

Rationing in the NHS

Background

Given the chronic underfunding of the NHS, it is no surprise that rationing appeals to commissioners as a way of limiting expenditure. However, this goes against the NHS Constitution (“The NHS provides a comprehensive service, available to all”; “Access to NHS services is based on clinical need, not an individual’s ability to pay”)(1) and is therefore approached in a covert manner.

The most obvious form of rationing is the waiting list: between March 2013 and November 2018, the number of people still waiting for their treatment grew from 2.7 million to 4.2 million, and the number waiting more than 18 weeks grew from 153,000 to 528,000 (2). In addition, demands for exceptional funding requests, originally used to limit cosmetic and fertility treatment, have massively increased for other interventions including hip and knee surgery as Clinical Commissioning Groups (CCG) seek to limit patient access. Bristol, North Somerset and Gloucestershire CCG now list 104 treatments that are restricted, with GPs no longer being able to decide when a patient should be referred for a consultant opinion. In many situations ‘rationing’ has been disguised as “addressing unwarranted variation”; “evidence based medicine”; and even “patient choice” (3).

Simon Stevens, The World Economic Forum, and McKinsey

In 2012 a report from the World Economic Forum (WEF) (based on work led by Simon Stevens, then head of UnitedHealth’s Global Division and now Chief Executive of NHS England) focused on economically challenged health care systems and how to: “*help existing models become sustainable*”. One proposal was to: “*. . . ration access to care . . . for example, restricting coverage; imposing cash-limited budgets and allowing waiting lists to rise; or reducing the scope of services covered . . .*”. As Stuart Player pointed out, the [Five Year Forward View](#) of October 2014, which Sustainability and Transformation Partnerships are now set to implement, is drawn directly from the WEF’s diagnosis of, and prescription for, the healthcare crisis (4).

The WEF report was produced in association with management consultants McKinsey and Company, who in 2009 had advised the Department of Health (DH) on: “how commissioners might achieve world class NHS productivity”. In their presentation to the DH (5), slides 51 & 52 outlined the potential for savings through decommissioning of procedures of ‘limited clinical benefit’. These included: tonsillectomy, back pain, grommets, trigger finger, Dupuytren’s, knee washouts, D&C, minor skin surgery, aesthetic surgery of various types, knee surgery, hip surgery, cataract removal. Nearly all of these procedures are to be found in the ‘Croydon list’, NHS England’s (NHSE) ‘17 Evidence Based Interventions’ (17 EBI), and shopping lists for ‘self funding’ NHS patients (see below).

The obsession with “unwarranted variation”

Even before McKinsey’s work, in 2007 the London Health Observatory (set up by the DH) explored the potential savings that might be realised if only treatment access criteria could be standardised for certain procedures – the so called ‘Croydon list’ (6). Amongst other things, it was suggested that women would have to go through failed medical treatment before being allowed surgery for heavy menstrual bleeding. This focus on ‘variation’ has been continued under the strapline of ‘Getting It Right First Time’ (GIRFT) ([Getting it Right first Time. https://gettingitrightfirsttime.co.uk/](https://gettingitrightfirsttime.co.uk/)) – “*designed to improve the quality of care within the NHS by reducing unwarranted variations . . . as well as delivering efficiencies such as the reduction of unnecessary procedures and cost savings*”. NHS RightCare is also concerned with variation in outcomes between CCGs (<https://www.england.nhs.uk/rightcare/>). RightCare has been implicated in unjustified proposals to cut hip and knee replacement surgery and its methodology has been strongly criticised (7). The very real difficulties of measuring “unwarranted variation” are discussed by the King’s Fund (8). Their report contains a pertinent quote from Mulley (9): “*If all variation were bad, solutions would be easy. The difficulty is in reducing the bad variation, which reflects the limits of professional knowledge and failures in its application, while preserving the good variation that makes care patient centred. When we fail, we provide services to patients who don’t need or wouldn’t choose them while we withhold the same services from people who do or would . . .*”

NHS England and ‘17 Evidence Based Interventions’

‘Variation’ was also central to the 2018 NHSE consultation (and subsequent recommendations to commissioners) – ‘17 EBI’ (10). This identified four generally unwarranted procedures that should almost never be done, and 13 warranted procedures (breast reduction; removal of benign skin lesions; grommets for glue ear in children; tonsillectomy; haemorrhoid surgery; hysterectomy; chalazia removal; arthroscopic shoulder decompression; carpal tunnel syndrome release; Dupuytren’s contracture release; ganglion excision; trigger finger release; varicose vein surgery) where considerable reduction in activity was anticipated through standardising access criteria. In summary, where there were already existing National Institute for Health and Care Excellence (NICE) guidelines, NHSE recommendations generally conformed with these for 10 of 11; where there was no NICE guidance, NHSE is generally restrictive (skin lesions; breast reduction surgery; ganglion removal). It seems likely that CCGs and referring GPs will consider many of these treatments are to some extent off limits, making it more difficult for patients (including those who actually meet NHSE criteria) to access treatments. While arguably 4 of the 17 procedures are of little clinical benefit, restricting the others is likely to deprive some patients of valuable interventions.

