"In austere financial times, which procedures should be rationed and who should decide?"

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Good morning, my name is Maral Rouhani and I am a 5th year from Cambridge University. Thank you to the College for having me here today (*slide 1*).

We are all familiar with the current financial crisis, which has gripped the world for the past 4 years, and its implications for public sector spending. The NHS has been severely affected with the so-called Nicholson challenge in 2009 (*slide 2)* proposing that huge cuts be made over the next few years. At the same time the NHS is adjusting to the reality of an ageing population, where there is INCREASED demand on REDUCED supply.

So how are the Nicholson challenge cuts to be made? While the term rationing (*slide 3)* has been used as hyperbole in the media, it is a well-established concept in healthcare, where resources are limited. This principle (*slide 4*) has been used specifically to guide decisions of rationing procedures. However, there are several things which strike me about the concept of rationing, which lead me to believe it is FLAWED.

DISCRIMINATION (*slide 5)*
Denying access to procedures could favour those patients able to pay for private healthcare, causing an increased gap in health inequality.
Rationed procedures could also disadvantage the elderly who may not be deemed cost-effective when relative life expectancy is shorter.
And, under the new NHS reforms, individual Clinical Commissioning Groups around the country will decide on spending, so postcode lotteries might actually determine the care patients receive.

DEBT (*slide)*
Surgical procedures have been proven to be highly cost-effective when compared with the cost of longterm non-surgical intervention. Treating obesity with one-off gastric banding is clearly a preferable option when opposed to continued drug treatments. Not only is it cheaper in the long-term, it also will reduce the likelihood of further complications like diabetes, hypertension and ischaemic heart disease.
So rationing could actually cost the NHS MORE money in the long-term.

DELAYS (*slide)*
Surely limiting access and denying patients essential procedures merely causes delays in treatment? This might seem an abstract concept for policymakers, but is a tangible issue for patients enduring pain or worsening disability in the wait for the operation.
Delays result in a reduced quality of life for the patient and reduced standard of care from the NHS.

In fact, a report published earlier this year (*slide 6)* stated that 90% of PCTs are already imposing limits on some non-urgent procedures, leading to increased waiting times and restricted access to care by patients.

I think 'rationing' is ineffective because it is only a short-term cost-cutting measure. It is also arbitrary in its varied application across PCTs, and, certainly at the moment, is not implemented using standardised sources of evidence.

For example, Oxfordshire PCT (*slide 7)*, like many others, recommend a 'watch and wait' approach for asymptomatic hernias. There is no published evidence from NICE that this is the correct action.

South Staffordshire PCT's bariatric surgery policy (*slide 7)* only considers patients with BMI of over 50, amongst other criteria, contrary to NICE, which recommends surgery in BMI of 40 and over.

To address these 3 flaws of rationing (*slide 8),* there needs to be standardised evidence looking into the long-term cost-effectiveness of procedures which can also benefit patients NOW.

So, HOW should this evaluation be done, and WHO should decide? Politicians (*slide 9)*? Doctors*?* Or patients*?*

In the new structure of the NHS, the Commissioning Board (*slide 10)* will be in the best position to make decisions on resource allocation for elective surgical care pathways (*arrow 1 to patients*), through a partnership between NICE and the surgical speciality associations. The decisions should be made transparent to enable effective scrutiny.

NICE will be able to provide nationally-distributed evidence (*arrow 2)* for long-term cost-effectiveness and sustainability of procedures, and their effects on quality of life for patients. The evidence could act as criteria for referral as a starting point, and will enable the use of the budget to be maximised and clinical outcomes to be optimised.

Surgical speciality associations should also contribute data (*arrow 3)* and feed these decisions back to the front-line (*arrow 4)*, and ensure shared decision-making with patients (*arrow 5)*. This means that the right choice is made based on each patient's individual needs, in line with nationally agreed pathways of care.

Constant review will also be vital to measure outcomes to ensure it is working well (*circle arrow).*

The need to save money fundamentally shouldn't be forgotten (*slide 11)*, and I think there are several other areas which could be focussed on*:*

- reducing waste could save the NHS billions. It was recently reported that over 600 different types of surgical glove are bought across 61 trusts, at hugely varying prices. A simple measure like standardising equipment could go a long way.
- improving efficiency should always be a goal, and in the surgical world, this could be achieved by early recovery programs involving the whole MDT, slick changeover time in theatre and faster pre-admission clinics
- and, these measures which I have proposed today mean the evidence of cost-effectiveness of surgical procedures can be used to save money in the long-term.

So, in answer to the question (*slide 12)*, in THESE financial times, evidence-based cost-effective procedures need to be specifically tailored to the needs of patients, not rationed. Thank you.