Cut, cut, cut

WHY TO CUT?

When bankers are openly pocketing many millions of pounds in bonuses, and when the wealth of the country remains obscenely concentrated in the hands of a tiny plutocracy, should we contemplate slashing public expenditure aimed at the common good? Unfortunately, egalitarian principles are unlikely to cut much ice with an incoming Tory government, nor yet with an improbable renascent Labour one. So, the answer is 'Because that's what the Treasury demands'.

WHAT TO CUT?

Here are three suggestions: elderly toenails, the NICE value-for-money threshold, and the crap.

By the first, I mean that basic services, podiatry for example, that preserve the daily quality of life of our most vulnerable, should be preserved as a priority, while high-cost, high-risk, high-tech interventions should be focused more discriminatingly to achieve maximum benefit. Take the case of a slightly fictionalised older patient of mine, admitted 3 months ago for a routine hip replacement. This was complicated by a perioperative myocardial infarct; angiography indicated severe multivessel disease and she was listed for a coronary bypass. She then developed an ischaemic toe, and was sent for revascularisation of the leg — prior to which she had another infarct. She finally made it to the CABG, which was in turn complicated by a sternal wound infection, pericardial effusion, pneumonia, and renal failure: after 4 weeks on intensive care she died. Of course in retrospect it is easy to say that someone, somewhere along the line should have said enough is enough, but who, and when? We should be re-examining our priorities. The cost of this patient's final 3 months of life would have funded, probably, the annual salary of two full-time chiropodists. Which would have given better value-for-money?

My second target is the NICE threshold for the adoption of new therapies or interventions. The current system is an open invitation to any drug company to price their innovative drug as high as they can get away with. As for the recent decision that the threshold should be raised (that is, a higher cost be accepted by the NHS for treatments in the terminal phase of life), the ethical rationale escapes me. By pandering to the special pleading of the chemotherapy lobby, we are denying treatments to those who have more to gain from life, in both quality and quantity, while condemning others to months of misery for dubious benefit. The other glaring problem with the NICE approach is that there is no extra money to follow the adoption of a newly-approved treatment, so something else has to suffer — probably those poor old feet again.

Finally, as for the crap, by this I mean all those posts which have epithets such as 'czar(ina)', 'champion', 'coordinator', and 'advisor'; all initiatives that promise patients extra, but usually trivial, choice; all new primary care-based initiatives relating to obesity, exercise, and alcohol (the proper preserve of financial, educational and environmental agencies); all additions to the QOF; all booklets produced by the NHS and sent unsolicited in bulk to GPs' surgeries; the idle use of the words 'excellence', 'quality' and 'world-class' (although the latter should perhaps be spared as it can bring a burst of merriment into an otherwise dreary day); and finally, public consultations which promise to listen but refuse to hear.

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'What to cut? ... elderly toenails ...'

NHS cuts and services: can we afford it?

Although there are reassuring messages of protecting the NHS from cuts from both Gordon Brown and David Cameron there is an inevitability of reduced budgets that would be foolish to ignore. Politicians' pre-election promises hold little water and, as a profession, MPs are deft at delivering excuses for changes in direction. The UK budgetary imbalance is large and predicted as the largest in Europe. The IMF[1] has identified the NHS is a major resource of savings for the UK economy and McKinseys,[2] as management consultants to the NHS, have given their view on how this should be effected.

The NHS has received consistent budgetary increases since 2000. Much of this arose from a historical imbalance in UK health spending in terms of GDP compared with its EU neighbours,[3] but even with consistent increases the UK still remains behind. However, the current UK economic figures are stark and apparent savings have to be made and the NHS is a major source. Whatever way any government this year distributes cuts across the public sector, health will suffer. Currently the English NHS budget is £102 billion (£120 billion for the UK). The Kings Fund predicts a worse-case scenario with cuts of 2% per annum.[4] However, this relatively benign sounding reduction in funding needs to be offset. The same authors identify pressures on the NHS, just to stand still, in terms of quality and volume of activity. These pressures are identified as predominantly arising from a growing and ageing population: the over-75 population predicted to rise by 19% of current levels by 2017 with consequential increases in health demand inferred.

NHS spending has been under constant scrutiny for many decades and the spending regularly compared against the quality and volume of delivery of health care. Many different models of care