



LEGISLATIVE ASSEMBLY FOR
THE AUSTRALIAN CAPITAL TERRITORY

**Report on the Inquiry into
Public Hospital Waiting Lists**

**Report No. 3 of the
Standing Committee on Health
and Community Care**

November 1999

Resolution of Appointment

The following general purpose standing committees be established to inquire into and report on matters referred to it by the Assembly or, after the Assembly's endorsement, matters that are considered by the committee to be of concern to the community.

... a Standing Committee on Health and Community Care to examine matters related to health and community care policy, planning and purchasing acute, community health and population health services, hospitals and any other matter under the responsibility of the portfolio minister.

Legislative Assembly for the ACT, *Minutes of Proceedings*, (1998), No. 2, 28 April 1998, pp 15 and 16.

Terms of Reference

The Committee has the responsibility of inquiring into and reporting on public hospital waiting lists (both surgical and non-surgical), with particular reference to:

- (1) the factors contributing to the fluctuations in the current waiting lists;
- (2) the management of the operating theatres including utilisation of theatres and the allocation of theatre time to practitioners;
- (3) the effect on waiting lists of the allocation of the Medicare bonus funding and any Commonwealth Specific Purpose Payments;
- (4) the acceptability of the current clearance times, given the presence of two public hospitals in Canberra and the Territory's population;
- (5) the measures that are required to achieve the acceptable clearance times;
and
- (6) any other related matter.

Committee Membership

Mr Bill Wood, MLA (Chairman)

Mr Harold Hird, MLA (Deputy Chair)

Mr Dave Rugendyke, MLA

Secretary: Ms Beth Irvin (until 1 April 1999)

Mr David Skinner (from 12 April 1999)

Administrative Officers: Mrs Kim Blackburn

Mrs Judy Moitia

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SUMMARY OF RECOMMENDATIONS

RECOMMENDATION 1: The committee recommends that the Government consult with specialists and the Division of Surgery to work towards developing a trial for pooling public patients that addresses the over-servicing and medico-legal problems raised by the Division.

RECOMMENDATION 2: The committee recommends that the Government ensure that increased patient throughput is not jeopardised by excessive reductions in bed numbers.

RECOMMENDATION 3 : The committee recommends that the Government examine ways of improving theatre utilisation.

RECOMMENDATION 4: The committee recommends that surgical procedures which are social and not clinically required (as determined by the relevant specialist) be removed from ACT public hospital waiting lists and that procedures of this type be undertaken through the private health care system.

RECOMMENDATION 5: The committee recommends that the Government address the shortage of specialists and anaesthetists as a priority and reports any tangible action to the Assembly.

RECOMMENDATION 6: In keeping with principles of government accountability and transparency, the committee recommends that the Department more widely disseminate accurate, timely and easily accessible data on public hospital waiting lists and waiting times.

RECOMMENDATION 7: The committee recommends that the Government consult with the ACT Division of General Practice to encourage GPs to provide patients with the option (where clinically appropriate) of being referred to specialists with shorter waiting times.

RECOMMENDATION 8: The committee recommends that the Government produce an information pack or brochure, providing patients with a complete list of options available to them to minimise their time on the waiting list.

RECOMMENDATION 9: The committee recommends that the department investigate the usefulness and feasibility of collecting data on the length of time it takes patients to see specialists.

CHAPTER 1. BACKGROUND

1.1. For many years now, the issue of extended hospital waiting lists and waiting times has been of concern to communities and governments all around the world.

1.2. With increases in average life expectancy, advances in medical technology (enabling more treatment options), wider community awareness of health issues, and tight health budgets, increasing pressure is being placed on the public health care system in jurisdictions around Australia.

1.3. The ACT has not been immune to these pressures and the fact that the ACT's population is ageing faster than anywhere else in Australia will place additional pressure on its health system in years to come¹.

1.4. Current figures for elective surgery waiting times in the ACT show that many patients are waiting for periods exceeding clinically desirable timeframes. The committee agrees with the Government that current ACT public hospital waiting lists and times are unacceptable².

1.5. On December 4 1998, the Standing Committee on Health and Community Care resolved to inquire into and report on the issue of public hospital waiting lists (both surgical and non-surgical).

1.6. The committee placed advertisements in local newspapers calling for written submissions and subsequently received 12 submissions from numerous stakeholders. These are listed in Appendix A. The committee conducted public hearings on 29 April 1999 and 16 August 1999, taking evidence from representatives of 5 organisations which are listed in Appendix B. The committee also received a briefing from the ACT Government on 24 February 1999.

1.7. A comprehensive ACT Government submission provided the committee with an in-depth analysis of the many complex issues surrounding hospital waiting lists including current figures for waiting lists and times, causes of extended waiting lists and times and remedial measures aimed at improving performance in these areas.

1.8. The committee believes that the Government submission provides a solid basis for public debate on the issue of hospital waiting lists and is worthy of wider distribution. To this end, the committee has decided to include this submission as an attachment (Attachment A).

1.9. Notwithstanding the inclusion of the Government's detailed submission, the committee feels compelled to make a number of additional comments and highlight

¹ Submission 4 p. 15.

² *ibid* p 2.

several points made by stakeholders in the public hearing and in the twelve submissions it received. This will be the focus of the report.

Structure of report

1.10. A brief overview is provided in Chapter 2, outlining how patients are placed on hospital waiting lists and the importance of waiting times as a performance measure.

1.11. Several recent statistics on waiting lists and times are provided in Chapter 3.

1.12. The committee was advised that a variety of factors impact on the length of waiting lists and waiting times, and numerous remedial measures were proposed by stakeholders in evidence at the public hearing and in the submissions received. These issues are discussed in Chapter 4.

1.13. A number of witnesses informed the committee that there should be more transparency and accuracy in information provided about hospital waiting lists and times. It was submitted that this would improve the quality of public debate on the issue as well as giving patients better information to make choices about their treatment options. This is explored more in Chapter 4.

1.14. This report concentrates on elective surgery waiting lists and times as the committee was told that waiting lists are not kept for emergency surgery or non-surgical treatment in the ACT³.

1.15. Throughout the course of this inquiry, the Government has kept the committee apprised of developments in the management of ACT public hospital waiting lists. The committee has noted in this report areas that have changed and acknowledges that there has been some improvements in the Government's performance while other areas are still of concern to the committee.

³ *ibid* p. 6.

CHAPTER 2. OVERVIEW

What is a waiting list and how does a patient get on one?

2.1. An important element of the Australian health care system is the principle that medical treatment should be administered to patients on the basis of need rather than capacity to pay. Under the Australian Health Care Agreement, the ACT must conform to this principle⁴.

2.2. In keeping with the principle of need is the idea that the more urgent a medical condition/situation is, the more prompt its treatment should be.

2.3. Waiting lists are a means for health care administrators and professionals to manage the allocation of health care services according to need and urgency.

2.4. In the ACT, hospital waiting lists are kept only for elective surgery. Elective surgery is classified as any surgical intervention which is not urgent, that is, it does not need to be undertaken within 24 hours⁵.

