology	1526 (47.8)	1666 (52.2)	24.2	56.4	78.2	92.6
Gynaecology	5037 (60.2)	3333 (39.8)	40.6	72.3	83.9	91.6

*HAA data.

TABLE II—*Number of cases admitted, by source, and cumulative percentages of waiting-list cases having general surgery, by waiting times: Avon AHA, 1977**

	Numbers from waiting list	Numbers not on waiting list	Percentages admitted from waiting list within			
			One month	Three months	Six months	12 months
	%	%	%	%	%	%
Inguinal hernia	861 (75.6)	288 (25.3)	19.9	44.4	62.1	83.7
Varicose veins	560 (83.0)	115 (17.0)	13.7	40.9	68.6	85.3
Cholecystectomy	488 (65.3)	259 (34.7)	24.2	63.7	80.7	91.4
Avulsion of toenail	263 (78.7)	71 (21.3)	28.5	58.9	87.5	95.8
Others	4128 (44.9)	5061 (55.1)	38.9	66.6	81.3	92.9
Total	6300 (52.1)	5794 (47.9)	34.5	60.7	77.8	91.1

*HAA data.

TABLE III—*Number of cases admitted, by source, and cumulative percentages of waiting-list patients having ophthalmology operations, by waiting times, Avon AHA, 1977**

	Number from waiting list	Number not on waiting list	Percentages admitted from waiting list within			
			One month	Three months	Six months	12 months
	%	%	%	%	%	%
Squints	313 (81·7)	70 (18·3)	16·3	46·3	70·9	93·3
Cataracts	542 (77·0)	163 (23·0)	15·5	40·2	50·6	65·7
Others	587 (50·7)	570 (49·3)	38·7	80·9	92·0	97·6
Total	1442 (64·2)	803 (35·7)	25·1	58·1	71·8	84·7

*HAA data.

HAA data give no information about the reservoir of patients in the community who might benefit from surgery but who are not referred to a consultant. Nor do they give any indication of waiting times for an outpatient appointment or of patients put on a waiting list and for whatever reason not subsequently admitted. Also, 1977 data do not necessarily represent current waiting times in some specialties, notably orthopaedic surgery, in which technical advances are creating new sources of admission.

If it were concluded that waiting times should be reduced, a practical target might be that the six-month cumulative percentage figure (80%) should be achieved in three months and the 12-month cumulative figure (91%) within six months. In general surgery in Avon this would require the average number of operations to be increased from 1008 to 1098 a month, or by 9%. For the six specialties taken together, the number of operations per month would have to be increased from 2756 to 3020 or by 9.5%. In theory it would be desirable but in practice impossible to prevent any patient from having to wait more than 12 months, say, or for more than six months. Such theoretical targets would require increases in the numbers of surgical patients admitted of 4.8% and 11.5% respectively.

The six specialties accounted for 44.9% of total hospital admissions. In England and Wales hospital services as a whole take 57.5% of the total NHS budget. Since 1974 financial growth in real terms in the NHS has fluctuated but averaged about 2%. If these surgical services were to grow pro rata—that is, at about 2% per annum in real terms (in Avon there was a 5% increase in the number of surgical operations in the three years 1974-7)—the first target, requiring a 9.5% increase in the number of operations, might be expected to be met in five years of normal growth. This would happen only if waiting times varied inversely with increasing surgical capability. The number of surgeons in England and Wales in all specialties in 1959 was 2803 and, in 1976, 4166, a rise of 49%. Between the same dates the national queue for surgery rose by 43% (from 431 000 to 616 000). The size of the average waiting list per surgeon for each year between 1959 and 1976 remained remarkably constant at 145 (SD±7: range 130-153). As the surgical capacity increased, more operations were carried out, but the total waiting list increased in proportion to the number of surgeons. The size of the reservoir of unmet need, which generates this increased demand, is shown by the continuing rise in health costs in the USA, where the number of surgeons per 100 000 population is five times greater than here.[3] If average waiting lists per surgeon are relatively constant are waiting times also? Does NHS growth lead to a greater volume of service for the public but not to a quicker service? In that event, special measures designed to reduce waiting times would have to ensure that increased surgical capacity was not directed to meeting increased demand.

This can be done, though it is not easy, by the temporary assembly of additional local resources to work off a particularly lengthy queue in a specialty. But for a health authority to attempt by an act of policy to bring about a general reduction in waiting times—for example, by increasing resources with the object of halving the percentages of patients who wait more than six months and more than 12 months—would necessitate rationing: new patients would have to be restricted to ensure that waiting times did not exceed the standard set. To obtain maximum efficiency allocations would no doubt have to be made for each type of operation within a specialty, with norms established according to the cost benefit ratios. Perhaps an economic as well as a clinical assessment on each patient would then be necessary to determine his priority. Culyer[1] has discussed decision rules for admissions and suggested an index based on several criteria, including the social productivity of the patient.

If this is undesirable the profession and the politicians should recognise that so long as there is an unmet need for surgery—and this is world wide—present waiting times for non-urgent operations are a phenomenon that will not go away, even with more resources.

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References

[1] Avery Jones, F, and McCarthy, K, *Lancet*, 1978, **2**, 34.
[2] Yates, J M, *In-Patient Waiting List Statistics: Handle With Care*, Health Services Management Centre, University of Birmingham. To be published.
[3] Culliton, B J, and Waterfall, W K, 1979, *British Medical Journal*, 1979, **2**, 1267.
[4] Culyer, A J, *Need and the National Health Service*. London, Martin Robinson, 1976.

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Standing Commission on Pay Comparability

Ambulancemen are to receive increases ranging from 12.8% (£6·56) to 25.8% (£15·40) as a result of the first Report of the Standing Commission on Pay Comparability (Cmnd 7641, £2·25). The report covers local authority and university manual workers and NHS ancillary staff as well as ambulancemen—over 1·4 million workers (nearly 80% employed by local authorities). Increases for ancillary staff range from 3.8% to 16.9% (£9·72). Council and health service staffs have already received £1 a week on account and this will now be deducted from the awards. The commission estimates that the recommendations will add to existing total paybills (including the £1 a week on account) as follows: local authority manuals £217·9m; NHS ancillaries £63·7m; university manuals £1·7m; ambulancemen £17·7m. Professor H A Clegg is chairman of the commission and the other members are Mr P D Gibson, Professor Joan Mitchell, Sir William Ryland, Mr Harry Urwin, and Sir Leslie Williams. For university technicians (Report No 2, Cmnd 7640, £1·25) the commission says that its inquiries have not provided the basis for a full comparative assessment but they give a good indication of the minimum increase likely to emerge from a full study the commission intends to undertake. Meanwhile, an interim increase of 13% for all levels is recommended. The terms of reference for these two groups asked the commission to report by 1 August. Later references have no specific deadline and include nurses and midwives, professions supplementary to medicine, and ambulance officers.