# Rationing in the NHS in the Current Fiscal Climate

By Elliot Bidgood (November 2012)

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## Introduction

The National Health Service is currently facing what is widely acknowledged to be its toughest budgetary challenge since the 1950s, as NHS spending has been frozen in real terms. Under the Quality Innovation Productivity and Prevention (QIPP) programme launched in 2009, the NHS is also currently tasked with making efficiency savings worth £4 billion every year towards a total saving of £20 billion by 2015. This programme is intended to cut waste and allow reinvestment in frontline patient care, but concerns exist about whether it is being delivered without reductions in access to services. Additionally, the NHS faces constant pressure from demographic factors, such as population ageing and obesity, and is undergoing an estimated £1.5 billion reorganisation, the largest restructuring in its history. Combined, these pressures would appear to make increased rationing of care within the NHS a risk in the current fiscal climate, potentially challenging the NHS's core obligation to provide high-quality, equitable care that is free at the point of use.

Furthermore, there have been indications that this may already be occurring and that reductions in access to care vary based on geography, raising concerns that the 'postcode lottery' in the NHS may be getting worse. The Department of Health has so far largely denied that cost-based rationing is taking place, pointing to measures taken in 2011 that were intended to bar Primary Care Trusts (PCTs) from imposing blanket bans[1]. However, rationing can occur in a variety of ways, some more noticeable or justifiable than others, so it is important that we are able to identify rationing and its implications.

Above all, the foundations of the NHS as a tax-funded public health system with a set budget has always meant that rationing is a part of its day-to-day operations, a reality that is brought into sharper focus during times of hardship and fiscal restraint. Therefore, a public debate about rationing, the truth of how the NHS works and how the current fiscal climate is likely to affect patient care is vital if we are to develop a coherent approach to the challenges the NHS will face over the coming years. The aim of this report is to explore the evidence that is available relating to rationing in the NHS at the current time, in order to discover how much we can ascertain about the current situation within the service.

## Background

Averaged across the entire history of the NHS, NHS funding has increased by an average of 4% a year. In the history of the NHS, the single most constrained period of funding prior to now was 1950-1955, when real-terms spending decreased by an average of 2.4%[2]. At the time, this led to the introduction of charges on prescriptions and other minor services. Under the Blair/Brown Labour government, additional investment in the NHS meant that growth in the NHS budget was above the 4% growth average, 6.4% across 11 years. However, although the current coalition government has aimed to ring-fence the NHS against absolute reductions in spending, due to the need to bring the deficit under control a real-term freeze is now in effect in the English NHS. This means that combined with structural reforms and rising demographic pressures, the NHS faces what can be described as its greatest fiscal challenge in sixty years. It was in anticipation of these difficulties that NHS Chief Executive David Nicholson launched QIPP in 2009, sometimes known as the 'Nicholson challenge', which aims to make £20 billion in savings by 2015 through 'back office efficiency', better procurement practices and other reductions in waste on the administrative side of the NHS. However, there are concerns that the

near-unprecedented spending constraints faced by the service are leading to increased rationing of frontline services as well.

We can define rationing as "any implicit or explicit mechanisms that allow people to go without beneficial services", due to cost constraints[3]. However, in practice, rationing will sometimes be referred to in oblique terms, such as 'prioritisation'. It can also come in different forms. Rationing by dilution has been described as the "least visible, but...most pervasive" type of rationing, as it occurs simply when a lack of resources, time or manpower prevent adequate provision, rather than by design or clear criteria[4]. This is a concern, as it is both hard to identify and hard to assess. Rationing by denial, by contrast, is more identifiable, as it occurs when clear decisions are made not to provide certain treatments on the basis that they are cost-ineffective, 'non-urgent' or of 'limited clinical value'. Rationing by delay is a practice in which waiting times are deliberately increased, even if they are deliberately kept within central NHS target limits, in order to defer costs and cause less-urgent patients to drop from the lists[5]. Additionally, two other types of rationing, selection (where specific eligibility criteria are imposed) and deflection (where patients are sent to another institution in order to shift costs to other parts of the NHS) are also sometimes observed[6].

As the NHS has a limited centrally-set budget funded from public taxation, limits on the overall amount of care that can be provided to the population have always been a reality of the service. In 2007, for example, before the start of the economic crisis and when spending was at a historic high, a poll of medical professionals claimed that rationing was "rife" in the service and that 53% of doctors claimed to know of cases in which patients had suffered as a result of rationing[7]. This is an arguable result of the structure and financing that underpin the NHS, as the reality of the service as a public sector monopoly with set financial targets means that the service is characterised by a natural discrepancy between supply and demand. A previous work published in 2000 by Civitas, *Why Ration Health Care?*, explored why other leading Western nations such as France, Germany and the United States have less rationing and better health outcomes than the UK and noted that the UK has "abnormally low" health expenditure by OECD standards, although the NHS was noted to be productive "in terms of output and utilisation of its inadequate resources"[8]. Furthermore, despite rises in UK health spending in the 2000s, the UK still ranked 13$^{th}$ in spending among the OECD in 2009, prior to the start of QIPP. This would appear to strengthen the case for the belief that the current fiscal climate will adversely affect patient care, as if the NHS is under-funded and structurally rationing-prone by international standards even in better times, it stands to reason that the effects of renewed fiscal restraint may well be felt rapidly and severely in the service.

