Legislative Assembly for the ACT

STANDING COMMITTEE ON PUBLIC ACCOUNTS

Review of Auditor-General's Report No 8 of 2004: *Waiting Lists for Elective Surgery and Medical Treatment*

SEPTEMBER 2007

Report 11

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Resolution of appointment[1]

The Legislative Assembly appointed the Standing Committee on Public Accounts on 7 December 2004 to:

(i) examine:

(A) the accounts of the receipts and expenditure of the Australian Capital Territory and its authorities; and

(B) all reports of the Auditor-General which have been presented to the Assembly;

(ii) report to the Assembly any items or matters in those accounts, statements and reports, or any circumstances connected with them, to which the Committee is of the opinion that the attention of the Assembly should be directed;

(iii) inquire into any question in connection with the public accounts which is referred to it by the Assembly and to report to the Assembly on that question; and

(iv) examine matters relating to economic and business development, small business, tourism, market and regulatory reform, public sector management, taxation and revenue and sustainability.

[1] Legislative Assembly for the ACT, Minutes of Proceedings, Tuesday 7 December 2004, p 12.

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2.13 The Committee recommends that ACT Health inform the ACT Legislative Assembly on the results of the 2005 Reporting Review.

RECOMMENDATION 2

5.23 The Committee recommends, to the extent that work is not already taking place, that ACT Health should use the renegotiation of the 2008-2013 Australian Health Care Agreements to negotiate a five year arrangement with NSW regarding cross border payments for hospital care.

RECOMMENDATION 3

5.27 The Committee recommends that ACT Health explore the feasibility of trialling further ways of sharing responsibility with NSW in the area of an integrated health system.

RECOMMENDATION 4

6.51 The Committee recommends that ACT Health explore, in conjunction with the Canberra and Calvary Hospitals, the rationalisation of operating theatre lists to a single six and a half hour list, with a single shift of staff.

RECOMMENDATION 5

6.64 The Committee recommends, to the extent that work is not already taking place, that the Canberra Hospital routinely produce and analyse theatre performance information falling under the following headings: capacity utilisation ratios in terms of hours and sessions; average number of cases per hour; cancelled schedule lists; cancelled operations; utilisation of scheduled theatre hours; review of list start and finish times; numbers of patients operated on compared with planned numbers; incidence of out-of-hours operating; theatre incident rates and patterns; and break up of public, private and Department of Veteran's Affairs patients.

RECOMMENDATION 6

6.77 The Committee recommends that ACT Health commission an independent economic evaluation of The Canberra Hospital's practice of pursuing privately insured patients from a whole system perspective.

RECOMMENDATION 7

7.7 The Committee recommends, to the extent that work is not already taking place, that ACT Health should specifically incorporate into induction programs for all new staff, training and education in relation to the management of waiting lists and compilation and reporting of waiting list data.

RECOMMENDATION 8

7.11 The Committee recommends, to the extent that work is not already taking place, that ACT Health model elective surgery activity using a capacity planning model to plan for changes in demand and consequent changes in capacity. This should include not only matching capacity prospectively with planned workload, but also undertaking retrospective reviews of activity, and subsequent analysis of reasons for any discrepancies.

RECOMMENDATION 9

7.13 The Committee recommends that ACT Health should state in its *Elective Surgery Waiting List Management Policy* that compliance with the Policy is mandatory.

RECOMMENDATION 10

7.15 The Committee recommends that ACT Health should consider devising a specific disciplinary code identifying appropriate actions to be taken where it is proven that there has been a failure to comply with ACT Health's *Elective Surgery Waiting List Management Policy*.

RECOMMENDATION 11

7.17 The Committee recommends that ACT Health give consideration to a public review of the *Elective Surgery Waiting List Management Policy* after three years of operation.

RECOMMENDATION 12

7.20 The Committee recommends that ACT Health provide, on the relevant webpage, some user-friendly measurements of the statistical significance of waiting times differences across providers.

RECOMMENDATION 13

7.30 The Committee recommends that ACT Health consider the development of a 'Not Ready for Care' policy to respond to people who delay surgery repeatedly without an adequate reason. This policy should stress to patients the consequences of failure to attend for scheduled surgery.

RECOMMENDATION 14

8.46 The Committee recommends that ACT Health undertake more research to better understand variations in clinical priorities and treatment thresholds, as part of a more systematic program of demand management.

RECOMMENDATION 15

8.50 The Committee recommends that ACT Health evaluate the dynamic effects of priority scoring systems over time on case mix, distribution of waiting times, and patterns of resource use.

RECOMMENDATION 16

9.13 The Committee recommends that ACT Health ensure that membership of the Surgical Services Taskforce is representative of all members of the multidisciplinary care team.

Abbreviations and acronyms

AESP	Auburn Elective Surgery Program
AHCA	Australian Health Care Agreement
AHCRA	Australian Health Care Reform Alliance
AIHW	Australian Institute of Health and Welfare
AIP	Access Improvement Program
AMA	Australian Medical Association
APHA	Australian Private Hospitals Association
ASMOF	Australian Salaried Medical Officers' Federation
COTA-ACT	Council on the Ageing - National Seniors (ACT)
DOH	Department of Health (NSW)
DOSA	Day of surgery admission
DVA	Department of Veterans' Affairs (Commonwealth)
ED	Emergency Department
GDP	Gross Domestic Product
GP	General Practitioner
GSAHS	Greater Southern Area Health Service
HCCA-ACT	Health Care Consumers' Association of the ACT
ICAC-NSW	Independent Commission against Corruption (NSW)
JJMH	John James Memorial Hospital
MBS	Medicare Benefits Schedule
NATCAP	National Capital Private Hospital
NRFC	Not Ready for Care
OECD	Organisation for Economic Cooperation & Development
RCNA	Royal College of Nursing Australia

RFA	Request for Admission
RFC	Ready for Care
SAHS	Southern Area Health Service
TCH	The Canberra Hospital
VMOA	ACT Visiting Medical Officers' Association
VMO	Visiting Medical Officer
WHO	World Health Organization

1 INTRODUCTION AND CONDUCT OF INQUIRY

Referral of the inquiry

Auditor-General's Performance Audit Report No 8 of 2004: Waiting Lists for Elective Surgery and Medical Treatment (the Audit Report)

1.1 The Audit Report was presented to the Legislative Assembly on 7 December 2004 and consequently referred to the Committee for inquiry.[2]

1.2 The Audit Report presents the results of a performance audit that reviewed whether waiting list information is generated and used effectively, and in particular whether:

- information on waiting lists published by ACT Health is complete, reliable and timely;
- systems to produce waiting list numbers are efficient;
- patient priorities are accurate; and
- ACT Health uses waiting list information effectively.[3]

Terms of reference

1.3 The Committee's terms of reference were to examine the Audit Report and report to the ACT Legislative Assembly. The Committee's inquiry was limited to the issues contained within the Audit Report.

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[2] Legislative Assembly for the ACT, Sixth Assembly, Minutes of Proceedings No. 2, Thursday 7 December 2004, p 16.

[3] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 3.

Conduct of the inquiry

1.4 The Committee received a briefing from the Auditor-General on the Audit Report on 24 February 2005. The Committee also received a submission from the Minister for Health in relation to the findings of the Audit Report.[4]

1.5 The Committee sought views from a range of people and organisations including: health care consumers; clinicians; academic organisations; private hospitals; and key stakeholders on the information contained in the Audit Report.

Advertisement

1.6 The Committee invited submissions from a wide range of stakeholders by invitation.

Submissions

1.7 The Committee received six submissions. The individuals and organisations that lodged submissions are listed at **Appendix A**.

Public hearings

1.8 The Committee held public hearings on 27 April, 15 June, 1 September, 7 December 2005, 28 July and 28 September 2006. Witnesses who attended the public hearings are listed at **Appendix B**.

1.9 The Committee met on 13 September 2007 to discuss the Chair's draft report, which was adopted on 13 September 2007.

Structure of the report

1.10 The Committee's report examines a selection of the significant issues, including the key findings and recommendations raised by the Auditor-General in relation to whether waiting list information is generated and used effectively. The report also includes comments from witnesses on these issues.

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[4] Dated 26 April 2005.

1.11 The Committee's report is divided into five parts and covers the following main topics:

Part 1 – Background to the inquiry

- Chapter 1 – Introduction and conduct of the inquiry
- Chapter 2 – Audit findings

Part 2 – An overview of the Australian public health system

- Chapter 3 – Elective surgery in context
- Chapter 4 – Theory of waiting

Part 3 - Efficiency, effectiveness and economy of elective surgery management

- Chapter 5 – Demand for elective surgery
- Chapter 6 – Capacity of the system
- Chapter 7 – Waiting list management

Part 4 – Increasing supply and managing demand

- Chapter 8 – Strategies to reduce waiting times
- Chapter 9 – Strategies for sustainable reduction

Part 5 – Summary and conclusions

- Chapter 10 – Committee summary and conclusions

Acknowledgements

1.12 The Committee thanks all those who contributed to the inquiry by making submissions, providing additional information or appearing before it to give evidence.

