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COMMENTARY

Backlogs and Bulges: Can Value Chains Fix the National Health Service Waiting List?

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Previous solutions to the waiting list for elective care in England have been too narrowly focused, thereby shifting the problem to other parts of the care pathway.

One in eight people are currently waiting for elective care in the National Health Service (NHS) in England. High numbers of waits for treatment are not new; while the Covid-19 pandemic disrupted services, prior to the pandemic there were already 4.43 million people waiting for care. This number has steadily increased to 6.61 million, with 37% of people having waited over 18 weeks and 5% having waited over a year.[1]

The only reason this care crisis is not consistently dominating front page news in England at the moment is because it has been superseded by other crises, including and in particular the political turmoil. Now that a new government is in place and ready to mobilize action, the access crisis is front and center as a priority problem to be addressed. Indeed, it was already central to leadership campaigns, described as a "national emergency." Polling on health care priorities shows access to routine services is the number-one public concern in England.[2]

As we look ahead, it is important to recognize that addressing access will not fix all our health care problems. To use a medical analogy, waiting times are just a manifestation of the problems that are present in U.K. health care, not the "disease" itself. Political pressure focused on just one issue is not only likely to fail, but may actually cause harm. Instead, we need to think about whole value chains[3] for care delivery beyond access, i.e., the sets of activities required to meet the needs of different sets of patients. We also need to create a market context for driving improvement that can make progress independently of, rather than waiting for, political intervention.

The Failure of Previous Fixes

How long patients wait for care is a key factor in the outcome of their treatment and their experience of the care they receive. The Labour government (1997–2010) in England introduced a series of waiting time standards as a tool for improving services, setting out the maximum amount of time most patients should have to wait to access services, to improve performance and measure the impact of increased levels of investment in the NHS at the time. Over the past decade, many of these standards have not been met, including the 62-day standard for cancer and the 18-week standard for elective care from referral to treatment.

Waiting for elective care has continued to grow. Those waits are not equal, with both geographic variation in average waiting times and variation across specialities. Differences in outcomes on waiting are also found based on deprivation, with those in the most deprived areas 1.8 times more likely to wait over a year than those in less deprived areas. Access to emergency care, mental health, primary care, community care, and social care have also deteriorated. Failing to make headway on the backlog could place additional burden on primary care as people experience wider impacts of their wait for treatment. The ongoing workforce crisis, with staff shortages across all services, presents a critical challenge to progress.

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In May 2021, the NHS invested £160 million in an "elective accelerator" program,[4] which aimed to increase elective care capacity to 120% of pre-pandemic levels. Subsequent NHS operational planning guidance in February 2022 sets out the expectation to increase activity levels to 130% of pre-pandemic levels by 2024–25.[5]

Shifting the Locus of the Problem

A focus on delivering increased capacity is likely to skew the organization's ability to deliver results for the value chain. Access pressure will be shunted down the pathway, creating a "bulge" in the form of increased need for follow-up appointments, rehabilitation support, etc., where capacity increases have not yet been put in place. While fewer patients may be waiting for elective procedures, the pressure on the system is moved to another part of the value chain. Furthermore, to achieve that increased elective care capacity, workforce would need to be redeployed from other services, creating even more pressure on service capacity for other parts of the system. Additional independent sector surgical capacity, which is a key part of the proposed solution nationally, can only be mobilized with support from NHS staff to work in those facilities.

The national metrics to manage the health system reinforce the skewed focus, emphasizing waiting time, activity, and the waiting list tracker for elective care (i.e., the number of people waiting by length of wait time and clinical pathway). Before the value chain can be considered complete, new

metrics are needed to ensure patients on the waiting list have received their full pathway of care and are discharged. Additional data is needed to enhance understanding of the overall process. In particular, the knowledge of frontline staff and patient insights can be harnessed.

How to Focus Organizations on the Whole Value Chain

There are thoughtful observers who believe that the U.K. health care system is, quite simply, underfunded compared to the health care systems in other Western countries.[6,7] They argue that the problems afflicting the NHS cannot be fixed without a substantial infusion of money. While that may be true, I would argue that money alone will not be sufficient to drive the transformative improvement that the NHS needs.

Even more challenging than winning more funding, perhaps, is the shift in mindset to embrace ownership of the entire value chain of activities that matter to their patients. Transition to value-based health care (health outcomes achieved per dollar/pound spent) has been an increasingly important focus for health care providers around the world over the last couple of decades. In the U.K., health policy experts have recognized that historical organizational structures have not quite been the right units of analysis for creating value for patients.[8] Integrated care systems (ICS) are the latest organizational design, partnerships of organizations that come together to plan and deliver health care services for people living in their geographical area. Cynics can be forgiven if they roll their eyes and lower their already low expectations. But the fact is that the struggle to find the right organizational model is a struggle worth undertaking. And the U.K. will know that progress is being made when ICSs and other organizational structures, such as provider alliances, are working on value chains that can improve, in parallel, efficiency and flow, patient experience, staff experience, and patient outcomes.

Porter and Lee described the need, as health care systems transition into post–Covid-19 pandemic service delivery, "to understand the entire value chain for their key patient populations and optimize the entire process — not just the processes under their immediate control."[3] Health care delivery organizations including ICSs should recognize that their wider pathways of care consist of a series of connected value chains, where the activities of multiple providers are connected. They should have a market context in which they are pressured and rewarded to ensure that patients receive seamless care as they transition between organizations, to deliver the care and achieve desired health outcomes.

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What might that market context look like? It would include transparency regarding data on access, but that would be only one type of data that are shared publicly. And that data would be seen as a condiment, not the main course. The main course is the actual care that patients receive. Thus, data capture and public reporting must include outcomes (including patient-reported outcomes and patient experience). These outcomes data should be collected and reported for patient segments

(e.g., for different pathways such as patients with diabetes, or breast cancer, or heart failure, and critically for different demographic and social contexts relevant to understanding inequalities).

It is important to recognize that at the level of an individual patient journey, value is not additive. The value conferred at a single step of a pathway is dependent on what has come before and what follows. For example, diagnosis loses value if there is no treatment, and value conferred at treatment can be squandered if there is not access to appropriate levels of post-treatment rehabilitation. Furthermore, the value for an individual patient is also more than a pathway of diagnosis to treatment to rehabilitation for a single condition, and the potential value conferred by an elective pathway may not be realized due to poor management of other comorbidities or intersecting pathways. Acknowledgement of the growing proportion of the population with comorbidities has increased attention to the implications of single-condition interdependencies for management and treatment.

There is always risk of missed steps in a care pathway that can dissipate value. The key to any notion of optimizing value at the system level is to recognize the communication, connections, and right balance of resources. Health systems must make a pragmatic choice in where to draw the boundaries around their nested spheres of responsibility, influence, and concern.

With regard to the elective recovery waiting list, given the potential to shunt pressure from waiting lists to other points along the pathway, I believe that value chains should be created around the wider spectrum of diagnosis to treatment to rehabilitation and discharge to mitigate this risk and balance system management.

In sum, explicit consideration needs to be given to where value chains begin and end, and how to connect the entire pathway, if health systems are to achieve maximal value when tackling the waiting list backlog. These value chains vary according to patient conditions, because the needs of patients and the services required to meet those needs vary from segment to segment. The "ownership" of managing and improving the various value chains for different conditions belongs to the ICSs, to the NHS trusts (care provider organizations), and to the smaller units of organization in health care down to individual physician practices. But that ownership is more likely to be recognized and embraced if political pressure on access alone does not distract health care providers from the real work at hand.

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