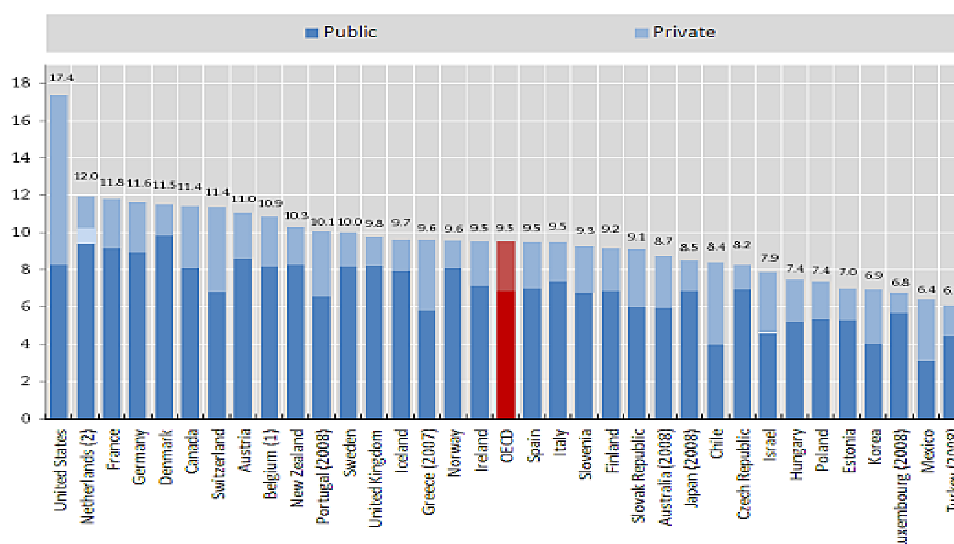


**Figure 1: Total health expenditure as a share of GDP in 2009, pre-QIPP in the UK (Source: OECD, 2011)[9]**

## The Current Debate

A variety of medical sources have already uncovered evidence of increased rationing in the past two years or so, coinciding roughly with the tightening of the NHS budget. In December 2010, the *Health Service Journal* reported that restrictions on "low priority" procedures, referral thresholds and deliberate delays had become "common across the NHS"[10]. In response, NHS Confederation Chief Executive Nigel Edwards commented that restrictions were being imposed on financial grounds and "with a lack of subtlety and lack of clinical involvement"[11]. In June 2012, a Freedom of Information (FOI) investigation by *GP* magazine showed that 91% of responding PCTs had some type of restriction in place, with tonsillectomies (in 89% of PCTs), bariatric surgeries (59% of PCTs), joint replacements (59% of PCTs) and cataract procedures (66% of PCTs) all common[12].

A March 2012 FOI investigation by another GP's magazine, *Pulse*, meanwhile, found a slight but direct increase, reporting that 25 PCTs had introduced new restrictions since April 2011[13]. *GP* also reported in November 2011 that at least 19 PCTs were "blacklisting" drugs approved by the National Institute for Health and Clinical Excellence (NICE), a finding which prompted a pledge by the Department of Health in January 2012 to confront blacklisting through an 'effective compliance regime' for enforcing NICE guidance with regard to prescribing. This was followed by a second announcement in August 2012 that from April 2013, NHS contracts would feature a specific clause banning drug blacklisting[14].

In May 2012, The King's Fund suggested in their quarterly investigations of NHS performance that A&E waiting times had risen between October 2011 and March 2012 and that 14,900 staff had been cut between 2010 and 2011, both possible signs of dilution in services. However, the report did also show that 18 week waiting times remained relatively stable, showing that rationing by delay is perhaps not yet severe in the NHS[15]. More recently, the September report by The King's Fund suggested that while 18 week waiting times have again continued to hold

firm, NHS finance directors remain concerned about the impact of the budgetary situation on the NHS and that A&E waiting times have increased to a level not seen "since 2004/5" in the equivalent quarter [16]. Opinion polls in 2011 and 2012 have reported that medical professionals are seeing more rationing, that 83% believe that financial pressures on the NHS will lead to more rationing[17] and that 85% of GPs believe that the Department of Health needs to clearly set out "what is and what is not available to patients free at the point of use"[18]. Public opinion also appears to be fearful of rationing, as a September 2012 ComRes poll for the BBC showed that while the public are opposed to rationing and 73% feel at least some savings can be made without it, 61% nevertheless expect that the NHS will stop providing "some treatments and services"[19]. In July 2012, Shadow Health Secretary Andy Burnham claimed to have evidence that NHS Sussex was restricting cataract operations in contradiction to Department of Health guidance, resulting in an apparent drop in the number of such procedures performed in the area between 2010 and 2011. However, the opposition claims were denied by then Health Secretary Andrew Lansley, who described the allegation as "fictional", although Lansley did promise to investigate the Sussex case[20].

There has been some contrary evidence on rationing, it is worth noting. In February 2012, Prime Minister David Cameron claimed that average waiting times were 8.1 weeks, lower than when the coalition took office (8.4 weeks)[21]. In July 2012, Andrew Lansley provided his annual report on the performance of the NHS, claiming that A&E waits were within the 4 hour target for 96% of patients and that 18 week waiting times were stable[22], largely consistent with the earlier findings by The King's Fund. However, his report was criticised in some quarters for ignoring concerns about rationing and the body of evidence suggesting that other forms of rationing may be taking place[23]. Furthermore, the measures taken in January and August of 2012 against reported drug blacklisting and the July 2012 pledge by the Secretary of State to investigate reports of rationing in Sussex can be read as effective admissions that rationing is a reality in at least some parts of the system.