2 AUDIT FINDINGS

Audit objectives

2.1 The objectives of the Auditor-General's performance audit were to provide an independent opinion on whether waiting list information is generated and used effectively, and in particular whether:

- information on waiting lists published by ACT Health is complete, reliable and timely;
- systems to produce waiting list numbers are efficient;
- patient priorities are accurate; and
- ACT Health uses waiting list information effectively.[5]

Audit opinion

2.2 In relation to each of the above objectives, the Auditor-General formed the following audit opinions:

Objective 1 – Information on waiting lists published by ACT Health is complete, reliable and timely.[6]

That waiting times in the ACT were generally worse than for other Australian jurisdictions, and became longer in the last two to three years.[7]

Objective 2 – Systems to produce the waiting list numbers are efficient.[8]

There was significant scope for improvement in the generation and use of waiting list information by ACT Health. In particular:

- waiting list data were, at times, neither accurate nor valid;

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[5] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, pp 3; 63-65.

[6] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 63-64.

[7] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 4.

[8] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 64.

- information on surgical waiting lists was more frequent but less comprehensive than in other jurisdictions;
- information on non-surgical waiting lists was patchy and inconsistent;
- systems to produce surgical waiting lists were complex and time-consuming for administrative staff;
- the process of prioritising patients did not always achieve equity in the treatment of patients;
- communications with patients waiting for treatment covers essential requirements, but could be improved to provide a better service; and
- there could be better use of waiting list information to enable patients and General Practitioners to select specialists with shorter waiting lists, and better allocation of resources between surgeons.[9]

Objective 3 – Patient priorities are accurate.[10]

Information on surgical waiting lists, although containing some errors, was in broad terms sufficiently reliable to support management decisions.[11]

Objective 4 – ACT Health uses waiting list information effectively.[12]

ACT Health used surgical waiting list information effectively to direct available funding primarily to those areas with longer waiting times.[13]

ACT Elective Surgery Waiting List Management Policy

2.3 In its submissions and evidence to the Committee, the Government noted that a number of the audit recommendations would be addressed by the effective implementation of the *ACT Elective Surgery Waiting List Management Policy* in September 2004.[14]

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[9] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 4.

[10] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 64.

[11] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 4.

[12] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 64.

[13] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 4.

[14] Submission No. 2, April 2005, p 1.

2.4 The Auditor-General noted:

> ACT Health approved a new waiting list policy in September 2004, towards the end of the audit. Several of the issues listed below (and the recommendations that follow) would be addressed by the effective implementation of this policy.[15]

2.5 In evidence to the Committee, the Chief Executive of ACT Health[16] stated:

> …we published a waiting list policy in November, as the Auditor-General's recommendations were being made known to us. We structured a policy that dealt with a lot of the issues that were raised in this report.[17]

2.6 In response to a question taken on notice, the then Minister for Health[18] advised the ACT Legislative Assembly that:

> …the new policy is a technical document for internal use by hospital staff involved in the management of the elective surgery waiting list. It is available on the ACT Health intranet. A consumer's version of the policy is presently being developed which will be available publicly on the ACT Health Internet and will be sent to all patients booked on the waiting list.[19]

2.7 Further, the Minister for Health told the ACT Legislative Assembly that:

> The policy was developed because no current policy existed to guide the management of the elective surgery waiting list. The policy will ensure that management of the waiting list is consistent and accurate. The direction of the policy is based on equity of access for all patients.[20]

2.8 In evidence to the Committee, the Auditor-General also noted:

> …that the department has issued the new policy on management of waiting lists, which I believe will address a number of concerns we had during the audit.[21]

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[15] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 4.

[16] Dr Tony Sherbon, Chief Executive, ACT Health June 2003 to June 2006; Mr Mark Cormack, Chief Executive, ACT Health, November 2006 to current..

[17] Transcript of evidence, 27 April 2005, pp 15-16.

[18] Mr Simon Corbell MLA, ACT Minister for Health, December 2002 to April 2006; Ms Katy Gallagher MLA, ACT Minister for Health, April 2006 to current.

[19] Legislative Assembly for the ACT, Hansard, 9 December 2004, p 342.

[20] Legislative Assembly for the ACT, Hansard, 9 December 2004, p 342.

[21] Transcript of evidence, 15 June 2005, p 33.

2.9 In subsequent evidence responding to changes that have occurred since the Auditor-General reported, the Acting Chief Executive of ACT Health[22] advised the Committee that:

> …a number of changes have been made. One of them is that we now have a clearer elective surgery waiting list policy. That is published on our website and it largely addressed the policy issues that were raised in the Auditor-General's report. A second key element of the Auditor-General's report was really the administration and management of the lists themselves. We have now established a single waiting list arrangement across the territory, whereas we had a fairly clumsy hospital-by-hospital arrangement and at times there were people on two lists at the same time, so you were getting a bit of a distortion there. We don't have that anymore. We've got a single, integrated web-based system.
>
> Thirdly, we publish on a dynamic basis a surgeon's waiting times on the website. That has been up and running for, I think, just under a year, and general practitioners and consumers have access to it. If they have to have a hip replacement, for example, they can literally go to the website, call up the list of doctors who have public hospital admitting rights and look up the waiting times, and that can guide their choice. We encourage them to make that choice with their general practitioner, who, of course, guides patients in that choice. So we have been able to do that.
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> We have also concentrated on a clerical audit. Because people on the waiting lists can, unfortunately, be there for a long time, we need to make sure that we continually update their details. We need to make sure that they still need their surgery, because we do find that some people might have their name on a list here, they might have their name on a list in New South Wales, they might have their name on a list in Victoria, and then, if they get fed up with all three, they may just use their private health insurance and get it done privately. We don't automatically know that. That is why we have a routine program of audit and the staff you see behind me are responsible for managing that process of audit. Certainly a lot of the nuts and bolts of managing the lists has improved significantly.[23]

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[22] Mr Mark McCormack, Acting Chief Executive ACT Health, June 2006 to November 2006.

[23] Transcript of evidence, 28 September 2006, pp 101-102.

2005 Reporting review

2.10 In its submissions and evidence to the Committee, the Government noted that a number of the audit recommendations were to be addressed by a reporting review to be conducted by ACT Health in 2005.

2.11 In response to a question seeking more information on the scope of the review and how its outcomes would be implemented, the Minister for Health stated:

> It will be an incremental process…the department and the two hospitals collectively are continuing to work to refine the waiting list data and to develop more meaningful reporting of that data. It is certainly the intention, in relation to recommendation 24, that we will work towards including reporting on elective medical procedures in regular reports and medical services such as endoscopy and angiography...we will be continually refining the list. It is a result of the refining of the data and our interpretation of that data that has led us to get a much better handle on where the growth is coming from in our system…it is a result of the work the department is doing that we are getting a better handle on that and, in the same way, we will be continuing to refine the list, refine our interpretation of it, and report in more meaningful ways on a whole range of indicators that that work discloses.[24]

2.12 The Committee understands that the results of the 2005 Reporting Review conducted by ACT Health are likely to be summarised as part of an internal departmental document and is of the view that the disclosure of this information would be in the public interest.

RECOMMENDATION 1

2.13 **The Committee recommends that ACT Health inform the ACT Legislative Assembly on the results of the 2005 Reporting Review.**

Auburn Elective Surgery Program (AESP)

2.14 During its inquiry the Committee profiled the AESP. This included meeting with the key people involved in the design, implementation and evaluation of

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[24] Transcript of evidence, 27 April 2005, p 20.

the AESP. The aim of the program is to increase rates of day surgery, reduce elective surgical waiting lists, provide patients with a guaranteed date of surgery and improve operating theatre utilisation. The Committee understands that the guiding principle behind the program is treating the administration of elective surgery as a separate business unit, distinct from emergency surgery.[25]

2.15 Researchers and economists evaluating the program have concluded that:

> ..the lessons from this relatively small scale project are applicable to large Area Health Services, including those such as Westmead Hospital – a large teaching hospital with a mix of public and private patients and a trauma service.[26]

2.16 The AESP approach has been adopted by other NSW metropolitan hospitals – Campbelltown, Liverpool and Fairfield – with similar results. Clinicians have reported greater access to operating theatres, fewer delays, reduction of average length of stay and shorter waiting times.[27]

2.17 The fundamental principles behind the AESP is the treatment of elective surgical admissions as predictable events conducive to cultivation as separate business events compared with emergency surgical admissions, uses of model pathways, quarantined beds and theatre time and restructuring theatre utilisation.[28]

2.18 The Committee is of the view that this coordinated and clinically directed approach has resulted in a more efficient, cost effective elective surgery admission with high level of patient satisfaction.

2.19 The Committee is also of the view that components of the AESP are applicable to other health services and components of the model can be transferred to other settings. Throughout its report the Committee has made comment regarding this and where applicable made recommendations to implement components of the model in the ACT.

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[25] Singh, N. et al., 'The Auburn Elective Surgery Pilot Project', *Australia New Zealand Journal of Surgery*, 2005, 75: 768-775.