2.5. Hospitals keep waiting lists for elective surgery patients because ‘admission dates for elective surgery cannot usually be allocated when surgery is first requested’⁶. This is largely the result of emergency workloads taking priority over elective or non-urgent surgery. As the Minister for Health and Community care noted in his evidence before the committee, ‘one of the things we are talking about [in the health care system] is a form of rationing. It is not a rationing to say yes or no [to surgery] but it is a rationing to say when’⁷.

2.6. Waiting lists are not maintained for patients requiring emergency or semi-urgent surgery because the high clinical urgency of treating these patients is such that the required surgical procedures cannot be delayed. Following on from this, a hospital system’s first priority is to deliver prompt and effective treatment to its emergency patients. The Government pointed out that ‘the ACT public hospital system’s management of emergency cases is excellent and ranks with the best in Australia’⁸.

2.7. The Government also noted that there are no waiting lists for non-surgical procedures or treatments:

This is because the type of treatment required for disease and disorders of a non-surgical nature is dependent on the condition presenting itself and therefore it is difficult to keep lists on this type of care. There may be of course some wait for non-surgical services but generally this is limited to non-inpatient care or community based care. For those

⁴ *ibid*, p 4.

⁵ *ibid* p 4. One submitter indicated that the term elective surgery was inappropriate for describing this sort of surgery as it implies that the procedure is somehow optional. This is explored in more detail in Chapter 4.

⁶ Australian Institute of Health and Welfare (1998) “Australia’s Health” 1998. p. 205.

⁷ Transcript, 29 April 1999, Mr Moore, p 38.

⁸ Submission 4 p 4.

patients who do require inpatient care in the medicine specialties, there has essentially been no waiting time.⁹

2.8. Under the referral process, a General Practitioner refers a public patient who may be in need of surgical treatment to a relevant specialist. After determining that a patient requires elective surgery, the specialist places that patient on the public hospital waiting list¹⁰.

2.9. Under the Medicare system, a patient who is not a war veteran, eligible for compensation or a foreign national, is considered a public patient¹¹. Public patients do not have to pay for most of the services that they receive during their time in hospital.

2.10. Patients with private health insurance can elect to be classified as private patients, which entitles them to choice of specialist. The committee was informed that while public patients are not entitled to this choice, ACT referral practices have meant that public patients do end up with a degree of choice¹².

Categorisations of clinical urgency/need

2.11. To assist health administrators and professionals in determining the relative levels of need, specialists assign one of three nationally recognised categories to a patient according to the seriousness of their medical condition.

2.12. These three categories of clinical urgency have been established by the Royal Australasian College of Surgeons and are published in the National Health Data Dictionary published by the Australian Institute of Health and Welfare. They are:

Category One: urgent admission is desirable within 30 days for a condition that could deteriorate

Category Two: semi-urgent admission is desirable within 90 days for a condition that may influence the person's health status over the longer term

Category Three: admission at some stage in the future for a condition that is causing minimal or no pain, dysfunction or disability [the ACT has set out that patients in this category should be treated within 12 months of being put on the waiting list]¹³.

2.13. The clinical urgency category that has been assigned to a patient will, to a large extent, determine how long a patient waits to receive surgery. However, there are several other factors that affect the length of wait experienced by patients which are explored in chapter 4.

2.14. The committee was told that patients could move between categories if the status of their condition changes. The Government submission pointed out that:

⁹ *ibid* p 6.

¹⁰ *ibid* p 5.

¹¹ Submission 4 p 5.

¹² Transcript, 24 February 1999, p 7-8, Mr Lee Koo.

¹³ Submission 4, p 7.

... a patient's condition can and does change over time and it is possible that a clinician will change a person's urgency categorisation to reflect a change in clinical condition¹⁴.

2.15. A number of witnesses and submissions argued that the clinical urgency criteria outlined above are in need of review and refinement as they are inadequate for assessing relative urgency. This issue is raised in more detail in Chapter 4.

Waiting lists versus waiting times

2.16. Numerous stakeholders informed the committee that waiting lists are not an accurate measure of the efficiency and effectiveness of the public hospital system.

2.17. The Government noted in its submission that:

A waiting list... does not necessarily reflect poor access to health services. In fact on the basis of raw Separations (ie the raw number of inpatients discharged from hospital), the waiting lists represent a total of less than ten percent of the combined annual workload for public hospitals in the ACT¹⁵.

2.18. In terms of patients' experiences in the public hospital system, the actual length of time it takes to receive an operation is obviously far more important than the size of a waiting list. In this regard, it was submitted that waiting times are a more useful indicator for measuring the effectiveness of a health care system. The Government noted that:

.... the most important issue for the community and individuals is the length of time a patient must wait before receiving the required treatment.... [This] is a far better indicator of access to health services and a far more effective measure of the overall efficiency of any given health care system¹⁶.

2.19. The committee was advised that patients who have been assigned to one of the three categories above, and who have not received surgery within the clinically recommended time frame, are considered 'long wait' patients¹⁷.

2.20. Essentially the length of a waiting list is not as relevant as the waiting times experienced by patients. It is the health system's capacity to remove patients from the list within clinically appropriate time frames, however long or short the list, which matters. The committee considers the number of long wait patients on the list is an important measure of an effective health care service in the ACT community - the fewer long wait patients as a percentage of the number of people on the list, the more efficient the service.

¹⁴ *ibid* p 7.

¹⁵ *ibid* p 5.

¹⁶ *ibid* p 6.

¹⁷ Transcript, 24 February 1999, p 2-3, Professor MacLellan.

CHAPTER 3. STATISTICS

3.1. The committee was told that information on waiting lists and times is compiled by the ACT's two public hospitals independently from each other¹⁸ and these two streams of information are submitted to the Department of Health and Community Care.

3.2. The figures in the Government submission showed that between December 1997 and December 1998 there was a marked increase in the number of people on public hospital waiting lists and in the waiting times experienced by patients.

3.3. A number of figures are provided below, including recent figures made available to the committee in August 1999. The committee considers that it is worthwhile including figures from December 1998 to help illustrate any recent improvements and the extent that problems existed at this time.

3.4. An extensive array of figures is contained in the Government submission (Attachment A).

Aggregate waiting list figures

3.5. The committee was advised that the number of patients on waiting lists will go up and down according to the number of separations, that is, the number of patients who have been discharged after receiving surgery, and additions (new patients)¹⁹. As the Government stated the obvious, 'put simply waiting lists will change when the numbers of admissions to the list are greater than or less than the numbers of patients removed'²⁰.

3.6. The committee was informed that in the 1997-1998 financial year there were 11,505 removals from waiting lists and 12,074 additions, which is a net increase of 569 patients to the lists²¹. The committee noted with concern that in only six months during 1998-1999, there were 5,762 removals and 6,465 additions, which is a net increase of 703 patients to the list²².

3.7. As at 31 December 1998, 4,845 people were waiting for elective surgery in the ACT²³, of this number, 3,402 were waiting at The Canberra Hospital and 1,443 at Calvary Public Hospital²⁴.