### Additional Research: Is Rationing Occurring?

Hospital Episode Statistics (HES) data has sometimes been used to analyse trends in the NHS with regard to certain procedures and interventions, which we can approximately measure using the aggregated Finished Consultant Episode (FCE) data on the main procedures and interventions that HES records. These are the closest readily available public estimations of how many main operative procedures are being performed. Of particular interest, among its headline figures HES lists the number of FCEs for hip replacements, cataract surgeries, kidney transplants and for two types of heart operation commonly used to treat coronary heart disease, coronary artery bypass grafts (CABGs) and percutaneous transluminal coronary angioplasties (PTCA). It also provides data on certain other types of intervention, including renal dialysis. In the 1990s, concerns had been raised about the rationing of surgical treatments for coronary heart disease under the NHS, as evidence suggested that rationing decisions made by individual doctors, often without clinical guidance and based on patient factors such as smoking and old age, had resulted in unnecessary patient deaths. Similarly, rationing of renal dialysis for patients suffering from kidney failure has also been a concern, as in the 1990s there was evidence that this treatment was less available in the UK than in the US and Canada[24]. Since it is a possibility that the renewed funding squeeze on the NHS may have once again affected the availability of these services, this should also be investigated.

| Finish Consultant Episodes (FCEs) with interventions | 1998-1999 | 2006-2007 | 2007-2008 | 2008-2009 | 2009-2010 | 2010-2011 |
|---|---|---|---|---|---|---|
| Cataract | 201682 | 289590 | 325471 | 344591 | 348660 | 343782 |
| Heart (CABG) | 22494 | 21596 | 23488 | 22966 | 20818 | 19891 |
| Heart (PTCA) | 18505 | 59796 | 59225 | 62104 | 64614 | 67557 |
| Hip | 68025 | 89254 | 97026 | 100581 | 101020 | 105979 |
| Kidney Transplants | 1316 | 1790 | 1876 | 2125 | 2281 | 2238 |

**Figure 2: Headline Finished Consultant Episode statistics, 1998-1999 & 2006-2011 (Source: Hospital Episode Statistics Online)[25]**

The data on cataract procedures clearly shows that after years of consistent and substantial rises, we see a stabilisation in the rate of increase on cataract procedures between 2008-2009 and 2009-2010, followed by a small drop between 2009-2010 and 2010-2011. This clearly coincides with the beginning of financial difficulties in the UK and is also consistent with existing evidence on possible cataract rationing, strongly suggesting that this is the result of rationing. However, with hip replacement procedures, we see continuing increases, in contrast to the reports of widespread rationing of joint replacements, although the figures provided by HES do not include clear data for knee operations or other joint replacements, so this is only a partial representation.

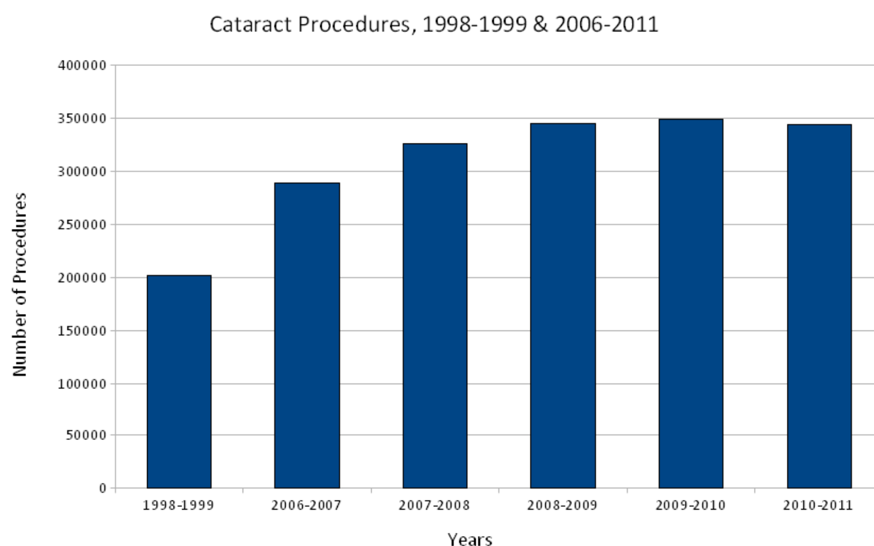


**Figure 3: Headline Finished Consultant Episode statistics on cataract procedures, 1998-1999 & 2006-2011 (Source: Hospital Episode Statistics Online)**

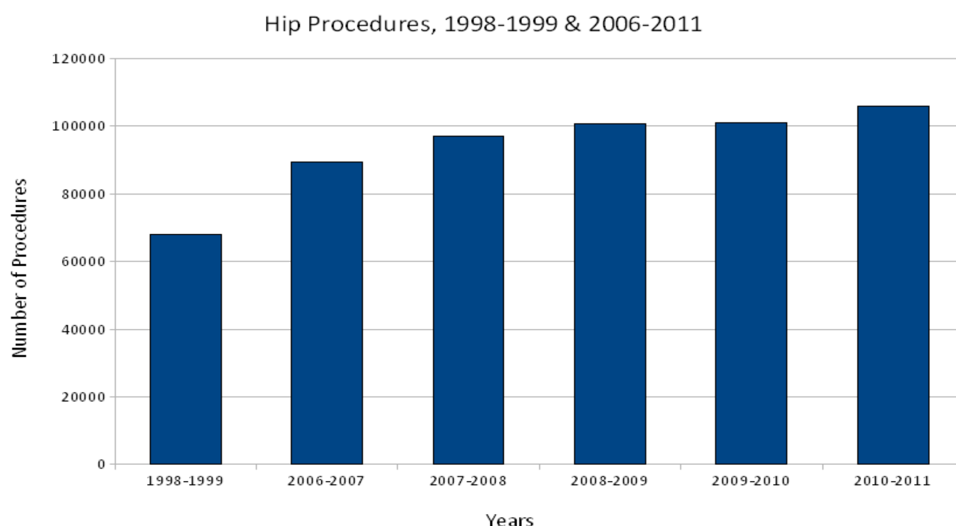


**Figure 4: Headline Finished Consultant Episode statistics on hip replacements, 1998-1999 & 2006-2011 (Source: Hospital Episode Statistics Online)**

With heart operations, it again appears difficult to see an unambiguous pattern. Angioplasties, which are now the preferred method of vascular surgery and have outpaced the number of coronary bypasses performed on the NHS since 2000-2001, continued to rise in 2010-2011. Meanwhile, although bypasses have seen a decline since 2007-2008, unlike with cataract operations this may not be purely cost-related, as there have been previous rises and falls since 1998 (full 1998-2011 data on CABGs provided to demonstrate this).