[26] Singh, N. et al., 'The Auburn Elective Surgery Pilot Project', *Australia New Zealand Journal of Surgery*, 2005, 75: 768-775.

[27] NSW Legislative Assembly Hansard, 28 May 2003, pp 1340.

[28] Singh, N. et al., 'The Auburn Elective Surgery Pilot Project', *Australia New Zealand Journal of Surgery*, 2005, 75: 768-775.

Audit recommendations

2.20 The Auditor-General made twenty-nine recommendations to ACT Health for future action to address the audit findings in relation to whether waiting list information is generated and used effectively in the Territory.[29] A list of these follows, including the Government's response.

2.21 Further, the Auditor-General highlighted the importance of recommendations 1, 3, 5, 7, 9, 11, 16, 18, 19, 24, 26 and 28.[30]

2.22 The Committee notes that most of the recommendations were geared towards improving fairness of waiting lists across categories and types of patients and general efficiency of operations. A small number addressed improving the efficiency of surgical procedures.[31]

2.23 In conducting the Audit and formulating the recommendations, the Audit team consulted widely and talked to a number of professional groups. As to the ease with which the recommendations could be implemented, the Auditor-General stated:

> …in our minds we are quite convinced that all our recommendations would be easy to implement, are quite practical, and can be done within the short or medium term.[32]

Audit Recommendation 1 Development of better clinical guidelines to improve categorisation

2.24 The Auditor-General recommended that ACT Health should work with other jurisdictions to develop better clinical guidelines to improve categorisation. This would also include establishing policy on the extent to which social factors can be used in prioritising within clinical urgency categories.[33]

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[29] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 6.

[30] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 6.

[31] Transcript of evidence, 15 June 2005, p 36.

[32] Transcript of evidence, 15 June 2005, pp 36-37.

[33] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 8.

2.25 The Government agreed with the recommendation stating that it would raise the development of better clinical guidelines to improve categorisation at appropriate national leadership forums.[34]

2.26 Further, the Government advised that it had commenced the development of clinical priority assessment criteria, which places significant weighting on social factors, for calculating the severity of a patient's condition. The first speciality to implement the assessment criteria would be ophthalmology.[35]

Audit Recommendation 2 Intermediate categorisation

2.27 The Auditor-General recommended that ACT Health should consider establishing an intermediate category between the current categories 2 and 3 in order to distinguish between those patients who require treatment in a maximum of one year and those who can wait longer.[36]

2.28 ACT Health advised the Auditor-General that it did not agree with the recommendation, stating that it would only increase the complexity of managing the list.[37] However, in the Government's submission to the Committee, it advised that it agreed in principle with the recommendation and was investigating options for increasing the sensitivity and decreasing the complexity of waiting list management.[38]

2.29 In response to a question seeking information on how intermediary categories would work, the Deputy Chief Executive of ACT Health[39] stated:

> It is relatively simple to redesign a request for admission form to incorporate new categories. That is the easy bit. What we do need to undertake is the development of an urgency rating system that is a bit more sensitive than the 1, 2, 3 that we have got at the moment. But we also need to work with the individual specialty groups because the categories 1, 2 and 3 apply across

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[34] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 8; Submission No. 2, April 2005, p 1.

[35] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, pp 8-9; Submission No. 2, April 2005, p 1.

[36] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 9.

[37] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 9.

[38] Submission No. 2, April 2005, pp 1-2.

[39] Mr Mark Cormack, Deputy Chief Executive ACT Health, February 2005 to June 2006.

> neurosurgery, ophthalmology, orthopaedics, general surgery, et cetera. So there will be a bit of work required.
>
> We are engaging the services of an obstetrician/gynaecologist who does this sort of work in a consulting sense. He will be working with us to look at the way we are codifying the levels of urgency, but we will need to do that on a speciality-by-speciality basis. Once that is complete, we think that will further refine the decision making in terms of the next patient off the list to get the next slot in a surgical session. So it is work in progress and will take some time to fully refine.[40]

2.30 Further, the Government advised that it envisaged a substantial portion of the aforementioned work would be completed within the subsequent three to four months as a precursor to conversion into a refined Request for Admission (RFA).[41]

2.31 The Committee notes that in evidence, the Auditor-General maintained that the current categories did not assist in the management of the waiting list as people in category 3 could wait forever, stating:

> A number of surgeons believe that, if they put their patient on category 3 it may take years, hence they upgrade them to category 2 without good medical reasons, just because they are worried about the waiting time.[42]

Audit Recommendation 3 Consistent priority categories

2.32 The Auditor-General recommended that ACT Health should seek to have all hospital departments with waiting lists use consistent priority categories.[43]

2.33 The Government agreed with the recommendation, stating that a review of the management of non-surgical waiting lists in relevant hospital departments would be conducted to ensure that consistent priority categories were used.[44]

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[40] Transcript of evidence, 27 April 2005, pp 20-21.

[41] Transcript of evidence, 27 April 2005, p 21.

[42] Transcript of evidence, 15 June 2005, p 35.

[43] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 9.

[44] Submission No. 2, April 2005, p 2; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 9.

Audit Recommendation 4 Information on waiting times for specialist consultation

2.34 The Auditor-General recommended that ACT Health should consider options to get better information on waiting times for specialist consultation.[45]

2.35 In its response, the Government agreed in principle with the recommendation, stating that it could not conduct a survey without surgeon and General Practitioner (GP) approval, but would explore this option with surgeons and GPs. Further, the Government noted that the mechanism of referral from GP to surgeon in the ACT is a private referral outside its control.[46]

2.36 The Committee notes that the provision of information on waiting times for specialist consultation has a number of issues relating to confidentiality and measurement. The Minister for Health advised:

> On the issue of the waiting time for how long it takes to see the specialist or indeed to see the GP or to see the GP again, some specialists and GPs are willing to look at that; others aren't.
>
> The advice I have from the department is that at this stage the focus should be on reporting the waiting times from the consultation to the procedure by a specialist rather than immediately go to the issue of how long you have to wait to see the specialist, but that is certainly something which, at a later stage, we contemplate addressing.[47]

2.37 In response to a question seeking clarification as to ACT Health's reasoning for the aforementioned position on reporting waiting times, the Minister for Health told the Committee:

> Some see it as intrusive; they don't see it as the government's business how long it takes for them to see an individual. Others cite patient confidentiality reasons, but Dr Sherbon can elaborate a bit more.[48]

2.38 The Chief Executive of ACT Health commented, in addition to the primary reasons cited by the Minister:

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[45] ACT Auditor-General's Report No 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 9.

[46] Submission No. 2, April 2005, p 2; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 9.

[47] Transcript of evidence, 27 April 2005, p 12.

[48] Transcript of evidence, 27 April 2005, p 12.

> …that there is no measurement tool; we don't have urgency categorisations like we have for admission to hospital—urgency one, two, three that you are all familiar with from reading the briefs and the information published by the minister for waiting times to get into hospital. There is no such system for waiting times for consultation, and the practice for consultation is slightly different to admission to hospital. [49]

2.39 The Government noted that it was essentially a Commonwealth government issue as to how long people wait to see a specialist and until such a system was in place, the Chief Executive of ACT Health stated:

> …my advice to the minister, as the minister has just outlined, is: we secure information for consumers on wait times for admission to public hospital through negotiation with surgeons and GPs—and we are about to present a model to surgeons and GPs for publication on the web—before we start a more intrusive and less scientifically formatted process of negotiating measurement of waiting times for consultation which will require commonwealth and GP and specialist cooperation.[50]

2.40 The Committee notes that success in reducing very long waiting times has been tempered by concerns over 'hidden waits', the time spent by a patient waiting to see a specialist for the first time and being placed on an inpatient waiting list, which typically involved long waits for diagnostic tests such as scans.[51]

Audit Recommendation 5 Posting of surgeon waiting times by procedure on the web

2.41 The Auditor-General recommended that ACT Health (should) negotiate with surgeons and review the application of privacy laws with a view to posting wait times by surgeon by procedure on the web, as in NSW and WA.[52]

2.42 The Government agreed with the recommendation, stating that the *ACT Elective Surgery Waiting List Management Policy* adopted in September 2004

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[49] Transcript of evidence, 27 April 2005, pp 12-13.

[50] Transcript of evidence, 27 April 2005, p 13.

[51] King's Fund, *NHS Waiting Times*, April 2005.