¹⁸ *ibid* p 2.

¹⁹ There are other reasons that patients are removed from waiting lists such as death, pre-surgery recovery and the duplication of a patient on both hospital lists.

²⁰ Submission 4 p 15.

²¹ *ibid* p 16.

²² *ibid* p 16.

²³ *ibid* p 8.

²⁴ *ibid* p 14.

3.8. Recent figures supplied by the Government in August 1999 show that there has been a slight improvement with 4,643 people listed as waiting for elective surgery as at July. Of this total, 3,413 were waiting in The Canberra Hospital and 1,230 at Calvary Public Hospital²⁵.

Waiting times

3.9. As noted earlier, waiting times are a better measure of the effectiveness of a health care system than the length of waiting lists.

3.10. With this in mind, the Government observed that:

Of the total numbers waiting for elective surgery, some 1,710 or 35% are [as at December 1998] classified as waiting longer than clinically desirable [ie beyond the recommended period set out in the clinical urgency categories]²⁶.

3.11. The Government pointed out that, as at December 1998 there were 96% more 'long wait' patients than one year previously²⁷. This was a matter of concern to the committee.

3.12. The following table shows the increases in the number of overdue or long wait patients in the ACT (by clinical urgency category) between December 1997 and December 1998, and improvements that have been made between December 1998 and July 1999²⁸.

	End of December 1997	End of December 1998	Change (between 1997 and 1998)	End of July 1999	Change (between December 1998 and July 1999)
Category 1 > 30 days	0	51	+51	28	-23
Category 2 > 90 days	371	1,026	+655 (+177%)	820	-206
Category 3 > 1 year	501	633	+132 (+26%)	750	+117
TOTAL	872	1,710	+838 (+96%)	1598	-112

3.13. The figures show that there have been significant increases in the number of long wait patients for all three clinical urgency categories between December 1997 and December 1998. However, the committee notes that there has been some progress made between December and July in the number of long wait patients in categories 1 and 2.

²⁵ Submission 12, pp 3, 9, 10.

²⁶ Submission 4, p 8.

²⁷ *ibid* p 9.

²⁸ *ibid* p 9 and submission 12, p 6.

Category one patients

3.14. In its submission, the Government argued that ‘generally both ACT public hospitals perform well in relation to the clearance of category 1 patients although focus still needs to be given to the waiting times for some category 2 and 3 patients’²⁹.

3.15. The committee agrees that a particular problem does exist in terms of the increase in waiting times for category 2 and 3 patients but does not accept that the number of long wait patients in category 1 is acceptable.

3.16. Although category 1 patients do not make up a large part of waiting lists, category 1 patients are the patients in the most need, with conditions that could deteriorate and become an emergency. For this reason it is imperative that category 1 patients are treated within the recommended timeframe and unfortunately it appears that many are not.

3.17. The committee noted the following in relation to category 1 patients:

- at the end of July 1999, 28 patients requiring surgical treatment within ‘30 days for a condition that could deteriorate’ (category 1) had not received that treatment within the appropriate time frame³⁰;
- there was a decrease in the percentage of category 1 patients at The Canberra Hospital who were considered long wait between December 1998 and July 1999, from over 50 per cent to around 13 per cent³¹;
- at the end of December 1998, 18.9% of Calvary’s category 1 patients were long wait patients, as at April 1999 there were no category 1 long waits at Calvary but as at July 1999, 22.7% of Calvary’s category 1 patients were considered long wait³²; and
- the mean waiting time for category 1 long wait patients still on the list at the end of December 1998 was 78 days at The Canberra Hospital (over twice the recommended time frame) and 43 days at Calvary³³.

Category two and three patients

3.18. According to the Government submission, category 2 and 3 patients, although less urgent, have a large number of long wait patients. The more recent figures provided in August show that there has been no major reduction in the number of long wait patients in these two categories.

²⁹ Submission 4 p 10.

³⁰ Submission 12, p 6.

³¹ Submission 4 p 14 and submission 12, p 9.

³² *ibid* p 14 and submission 12, p 10.

³³ *ibid* p 11.

3.19. The committee noted the following:

- at the end of July 1999, 51.4 per cent of category 2 patients on The Canberra Hospital list were long wait patients and 29.8 per cent of category 3 patients were long wait³⁴;
- at the end of July 1999, approximately 33.2 per cent of category 2 patients on Calvary's list were long wait and 22.5 per cent of category 3 patients were long wait³⁵;
- at The Canberra Hospital, there was a mean waiting time of 219 days for category 2 long wait patients on the list at the end of December 1998 (over double the clinically recommended time frame) and a mean waiting time of 732 days for category 3 long wait patients (twice the recommended time frame)³⁶;
- at Calvary public hospital, there was a mean waiting time of 205 days for category 2 long wait patients on the list at the end of December 1998 and a mean waiting time of 515 days for category 3 long wait patients³⁷;
- between December 1998 and July 1999 there was a decrease of 206 long wait patients in category 2, bringing the total number to 820 (both hospitals)³⁸;
- between these seven months, the number of long wait patients in category 3 increased from 633 to 750 (both hospitals)³⁹; and
- the total number of long wait patients in the ACT public hospital system as at July 1999 was 1598, 112 less than as at December 1998⁴⁰.

3.20. The committee is concerned that there have been no major improvements in the number of long wait patients in categories 2 and 3 and agrees with the Government when it says that 'the current level of waiting times for elective surgery is unacceptable'⁴¹. Of particular concern is the continuing increase in the number of long wait patients in category 3.

3.21. Despite the minor improvements since December 1998, the committee is of the view that these figures suggest that a significant number of public patients are being failed by the public health care system, in that many patients are waiting longer than the clinically appropriate timeframes.

3.22. The committee commends the areas where the Government has improved in reducing the number of long wait patients. However, in evidence before the

³⁴ Submission 12, p 9.

³⁵ *ibid*, p 10.

³⁶ Submission 4, p 11.

³⁷ *ibid* p 11.

³⁸ Submission 12, p 6.

³⁹ *ibid*

⁴⁰ *ibid*

⁴¹ Submission 4 p 30.

committee, the Department submitted that ‘ideally there should be no long waits for any category’⁴². The committee urges the Government to realise this ideal.

⁴² Transcript, 29 April 1999, p 4, Mr Lee Koo.

CHAPTER 4. ISSUES

4.1. The following chapter is a selective exploration of some of the factors affecting the length of hospital waiting lists and times and an examination of several measures proposed by stakeholders aimed at ameliorating problems in this area.

4.2. Additional analysis can be found in the Government submission.

Funding

4.3. The committee supports the additional funding of \$3 million in each of 1999-2000 and 2000-01 for the purchase of increased surgical throughput and also supports the capital works allocation of \$850,000 to develop improved day surgery facilities at The Canberra Hospital⁴³.

4.4. While The Canberra Hospital operating deficit is beyond the scope of this inquiry, the committee is concerned that the extent of The Canberra Hospital operating deficit has meant that funding which could otherwise be spent on increasing surgery throughput and on reducing waiting times is not available.