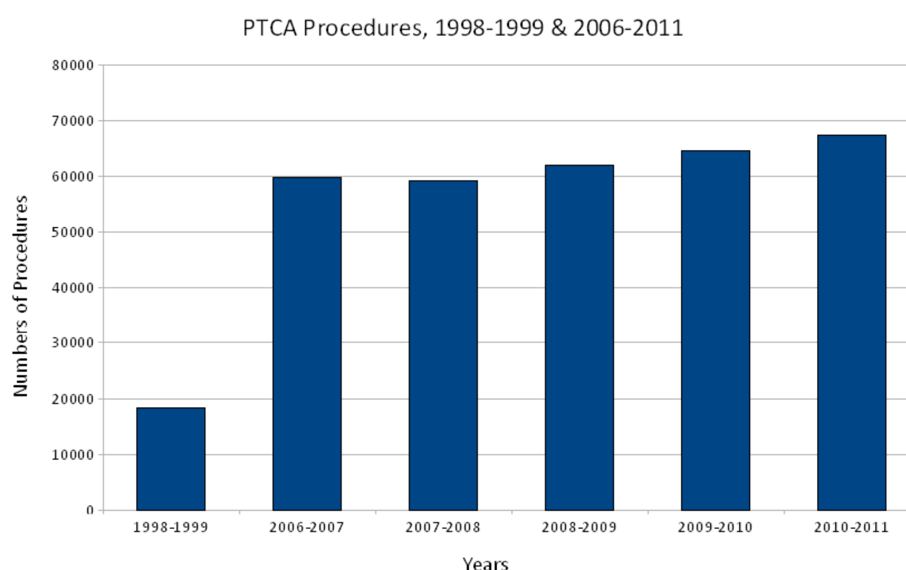


**Figure 5: Headline Finished Consultant Episode statistics on percutaneous transluminal coronary angioplasties (PTCA), 1998-1999 & 2006-2011 (Source: Hospital Episode Statistics Online)**

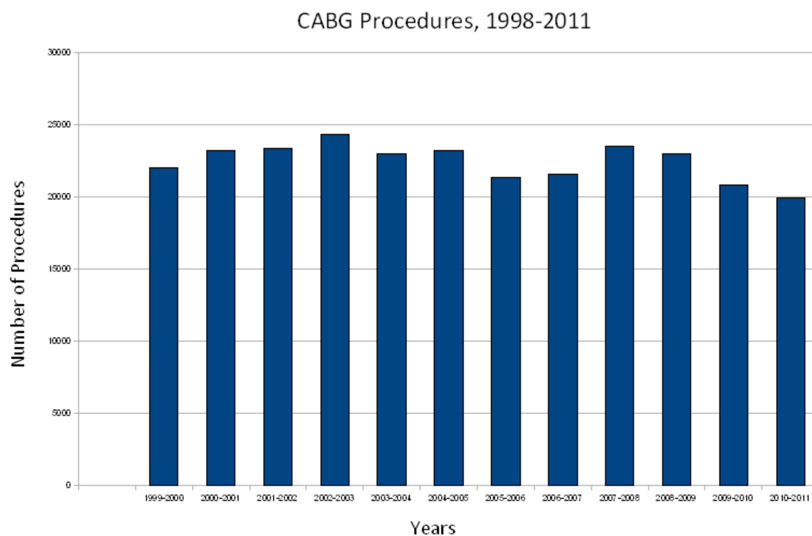


**Figure 6: Headline Finished Consultant Episode statistics on coronary artery bypass grafts (CABGs), 1998-2011 (Source: Hospital Episode Statistics Online)**

With kidney transplants we see a slight drop between 2009-2010 and 2010-2011, after years of consistent rises, another potential example of the impact of renewed fiscal constraints. With renal dialysis, for which the first year of data available for comparison is 2000-2001, we see consistent drops after 2006-2007 and a low of 556 in 2010-2011, but it is also notable that drops in NHS provision of dialysis have been seen since long before the economic crisis, dating back to at least 2000-2001.

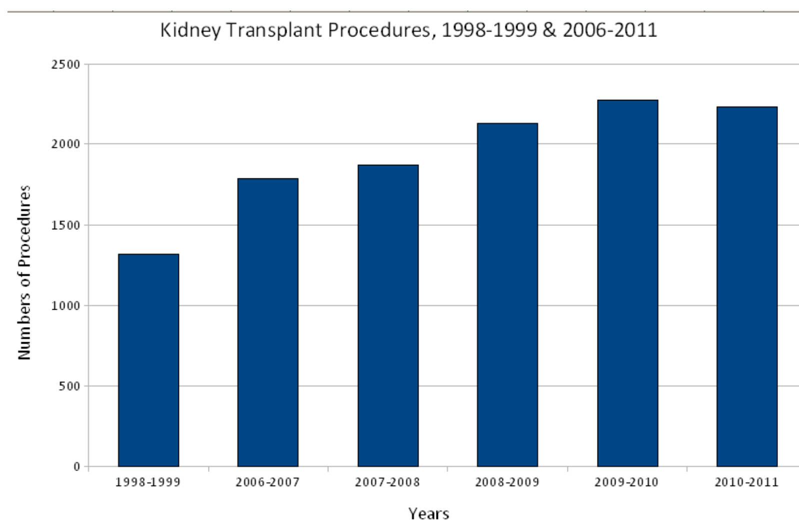


**Figure 7: Headline Finished Consultant Episode statistics on kidney transplant procedures, 1998-1999 & 2006-2011 (Source: Hospital Episode Statistics Online)**