[52] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 9.

supported the posting of surgeon waiting times by procedure on the web. Further, ACT Health advised that it expected progress on this in 2005.[53]

2.43 In evidence, the Minister for Health advised:

> …we are trying to get together elective surgery waiting list data from both TCH and Calvary so that we can publish on the web accurate and relevant data on waiting times for individual surgeons so that patients and GPs can see who is busy and what the average wait is so that when they are referring someone to a specialist they might look at how the specialists are tracking in terms of how busy they are and then say, "Look, I would recommend x, y or z specialist and, for your information, this is how long you would expect to wait, once you have had a consult with them, to get the procedure done, depending on clinical priority and so on."[54]

2.44 The Minister further advised that the time frame for publishing surgeon waiting times by procedure was:

> …August 2005 for completion of that project, which would allow us to publish accurate and relevant data on waiting times for individual surgeons on the ACT Health web page.[55]

2.45 In subsequent evidence responding to changes that have occurred since the Auditor-General reported, the Acting Chief Executive of ACT Health told the Committee that:

> …we publish on a dynamic basis a surgeon's waiting times on the website. That has been up and running for, I think, just under a year, and general practitioners and consumers have access to it. If they have to have a hip replacement, for example, they can literally go to the website, call up the list of doctors who have public hospital admitting rights and look up the waiting times, and that can guide their choice. We encourage them to make that choice with their general practitioner, who, of course, guides patients in that choice. So we have been able to do that.[56]

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[53] Submission No. 2, April 2005, p 3; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 9.

[54] Transcript of evidence, 27 April 2005, p 12.

[55] Transcript of evidence, 27 April 2005, p 29.

[56] Transcript of evidence, 28 September 2006, p 101.

2.46 The Committee notes anecdotal evidence on publishing of surgeon's waiting times that the information is retrospective data (a quarter behind) and the provision of data on surgeon wait times can create false expectations.

Audit Recommendation 6 Patient education information

2.47 The Auditor-General recommended that ACT Health should develop and publish material to encourage patients and GPs to consider wait times when selecting their surgeon.[57]

2.48 The Government agreed with the recommendation, stating that an information brochure was to be developed advising consumers and GPs that information on surgeon waiting times by procedure would be published on the web. The contact details for the Elective Surgery Information Service would also be included in the brochure to provide consumers and GPs with the option to phone for information on waiting times.[58]

2.49 Further, the Government advised that a consumer version of the *ACT Elective Surgery Waiting List Management Policy* was being developed.[59]

2.50 The Committee understands that the consumer version was finalised in September 2005.

Audit Recommendation 7 Equalisation of category 3 wait times

2.51 The Auditor-General recommended that ACT Health should seek to equalise category 3 wait times by means such as discouraging category 3 requests for admission from surgeons with very long (compared to peers) category 3 waiting times, or by encouraging pooling of category 3 patients.[60]

2.52 The Government did not agree with the recommendation, stating that it cannot discourage category 3 requests for admission, as this would constitute a breach

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[57] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 10.

[58] Submission No. 2, April 2005, p 3; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 10.

[59] Submission No. 2, April 2005, p 3.

[60] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 10.

of the Australian Health Care Agreement[61] (the AHCA). According to ACT Health, the AHCA does not permit any patient to be treated differently with respect to requesting treatment in a public hospital.[62]

2.53 Further, the Government advised that it would continue to encourage pooling with cooperative surgeons.[63]

2.54 In reply to the Government's response, the Auditor-General advised the Committee:

> We believe that this is an important issue, given our evidence on category 3. The waiting lists vary, say for a cataract removal, from 30 days for one surgeon to 520 days for another surgeon. We believe there should be scope for the department to put effort into providing more information regarding the long waiting lists of the surgeons to GPs and patients, hence encouraging a patient or a GP not to choose a surgeon with a long waiting list, so that we could hopefully equalise the waiting time for category 3. The department will publish some information on the web, I believe, during this year. That will help surgeons and also the practitioners and the patients to choose a surgeon with, hopefully, a shorter waiting list.[64]

Audit Recommendation 8 Improvement of consumer education information on category wait times

2.55 The Auditor-General recommended that ACT Health should improve information brochures to advise patients that they have a right to know their urgency category and the means by which they can seek to have it changed.[65]

2.56 The Government agreed with the recommendation, stating that it would be addressed as part of the development of a consumer version of the new *Elective Surgery Waiting List Management Policy*.[66]

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[61] An agreement, in accordance with the *Commonwealth Health Care (Appropriation) Act 1998,* between the Commonwealth of Australia and respective states and territories for public hospital services funding. Agreements are negotiated for five year terms.

[62] Submission No. 2, April 2005, p 3; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 10.

[63] Submission No. 2, April 2005, p 3.

[64] Transcript of evidence, 15 June 2005, p 33.

[65] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 10.

[66] Submission No. 2, April 2005, p 4.

Audit Recommendation 9 Information needs of consumers, surgeons & GPs

2.57 The Auditor-General recommended that ACT Health should conduct a review of information needs of patients, GPs and surgeons, such as desired frequency of contact, and preferred mode of contact, with a view to improving communication with stakeholders.[67]

2.58 The Government agreed with the recommendation, stating that this information would be obtained in 2005, during negotiations with surgeons and GPs and, via a survey of patients on waiting lists.[68]

Audit Recommendation 10 Not ready for care status

2.59 The Auditor-General recommended that ACT Health should establish a rule that changing a patient to Not Ready for Care (NRFC) status requires either a specific written or verbal assent of either the patient or their specialist, or that the patient is clearly informed that they have been placed in the NRFC category.[69]

2.60 The Government did not agree with the recommendation, stating that the rules for changing patients to a NRFC category would be tightened with the implementation of the *Elective Surgery Waiting List Management Policy*. The revised rules would require that all patients assigned to the NRFC category be assigned a 'status review date'. When the date becomes current, the patient or surgeon would be contacted to determine the patient's future status.[70]

2.61 In evidence, the Chief Executive of ACT Health stated:

> What we have built into our new policy is a mechanism to ensure people are reviewed. There was no mechanism previously, and people, quite rightly, were pointing out that they did not wish to remain on the not-ready-for-care list forever; they still wished to have their operation even if they weren't available to have it now or in the near future. So, we built in a review mechanism to deal

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[67] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 10.

[68] Submission No. 2, April 2005, p 4.

[69] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, pp 10-11.

[70] Submission No. 2, April 2005, p 4; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 11.

> with that. There now is a requirement that a date for review be installed on every occasion that a patient is classified as not ready for care.[71]

2.62 In response to why the Government did not agree with getting written permission from the patient or specialist before changing a patient to NRFC, the Chief Executive of ACT Health stated:

> The simple answer is that the waiting list is an organic creature in a way in that there are people coming in and out of the waiting list by the dozens every day. And the waiting list management process is complex enough as it is without waiting for two or three signatures before the patient is re-categorised… It is simply administratively extremely cumbersome to chase two signatures on every occasion.[72]

2.63 The Minister for Health also added:

> …it is administratively a real headache. It is not a trivial thing; you are talking about thousands and thousands of people being managed every single year. And to add another layer of bureaucracy in terms of the management of the list, what is it going to add to the overall management of the elective surgery waiting list? My view is that it is not going to add very much at all; it is not going to add very much at all to the way the list works, to the effective management of the list, to make sure as many people get access to surgery when they need it.
>
> It might be a courtesy, but it doesn't really add a lot to the overall efficacy of the list, of the management of the list. And that has got to be the key priority. It has got to be the key priority, managing the list effectively, so that as many people get access to surgery as they need, as we can manage.[73]

2.64 Further, the Government noted that the Independent Commission against Corruption's (ICAC-NSW) Report, *Investigation into Alleged Misreporting of Hospital Waiting List Data,* did not recommend establishing the rule as suggested by the Auditor-General.[74]

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[71] Transcript of evidence, 27 April 2005, p 18.

[72] Transcript of evidence, 27 April 2005, p16.

[73] Transcript of evidence, 27 April 2005, p 17.

[74] Submission No. 2, April 2005, p 4; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 11.

2.65 However, the Committee understands that the basis on which the ICAC-NSW report may not have supported such a rule was due to uncertainty and confusion surrounding the NRFC classification.[75] The ICAC-NSW report stated:

> Overall, the Commission is of the opinion that the primary cause of erroneous or inappropriate staged not-ready-for-care classifications identified by the DOH reviewers was the simple fact that this classification, which is very far from straightforward and encompasses a myriad of different factual circumstances, was not defined in the then existing waiting list guidelines. The extent to which those guidelines were deficient is evident from the fact that the existing guidelines, issued on 17 September 2003, contain new definitions and explanations of the staged not-ready-for-care classification occupying some 14 separate pages.[76]

2.66 In reply to the Government's response, the Auditor-General told the Committee:

> In this recommendation it is important to us that the patient should know what will happen to them. Hence, if a decision is made to put them on to the "not ready for care" list, they should be informed of that decision.
>
> Although the department will tighten the way they manage and review the people in this "not ready for care" category, it doesn't address our concern that patients are still left in the dark about whether or not they are taken off the normal waiting list and when they will be back on it. In the evidence given to the committee, Dr Sherbon mentioned that it would be administratively cumbersome to obtain two or three signatures. That is not what we are recommending. We are recommending that documentation, or some record, should be kept to justify the decision of the hospital to put people on the "not ready for care" list. An example is that Mr Smith called me on Saturday saying that he was not available for surgery within the next six months, so we record the reason to put him to a NRFC list.[77]

2.67 The Committee notes that the intent of the recommendation is not about pursuing two or three signatures as the decision to place a patient on the

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[75] ICAC-NSW, *Investigation into Alleged Misreporting of Hospital Waiting List Data*, February 2004, pp 37-48.