NSW patients and cross border payments

4.5. The committee heard that approximately 21 per cent of patient throughput in ACT hospitals relates to patients from NSW. However the Government noted that ‘...in relation to weighted separations (based on diagnostic related groups [DRGs], which measure all hospital procedures relative to each other) NSW residents account for 25% of our throughput’⁴⁴.

4.6. This indicates that NSW residents receiving care in ACT hospitals are, on average, likely to be more complex and possibly more sick than ACT patients.

4.7. Despite the fact that NSW residents make up 25 per cent of throughput on the basis of cost-weighted separations, NSW contributes only 20 per cent to the total cost of running public hospitals in the ACT⁴⁵.

4.8. In recent years there have been disputes between the ACT and the NSW governments with respect to cross border payments from NSW. The ACT has consistently presented the argument that cross border payments are designed to compensate states and territories for the actual financial cost of treating patients from other jurisdictions⁴⁶. However, NSW has argued that the cost of treating patients in the ACT is exorbitantly high and that it should be able to pay compensation on a national average basis.

⁴³ Submission 4, p 25-26.

⁴⁴ Government response to question on notice, 29 June 1999, p 1.

⁴⁵ *ibid*, p 1.

⁴⁶ *ibid*, p 3.

4.9. Between 1997-1998 and 1998-1999, NSW paid the ACT on the basis of total cost weighted separations, multiplied by an agreed national average price plus a loading of 5 per cent, reflecting the additional cost of treating patients in the ACT. In 1999-2000, NSW will be required to pay only the national average price⁴⁷.

4.10. In its most recent dispute with NSW, the ACT Government is arguing that ACT's capital costs for treating NSW patients are not being properly reimbursed. The Government has argued that capital costs are not an issue for other jurisdictions because the use of public hospitals by residents from other states/territories is marginal. However, the 25 percent usage of ACT hospitals by NSW residents represents a considerable portion of total patient throughput. Following on from this, the ACT Government is seeking payments from NSW for both opportunity costs and capital depreciation costs.

4.11. In relation to opportunity cost the ACT Government submitted that:

Justification for seeking an opportunity cost payment is largely on the basis that the number of NSW residents provided with inpatient treatment in ACT hospitals represents a significant proportion (in the order of 25 %) of the total ACT workload. As a consequence, the ACT has been required to invest and maintain hospital infrastructure (arguably a medium size hospital such as Calvary) to service the NSW resident workload.

Based on the Report of Government Services, the replacement cost of the ACT hospital infrastructure is \$314m. Based on 25% of the infrastructure being for NSW residents, this would equate to \$78.5m. We consider that a reasonable "alternative use" of this capital could be the Treasury 10 year bond rate for June 1997-98 as published in the Reserve Bank of Australia Bulletin of July 1998. This rate is 5.58%, \$4.38 m annually. This translates to a cost of \$308.54 per cost weighted separation⁴⁸.

4.12. In relation to reimbursement for capital depreciation, the Government submitted that:

The second component of capital reimbursement sought applies to the traditional asset replacement requirement that is typically derived on the basis of a depreciation allowance and acts as a return for the consumption of capital. For the purpose of 1998/99, the ACT wants an approach based of the Fourth Review of Commonwealth/State Service Provision. The report identifies a depreciation charge of \$150 in NSW (\$765 for buildings and \$74 for equipment) or an estimated annual payment of \$2.247m⁴⁹.

4.13. There is no question that ACT public hospitals should continue to provide services to residents from all jurisdictions based on clinical need. However, it appears that the ACT is to some extent subsidising NSW patients using our hospitals. There is a strong argument that if the ACT was properly compensated for treating NSW patients, more resources could be applied to increase throughput and hence reduce the waiting times experienced by patients.

⁴⁷ *ibid*, p 3.

⁴⁸ *ibid*, p 4.

⁴⁹ *ibid*, p 4.

4.14. It is the committee's view that the approach taken by the ACT Government in recent negotiations with NSW has been the correct approach and the committee supports attempts by the Government to address issues surrounding inadequate cross border payments from NSW.

Targeting high priority areas

4.15. The Government advised the committee that one factor that has upwardly affected the waiting list, particularly at The Canberra Hospital, is the decision to focus on throughput in the high priority areas.

4.16. The Government submitted that:

The Department purchases cost-weighted separations from the hospitals as opposed to the raw number of people actually on the waiting list. TCH [The Canberra Hospital] and Calvary are now treating more and more category one patients than ever before. These patients are clinically complex and tend to have urgent needs for medical care. As a result, they require more hospital resources for treatment than do patients with a less serious medical condition. For this reason, the volume of patients is lower when treating more complex patients than is the case when treating less complex patients, given the same amount of resources⁵⁰.

4.17. The committee supports the principle that the most needy patients should receive priority and acknowledges that procedures in this category are more resource-intensive. The committee trusts that the additional \$6 million in funding over the next two years will allow an impact to be made not just on category 1 long waits but also in reducing the number of long waits in category 2 and 3.

Pooling of public patients

4.18. The committee was advised that public patients in the ACT are effectively given choice of specialist, a choice that they are not entitled to under the Australian Health Care Agreement⁵¹.

4.19. This occurs because of Visiting Medical Officers' (VMOs') tendency to 'hold-on' to patients referred to them by GPs rather than passing them on to surgeons who may be able to perform the surgery in a shorter time frame.

4.20. When a patient presents to a GP with a problem requiring surgical intervention, that patient is referred to a suitable specialist, who then places the patient on the waiting list. In the ACT, for all intents and purposes, the specialist who places the patient on the list 'owns' the patient from that point on and will, in most cases, perform the surgery⁵².

⁵⁰ Government response to question on notice, 17 May 1999.

⁵¹ Transcript, 24 February 1999, p 7-8, Mr Lee Koo.

⁵² *ibid* p 3, Professor MacLellan.

4.21. The effect of this is that patients who end up on the list of a specialist who is in high demand, will inevitably experience longer waits than patients who are on a less-sought-after doctor's list.

4.22. One submission from a private citizen outlined how this situation is clearly inequitable:

The consequence of this choice of specialist is that the principles of access to services based on need and of the most needy people being treated first are not followed by the specialist or the hospital.

...a specialist with a short waiting list may be treating category 3 clients, while at the same time another [more popular] specialist in the same specialty will have "overdue" category 2 clients, and regardless of whether these overdue clients could be treated by a third specialist within the clinically indicated waiting time⁵³.

4.23. In a similar vein, Calvary Public Hospital submitted that:

I will go along to one particular... doctor to have something done - I might be a category 2 needing an arthroscopy and if that is a popular doctor I would expect to wait a very significant period of time. I could go to his colleague down the road who might not be so popular or who might have less of a referral base or less access to the hospitals and I could be done in a significantly shorter period of time for exactly the same complaint⁵⁴.

4.24. Specialists raised the point that the reason some surgeons have shorter lists is because they choose to consult less⁵⁵.