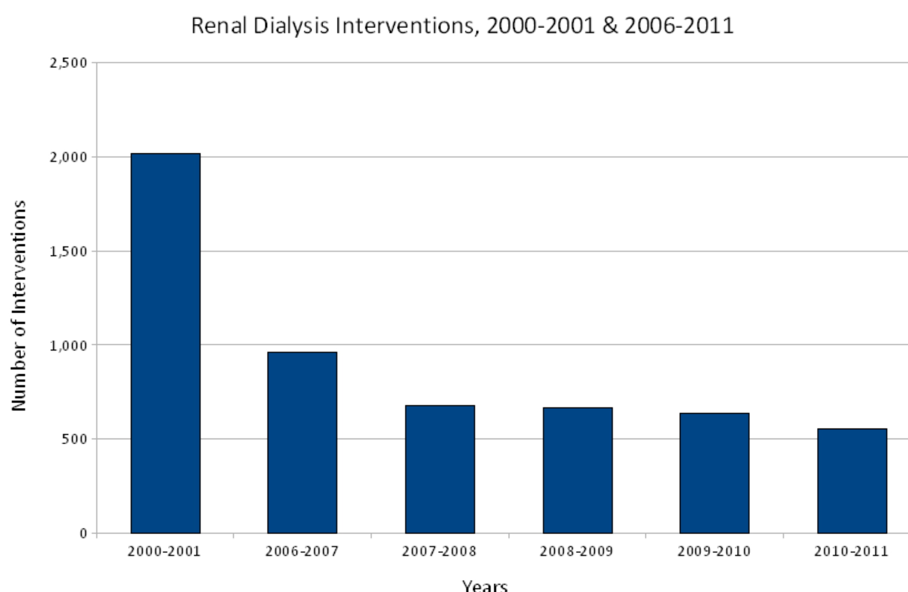


**Figure 8: Finished Consultant Episode statistics on renal dialysis, 1998-1999 & 2006-2011 (Source: Hospital Episode Statistics Online)**

Therefore, we can identify clear and unforeseen falls in the number of cataract and kidney interventions, both of which can perhaps be linked to rationing. However, with hip procedures and angioplasties we see continued increases, while longer-term medical trends may explain apparent falls in the use of bypass grafts and renal dialysis after 2007-2008. It will be vital to discover what the data for 2011-2012 reveals when this is made available, if we are to confirm the nature of some of these trends.

In order to gain some additional information on rationing practices, I also contacted 18 PCTs and PCT clusters with Freedom of Information requests, two from each English region. I asked four standardised questions, covering whether they had restrictions on interventions designated to be of 'limited clinical value', whether these policies had been amended since the start of 2011, what clinical guidance any amendments were based upon and whether any restrictions were planned in the future. Virtually all responded, although with some variances in what exactly was revealed. Most PCTs have detailed policies on their websites outlining their policies on clinical restrictions, usually referred to either as Procedures of Low/Limited Clinical Value (PLCV) or Interventions Not Normally Funded (INF), which most referred my enquiries to.

NHS Derby City & Derbyshire County made clear that its PLCV policy had undergone revisions in April and September of 2011. This included fresh policies on cataract and joint operations, tonsillectomies and varicose vein procedures, findings which were common to other responding PCTs. Derby and Derbyshire also stressed that these revisions were "a result of new research or a statement by NICE", mentioning the Cochrane Institute, Royal Colleges and peer-reviewed journals as examples of research sources, while other policies are made clear to be in line with regional NHS practice, such as those on cosmetics. However, although NICE guidance is cited in-text with some restrictions, specific details are not provided of the claimed research basis for most procedures, making their clinical justification difficult to verify. The NHS Derby City & Derbyshire County PLCV statement is however notable for its direct approach to explaining the reality of rationing:

"NHS Derby City and NHS Derbyshire County buy healthcare on behalf of the local population. The money for this comes from a fixed budget. By law, we are required to keep within this budget. Demand for healthcare is greater than can be funded from this fixed budget. Unfortunately, this means that some healthcare which patients might wish to receive and which professionals might wish to offer cannot be funded. This has always been the situation since the start of the NHS...Our approach to this situation is to prioritise what we spend, so that the local population gets access to the healthcare that is most needed. This assessment of need is made across the whole population and, wherever possible, on the basis of best evidence about what works. We also aim to do this in a way that is fair, so that different people with equal need have equal opportunity to access services. This approach is not new. It is consistent with other NHS organisations who buy healthcare for their local populations. One result of this kind of assessment is a list of some of the treatments which can only be paid for by the local NHS in certain restricted circumstances, and also a number of treatments which don't work well enough to justify any use within the local NHS."

**Commissioning Policy for Procedures of Limited Clinical Value (PLCV)**
**NHS Derby City & Derbyshire County, September 2011**[26]

NHS Bath & North East Somerset also makes clear that NICE is not its only source of guidance and that individual judgement on the ground is a factor:

"NICE guidance does not override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their guardian or carer."

