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Summary

Policy paper

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The War on Waiting for Hospital Treatment

What has Labour achieved and what challenges remain?

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Summary

The need to wait for health care has been a feature of the NHS since its inception. This paper begins with a description of the task the Labour government faced when it came into power in 1997 and assesses the policy initiatives it has taken since then. It also looks at what the government should do next. The paper draws on previous studies by the King's Fund on waiting list policy and the ways in which individual trusts have responded to national targets.

When Labour came to power in 1997, total numbers waiting stood at 1.3 million – the highest since the NHS began in 1948. It pledged to reduce the number of people on English NHS waiting lists by 100,000 within its first term. That goal was achieved by 2000. The government went on to target waiting times, first by setting new maximum waits for outpatient consultations and inpatient treatment; second by setting a new target of 18 weeks covering the whole period from the initial GP consultations through to final treatment. This is to be achieved by 2008.

By the time of the 2005 election, substantial progress had been made in reducing the number of long waits. While average waiting times had not changed by much, waiting times for some operations, such as cataract removals and some heart operations, had fallen rapidly. So too had the total number of people waiting to be treated. By this time, however, some of the government's policies, particularly the greater use of privately run treatment centres, were only just starting to have an impact. The government therefore has reason to be confident that the 2008 target can be met.

Nevertheless challenges remain. Achievement of the target is threatened by a number of factors, such as financial pressures, unanticipated increases in demand, and staff shortages in critical areas. A number of steps can be taken to reduce these risks.

Even if the 18-week target is reached by 2008, the government needs to go on to define a new set of objectives that more accurately reflect the underlying NHS objective of providing equal access for equal need.

Policy phases of the 'war on waiting'

The policies that the government has adopted, or currently has in place, in its 'war on waiting' fall into three phases: Phase 1 (1997–2000), Phase 2 (2000–2004) and Phase 3 (2005–2008 and beyond).

Phase 1 (1997–2000)

During this phase Labour focused on reducing the number of people waiting rather than reducing the time of waiting, although it did undertake to maintain the Conservatives' existing Maximum Wait Guarantee of 18 months.

To achieve the target of 100,000 fewer patients waiting for treatment by the end of its first term, the government took action in two main areas:

- Directing funds at specific initiatives: in 1998 the NHS Executive allocated £320 million to fund extra efforts to reduce waiting lists, followed by more money for specific initiatives. This money was made available on an *ad hoc* basis, and NHS managers were never in a position to make long-term plans for service improvements in the expectation that the finance would be available to implement them. Compared with later increases, the NHS budget only rose slightly in this phase.
- Increasing operational and technical support: this was aimed at helping individual NHS providers meet their waiting times targets and disseminate the lessons learnt in individual trusts throughout the NHS. Specific initiatives included the National Patients' Action Team, which advised hospitals on how to improve practice, and collaboratives around specific areas of hospital work, which were designed to rapidly spread information about successful innovation.

These measures were backed by pressure on hospitals managers from ministers and the performance management system.

ASSESSMENT OF PHASE 1

Waiting lists rose steadily after 1997, increasing the task the government had set itself. But by mid-1998 the first signs of a fall appeared and by early 2000 the government had achieved its target of reducing waiting lists 100,000 below the level it inherited.

By the end of Phase 1, however, the government had accepted that reducing the numbers of people waiting was an inappropriate objective given that what patients were most concerned about was how long they spent waiting.

New objectives were therefore required and a new set of policies.

Phase 2 (2000–2004)

In March 2000 the Chancellor announced that the government would substantially increase NHS funding with the proviso that the NHS reformed. This was followed by publication of *The NHS Plan*, which, coupled with the increased funding, provided the government with an opportunity to develop new policies and modify the targets first set in 1997.

The new targets set for the NHS in this phase included:

- abolishing waiting lists and replacing them with booking systems for patients
- halving the maximum waiting time for routine outpatient appointments from more than six months to three months, and reducing the average time to five weeks
- reducing the maximum wait for inpatient treatment from eighteen months to six, and the average time from three months to seven weeks.

These targets were accompanied by a wide-ranging set of policies to help transform the way that elective care was provided.