4.25. In a system of pooling for public patients, a public patient is not put on a particular surgeon's waiting list but is assigned a surgeon by the hospital based on a clinical assessment (the paramount consideration) *as well as* the capacity of a particular surgeon to undertake the surgery in a clinically appropriate time frame.

4.26. The committee is of the view that this approach better utilises the available supply of surgical skills, not relying to the same extent on competitive forces which have the potential to subordinate the length of waiting times experienced by patients to the private interests of surgeons.

4.27. Essentially, this argument conceives the pooling of public patients as being more efficient and equitable because it distributes demand for surgical services according to capacity to supply these services within clinically appropriate timeframes.

4.28. However, efficiency is only one consideration. The point was raised that one reason some doctors are more popular than others is because they are more skilled.

⁵³ Submission 2 p 3.

⁵⁴ Transcript, 29 April 1999, Mr Dyer p 47.

⁵⁵ Submission 6, p 1 and submission 5, p 2.

4.29. Calvary Public Hospital noted that, ‘... to a degree it is a perception that some doctors are more skilled than others. In some cases I think this is true’⁵⁶. This is certainly true in terms of sub-specialisation within particular surgical specialties, where the level of skills between surgeons for a range of procedures varies quite markedly.

4.30. In evidence to the committee Calvary Public Hospital noted that:

If you happen to have something wrong with your wrist, although there are 10 orthopaedic surgeons at the moment in Canberra, there is only one or two who are really especially good at wrists. So, instead of 10 to choose from, you have got two... whereas, if it is a hip or a knee, you might have seven of the 10 to choose from⁵⁷.

4.31. With regard to sub-specialisation and pooling, the Division of Surgery advised the committee that, ‘it would be bad patient care to have your knee operation performed by someone who specialises in hand surgery just because you were pooled into the orthopaedic pool’⁵⁸.

4.32. In keeping with this, the committee believes that it is important that any pooling of public patients should take place within appropriate clinical parameters, that is, with the weight of a particular specialist’s clinical assessment as the determining factor. Where a particular surgeon is an expert in a particular area of their specialty, and offers the best chance of a curative outcome, then obviously that surgeon should undertake the surgery.

4.33. However, the committee understands that there are some generic surgical procedures, such as routine hernia operations, which can be undertaken safely and effectively by any number of surgeons. There are also surgical procedures that are generic to a particular specialty, such as cataract removal within the ophthalmological specialty.

4.34. Where clinically appropriate, the committee can see no compelling reason why patients awaiting surgery of these generic types shouldn’t be directed to a common public waiting list and treated by a surgeon who can expedite the surgery within the appropriate time frame.

4.35. The committee received evidence from a number of specialists and the Division of Surgery raising other problems with the concept of public pooling.

4.36. The Division of Surgery argued that pooling public patients presents significant medico-legal problems relating to the informed consent of patients. In its submission, the Division advised the committee that:

⁵⁶ Transcript, 29 April 1999, p 48, Mr Dyer.

⁵⁷ *ibid* p 47, Mr Dyer.

⁵⁸ Submission 5, p 2.

Patients now are entitled to and expect that they be fully informed about any proposed surgery. This is currently done for elective surgery in the surgeon's office or clinic. Even if the patient is to be admitted as a hospital patient the patient has an expectation that the operation will be performed in the manner that was described by the original surgeon. If another surgeon then takes over the care of the patient (as would happen in pooling) then it is quite likely that the operation would not be done as originally described or consented to. This is true no matter the complexity of the operation as different surgeons may do even quite simple operations with quite varying techniques. It is not satisfactory in 1999 to say that the patient did not need to know or had no rights just because they were a medicare patient⁵⁹.

4.37. The Division argued that in order to ensure informed consent, a patient would need to have another consultation with the new doctor to whom they had been referred. The Division conceived such a situation as 'directed over-servicing'⁶⁰ or a mandated duplication of consultation by the hospitals.

4.37. Evidence from surgeons also indicated that increased bed availability, improved utilisation of theatres and the increased allocation of theatre time to high-demand surgeons would contribute to an improvement in surgical throughput. The division of surgery argued that, 'It would seem to be better to give increased operating time to those surgeons with longer waiting lists than to simply transfer the patients care without patient consideration to another surgeon'⁶¹. Another surgeon noted that the ACT is in need of more surgeons but that 'there is absolutely no point in doing that [increasing the number] unless extra operating time can be provided for those surgeons and extra beds can be provided for the patients'⁶².

4.38. The committee considers that the views expressed by the Division and individual surgeons must be considered in any attempt to introduce a system of pooling public patients. However, the problems raised by the Division cannot be seen as insurmountable and the committee urges the Government and the surgeons to examine creative ways of implementing a pooling arrangement that works towards increased patient throughput without the dangers of forgoing informed consent or patient care more generally.

4.39. One paediatric surgeon submitted that, 'we [the Paediatric Surgery unit] understand the economic and organisational advantages of pooling patients and would be happy to comply with this in certain situations. The concept of pooling would only be acceptable to the Paediatric Surgery unit where the surgeon responsible for submitting the patient for surgery made the decision regarding whether that patient was pooled or not'⁶³.

⁵⁹ *ibid*, p 1.

⁶⁰ Transcript, 16 August 1999, p 89, Dr Bradshaw.

⁶¹ Submission 5, p 2.

⁶² Submission 6, p 1.

⁶³ Submission 10, p 1.

4.40. It is the committee's view that it is not beyond the Government and surgeons to negotiate about what 'certain situations' would warrant a pooling arrangement and how the decision to pool a patient would be made in such an arrangement.

4.41. The committee was told that some pooling does take place in the ACT and the specialty of urology was cited as one area where progress is being made.

4.42. The Government noted that:

We have already started [pooling] in urology. We have employed a specialist urologist in the hospital and we have been saying to public patients who are on the waiting lists of some of the other specialists, "if you want your operation done now, then you have this other choice of another specialist"⁶⁴.

4.43. However, it could be argued that this pooling arrangement has been successful only because of the fact that a staff specialist is the locus of re-directions. It is difficult to see VMOs as being as eager to pass on 'their' patients to other surgeons.

4.44. The Government noted that:

...there is also a prerogative as I see it, and we would be very interested in the committee's opinion, as to whether we simply pool the lists and say, "No, they are not your [specialists'] lists at all". They are public patient lists and therefore you will be assigned the people⁶⁵.

4.45. The committee supports the Government's endeavours to introduce a system of public patient pooling which addresses the medico-legal and over-servicing problems raised by the Division of Surgery.

RECOMMENDATION 1: The committee recommends that the Government consult with specialists and the Division of Surgery to work towards developing a trial for pooling public patients that addresses the over-servicing and medico-legal problems raised by the Division.

Bed availability

4.46. As noted above, specialists have cited the drop in bed numbers as one impediment to increased patient throughput. In evidence, one specialist argued that, 'When I bring this argument [about a lack of beds] up with powers that be they say, "we run at 10 per cent vacant bed occupancy". I am actually staggered if I can ever find these beds. I am not sure how these numbers get up and whether people are playing games... but... [the beds] do not seem to be there when you need them'⁶⁶.