**Policy Framework: Interventions Not Normally Funded**
**NHS Bath & North East Somerset, April 2008**[27]

Central Lancashire PCT was detailed in its response to all questions, revealing that it was part of a "collaborative review of commissioning policies" with four other Lancashire PCTs on policies of 'Limited Clinical Value', defined as policies that are of "minimal clinical benefit in improving a patient's medical condition, or where more modern and effective treatments are now available that no longer need surgery". These determinations are based on clinical evidence and literature reviews, but again, the PCT was not specific about the sources used. NHS Airedale & Bradford, meanwhile, stated that it "does not recognise the term of 'limited clinical value' and do not include any such restrictions in our policies", a finding consistent with the content of its website and the public results regarding Bradford & Airedale in previous FOI investigations by specialist GP magazines. NHS North of Tyne outlined how it sets its policies along with the rest of NHS North East in order to ensure regional consistency:

"Each NHS body has to establish and put in placement arrangements for dealing with requests that fall outside the current contracting arrangements. To ensure that individual funding requests are dealt with fairly and consistently this policy has been developed. The implementation of this policy across the NHS North East will ensure that a "postcode lottery" is reduced/eliminated."

**Section 8 of the Individual Funding Request Policy,**
**Value Based Clinical Commissioning Policies, NHS North of Tyne, May 2012**[28]

The clinical policies listed by the PCTs do provide clear examples of policies that are being restricted, consistent with the existing research, suggesting that rationing is occurring. Furthermore, most PCTs had information on INF/PLCV on their public websites. However, while information tends to be publicly available, the level of detail the documents provide about practices and the specific clinical guidance that underpins them is varied and often vague. This makes it difficult overall for us to discern whether the claimed clinical rationales for these

restrictions are in fact sound and on what basis the resultant cost-effectiveness decisions are reached, although in any case, there is clear variance on certain policies, which indicates a "postcode lottery". It is perhaps therefore recommendable that PCTs should provide more detail and work towards standardisation in how they outline these practices. Further, while it is encouraging to see some PCTs taking on the responsibility to educate the public about the realistic limits of NHS provision and how this may affect local services, it would perhaps beneficial if this too could be more standard.

### Patterns in Rationing?

Existing secondary data and our own investigations all appear to suggest that rationing is taking place in some parts of the NHS, with restrictions imposed and variances in where these are occurring. However, I also explored whether there was a link between which PCTs were reported to be rationing, using the data *GP* magazine published in June 2012, and the circumstances of different PCTs, such as local average income in the PCT population, the proportion of over-65s in the population and the per capita funding allocation the PCT receives from the Department of Health. This may allow us to analyse whether there are any specific determinants behind the "postcode lottery".

Using ONS statistics on local average income, no clear link could be established between how many of the *GP* restrictions PCTs had in place and the average income in their local populations. For example, among the 10 PCTs with the highest average incomes, 8 had almost all of the *GP* restrictions. Meanwhile among the bottom 10 in terms of average income, these restrictions were slightly less common. Isle of Wight Primary Care Trust, the PCT with the eighth lowest average income according to the ONS, has none of the reported restrictions. Therefore, at least on the evidence about rationing we have available, rationing at least does not appear to disproportionately affect poorer areas.

NHS Sussex, including at least two of its constituent PCTs (West Sussex and East Sussex Downs & Weald) has been reported as having restrictions on cataract operations, a fact that the current Labour opposition have claimed resulted in a fall in the number of operations there, as previously mentioned. This is perhaps notable, as cataract operations are overwhelmingly sought by older patients and according to the most recent Department of Health data, these two PCTs have an above average number of over-65s in their populations (23.51% of the population in East Sussex Downs & Weald and 20.76% in West Sussex, compared to a national average of approximately 16%). However, although this suggests a potential link with age demographics, when tested nationally, a link of this nature becomes less clear. Therefore, although cataract restrictions have been reported to be in place in many PCTs and there has been a clear national fall in the number of operations, on the ground, it does not necessarily appear to be the case that PCTs choose to restrict these procedures in response to relative demand in their particular areas, likely suggesting that more general budgetary factors are a determinant.

| Restrictions on Cataract Operations | Data | |
|---|---|---|
| No Restrictions on Cataract Ops | Number of PCTs | 38 |
| | Average % of Over-65s | 17.69 |
| Restrictions on Cataract Ops | Nunber of PCTs | 56 |
| | Average % of Over-65s | 15.57 |
| **Total Count - PCT** | | **94** |
| **Total Average - % Over-65s** | | **16.42** |

**Figure 9: Average Proportions of Over-65s in PCT local populations correlated by which PCTs are reported to have restrictions in place on cataract operations (Sources: population age data from the Department of Health, 2011-2012[29], cataract restriction data from *GP* magazine, June 2012)**

These findings may instead be affected by central revenue allocations and the capitation formulae that underpin them, something which the Department of Health has direct control over. After 1971, the Crossman formula decided how funding was allocated to PCTs in the NHS. This formula takes into account population, age, sex, bed numbers, speciality costs and case numbers, among other factors. However, it has been highlighted in the past that when measured per capita, this formula amounts to a "large inequity in the level of funding" PCTs receive[30]. The most recent Department of Health explanation of the weighted capitation formula makes clear that it still operates broadly based on this approach, as PCTs with larger populations, more elderly populations, less healthy populations and higher costs receive higher allocations. However, the difference between recurrent baseline (adjusted yearly allocation) and target allocations (target shares of resources), and the pace of change at which this gap is closed in order to ensure "fair" allocations, are also factors. This formula is of course intended to secure equal access to healthcare, although the nature of commissioning is that once these allocations are set, PCTs must then choose how to use these funds in order to meet the needs of its local health economy, albeit within certain centrally-set guidelines. Since the Department of Health does make this data available annually, it is possible to test it against the *GP* data on actual restrictions.