INITIATIVES TO INCREASE SUPPLY

During this phase the government also introduced a number of ideas and programmes aimed at increasing supply within the health service:

- **Treatment centres** The main idea behind treatment centres was that they would have their work ring-fenced, that is, isolated from other hospital activities either through physical or operational separation. The private sector, in particular overseas providers, was invited to bid to run some treatment centre facilities, especially in areas where NHS performance was poor or there was an urgent need to increase capacity.
- **Day surgery** Sixty-six per cent of operations in 2000/01 were carried out on a day basis. The government aimed to increase this proportion to 75 per cent through promoting the wider use of day surgery.
- **Operational support initiatives** The NHS Modernisation Agency took over the existing operational support programmes and extended their scope. Before being drastically slimmed down, it published a vast amount of advice on how to achieve reductions in waiting times.
- **Speciality programmes** Ophthalmology and orthopaedics were two specialities with particularly long waiting lists. To help reduce these lists, additional programmes were established in these specific areas.
- **Patient choice** Starting with a pilot scheme in London, the government gave patients facing long waits the right to go to another hospital. To enable the scheme to apply nationally, a new system known as Payment by Results (PBR) was introduced, which directly linked a hospital's income to the amount of work it performed.

DEMAND MANAGEMENT

Although the focus was on increasing supply, the government also supported the development of new services in community settings, such as GPs with special interests to reduce hospital referrals.

IMPROVING THE WHOLE SYSTEM

To reduce pressure on hospitals, the government set targets for increasing the overall number of hospital beds. It developed programmes that were designed to make better use of the existing bed stock by encouraging more rapid discharge of patients from both emergency and elective beds.

SYSTEM MANAGEMENT

The government also introduced a star-rating system to provide a measure of trusts' overall performance in order to distribute a (relatively small) performance fund. However, the use of the star-rating system expanded to identify trusts in need of 'special measures' (for example, franchising of a senior management team) and to select potential candidates for foundation trust status. Five out of the nine 'key targets' of the star-rating system were related to waiting. The Department of Health's performance-management system meant that hospital management remained under strong pressure to meet waiting time targets.

ASSESSMENT OF PHASE 2

The targets for eliminating long waits were met during this phase but the numbers of people treated on the waiting list actually fell during this phase. Seemingly at odds with this, so did the numbers waiting. There were a variety of possible reasons for this:

- The number of some procedures carried out declined sharply in line with an evidence-based approach, which identified some treatments, such as tonsillectomies, as being of low therapeutic value.
- Some procedures were reclassified as planned operations or treated as diagnostic (neither planned operations nor diagnostic procedures are included in waiting lists).
- There was a significant reduction in the number of people put onto the waiting list, which pointed to some degree of 'informal demand management'.

The measures introduced in this phase to improve capacity and overall system performance had little impact during this period. In particular, treatment centres ran with spare capacity, while private sector and overseas providers only made very modest contributions to reducing waiting lists.

Nonetheless, the government's policies set out in Phase 2 represented substantial progress compared with the previous phase. Overall, policy objectives were significantly improved by the introduction of targets set in terms of a progressive reduction in maximum waiting times. And for the first time in the history of the NHS, these objectives were set within a long-term framework, backed by a sustained increase in resources.

Phase 3 (2005–2008 and beyond)

In 2004, the government announced a new target for the NHS: by 2008, no one should wait longer than 18 weeks from referral by a GP to hospital treatment. By setting a target that took into account the total time patients waited, the government acknowledged that waiting for diagnostic tests and their results, not previously counted in the statistics as 'waiting', was just as important as waiting at other stages of the patient journey.

The government felt that if this target could be achieved then waiting for elective care would cease to be the major concern facing the NHS. It could then tackle other priorities, in particular, increasing the quality of life of people with long-term chronic health conditions.

Although the 18-week target is a challenging one, the government has reasons to feel optimistic about the capacity of the NHS to reach it. Some of these include:

- The total number of people waiting for treatment has continued to fall rapidly since 2004.
- The extra capacity purchased in the private sector has begun to become available, and this will increase.
- In early 2005 it agreed to £3 billion worth of contracts with the private sector to overcome shortfalls in diagnostic capacity.

If all the policies in place by the middle of 2005 work in line with government expectations, the NHS elective care system will shortly be transformed from the 'command economy'

of the first two phases into a quasi-market economy. Hospital trusts will be put under unprecedented pressure from patients exercising choice (and taking the finance for their treatment elsewhere), other trusts offering quicker access and the private sector potentially removing business out of the NHS altogether.