4.47. Bed statistics provided in *The Canberra Hospital Information Bulletin, Monthly Patient Activity Data* indicate a decrease in available bed numbers. Until July 1998

⁶⁴ Transcript, 29 April 1999, p 44, Mr Moore.

⁶⁵ *ibid*, p 44.

⁶⁶ Transcript, 29 April 1999, p 60, Dr Collignon.

the available number of beds was consistently 591. For July 1998 this dropped to 563; for August 1998 it was 573; for March 1999 there were 537 available beds; for April 1999 a 'low' of 527 beds; and for May 1999 there were 538 available beds⁶⁷.

4.48. For April and May 1999 the lower bed numbers coincided with a drop in the number of surgical operations for those months, compared with the numbers for the same months in the previous two years when there were over 50 more available beds.

4.49. In answers to questions on hospital waiting lists, 29 June 1999, the Minister for Health and Community Care, Michael Moore, stated:

As with waiting list numbers, bed numbers themselves are relatively meaningless. The numbers of beds required is more dependent on acuity rather than throughput. For a number of years, TCH has been involved in many innovative programs that have resulted in reduced lengths of stay for many patients⁶⁸.

4.50. The committee supports the Government's endeavours to reduce the length of time that patients spend in hospital such as the Hospital in Home program; early discharge programs; increases in day surgery for some procedures; day of surgery admission; and retention by exception policies. The Government advised the committee that these schemes have 'reduced the need for beds to maintain the same level of throughput'⁶⁹.

4.51. However, the committee is concerned that further rationalisation of beds may have the effect of creating a bottleneck in the system.

RECOMMENDATION 2: The committee recommends that the Government ensure that increased patient throughput is not jeopardised by excessive reductions in bed numbers.

Theatre utilisation

4.52. As noted above, specialists put the view to the committee that theatre utilisation is an area affecting patient throughput, with one specialist simply stating, 'the theatres [at The Canberra Hospital] are inefficient'⁷⁰.

4.53. The Government advised the committee that there is no data available on the extent to which unavailability of theatre space has extended waiting lists and times but submitted that the Calvary Public Hospital has 'sufficient suitable theatre space' and was 'not thought to be a significant issue at TCH'⁷¹. In evidence, The Canberra Hospital submitted that its theatres are operating at 85 per cent efficiency⁷².

⁶⁷ The Canberra Hospital Information Bulletin, Monthly Patient Activity Data.

⁶⁸ Government response to question on notice, 29 June 1999, p 3.

⁶⁹ *ibid.*

⁷⁰ Submission 6, p 2.

⁷¹ Government Response to question on notice, 29 June 1999, p 7.

⁷² Transcript, 24 February 1999, p 16, Professor MacLellan.

4.54. However, the Government submission identified improved theatre utilisation as one area that should be addressed as part of an effort to reduce the length of waiting times for patients.

4.55. While the committee did not receive sufficient evidence to provide an indication of the extent of theatre under-utilisation and its affect on waiting lists and times, it believes that the government would be wise to consider improvements in this area.

RECOMMENDATION 3 : The committee recommends that the Government examine ways of improving theatre utilisation.

Industrial issues

4.56. An abiding feature of the ACT health care system has been the friction between ACT governments and health professionals.

4.57. In 1998, a protracted industrial dispute broke out between the ACT Government and VMOs regarding the renewal of VMO contracts and a move from a fee-for-service arrangement to sessional fees.

4.58. The effect was a significant decrease in the number of patients being removed from waiting lists during the months of the dispute.

4.59. The Government submitted that:

a significant change in waiting times and waiting lists occurred during the VMO dispute in June, July and August last year. Surgery was severely cut (by two thirds, or 700 patients in June), and a large number of patients were subsequently added to the lists. This backlog resulted in almost 1000 fewer patients receiving surgery in those three months than in the equivalent period in the previous year - more than the increase in long wait patients⁷³.

4.60. Effectively, while VMOs continued to add patients to the list, the drop off in surgery meant that very few patients were removed from the list. A graphic illustration is provided on page 15 of the Government submission (Attachment A) showing the drastic dip in removals during the period of the dispute.

4.61. The committee was advised that the public hospital system is still recovering from the effects of the dispute⁷⁴.

4.62. The committee supports the advent of staggered contracts for VMOs as a means of reducing the possibility of another crisis.

4.63. The committee does not want to focus on the issue of the Government/VMO relationship in detail, nor does it want to apportion blame. However, it must be acknowledged that industrial disputes of this kind have significant and lasting effects

⁷³ Submission 4, p 10.

⁷⁴ Transcript, 29 April 1999, p 37, Mr Moore.

on the length of waiting lists and times as well as on the quality of life of many patients.

Procedures which are not clinically required

4.64. The committee was made aware that a significant portion of waiting lists are made up of patients who do not clinically require surgery. A question arises as to whether these patients should be on the public hospital waiting lists at all or whether the procedures that these patients choose to have should be undertaken through the private system.

4.65. A private citizen posed the problem using social circumcision as an example:

There are hundreds of people on the waiting list, whose priority or urgency of need is low and who are unlikely ever to be treated as a public patient.

For example, I understand that there are several males⁷⁵ on the waiting list, “waiting for circumcision”. Aside from the debate whether this is a necessary routine operation, or whether it should be publicly funded, it is unlikely that this service will be provided (unless in some clinically indicated situation). Why have these people on the list, why not tell them or their parents, this is low priority of need and will not ever be done in a public hospital⁷⁶.

4.66. In evidence to the committee, the Government noted that patients awaiting social surgical procedures were unlikely to be treated for a very significant period of time, if ever⁷⁷.

4.67. This has the effect of artificially inflating the number of long wait patients on the list as well as unnecessarily raising the expectations of the patients or their parents.

4.68. Accepting that there will always be patients on public hospital waiting lists who clinically require surgery to improve quality of life or treat life-threatening afflictions, it is hard to see how patients awaiting social surgical procedures can expect to receive the treatment through the public system.

4.69. The Government informed the committee that the Clinical Priorities Committee within the Department of Health and Community Care was examining the appropriateness of having procedures of this type on the waiting list.

4.70. The Government noted:

... the clinical priorities committee ... is looking at the clinical need for various procedures and the urgency for those procedures. We are looking at a systematic way of working with clinicians and looking at those things that maybe should not be put on the waiting lists. Some of these will be these ones where people sit on the waiting list but

⁷⁵ The committee understands that this figure is more like several hundred.

⁷⁶ Submission 2, p 6.

⁷⁷ Transcript, 29 April 1999, p 37, Mr Butt.

cannot really expect to ever end up getting treatment because it may be... not a clinical priority; it may be a social issue or it may be something to do with personal desire⁷⁸.

4.71. In August, the Government informed the committee that as a result of a clinical decision, social circumcisions would be placed in category 5 and not appear on the waiting list. The committee supports this decision.

RECOMMENDATION 4: The committee recommends that surgical procedures which are social and not clinically required (as determined by the relevant specialist) be removed from ACT public hospital waiting lists and that procedures of this type be undertaken through the private health care system.

