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Editorial

In this issue we publish an article examining the mechanism some purchasing authorities in the United Kingdom (UK) are using to restrict access to 'cosmetic' surgery within the National Health Service (NHS). Our journal has not often entered the political arena, and it may seem contrary to focus on a particular area of UK practice when we are an international journal. In justification, the issues raised are likely to be reflected in other healthcare systems, and some concern the very heart of the specialty of Plastic Surgery.

The NHS in the UK occupies a special position in the people's esteem. It symbolises a post-war idealism embodying collective caring and generosity and is the jewel in the crown of the nation's welfare state. It provides healthcare free at the point of delivery and is funded from the public purse. The NHS probably cannot fund all the healthcare the population expects and yet successive governments are loathe to be the first to restrict access to NHS care. Now it appears that Plastic Surgery may be identified as a relatively uncontroversial area in which to begin to restrict access. In at least one part of England some plastic surgery operations will no longer be funded in the NHS and so the public hospitals will no longer allow their surgeons to perform these procedures.

The list of operations that will be excluded may derive from the concepts that, firstly, some surgery of appearance is not treating ill-health but enhancing lifestyle, and, secondly, that even if it were concerned with ill-health it would be of a lower priority than many other areas of surgery. The list includes many commonly requested procedures such as otoplasty, breast reduction, breast augmentation and so on. But many surgeons and psychologists believe these procedures can be effective in increasing self-esteem or reducing depression, or allowing better social functioning. Is that health or lifestyle?

In deciding what to exclude from state funding it is possible that focussing on the procedure is not the best way forward. In the unit in which I work we have attempted to focus on the symptomatic indications instead, and particularly on the psychosocial symptoms. This extends the concept of function in a seductively holistic manner but is founded on little science, is open to manipulation, and in the final analysis still requires some political interpretation of the relative values of symptoms. It seems likely that restriction of access will be continue to be procedure based.

However polemical the debate may become, all plastic surgeons recognise procedures such as face-lifting that are unlikely candidates for state funding and others that are strong candidates, for instance cleft lip repair. Each of these extreme examples is more concerned with appearance than function but our society values them very differently. When reflecting why this is one can make arguments around the normal process of ageing or the abnormal process of genetic malformations, or argue about health and disease. The arguments become more difficult when we consider the more common prominent ear, the large breast, the flat chest or the pendulous abdomen. Here we can see real problems for those who would restrict access to treatment, and in the past such decisions have been left to that most unscientific of things, surgical judgement. A new system may be needed but one that is fair and rational has not yet appeared. In designing such a system it might be better if the debate was founded on key concepts. These might usefully include definitions of health (and so of ill-health), and of cosmetic surgery. A mission statement for the NHS would also be helpful, then all would know clearly and transparently what is to be achieved, and the rightness of excluding patients from healthcare because they seek frivolous cosmetic surgery would be self evident.

Plastic Surgeons will legitimately be peeved if their surgery is regarded as an easy target for rationing, especially if this is the result of public misconceptions about the worth of plastic surgery. The fundholders must demonstrate an even handed and objective evaluation of what is health-giving surgery and what is lifestyle surgery in all specialties, and this evaluation should be made on the basis of agreed principles and objective criteria.

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This is not a parochial British concern: it will soon be exercising managers in other healthcare organisations regardless of funding mechanisms, and difficult questions will have to be considered. Most of these questions are not amenable to evidence-based solutions. Some will come down to arbitrary opinion and others will be more political. Given the unscientific nature of these decisions is it better that they are made by those managing the service, those funding it, those using it or those delivering it?

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