Setting priorities in waiting lists

Traditionally, surgical waiting lists have served to prioritize care, with the worst cases addressed first, along, in some instances, with those who have shouted the loudest. Patients with less severe symptoms have usually waited for much longer periods. This is now politically unacceptable.

Setting priorities in waiting lists would be far simpler and much less relevant were it not for the major discrepancies between demand and supply. These discrepancies, which have for so long been the norm in the NHS, lead to the creation of long waiting times.

Many of us are familiar with the concept of triage and few would argue against urgent treatment for a hip fracture or an abscess. What then of the many unfortunate patients languishing on the waiting list with levels of symptoms and disability almost as severe? Such patients are not well served by the crude division into a very broad group of 'elective' *vs* 'emergency' conditions.

The Department of Health now seeks to exercise control over our 'waiting-to-be-done' lists, for the political advantage that this promises. There exists a major incongruity between the doctor who attempts to treat his or her patients on the basis of clinical need and ethical priority, as endorsed by the General Medical Council (2001), and the minister who attempts progressively to reduce the length of the tail of inpatient waiting lists. Fundamentally, the doctor is focused primarily on those patients at the front of the list (clinically defined), the government on those at the end (also clinically defined). Given finite resources, these two agendas are incompatible.

SCORING SYSTEMS

Scoring systems offer a potential comparator which is both scientific and transparent. Comparison is valid, certainly within diagnoses or similar conditions, and may be valid within specialities and between them too. However, the greater the range of disorders considered, the more difficult the comparisons are. For example, assessing the relative need for urgent surgery of a coronary artery bypass patient with that of a severe polyarthritic is either simple (one is life-threatening, the other not) or complicated. It depends on the criteria used for evaluation.

Scoring systems can be criticized for their potential for 'gaming', where alert individuals enhance their score by exaggerating their responses in the hope of expediting treatment by elevating their position on the list. However, this phenomenon occurs anyway, with or without scoring.

Scoring systems can be used to incorporate not just clinical features, but also the 'cost to society' of a disability. They are particularly adaptable to use by community-based services as postal or telephone questionnaires, perhaps under the auspices of the new primary care trusts, who increasingly appear interested in assuming some responsibility for hospital waiting lists. Most importantly, scoring systems have the power, through repeated use, to recognize that the symptoms of some patients progress while others do not.

The study by Harry et al (2000) showed the distortion which occurs to clinical priorities when an overloaded system is further constrained by arbitrary maximum waiting times. Inevitably after a period, virtually all patients wait to the maximum period and clinical priority is lost almost completely.

The irony in this specific example (Harry et al, 2000), featuring patients awaiting major joint replacements, is the need for additional expensive operative time and hardware when severe cases are allowed to deteriorate. There is also the potential for a reduction in longevity of these replaced joints because of the increased wait. In other words, the result may be a poorer quality outcome for the patient.

To be useful in the broader context, scoring systems will require considerable further development and validation. A generic system, not dissimilar to the Health Status Questionnaire SF36 outcome measure (Radosevch et al, 1994), may have a place.

Such a measure would need to be able to demonstrate relative importance both within conditions (i.e. severity) and between conditions. Of course the measure would take no account of the current availability in the NHS of the appropriate surgical teams to treat them. These measures are most likely to be valuable when used in association with a condition-specific score and both of these could be generated automatically by current information technology using touch-screen computers in the outpatient waiting area.

Finally, given the persistence of a demand and supply mismatch, scoring systems define the capacity threshold below which a local facility is unable to offer surgery. This therefore highlights the specific unmet need (the number of patients exceeding the clinical threshold yet not reaching the local capacity threshold).

BOOKING SYSTEMS

Booking systems have been proposed (Gauld and Derrett, 2000) and may function where there is no major backlog of cases. For the majority of inpatient conditions, however, especially where units are functioning to near capacity and/or relying on additional out-of-hours work to meet targets, inadequate flexibility for the variable number of 'emergency' cases and for other confounding factors (such as staffing or equipment problems), makes it likely that serious operational problems will occur (Gallivan et al, 2002). Once again the problem is the demand *vs* supply mismatch.

Redefining the over-simplified emergency and elective categories to include a number of additional intermediate groups would go some way towards establishing priorities on the basis of clinical need, even without the requirement for a formal scoring assessment.

THE FUTURE

The problem of priorities in waiting lists is not about to go away. There have been many waiting list initiatives over the years and these have rarely focussed on clinical priorities. Improvements in waiting lists have almost always been short-lived (Frankel and West, 1993). In keeping with the recent Wanless report (2002) and others, chaos theory predicts the need for a different order of magnitude of increase in resources, far in excess of those recently promised by the Chancellor, if the current workings of the NHS are to persist (Papadopoulos et al, 2001).

The public, who so far have been excluded from the debate, have a right to be engaged in the setting of priorities in both waiting lists and the broader NHS, and the 'rationing debate', if it ever happens, will require some carefully worded questions if meaningful answers are to be obtained.

Until then, it is the author's opinion that the current waiting list targets to which we are subjected are incompatible with the setting of ethical priorities and inhibit the ability to provide a truly equitable and transparent service to all patients. HM

KEY POINTS

- The NHS cannot meet the demand for its services.
- Traditional waiting lists prioritize care and a low level of symptoms can mean a long wait for surgery.
- Doctors focus on patients at the front of waiting lists, the government on those at the end.
- Current targets distort clinical priorities and may compromise patients.
- Scoring systems have a place in helping to re-establish clinical priorities and transparency.

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