[76] ICAC-NSW, *Investigation into Alleged Misreporting of Hospital Waiting List Data*, February 2004, p 48.

[77] Transcript of evidence, 15 June 2005, p 34.

NRFC list could be triggered by a patient's or surgeon's request and there is not a requirement for consent from both parties. The Committee is of the view that the suggestion for a record to be made justifying a decision to place a patient on the NRFC list is not a major administrative burden. Further, the Committee believes that there is merit for the Government to reconsider its response to recommendation ten.[78]

2.68 In evidence to the Committee, the ACT Visiting Medical Officers' Association (the ACT VMO Association) outlined a particular case supporting the Auditor-General's concern that there was insufficient documentation to confirm that people were fully aware of what a deferral might mean in terms of their place on the list. A representative of the ACT VMO Association stated:

> I certainly have a patient who this year was to come to the pre-admitting clinic at the Canberra Hospital. She was rung the day before by someone from the admissions office at the hospital and told that she need not come to the pre-admitting clinic because her surgery had been deferred. I did not find out that that was the case until four months later when I discovered her admission papers, with a note saying that, because she had not attended the pre-admitting clinic, she was taken off the waiting list.
>
> Now, no one had ever spoken to that lady about what had happened to her, why her surgery was not going ahead and no one had spoken to me. It was simply a question of putting a note on the admission papers and shoving them in an envelope, which somehow went around the hospital until I eventually came across it. So I think there is a serious problem with treating these clients as actual people.[79]

Audit Recommendation 11 Not ready for care status

2.69 The Auditor-General recommended that ACT Health should establish, through consultation with the patient or medical practitioner, an expected time that a patient will cease to be NRFC and check status with the patient or medical practitioner at that time.[80]

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[78] Transcript of evidence, 15 June 2005, pp 33-34.

[79] Transcript of evidence, 15 June 2005, p 51.

[80] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 11.

2.70 The Government agreed with the recommendation, stating that it would be addressed by the implementation of the new *Elective Surgery Waiting List Management Policy.* Further, the Government referred to its response in connection with recommendation ten.[81]

Audit Recommendation 12 Clinical urgency priority

2.71 The Auditor-General recommended that ACT Health should reiterate the policy that patients should, subject to resource limitations only, be seen in clinical urgency priority: all category 2 patients should get priority over any category 3 patient.[82]

2.72 The Government agreed in part with this recommendation, stating that, whenever possible, this already occurred with individual doctors' lists. When a space becomes available in the list, if no category 2 patients are available, to ensure effective resource utilisation of theatre lists a category 3 patient is substituted.[83]

Audit Recommendation 13 Surgical procedure definitions

2.73 The Auditor-General recommended that ACT Health should ensure that the list of surgical procedures included in the list is rigorously defined; in particular defining any procedures that are (a) not suitable for public funding; and (b) not counted as elective surgery even though defined as surgery under the Medicare Benefits Schedule (MBS).[84]

2.74 The Government agreed with the recommendation, stating that it would be addressed with the implementation of the implementation of the new *Elective Surgery Waiting List Management Policy.*[85]

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[81] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 11; Submission No. 2, April 2005, p 5.

[82] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 11.

[83] Submission No. 2, April 2005, p 5; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 11.

[84] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 11.

[85] Submission No. 2, April 2005, p 5; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 12.

Audit Recommendation 14 Integration of hospital and ACT Health databases

2.75 The Auditor-General recommended that ACT Health should investigate the possibility of better integration of hospital and ACT Health databases in order to produce more flexible, reliable and faster analysis of waiting times.[86]

2.76 The Government agreed with the recommendation, advising that it was investigating the establishment of a single integrated waiting list for public elective surgery.[87]

2.77 In evidence the Deputy Chief Executive of ACT Health told the Committee that at the present time there:

> …are two separate lists that we pull together and check for reporting purposes. There is a regular process of audit whereby we are able to identify any duplicate entries or any issues relating to the quality and the management of that information.[88]

2.78 In relation to the establishment of a single integrated waiting list for public elective surgery, the Deputy Chief Executive of ACT Health stated:

> We have commenced a process of work whereby we will have a tighter central database which will—I do not wish to sound too technical—take a direct data feed from two separate databases and effectively integrate it at a central level, and that will enable us to avoid some of the double handling and will also enable us to avoid any potential risks, such as inadvertent change of status or duplication on the list. That work is proceeding well. In fact, we are doing a lot of development work on our information management systems and that will be progressively rectified over the next two to three months so that we will have a much more up-to-date and robust data set.[89]

2.79 In subsequent evidence responding to changes that have occurred since the Auditor-General reported, the Acting Chief Executive of ACT Health told the Committee that:

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[86] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 12.

[87] Submission No. 2, April 2005, p 6; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 12.

[88] Transcript of evidence, 27 April 2005, p 19.

[89] Transcript of evidence, 27 April 2005, p 19.

> We have now established a single waiting list arrangement across the territory, whereas we had a fairly clumsy hospital-by-hospital arrangement and at times there were people on two lists at the same time, so you were getting a bit of a distortion there. We don't have that anymore. We've got a single, integrated web-based system.[90]

Audit Recommendation 15 Staff training & quality assurance

2.80 The Auditor-General recommended that ACT Health should improve the accuracy of data entry by means such as training, and conduct of quality assurance checks.[91]

2.81 The Government agreed with the recommendation, stating that both hospitals were implementing improved staff training.[92]

Audit Recommendation 16 NRFC record keeping

2.82 The Auditor-General recommended that ACT Health should maintain records of assent to patients joining the NRFC list, ideally in writing by the patient or specialist, but at least keeping a signed and dated note of conversation with the patient or specialist.[93]

2.83 The Government agreed in part with the recommendation, stating that NRFC patients would be assigned a 'status review' date and their status would be reviewed when this date becomes current.[94]

2.84 Further, the Government was of the view that there was a need to reduce the complexity of waiting list management, not increase it. The Government noted that record keeping was covered in the new *ACT Elective Surgery Waiting*

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[90] Transcript of evidence, 28 September 2006, p 101.

[91] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 12.

[92] Submission No. 2, April 2005, p 6; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 12.

[93] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 12.

[94] Submission No. 2, April 2005, p 6; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 12.

List Management Policy. This included reference to documenting any change in clinical priority on the RFA and waiting list database.[95]

Audit Recommendation 17 Independent audits of NRFC lists

2.85 The Auditor-General recommended that ACT Health should conduct regular independent audits of the NRFC list to minimise errors in NRFC categorisation and subsequent errors in statistical results.[96]

2.86 The Government agreed with the recommendation, stating that it would be addressed with the implementation of the new *ACT Elective Surgery Waiting List Management Policy*.[97]

Audit Recommendation 18 Changes to category

2.87 The Auditor-General recommended that ACT Health should ensure that all changes to category are based on sound medical reasons and are recorded appropriately.[98]

2.88 The Government agreed with the recommendation, stating that it would be addressed with the implementation of the new *ACT Elective Surgery Waiting List Management Policy*.[99]

Audit Recommendation 19 Measuring & reporting on medical services waits

2.89 The Auditor-General recommended that ACT Health should request that each hospital review its medical services to establish what services are subject to waits, and establish appropriate systems to measure and report to ACT Health on those waits.[100]

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[95] Submission No. 2, April 2005, p 6; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 12.

[96] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 12.

[97] Submission No. 2, April 2005, p 7; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 13.

[98] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 13.

[99] Submission No. 2, April 2005, p 7; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 13.

[100] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 13.

2.90 The Government agreed with the recommendation, stating that a review would be performed by both hospitals in 2005.[101]

Audit Recommendation 20 Combined hospital reporting

2.91 The Auditor-General recommended that ACT Health should combine reporting for the two hospitals so that an overall report on the health system is produced.[102]

2.92 The Government agreed with the recommendation, stating that this already takes place with the production and publication of the monthly *Access to Elective Surgery Report*.[103] Further, the Government noted that additional combined reporting was to be developed in 2005 as part of the reporting review.[104]

2.93 The Committee notes media reports that the Health Minister announced in August 2005 that the public would have unprecedented access to information about the performance of ACT public hospitals and other health services. This was to include plans to abandon monthly reports on elective surgery waiting lists and introduce quarterly audits of the performance of public hospitals, community and mental health services.[105]

2.94 According to the Health Minister's reported comments, monthly reports don't provide a good picture of performance because they can be influenced by month-to-month variations. Whereas quarterly figures are able to provide trends over a reasonable period of time and thus are more accurate and realistic.[106]

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[101] Submission No. 2, April 2005, p 7; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 13.

[102] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 13.

[103] Submission No. 2, April 2005, p 7; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 13.

[104] Submission No. 2, April 2005, p 7.

[105] Cronin, D., 'Corbell opens up on health services', *Canberra Times*, 11 August 2005, p 2.