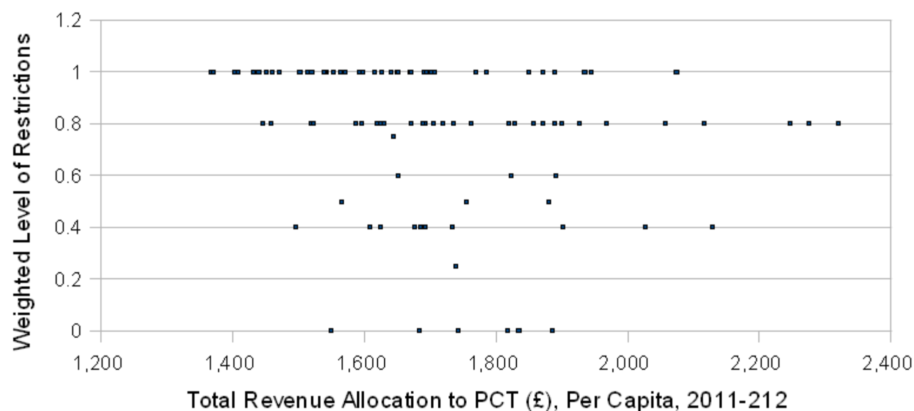


**Figure 10: Correlation Between DH Revenue Allocations and weighted level of restrictions that PCTs are reported to have in place (Sources: Revenue Allocation data from the Department of Health, 2011-2012, cataract restriction data from *GP* magazine, June 2012)**

By this barometer as well, however, it is again difficult to see clear patterns. What is notable is that some PCTs that are receiving above-average allocations still have many (or most) of the most common known restrictions. This may be related to the fact that higher allocations in turn suggest the presence of more of the local problems and demands on health services that the allocation formulae are designed to account for. For example, it has been noted in past that Tower Hamlets has a high target allocation compared to Wokingham, a PCT with fewer local

health demands[31]. In 2011-2012, Tower Hamlets had among the fifth highest per capita allocation in 2011-2012 and more reported restrictions, a finding it had in common with two other east London borough PCTs, Newham and City & Hackney. However, Blackpool, an example of a PCT that receives a very high per capita allocation and has a very low average income, has slightly fewer of the most common restrictions. Therefore, although the picture is mixed, this suggests that the current capitation formula does not entirely prevent PCTs with high-need populations from rationing care, a vital consideration that the Department of Health should take into account.

## Medical Organisations

In order to supplement my quantitative investigations with a deeper, more qualitative view of what is taking place inside the NHS, I also conducted telephone interviews with senior officials and staff from several medical organisations. During these conversations, I requested briefings as to the current state of rationing within the NHS from their perspectives and asked questions about their stances on the current situation.

In a conference call with the Head of Policy for the Royal College of Nurses (RCN), Howard Catton, and two other senior RCN staff, Mr Catton said that cuts to the frontline are of particular concern to the RCN, as it is believed that not all QIPP savings may be coming from reductions in waste and administration alone. This has prompted the College to launch the "Frontline First" campaign to raise awareness of this issue. For example, there have been reports of cuts in nursing posts, which in turn may lead to "care left undone", according to some research[32], something which could potentially be interpreted as an example of greater "rationing by dilution" occurring within the NHS, if correct. Other stated issues were:

- Potential instances of rationing will tend to be referred to by reference to "prioritisation" or other terms, given the sensitivity of the issue within the NHS
- Frontline service staff have also reported not seeing equivalent increases in support to maintain services during busier periods
- There are also some reports of delayed referrals, for example in North East England, and waiting times are being lengthened in some instances, though within the 18 week NHS limit so as not to break targets outright. Both of these are possible examples of "rationing by delay"
- There are also concerns that current reorganisations in acute services, designed to deliver care "closer to home", may not be fully supported by adequate funding or planning
- The RCN believes that "consistent eligibility" needs to be emphasised in both the NHS and Social Care
- The RCN remain concerned about the impact of the current reorganisation under the Health and Social Care Act 2012, given its cost and the dual challenge it creates, alongside QIPP
- Although there is concern about the current Department of Health stance on both the protection of frontline care services and the HSC, promised DH investigations into reported instances of rationing were described as "encouraging"

In a call with Professor Harminder Dua, President of the Royal College of Ophthalmologists (RCOPHTH), we discussed restrictions on access to eye care, particularly cataract procedures. Professor Dua explained that RCOPHTH believes that the dual pressures of QIPP and structural

reforms have created a fiscal environment in which “arbitrary” restrictions that are “not clinically based” are being seen, contrary to the official Department of Health stance. As a result, varied thresholds are being reported, based on financial priorities rather than clinical guidance alone. Other issues cited by the College were:

- Treatments on the second eye are being restricted, despite the adverse effect this has on depth perception and the risks this entails for individuals who go untreated
- Professor Dua cited data by the Royal National Institute of Blind People that suggests that the majority of the annual 270,000 falls in the UK are related to poor vision and that these cost around £2,000 each to treat. This means that reducing access to eye care simply “defers” costs or shifts them to other parts of the NHS
- Professor Dua also argued that although cataract operations are “the most cost-effective procedure on the human body”, it is the high volume of cataract operations that made them a potential target for restrictions
- Procedures to remove eyelid growths are being classified as “cosmetic” treatments and are therefore being restricted by some trusts, despite the negative quality of life impact that such growths can have
- If a simple three-part pathway is followed in which a cataract procedure is offered only when there are clear symptoms, a clear need and when the patient is informed of the risks of surgery, this could reduce the number of cataract procedures without the need for restrictions
- RCOPHTH is in disagreement with the Department of Health on its continued denials that cataract operations are being rationed