Shortage of surgeons

4.72. The committee received evidence from the Government that one of the factors affecting the length of waiting lists and waiting times is the limited availability of surgeons in some specialities. In response to a question put to the Government by the committee, the Minister for Health and Community Care made the following point:

One factor impeding increased throughput is the availability of specialist surgeons. For example in orthopaedics, which had 32% of long wait patients at December 1998, there is a shortage of surgeons. A workforce analysis of orthopaedic surgeons conducted in June 1999 indicated that the ACT should have 12 orthopaedic surgeons. There are currently 10 orthopaedic surgeons practising in the ACT. The Surgical Ministerial Clinical Advisory Committee (MCAC) is seeking to address this issue⁷⁹.

4.73. One specialist submitted that there is also a shortage of general surgeons ‘when compared with numbers for the rest of Australia’⁸⁰.

4.74. The committee understands that the lack of availability of anaesthetists has also had a negative impact on improving patient throughput and that this issue is being addressed at the hospital level⁸¹.

RECOMMENDATION 5: The committee recommends that the Government address the shortage of specialists and anaesthetists as a priority and reports any tangible action to the Assembly.

Improved information

Accuracy of information

4.75. The committee’s attention was drawn to the level of accuracy of information on waiting lists and waiting times provided by both public hospitals.

⁷⁸ *ibid.* p 37.

⁷⁹ Government response to question on notice, 5 October 1999, p 2.

⁸⁰ Submission 6, p 1.

⁸¹ Government response to question on notice, 5 October 1999, p 2.

4.76. In a letter responding to a question put by the committee, the Minister for Health and Community Care described data produced by the MediLinc system as being ‘considered to be of a poor quality’⁸². This was of concern to the committee given that monthly reporting on patient activity was largely based on MediLinc data.

4.77. The committee now understands that a new system called CareSys will replace MediLinc as the patient administration system. The Government submitted that this Year 2000 compliant system, together with the ORSOS theatre management system, will greatly improve the quality of data produced by The Canberra Hospital⁸³.

4.78. The committee found it problematic that The Canberra Hospital provided significantly less reporting data in its monthly information bulletins than the Calvary Public Hospital. Information regarding category listings, long wait data and data on mean waiting times did not appear in The Canberra Hospital reports. However, having informed the Government of this concern, the committee is pleased to note that that The Canberra Hospital now reports the same level of information.

Waiting list audits

4.79. The committee was advised that another reason that waiting lists cannot always accurately reflect the number of people awaiting elective surgery is because they are only a snapshot in time. The committee was informed that through regular audits of the waiting lists, many people are often removed because they have either had the operation, no longer require the operation, have deceased or have inadvertently been placed on both hospitals’ waiting lists.

4.80. The results of an audit conducted early in 1999 revealed that around 800 people were on the list that shouldn’t have been. The committee understands that a recent audit has found in the order of 200 or 300 people that shouldn’t be on the list⁸⁴.

4.81. This artificial inflation of the number on the list has the ability to distort the public perceptions of how the health system is faring (bearing in mind that waiting times are the better indicator).

Accessibility of information

4.82. While information about waiting lists and patient throughput is provided to MLAs, the committee understands that information about elective surgery waiting lists and times for the ACT’s two public hospitals is not widely available to members of the public.

4.83. Although information is provided publicly from time to time in the form of media reports, reports to the Legislative Assembly and ministerial announcements,

⁸² Mr Michael Moore, letter to the committee, 24 June 1999.

⁸³ Mr Michael Moore, letter to the committee, 29 July 1999

⁸⁴ Transcript, 16 August 1999, p 70, Mr Lee Koo.

members of the public are not able to access up-to-date information through, for instance, libraries, Government Shopfronts or the Internet.

4.84. The lack of easily accessible information about waiting lists and times was the source of frustration for some witnesses.

4.85. In evidence to the committee, the Council on the Ageing argued that:

[an] issue that we found very difficult in trying to write this submission was the [lack of] availability of information to us on the waiting lists themselves and what the waiting list contains.... When we talked to the department we did not get very far at all. We were basically told that the information in the form that we wanted was simply not available and what sort of information ought to be on these lists. We would like to make that point most strongly that the information that is available to organisations like us appears to be fairly limited⁸⁵.

4.86. The committee understands that the Department does provide information to members of the public when they formally request it. However, the committee believes that there is no reason that information on hospital waiting lists and times cannot be made more widely available.

4.87. The committee agrees with Council on the Ageing when it says, ‘the issue is largely one of transparency. The community has the right to know what is happening within their hospital system [and] how long surgery is taking...’⁸⁶.

RECOMMENDATION 6: In keeping with principles of government accountability and transparency, the committee recommends that the Department more widely disseminate accurate, timely and easily accessible data on public hospital waiting lists and waiting times.

Waiting list by specialist

4.88. The committee was advised that the Government keeps waiting lists on the patient throughput of individual specialists. These lists outline how many category 1, 2 and 3 patients are awaiting elective surgery from particular surgeons, mean waiting times for surgeons and the number of long wait patients they have.

4.89. These lists are made available to general practitioners who use the information to guide them in making referral choices for their patients. As the Government noted in a briefing with the committee, ‘the idea is really one about information for general practitioners so that they are more aware when they are referring patients about potentially the length of time the individual patients will be waiting before they can get treatment’⁸⁷.

⁸⁵ Transcript, 29 April 1999, p. 54, Mr Purcell.

⁸⁶ Submission 1, p. 4.

⁸⁷ Transcript, 24 February 1999, p. 22, Mr Butt.

4.90. The committee was advised that while the ACT Division of General Practice supports the provision of this information and finds it very useful, specialists are less enthusiastic⁸⁸.

4.91. The committee was informed that there might be some public benefit in publishing specialists waiting lists (as raised by one witness)⁸⁹, allowing patients to have more information at their disposal when making important decisions about their health care.

4.92. By publishing these lists, it is possible that referral patterns might change, with patients able to indicate a preference for a particular specialist who is able to perform the surgery most promptly.

4.93. However, the committee understands that patients are not generally in a position to make clinically informed decisions about appropriate specialists - this is the role of GPs.

4.94. Following on from this, the committee is of the view that the patient should be part of this decision making process. It is the role of the GP to make a clinical assessment of the most appropriate specialist for a given ailment but, within this parameter, patients should be able to indicate their preference for seeing a doctor with shorter patient waiting times. GPs should explain this option (where it exists) to all patients.

4.95. The Council on the Ageing pointed out that:

The GP ought to give the consumers, as we will call them, all the information that they need to make an informed decision, not simply to refer to a surgeon known to them or a surgeon that they use regularly. If the opportunity to have the operation done quickly exists then people ought to have that opportunity. Then they can make a decision of whether to go to that doctor or not⁹⁰.

4.96. This obviously happens in many cases but the committee believes that this practice should be widely promoted.

RECOMMENDATION 7: The committee recommends that the Government consult with the ACT Division of General Practice to encourage GPs to provide patients with the option (where clinically appropriate) of being referred to specialists with shorter waiting times.