[106] Cronin, D., 'Corbell opens up on health services', *Canberra Times*, 11 August 2005, p 2.

Audit Recommendation 21 Publication of NRFC numbers

2.95 The Auditor-General recommended that ACT Health should publish the number of patients in the NRFC category as a supplement to the waiting list statistics. Ideally, this would be split into their former category, for example 'NRFC: used to be category 1.[107]

2.96 The Government agreed in part with this recommendation, stating that the number of patients categorised as NRFC would be published. However, ACT Health was of the view that splitting the NRFC group into previous categories would require considerable resources and did not represent best value for money. Further, new hospital systems would report the patient's current clinical priority as 1, 2 or 3 and whether they were Ready for Care (RFC) or NRFC.[108]

2.97 In evidence the Minister for Health advised the Committee that NRFC patient numbers would be reported on the ACT Health web page from July 2005.[109]

Audit Recommendation 22 Waiting time performance

2.98 The Auditor-General recommended that ACT Health should publish waiting time performance calculated at the date of admission, to improve the relevance and internal consistency of data.[110]

2.99 The Government agreed with the recommendation, stating that quarterly waiting times published on the web were calculated on waiting time to admission. Further, the Government advised that other reporting measures would be developed on waiting time to admission as part of the reporting review.[111]

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[107] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 13.

[108] Submission No. 2, April 2005, p 8; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 13.

[109] Transcript of evidence, 27 April 2005, p 19.

[110] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 14

[111] Submission No. 2, April 2005, p 8; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 14.

Audit Recommendation 23 Analysis of waiting list trends

2.100 The Auditor-General recommended that in addition to the monthly reports, ACT Health should produce a more comprehensive analysis of waiting list trends on at least an annual basis.[112]

2.101 The Government agreed with the recommendation, stating that it would be done in the Annual Report.[113]

Audit Recommendation 24 Reporting on elective medical procedures

2.102 The Auditor-General recommended that ACT Health should work towards including reporting on elective medical procedures in regular public statistical reports.[114]

2.103 The Government agreed with the recommendation, stating that it would be included as part of the reporting review in 2005.[115]

Audit Recommendation 25 Cost effectiveness of DOSA, same-day surgery & evening & weekend surgery in addressing waiting lists

2.104 The Auditor-General recommended that ACT Health should consider the cost effectiveness of means such as increase Day of Surgery Admission (DOSA), same-day surgery and evening and weekend surgery in addressing waiting lists.[116]

2.105 The Government agreed in part with the recommendation, stating that this was already taking place with improvement in DOSA rates. The Government advised that it did not support evening and weekend surgery, as it was not cost effective due to high penalty payment rates for staff.[117]

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[112] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 14

[113] Submission No. 2, April 2005, p 8; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 14.

[114] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 14

[115] Submission No. 2, April 2005, p 8; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 14.

[116] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 14

[117] Submission No. 2, April 2005, p 9; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 14.

Audit Recommendation 26 Review & improvement of postponements

2.106 The Auditor-General recommended that ACT Health should encourage each hospital to review the causes of postponements with a view to reducing them, and in particular request the Canberra Hospital to take steps to improve planning so as to reduce postponements.[118]

2.107 The Government agreed with the recommendation, stating that the Canberra Hospital was already exploring mechanisms to reduce the postponement rate.[119]

Audit Recommendation 27 Reassignment of surgical sessions

2.108 The Auditor-General recommended that ACT Health should encourage each hospital to offer surgical sessions that become available, either permanently or through the temporary unavailability of a surgeon, to the surgeons with the longest Category 1 and Category 2 waits.[120]

2.109 The Government agreed with the recommendation, stating that this was current practice if the surgeon is available. However, in many instances surgeons are unable to accept sessions offered at short notice due to other commitments.[121]

2.110 To respond to the difficulties in reassigning surgical sessions at short notice, the Committee notes that the Auburn Elective Surgery Program (AESP) uses a dedicated surgical coordinator to plan operating lists and maintain backup lists.[122]

2.111 The Committee understands that by employing such a person, cancellations at various stages in the preoperative period, due to a patient's ill health or other circumstances, do not have to result in the 'waste' of operating list time, as

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[118] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 15

[119] Submission No. 2, April 2005, p 9; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 15.

[120] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 15

[121] Submission No. 2, April 2005, p 9; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 15.

[122] Singh, N. et al., 'The Auburn Elective Surgery Pilot Project', *Australia New Zealand Journal of Surgery*, 2005, 75: 773.

backup lists are maintained and filled appropriately, leading to more efficient resource utilisation.[123]

2.112 Further, in evidence to the Committee, it was noted that a possible explanation for difficulty in reassigning surgical sessions at short notice may be attributable to there being a limited number of surgeons in various specialities.[124]

Audit Recommendation 28 Implementation of Standing Committee on Health and Community Care 1999 inquiry into waiting lists

2.113 The Auditor-General recommended that ACT Health should complete implementation of agreed recommendations of the Standing Committee on Health and Community Care's 1999 inquiry into waiting lists.[125]

2.114 The Government agreed with the recommendation, stating that it had progressively implemented its response to the agreed recommendations.[126]

2.115 The Auditor-General commented that:

> …there has been unsatisfactory implementation of the recommendations of the Standing Committee on Health and Community Care's 1999 inquiry into waiting lists.[127]

2.116 The Committee notes that whilst an action plan was created to progress the implementation of the recommendations, the Auditor-General found that there was no record of its completion available until late 2004. Further, some undertakings stated as being current in the action plan -for example, progress in pooling patients- did not actually take place.[128]

2.117 In response to a request for more detail on the Government's implementation of recommendation 28, the Minister for Health stated:

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[123] Singh, N. et al., 'The Auburn Elective Surgery Pilot Project', *Australia New Zealand Journal of Surgery*, 2005, 75: 773.

[124] Transcript of evidence, 15 June 2005, pp 49-50.

[125] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 15

[126] Submission No. 2, April 2005, p 10; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 15.

[127] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 58.

[128] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 59.

> I read that report shortly after becoming minister and generally familiarised myself with it. Most of the recommendations in that report were adopted by the government of the day. It did make a range of recommendations for improvements in management of elective surgery, which were agreed to and implemented.[129]

2.118 In evidence, the Minister for Health agreed to take on notice the provision of a general summary of the key issues arising from the 1999 Standing Committee inquiry into waiting lists and what was being done in relation to those issues.[130]

2.119 Subsequent to the hearing, the Minister for Health provided advice regarding the 1999 recommendations agreed to by the Government and the current status on implementation.[131]

Audit Recommendation 29 Cost-effectiveness of private providers

2.120 The Auditor-General recommended that ACT Health should consider the feasibility and cost-effectiveness of acquiring services from private providers to address excessive waiting lists.[132]

2.121 The Government agreed with the recommendation, stating that it would consider the use of private providers where appropriate.[133]

2.122 In evidence, the Minister for Health stated:

> …the level of demand that we continue to see for elective surgery is unprecedented and significant levels of growth have occurred in a whole range of areas. Our system continues to work hard to address those areas but clearly, as with all other public hospitals around the country, access to elective surgery and management of elective surgery is a key area where all systems are facing considerable pressure. The ACT is no different in that regard.[134]

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[129] Transcript of evidence, 27 April 2005, p 27.

[130] Transcript of evidence, 27 April 2005, pp 27-28.

[131] 5 May 2005

[132] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 15

[133] Submission No. 2, April 2005, p 10; ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 15.

[134] Transcript of evidence, 27 April 2005, p 1.

3 ELECTIVE SURGERY IN CONTEXT

Defining elective surgery

3.1 Elective surgery is any form of surgery that a patient's doctor or health professional believes to be necessary but which can be delayed by at least 24 hours.[135] Much of the elective surgery undertaken in Australian hospitals is urgent and critical.[136]

3.2 Elective surgery waiting time is the time from the date a patient was added to the procedure's waiting list to the date the patient was admitted for the same procedure, less any time the patient was not ready for care.[137]

3.3 Public hospitals manage elective surgery through waiting lists and generally admit people on the same day their surgery will take place.[138]

The Australian public health system

3.4 An estimated $78.6 billion was spent on health care in Australia in 2004-05, the latest year for which full year expenditure figures are available. More than a quarter of this amount was spent in public hospitals. Of the $20.3 billion spent in public hospitals, the Australian Government spent $9.2 billion, state, territory and local governments $9.6 billion and private[139] sources $1.5 billion.[140] According to the Australian Institute of Health and Welfare (AIHW), in real terms, total recurrent expenditure on public hospitals increased by 4.9 per cent between 2003-04 and 2004-05.[141]

3.5 The Australian Government's contribution includes grants to states and territories through the Australian Health Care Agreements (AHCA), private

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[135] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 Report*, p 58.

[136] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 Report*, p 30.

[137] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 Report*, p 58.

[138] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 Report*, p 25.

[139] Private sources include private health insurance.

[140] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 Report*, p 12.