NHSE argued that the main cause for variation was doctors failing to observe accepted evidence based guidelines (despite the absence of such guidance for some of the procedures). Consequently, it was necessary to introduce economic levers to force providers to reduce activity by threat of non-payment for work

done. The title of the consultation ('evidence based') was meant to convey the impression that a rigorous review of relevant evidence underlies the recommendations. However, the methodology used is not transparent (unlike NICE) and does not conform with accepted standards for guideline development. It seems more likely that the authors started by drawing conclusions and then sought supporting evidence from a selective review of the literature. Although both relevant Royal Colleges and NICE were consulted (and appear on the front of the consultation document), they distance themselves from the recommendations made (with the exception of the uncritical Academy of Medical Royal Colleges), with NICE saying: *"This work was undertaken by NHS England rather than NICE. It would be inappropriate for us to comment on the validity of this work and the subsequent published guidance"* (private communication - JP).

What is it that underlies variation?

A large component of variation among providers for the '17 EBI' relates to treatment access policies devised first by Primary Care Trusts and then CCGs, which are increasingly at odds with NICE guidance. This is not acknowledged by NHSE, yet it becomes obvious by accessing their own website. For example, searching NHSE for 'breast reduction surgery' (<https://www.nhs.uk/conditions/breast-reduction-on-the-nhs/>), we find the following statement: *"Some CCGs do not fund breast reduction surgery at all, and others fund it selectively if you fulfil certain criteria"*. If the 'evidence based' criteria for treatment access from the '17 EBI' consultation process were strictly imposed, while projected activity in some CCG would fall, in others it would have to rise. It is striking therefore, that in the tables published by NHSE (10) estimating the possible effect of the recommendations, nowhere is there an increase in activity. This exposes the fact that both 'national' and 'evidence based' recommendations from NHSE are a sham,.

Consequences

The main purpose of '17 EBI' is to introduce a mind set in which the public accept that it is justifiable for some treatments (currently those seen as largely 'cosmetic' and therefore a soft touch) to no longer be provided free by the NHS. NHSE promise that many more procedures will be added to the list in due course. As there is no intention on the part of NHSE to advise CCGs to follow national guidance and commission services where they currently do not, this source of variation is not effectively addressed. The website Ration Watch (<http://www.rationwatch.co.uk/>) shows that many CCG are already routinely restricting access to treatments including hip and knee replacement, hernia repair, and cataract removal, and are simply ignoring NICE guidance (11). NHS Clinical Commissioners, the national body representing CCGs describes this state of affairs as a regrettable but often unavoidable consequence of the systemic financial pressures on the health service, confirming that financial concerns are the underlying driving force for such forms of rationing. Further undermining of the force of NHSE guidance is the fact that many restricted treatments are being made available to NHS patients at a price - the so called 'self funding' patient, highlighted in (but not unique to) Warrington (12).

Finally, simply using the term ‘evidence based’ does not legitimise a policy unless the methodology underlying recommendations is both transparent and scientifically robust. It should then be left to doctors to implement guidance after taking into account the individual needs and preferences of a patient (the real essence of evidence based medicine) rather than them being forced to follow a course of action imposed through economic sanctions. As NICE always states: *“When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service”*. It is indeed ironic that NHSE pay lip service to a: *“... new national ambition to embed personalised care across England so that shared decision making between patients and clinicians becomes the norm”* (10). Variation in the NHS is a topic deserving of scientific scrutiny, but as the King’s Fund point out, the patient must remain at the centre: *“A key focus will need to be to tackle clinical decisions . . . with patients as a way of driving out unwarranted, and promoting warranted, variation”* (8). Some treatment access policies are now being written for CCGs by the shadowy Clinical Commissioning Support Units (13). CCGs should be openly challenged on how such policies have been developed and in whose interests they operate. They must be asked to justify their rejection of NICE guidance where this exists. The claim of being ‘evidence based’ requires scrutiny and may well prove unfounded when examined carefully. (For more detailed information and full list of references please see: “17 Evidence Based Interventions – where are we now?” - <https://keepournhspublic.com/wp-content/uploads/2019/07/17-EBI-and-rationing-final.pdf>)

John Puntis, November 2019

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