Patient options brochure

4.97. The committee supports a Council on the Ageing recommendation that the Department of Health and Community Care prepare an information pack or brochure,

⁸⁸ *ibid* p. 23, Professor McLellan.

⁸⁹ *ibid* p. 23 -24, Professor McLellan.

⁹⁰ Transcript, 29 April 1999, p. 55, Mr Purcell.

which provides a list of options available to patients to reduce their time on the waiting list.

RECOMMENDATION 8: The committee recommends that the Government produce an information pack or brochure, providing patients with a complete list of options available to them to minimise their time on the waiting list.

Better clinical categorisation criteria

4.98. Information presented to the committee suggested that the three clinical urgency categories are inadequate classifications for accurately prioritising patients. A number of stakeholders argued that these categories were subject to manipulation and were not sufficiently objective or precise measures to provide equity and fairness for patients.

4.99. In his submission, a private citizen pointed out that, ‘major drawbacks [of the current categorisation system] are lack of precision in categorisation and therefore a lack of consistency in interpretation, because of the broad ranging definitions of the 3 categories’⁹¹.

4.100. At the public hearing the Government noted that:

... the categorisation system is a very crude way of prioritising patients on waiting lists as to who comes off. You have got three cut-off periods and the last one is anything up to a year... Even within 30 days, that is, category 1, it really does not tell you about those ones whose cancer is about to perforate and we need to expedite admission [as opposed to other less urgent category 1 patients]⁹².

4.101. The Council on the Ageing expressed concern that the categorisation of patients did not take into account ‘whole-of-life’ analyses, which has the effect of disadvantaging some patients and often their carers.

4.102. In their submission, Council on the Ageing noted:

For older people living with pain and disability can significantly affect their quality of life. If mobility is restricted, or pain not managed, depression and anxiety can permanently result in a reduced quality of life... Not only can the health of the person on the waiting list deteriorate, but so too can that of the spouse or other carer⁹³.

4.103. Because these other aspects are not taken into consideration under the current categorisation process, some patients with difficulties of the kind described could be further disadvantaged.

4.104. The committee understands that the Department of Health and Community Care is developing measures to improve the categorisation process.

⁹¹ Submission 2, p 4.

⁹² Transcript, 24 February 1999, p 12, Professor MacLellan.

⁹³ Submission 1, p 7.

4.105. In its submission the Government notes that:

A new measure aimed at making the categorisation process more equitable is currently being developed as a trial by the Department of Health and Community Care. It involves a process where, in addition to the basic clinical urgency categorisation, other clinical indicators are recorded by the surgeon to assist in further ranking of the patients on the list⁹⁴.

4.106. The committee supports the Government's move to refine the categorisation system to give more accurate assessments of priority based on a broad range of factors.

Terminology

4.107. The Council on the Ageing pointed out that the term 'elective surgery' can be misleading, connoting an unnecessary operation, while in its practical application the term often denotes prompt surgical intervention required to deal with very serious illnesses. In its submission, Council on the Ageing pointed out that:

The use of the term "Elective Surgery" can be misleading to the public. In colloquial usage, "elective" implies that something is optional. Many people think that "Elective surgery" refers to surgery that is not medically required.... The use of the term "elective while accurate from the medical perspective of differentiating it from "urgent surgery" required immediately to sustain life is misleading to the public⁹⁵.

4.108. The Council on the Ageing noted the examples of cataract surgery, preventing someone from going blind, and heart bypass surgery, allowing a person to live, are actually termed 'elective' in the current medical-administrative nomenclature.

4.109. It is the committee's view that the confusion engendered by the ambiguity of the term 'elective surgery' might have the effect of confusing some participants involved in the debate on public hospital waiting lists.

Waiting times for specialists

4.110. The Council on the Ageing submitted to the committee that the time it takes to see a specialist after being referred by a GP should be taken into account in the measuring waiting times.

4.111. Council on the Ageing argued that:

In terms of waiting time for elective surgery, the time spent waiting to be admitted to hospital is not the only consideration. The time between referral by a GP and seeing a specialist can also be considerable.... Where pain and loss of health is involved, it is important for the health system to take into account the total time required to wait for surgery⁹⁶.

⁹⁴ Submission 4, p 28.

⁹⁵ Submission 1, p 5.

⁹⁶ Submission 1, p 4.

4.112. The committee considers that the length of time it takes to see a specialist can impact adversely on patients and may be a useful indicator of effective and timely patient care. While the committee understands that collecting this data may be administratively complex, it believes that the issue warrants further investigation.

RECOMMENDATION 9: The committee recommends that the department investigate the usefulness and feasibility of collecting data on the length of time it takes patients to see specialists.

Administrative issues in Government submission

4.113. In its submission, the Government outlined a number of actions aimed at achieving acceptable clearance times, such as:

- improving and extending infrastructure at the hospitals;
- changes in purchasing practices;
- improving admission and discharge practices;
- the introduction of public pooling;
- the targeting of high volume procedures;
- increased day surgery throughput; and
- more frequent audits of waiting lists.

4.114. The committee supports these improvements as being sensible remedial measures aimed at developing productivity improvements and efficiencies within the ACT public hospital system⁹⁷. The committee looks forward to future progress reports in relation to these remedial measures.

⁹⁷ A complete list of measures aimed at achieving acceptable patient clearance times can be found in the Government submission – p 23 – 29.

CHAPTER 5. CONCLUSION

5.1. The issue of public hospital waiting lists and times is extraordinarily complex and this report in conjunction with the Government submission aims to provide a solid basis for public debate on what is to be done about reducing patient waiting times in the ACT.

5.2. The figures provided to the committee show that ACT public hospitals are letting down a significant percentage of patients, failing to administer surgical treatment within clinically recommended time frames.

5.3. The committee acknowledges that the Government has made some progress in reducing the length of waiting times experienced by patients but considers that there is still a vast amount of work needed to achieve an acceptable level of service.

5.4. The committee supports the remedial measures outlined in the Government submission as being sensible approaches to the management of this problem. It is mindful, however, of the compelling evidence provided by the ACT Division of Surgeons that any proposal to pool public patients must address the medico-legal and informed consent issues that necessarily arise.

5.5. The committee considers that improved information and expanded public access to information about waiting lists and waiting times is important in stimulating public debate on this issue and in allowing members of the ACT community to participate effectively.

Bill Wood, MLA
Chairman

15 November, 1999

APPENDIX A: LIST OF SUBMISSIONS

1. Council on the Ageing (ACT) Inc.
2. Nick van Weelden
3. Calvary Public Hospital
4. ACT Government
5. The Division of Surgery
6. Dr Phillip Jeans
7. Dr Alastair Taylor
8. Dr Peter Chapman
9. Dr Raymond L.G. Newcombe
10. Dr Erroll Simpson
11. Dr W. J. Coyle

APPENDIX B: WITNESSES BEFORE THE COMMITTEE

1. The ACT Government
2. Calvary Public Hospital
3. Council on the Ageing (ACT) Inc.
4. ACT Salaried Medical Officers Federation
5. The Division of Surgery