[141] AIHW, *Australian Hospital Statistics*, Canberra, 2006.

health insurance rebates and Department of Veterans' Affairs (DVA) payments for treating veterans and their dependents.[142]

3.6 Under the 2003-08 AHCA, the Australian Government will provide funding of up to $42 billion over the life of the Agreement to the states and territories to help them provide free public hospital services to public patients. In 2004-05 it provided $7.95 billion.[143]

3.7 Under the terms of the 2003-08 Agreement, each state and territory is required to increase funding for public hospitals to at least match the rate of growth of Australian Government funding over the same period. The states and territories exceeded this commitment in 2004-05 with a substantial increase in the recurrent[144] expenditure for their respective public hospitals.[145]

Private health sector

3.8 One of the distinguishing characteristics of the Australian health care system has always been its mixed economy.[146] Since the 1990s there have been significant shifts in the role of the private sector and private markets in health care funding and the delivery of services.[147]

3.9 The ongoing financial pressure on public health sector delivery systems and growth in consumer demand and expectations have provided, and will continue to provide, opportunities for the private health sector.[148]

Health service supply and demand

3.10 In the context of growing demand for health services, resources for health care are scarce. The share of national resources required for health care has doubled over the last 40 years, and is projected to increase significantly. For

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[142] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 Report*, p 12.

[143] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 Report*, p 12.

[144] Recurrent expenditure is expenditure on goods and services which are ongoing, for example expenditure on wages and salaries, medical and pharmaceutical supplies, and domestic services.[144]

[145] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 Report*, p 12.

[146] Foley in Bloom et al., *Health Reform in Australia and New Zealand*, 2000, p 99.

[147] Foley in Bloom et al., *Health Reform in Australia and New Zealand*, 2000, p 99.

[148] Foley in Bloom et al., *Health Reform in Australia and New Zealand*, 2000, p 100.

example, the Treasurer's *Intergenerational Report* (2002) projects Commonwealth government contributions as a share of Gross Domestic Product (GDP) to double between now and 2040.[149]

3.11 The Committee acknowledges that because the majority of health services are subsidised, with many offered at a zero price, a number of non-price rationing measures are used to restrict the quantity demanded. These initially take the form primarily of direct limitations on the numbers of medical staff and of infrastructure such as hospitals. In turn these are reflected in priority lists and extended waiting times for many health services, and in a restricted list of subsidised pharmaceuticals.[150]

3.12 According to Freebairn, there appear to be three broad sets of issues facing health policy for the supply and demand of health services. These are:

- **equity and access** – there is widespread agreement that all Australians should have access to the growing set of basic health services, but with different views on just what is meant by equity of access and about the choice of mechanism to meet the objective[151];
- **the quantity of resources and the sources of funds to allocate to health services** – ultimately this choice should compare marginal social benefits and costs. Given the extent and magnitude of subsidies, and that prices paid by consumers are below social opportunity costs, consumers may seek too many health services, and as a consequence non-price rationing interventions will need to be a key part of the policy package[152]; and
- **cost efficiency in supply** – potential areas of inefficiency include: the overlapping of responsibility of different levels of government and cost

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[149] Freebairn, J., in Dawkins & Steketee (eds), *Reforming Australia – New Policies for a New Generation*, Melbourne University Press, 2004, p 94.

[150] Freebairn, J., in Dawkins & Steketee (eds), *Reforming Australia – New Policies for a New Generation*, Melbourne University Press, 2004, p 94.

[151] Freebairn, J., in Dawkins & Steketee (eds), *Reforming Australia – New Policies for a New Generation*, Melbourne University Press, 2004, p 95.

[152] Freebairn, J., in Dawkins & Steketee (eds), *Reforming Australia – New Policies for a New Generation*, Melbourne University Press, 2004, p 95.

shifting games; lack of competition in supply; adherence to out-dated industrial relations; and how best to use new technology.[153]

3.13 By international standards, Australia may have a good health system, with most of the population having access to high quality medical care and achieving long and healthy lives. However, an ageing population with ever increasing expectations linked to advances in medical technology is putting the system under growing pressure.[154]

3.14 Elective surgery is one of many complex variables generating pressure on the public health system and driving increases in government outlays on health services.

3.15 The Committee is of the view that maintaining an appropriate focus on elective surgery in the context of growing hospital demand is a challenge for health services. It is essential that hospitals are able to effectively implement elective surgery management policies to ensure consistent, equitable and efficient access to elective surgery while at the same time providing a range of other competing elective and emergency services.

3.16 The Committee acknowledges that ACT Health faces a significant challenge managing consistent, equitable and efficient access to elective surgery within the context of providing a range of other competing elective and emergency services.

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[153] Freebairn, J., in Dawkins & Steketee (eds), *Reforming Australia – New Policies for a New Generation*, Melbourne University Press, 2004, p 95.

[154] Freebairn, J., in Dawkins & Steketee (eds), *Reforming Australia – New Policies for a New Generation*, Melbourne University Press, 2004, p 93.

4 THE THEORY OF WAITING

4.1 Waiting lists and, as a consequence, waiting times occur in a variety of situations, to fill vacancies in the nursing home sector, for public housing, and on another level there are waiting lists for returned theatre tickets or airline flights. Perhaps the most noticeable form of waiting occurs for elective surgery in the public health system of many industrialised countries.

4.2 It is important to recognise that an elective surgery waiting list is usually not a queue governed by 'first come first served' behaviour. Rather, a typical waiting list will consist of a number of different streams of patients differentiated by urgency categories.[155] Further, patients may be moved between urgency streams if their condition deteriorates or becomes unstable.

4.3 An elective surgery waiting list provides the stock of patients to be treated at a point in time, the waiting time is determined by the lag of time necessary to treat patients on the current waiting list through current and future supply of surgical treatments.[156]

4.4 By all accounts, waiting time is a far more relevant measure than the number of people waiting because longer waits for surgery may have health implications for patients. To really monitor the size of the problem of waiting, what really matters, is not how many patients are waiting but how long each one waits, or, at least, how many wait longer than some period that is deemed to be acceptable.

4.5 The COTA National Seniors (COTA-ACT) commented that reducing the length of waiting would address the problem. According to COTA-ACT inequities exists amongst the patients waiting to be treated and these inequities are exacerbated by the length of time one waits. The longer they

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[155] Harrison, A., & New, B., 'Access to elective care: what should really be done about waiting lists?', *King's Fund*, 2000.

[156] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003, p 15.

wait, the more people become concerned about those equities.[157] COTA-ACT stated:

> …the more structures that you give that support the waiting list, then the more a long waiting list is justified. These recommendations are bringing in quite a lot of structures to try and bring equity within a waiting list. So it justifies a long waiting list. That is our substantive criticism of it overall. Giving people more information is generally good. We question whether they do not have that information at the moment because we believe a lot of it is actually given by the doctors themselves, not through a formal structure. So the addition of information is rather marginal. There are some people that would miss out under the current arrangements, but we are not convinced that a whole structure will actually make it that much better for them.[158]

Costs of waiting

4.6 The Committee is aware that there have been a number of significant attempts to estimate directly both the adverse and positive consequences of waiting. The costs of delay can include: deterioration in the condition for which treatment is awaited, including death as an extreme outcome; the loss of utility from delay (especially if treatment can relieve significant pain or disability); an increase in the cost of surgery and of other treatments, pre- or post-surgery; additional loss of income from work; and additional income support payments (transfers), pre- or post-surgery. Such loss of benefits and costs are likely to vary greatly across conditions, across countries and through time. The consequences of long delays for serious conditions will be different from the consequences of short delays for mild conditions. The Committee notes that the following tentative conclusions may be drawn from the literature on the costs of waiting[159]:

4.7 Firstly, there is little evidence of deterioration in health during waiting in most studies reviewed, which cover a variety of procedures, a variety of waiting times, and a variety of countries. That may have been because waiting times

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[157] Transcript of evidence, 15 June 2005, p 54.

[158] Transcript of evidence, 15 June 2005, pp 54-55.

[159] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003.

are typically shorter for the more acute conditions, such as coronary artery disease. Also surgeons may be quite good at triage – that is reprioritising patients whose conditions become unstable or deteriorate.[160]

4.8 Secondly, there is evidence of considerable tolerance of short and moderate waiting depending on the severity of the symptoms.[161] However, general public opinion surveys (surveys not confined to people with recent experience of using health services) suggest that waiting for elective surgery is very unpopular.[162]

4.9 Thirdly, some studies of patients' willingness to pay for reductions in waiting, suggest that there is a moderate willingness to pay – perhaps around £65 (or $100) for a reduction in waiting of one month, at current price levels.[163]

4.10 Fourthly, a few studies suggest that some patients get better while waiting and no longer require surgery. More importantly, the savings in terms of avoided excess surgical capacity from maintaining waiting lists may be substantial.[164]

4.11 In evidence, the Minister for Health told the Committee:

> …the key for me will be the number of procedures that are being performed. That is, I think, a performance indicator which shows whether we are getting it right. We have had record amounts of elective surgery over the past year, but our lists remain pretty constant. Even though we have removed 9,120 from the list, the list remains hovering around 4,600. It has come down quite a bit, I should say, over the last 12 months and perhaps a better measure is removals

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[160] Feldman, R., 'The cost of rationing medical care by insurance coverage and by waiting', *Health Economics*, 1994, 3:361-372; Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003.

