

Good afternoon, my name is Jason Yuen, I'm a final year student from Oxford Medical School and I'm here to present to you my answer to which surgical procedures should be rationed nowadays and who should decide

In the context of healthcare, *rationing* seems to have become a bit of a dirty concept but we all know it is an intrinsic problem that we cannot avoid in the NHS
Because resources are always limited but medical complaints are almost endless
So it is not a new problem

But PCT trusts have been constantly criticised of letting down needy patients in order to help them to save every extra penny possible

And, this has become increasingly an issue when there are now

- 1) Tough financial conditions and govnt is discussing savings on the NHS all the time - NHS in England has to find £20bn in "efficiency savings" by 2015
- 2) Ageing population
- 3) More new, expensive treatments coming everyday

So what are the factors to consider when rationing the procedures? They are generally divided into 3 aspects – clinical, economic and ethical

Clinical

- As we should do no harm, the benefits of surgeries should outweigh the risks
- The way to assess this is to look at clinical trials
- But many surgeries do not seem to have trials with quality as high that for medical drugs' due to due to technical difficulties, for example in performing double-blinded trials

To quantify benefits, we need a systematic approach, the idea of QALY has been widely used by health economists for more than 30 years

However, it is always difficult to accept putting a price on patients' suffering

Obviously many disabled people have very fulfilling lives as well and it is hard to take every personal circumstance into account

Not practically possible to meet everyone's needs (one of the founding principles of NHS) but the following still holds → resources distributed based on clinical need

Currently PCTs are using arbitrary criteria to determine who gets what surgeries

We need to set up a standardised, national list of non-urgent surgeries that can be delayed in order to avoid postcode lottery

We definitely need to think about the economic factors

In a recent survey, 90% of Trusts admit they have rationed procedures they considered to be “non-urgent”, such as tonsillectomy, gastric bypass, cataract surgery and hernia repair

That, in itself, is not that controversial

But as mentioned, we must be fair in doing so and also avoid creating a false economy, for example

- (A medical condition stops some people from getting back to work)
- An early £900 **cataract operation** in an elderly patient might avoid a subsequent fall, as well as the £9,000 hip repair afterwards

Also new techniques such as **difficult robotic surgeries** are expensive but expertise would never be achieved if it was never done, so we need to consider the long-term benefits carefully

Having defined our agenda, we need to ask who should be hired on setting policies

To summarise

- NICE to weigh the evidence in clinical studies
- Necessary to liaise with Government and new GP commissioning board in order to introduce legislation to safeguard a fair system
- Health economists and statisticians to ensure treatments are cost-effective
- Royal Colleges + other professional bodies are important to be there to safeguard patients' best interest

Take home messages

- Rationing in the NHS is inevitable
- In order to prioritise procedures, factors to consider – clinical, economic, ethical
- Systematic and fair approach to distribute the resources
- A multidisciplinary team of the stakeholders should oversee this complex procedure

End of presentation, any questions?