Speech

1 - Intro	Good morning, my name is Mueez Waqar, I'm a 4th year medical student at the University of Liverpool. The title of my talk is rationing: a journey through time.
2 - Aims	I'm hoping to talk to you about the lessons we can learn from how rationing was implemented in the past, how it is currently employed and how we can decide which procedures should be rationed in the future.
3 - Present	Rationing is a reality. In a drive to find £20 billion, the NHS is facing perhaps its greatest challenge since it came into being. Cuts are being made far and wide, attracting the attention of media, healthcare workers and royal college representatives, who see some of these decisions as baseless and rather arbitrary.
4 - Present	• Primary care trusts are effectively rationing autonomously, by restricting access to those treatments they deem to be of a lower priority, through so-called "low-priority" procedure lists. • Surgery has been hit particularly hard due to the higher costs involved, from the perspective of primary care. • The inset shows the requirements which must be fulfilled for a cataract operation to be funded by one PCT, highlighting the rather arbitrary cut-offs, dependent on non-standard QoL measures or measures of visual acuity. • What is more worrying perhaps, is the lack of national consensus regarding such lists, creating another postcode lottery, and the distinct lack of significant surgical input into their design.
5 - Present	Is this the perfect way to ration? Surely an easier way would be to rank procedures based on cost-effectiveness and offer only those which are above a certain threshold? This is where we can learn a lot from history.
6 - Past	It is the summer of 1987 in the state of Oregon, USA. Coby Howard is a 7-year-old boy who has just been diagnosed with leaukemia. Despite widespread campaigning, he is denied access to a $100,000 life-saving bone marrow transplant, due to the state's earlier decision to exclude this treatment from its state-funded list.
7 - Past	Alas, the boy died, paying the ultimate price, representing the rather understated "minority" of individuals who suffer for the majority to benefit. What followed his death, was media frenzy, and a local initiative to prevent cases such as his from reoccurring: the Oregon Healthcare Plan.

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<tr><td>8 - Past</td><td>
This represented the collaborative effort of doctors, nurses and members of the public alike, a list of over 700 diagnoses and treatment pairs, in descending order of priority. Near the top of this list were those procedures deemed to be the most cost-effective and efficacious.
Click 1 - Officials then drew a line at 587, with a decision to offer all treatments above this line.
Initially it worked well, but, as the economy worsened, the line was moved further and further up the list (click 2), covering fewer treatments and fewer individuals.
Eventually, it was deemed unlawful to move it up any further. It was determined that the number of people insured under this plan was not significantly greater than its predecessor.
Oregon’s rationing system had failed in the face of rising cost.
The plan showcased to the world the flaws of ranking medical treatments.
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<tr><td>9 - Future</td><td>
So which procedures should we ration and who should decide?
NICE is an organization well known for its clinical guidelines, which incorporate cost-benefit analysis. It is well placed therefore, to undertake a different task: to create guidance for commissioning groups.
NICE priority recommendations represents a national collaboration to identify low efficacy surgical procedures at a national level as opposed to a local level.
Priority panels for each speciality would be formed, bringing together the expertise of surgeons and the financial knowledge of commissioning group representatives. The unique feature of this approach is in its prioritization on a speciality by speciality basis.
Expert surgical input is necessary given the difficulty in assessing effectiveness of surgical procedures, exemplified by the sparsity of level 1 evidence in surgery in general.
Those procedures which are deemed to be of a lower priority would be discouraged and almost exclusively be performed in the private sector.
Priority panels would also identify special circumstances where these procedures could be funded by the NHS.
NICE priority recommendations. Is this the future? Thank you for listening. I welcome any questions.
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