However, there are some potential constraints that may affect the ability of the NHS to respond in the way the government hopes:

- The financial climate is becoming less favourable than it was in the years between 2000 and 2005.
- It will be increasingly difficult for the NHS to continue to make progress with reducing waiting because it has proved far easier to make rapid reductions in *maximum* waits rather than *average* waits. As long waits continue to be eliminated, improvements will have to be made for shorter waits, which involves reducing the waiting time for many more patients.
- The government's estimates of the extra capacity required may prove to be wrong. There is a possibility that if waiting times reduce, demand will increase – for example, with more people moving from the private sector and GPs making more referrals.
- There will probably continue to be shortages of key personnel (for example, in diagnostics and particularly radiology).
- Trusts and patients may not respond to recent policy changes in the way the government expects. Payment by Results, for example, will be effective only if some trusts are able to expand and are prepared to accept the risks of doing so. Furthermore, it is uncertain how far patient choice will influence change.

ASSESSMENT OF PHASE 3

The targets set during Phase 3 represent a further improvement over those developed for the previous two phases. The current 18-week target – which combines waiting at all stages of the patient journey – reflects the actual experience of patients better than the targets that have preceded it. It also reduces the potential for measured aspects of care to be improved at the expense of previously unrecorded factors such as diagnostic waits.

The policies in place to achieve the new target, particularly the expansion in diagnostic and treatment capacity, should result in further reductions in waiting times. The risks identified above may be reduced by suitable policies.

Nevertheless, if the 2008 target is met, that will not represent an end to waiting.

Meeting the 2008 target: what else needs to be done?

From Phase 1 to Phase 3, the government improved the way it expressed the waiting reduction targets it set for the NHS. Nevertheless, there remain a number of contentious questions that the government has yet to resolve if the objectives for access to elective care are to be properly framed. These include:

- **Should there be a national target?** Setting targets has helped to achieve the changes in the NHS that the government has been pursuing. While the practice of setting targets should be retained, it may be that rigid adherence to them creates intolerable pressure

in specific situations. This could be ameliorated by slightly relaxing the targets in certain circumstances.

- **Should the targets be more ambitious?** More timely treatment is the overall goal of targets to reduce waiting, however it is unclear whether the financial cost of eliminating waiting completely would be prohibitive.
- **Is the target too ambitious?** A single target does not reflect the complexities of the different treatment that people require. In some cases, such as cancer, the patient pathway should obviously be as short as possible. For other conditions, longer waits might be more acceptable, especially if patients know with certainty how long their wait will be.
- **Should targets be based on time alone?** The NHS is based on a principle of 'equal access for equal need'. On its own, a waiting time target cannot achieve this. Genuine equity of access requires a wide range of policies, and there needs to be more progress across other areas of policy-making to support this.

The policies now in place to support the target contain risks related to both demand and supply:

- **Demand-side risks** Demand may rise more rapidly than has been assumed when the 18-week target was set, leading to insufficient capacity. Some form of demand management may therefore be required.
- **Supply-side risks** These relate to the consequences of substantial increases in capacity and the workforce and systemic issues this will raise, especially around Payment by Results and the role of the private sector.

Key recommendations

The government's determination to reduce waiting times in the English NHS has been rewarded with significant falls. To ensure that these achievements are sustained, the government needs to further develop:

- its objectives for waiting lists
- the policies that will achieve these objectives
- its understanding of the overall health system and, within that, what causes waiting.

Objectives

The government should:

- give more emphasis to reducing differences in access levels between similar populations
- undertake more research to better understand variations in clinical priorities and treatment thresholds, as part of a more systematic programme of demand management
- assess what the overall benefits would be for patients, and the costs and benefits for the NHS, of setting even more challenging targets for the NHS beyond the current 18-week target
- monitor future patient choices and potentially use these as the basis for setting objectives for access to elective care; this would mean a shift from centrally imposed universal targets to ones that reflect the preferences of individuals.

Policies

The government's present mix of policies are subject to a number of demand and supply side risks. To reduce these risks the government should:

- carefully monitor the impact of Payment by Results and adjust this policy if it leads to a net reduction in the number of NHS operations, or to an increase in emergency admissions
- pursue the agenda already set out for improving the supply of scarce skills (for example, in anaesthesia and radiology)
- monitor whether the policies it has introduced to better manage long-term conditions lead to reduced hospital admissions and lower overall NHS costs
- ensure the right balance between new capacity and better use of existing capacity, and between further ring-fencing of elective care and better management of elective and emergency flows within individual hospitals.

Understanding the system

The government should:

- improve monitoring frameworks and management systems nationally and locally
- increase its understanding of the effect of new policies on the elective care system
- improve the costing and financial control of the patient journey
- make the model for health decision-making more explicit and, like the Treasury model of the economy, open for everyone to assess and use to make their own forecasts
- ensure greater consistency between data about the elective care system so that it gives a reliable picture of how the overall health care system is working.

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Anthony Harrison and Bill New

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