I also spoke to Dr Keith Bragman, President of the Faculty of Pharmaceutical Medicine (FPM) and a fellow of the Royal College of Physicians, about both drug blacklisting and the general situation with rationing in the NHS. While the FPM is not heavily involved in frontline medicine, its principal concern is the wellbeing and fair treatment of patients and its staff hold some views on the current situation. Dr Bragman was able to provide some key insights:

- He expressed concern about restrictions on treatment for some serious conditions, such as retinal vein thrombosis in the elderly, which had recently been discussed in the press, and believes that a clear framework for all approved treatments is needed and should be uniformly implemented regarding the availability of drugs and procedures
- Dr Bragman also suggested that consultant referral of patients back to their GPs, to be referred on to a new speciality, was an example of bureaucracy and hospitals increasing their revenue as each new referral generates a fee
- He also referred to NICE Chairman Professor Sir Michael Rawlins' recent writings about rationing in the NHS[33]. While acknowledging the severe financial difficulties the NHS faces, he argued that where there is clear guidance from NICE, local institutions have a responsibility to follow national guidelines (although this does not address the local problem of PCTs and/or NHS hospital trusts running deficits and seeking ways to reduce the cost of care by prioritising patient access to treatment)

Simon Edwards, Head of Policy & Communications for the Royal College of Surgeons (RCS), discussed the origins of PLCV lists in the NHS in early 2011, which the RCS have analysed as part of its research into rationing. Since that time, the Department of Health has condemned “blanket bans”, but Edwards expressed concern that the imposition of stricter criteria may have emerged instead as a way for PCTs to ration. Additionally:

- Ear, nose and throat surgeries tend to be common on restriction lists
- Edwards pointed to research by the Patients Association which showed a 4.6% drop in the number of surgeries and a reported increase on waiting times for some surgeries between 2010 and 2011[34]
- The RCS considers QIPP and the Health and Social Care Act reforms to be “separate issues” that should not be conflated, taking a “critical engagement” stance on the latter

A Senior Policy Analyst with the British Medical Association (BMA), Sally Al-Zaidy, explained current BMA policy on rationing, as the organisation has been vocal on the issue and its GP members in particular are deeply involved in it. A resolution was passed at the 2012 BMA Annual Representative Meeting stating the following: “this Meeting believes that if “low priority treatments” and “referral thresholds” are truly evidence based as claimed by [Primary Care Organisations] then:- (i) all should be implemented nationally; (ii) local “low priority treatments” should then be correctly described as rationing”. Furthermore:

- GPs on the ground have noticed “implicit” referral guidelines
- The BMA is not aware of any mass redundancies
- Doubts exist about whether QIPP can deliver savings through increased efficiency on the administrative side alone, as ultimately no new money is being released, marking a change from what NHS staff have become accustomed to in terms of spending
- We should remember that bedside rationing is, to some extent, an everyday reality in the NHS
- Current BMA policy is for there to be an explicit national benefits package of core required treatments, accompanied by a peripheral local list of additional services. This was outlined in more detail in a 2007 discussion paper by the BMA, ‘A Rational Way Forward for the NHS in England’
- The BMA remains opposed to the Health and Social Care Act changes, although at the current time, it is hard to predict what precise impact they will have on rationing specifically, due to the cross-cutting impacts that the simultaneous introduction of more localised Clinical Commissioning Groups and the national NHS Commissioning Board may have

Overall, medical organisations appear to be acutely aware of the current fiscal situation in the NHS and the implications of this, and all were able to cite examples of some types of rationing about which they were concerned. It also appears that they generally want a clearer stance from the Department of Health on the current situation.

## Conclusion: A Clear Picture?

In conclusion, a mix of statistical data and testimonial evidence appear to suggest that rationing is indeed occurring in the NHS due to the current fiscal climate. This finding stands to reason given the historical realities of the NHS with regard to rationing and the near-unprecedented challenges the service currently faces. However, much of the data that is currently publicly available is not official and to some degree remains partial, as it has been published by interested non-governmental organisations. The general stance of the Department of Health, meanwhile, is still an official denial that cost-motivated rationing is taking place. However, this position means that no across-the-board official investigations are being carried out and no official data is being published on restrictions. Moreover, as we have very briefly explored,

current NHS budget allocation formulae may not be entirely effective at preventing rationing in high-need areas.

Crucially, this also means that getting an indisputably clear idea of the specific implications and exact determinants of rationing is difficult, in terms of whether PCTs fitting a certain profile are more prone to rationing or why certain restrictions may be preferred over others. Not all types of rationing are necessarily equal in terms of how detrimental their impact will be on patient care, but only if this is acknowledged can fair and reasonable priorities and standards be established. Moreover, some types are harder to detect and quantify than others, such as dilution as a result of strained services. The limited acknowledgements the Department of Health has offered in response to specific allegations, such as its promise to investigate cataract restrictions in Sussex, are somewhat encouraging in this regard. However, wider acknowledgement of these realities is needed if the NHS is to have a coherent approach to rationing in the next few years.

At the level of PCTs and successor CCGs, it is also arguable that more transparency on rationing is required. PCTs have generally been responsive to FOI requests, but clearer attribution of their clinical sources and a frank approach with the public about the determinations they are having to make would be beneficial.

Therefore, while the NHS faces unprecedented challenges, there are perhaps steps that both the NHS and the Department of Health can take to mitigate some of the effects of the current situation.

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