[161] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003; Dunn, E., et al., 'Patients acceptance of waiting for cataract surgery: what makes a wait too long?', *Social Science & Medicine*, 44, 11, pp 1603-1610, 1997; Dennet, V., et al., 'Priority access criteria for elective cholecystectomy: a comparison of three scoring methods', *New Zealand Medical Journal*, 111, pp 291-293, 1998.

[162] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003; Jowell, R. et al., *British Social Attitudes Survey*, The 17th Report, 2000.

[163] Feldman, R., 'The cost of rationing medical care by insurance coverage and by waiting', *Health Economics*, 1994, 3:361-372; Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003.

[164] Feldman, R., 'The cost of rationing medical care by insurance coverage and by waiting', *Health Economics*, 1994, 3:361-372; Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003.

> from the list and additions to the list. Maybe that gives you a better idea of what is going on than what the list is at any point in time.
>
> Over the past month, there has been an increase of 59, I think, on June 2006 in the waiting list. That gives you a snapshot, but it doesn't actually tell you what is going on. I am conscious of it. I know I have to keep responding to it. But the issue is, yes, we need to keep investing in elective surgery and we will probably need to keep investing in it. Every government will need to keep investing. We are getting older, we are getting more expensive to fix, we are living longer and we have got a pretty knowledgeable population here.[165]

4.12 The Committee understands that it is quite possible for waiting times to go down when waiting lists go up. The expectation that operations will be performed relatively quickly can lead to more people placing themselves on the waiting list for surgery while long waiting times can discourage people from placing their names on a list.[166]

4.13 Whilst the length of time that patients wait for elective treatment is seen as an important indicator of how well a health system functions, the Committee notes that the above suggests that elective surgery waiting lists may be a perverse indicator of performance.

4.14 In response to dramatic increases in the demand for elective surgical procedures in all OECD countries, Governments and insurers, in varying degrees, have increased the funds going into surgery. However, supply seems to have struggled to keep up with increasing demand in many countries. About half of OECD countries have continued to, or have begun to, experience problems with excessive waiting for elective surgery.[167]

Optimal surgery rates and optimal times

4.15 Research has suggested that elective surgery management is about responding to the challenges of: striving for optimum rates of elective surgery; and optimum waiting times for elective surgery. Further, these challenges exist

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[165] Transcript of evidence, 28 September 2006, p 107.

[166] Martin., & Smith, P.C., 'Rationing by waiting lists: an empirical investigation', *Journal of Public Economics*, 1999, 71: 141-164.

[167] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003, p 10.

whether the systems are based primarily on private market mechanisms or whether they are heavily regulated by government or a mixture of the two.[168]

4.16 The Committee recognises that both markets and policy makers face the challenge of searching for optimal surgery rates and optimum waiting times. In publicly funded systems two of the key policy levers to achieve these goals are: changing the rate of surgery, which will depend both on surgical capacity and the productivity with which capacity is used; and changing the rate of entry to waiting lists by influencing the clinical thresholds for admitting patients to lists, a process managed mainly by surgeons.[169]

Non-price rationing

4.17 Waiting lists are an integral part of health systems that use public funding and public production and are used to ration supply to a level estimated to be efficient by the central purchaser. These arrangements substitute for price signals in the normal market, where consumers make this determination through their own purchasing decisions.

4.18 Waiting lists for elective surgery are generally used in countries which combine public health insurance, with zero or low patient cost sharing and constraints on surgical capacity. Public health insurance and zero cost sharing remove the financial barriers to access surgery. Constraints on capacity prevent supply from matching demand. Under such circumstances, non-price rationing, in the form of waiting times for elective surgery, takes over from price rationing as a means of equilibrating demand and supply.[170]

4.19 In an analysis of waiting lists, the OECD reported that the availability of doctors most strongly influenced waiting lists, and also that an overall health expenditure increase of US$100 per head reduced waiting times by 6.6 days.[171]

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[168] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003.

[169] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003, p 21.

[170] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003, p 13.

[171] Siciliani, Luigi & Hurst, J., 'Explaining Waiting Times Variations for Elective Surgery Across OECD Countries', *OECD Health Working Papers No. 7*, 2003, p 4.

Countries[172] that did not report waiting times were characterised by a higher level of capacity (doctors and beds), and a higher level of spending, which translated into higher production (more surgery).[173]

4.20 In understanding the elective surgery system, waiting times must also be seen under the aspect of allocation. Forced waiting might be an effective instrument of rationing but it is hardly an efficient one. One reason is that the administration of waiting queues is costly. 'Administration' here means continuous checking and re-checking of the health condition of the patients on the waiting list and of 'prioritising' them, i.e. of placing them forward and backward on the list according to their changing health condition relative to other patients. The effect is that waiting lists, to a certain degree, feed themselves and are, thus, only a second-best instrument.[174]

4.21 From another perspective, countries without waiting lists spend, on average, a higher share of GDP on their health systems. The OECD estimates that it costs two additional percentage points of GDP to move from long to short waiting lists. Low or no waiting time countries conduct also more – for some types of surgery, much more – elective surgery operations per 100, 000 of the population per year, without exhibiting a significant effect on the health situation of the population.[175]

4.22 In summary, waiting lists for elective surgery exist because demand for elective surgery exceeds supply, and therefore a rationing process is inevitable.

Elective surgery – a national perspective

4.23 Each year elective surgery makes up a significant part of the work of Australia's public hospitals. According to the *State of our Public Hospitals June 2006 Report*, in 2004-05, there were 556,344 public patients admitted from

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[172] Austria, Belgium, France, Germany, Japan, Luxembourg, Switzerland and the United States (Siciliani, Luigi & Hurst, J., 'Explaining Waiting Times Variations for Elective Surgery Across OECD Countries', *OECD Health Working Papers No. 7*, 2003, Annex 1, pp 49-61.

[173] Siciliani, Luigi & Hurst, J., 'Explaining Waiting Times Variations for Elective Surgery Across OECD Countries', *OECD Health Working Papers No. 7*, 2003, p 26.

[174] OECD, *The OECD Health Project: Towards High-Performing Health Systems*, 2004.

[175] OECD, *The OECD Health Project: Towards High-Performing Health Systems*, 2004.

elective surgery waiting lists, representing a four per cent increase from 2003-04, and continuing a trend of steady increases in recent years.[176]

4.24 As the provision of elective surgery has to take account of the differing urgency with which interventions are required, public patients requiring elective surgery are assigned to one of three categories of urgency. Nationally in 2004-05, 34 per cent of public admissions for elective surgery were assigned to category 1[177]; 36 per cent to category 2[178]; and 30 per cent to category 3[179].

4.25 Nationally in 2004-05, 84 per cent of category 1 patients were admitted within 30 days, 77 per cent of category 2 within 90 days and 87 per cent of category 3 patients within one year.[180]

4.26 The Committee understands that the capacity of hospitals in each state and territory to provide elective surgery to patients within the recommended time for each category is an important performance measure.[181] Thus, waiting times for elective surgery are viewed as an indicator of the effectiveness of access to public hospitals.[182]

Elective surgery – an ACT perspective

4.27 In evidence to the Committee, the Minister for Health noted:

> …that the level of demand that we continue to see for elective surgery is unprecedented and significant levels of growth have occurred in a whole range of areas. Our system continues to work hard to address those areas but clearly, as with all other public hospitals around the country, access to elective surgery

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[176] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 report*, p 26.

[177] Category 1 – admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency (Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 report*, p 26).

[178] Category 2 – admission within 90 days desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly, or become an emergency (Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 report*, p 26).

[179] Category 3 – admission at some time in the future for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly, and which does not have the potential to become an emergency. For the purposes of the Australian Health Care Agreements, category 3 is reported on the basis that admission is desirable within 12 months (Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 report*, p 26).

[180] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 report*, p 27.

[181] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 report*, p 27.

[182] Productivity Commission, *Report on Government Services 2007*, p 9.22.

and management of elective surgery is a key area where all systems are facing considerable pressure. The ACT is no different in that regard.[183]

Patients undergoing elective surgery

4.28 In 2004-05, more than 8, 600 patients underwent some form of elective surgery procedure as public patients in the ACT.[184] For the same period, 91 per cent of category 1 patients were admitted within 30 days, 44 per cent of category 2 within 90 days and 70 per cent of category 3 patients within one year.[185]

4.29 According to ACT Health, 9,120 elective surgery procedures were provided in 2005-06 (9071 in ACT public hospitals and another 49 through an agreement with the private sector). The 2005-06 total was 503 more than the 8,617 provided in 2004-05.[186]

Waiting times

4.30 Waiting times for different procedures vary. While elective surgery procedures considered urgent are dealt with quickly in public hospitals, less urgent procedures may be preceded by very long waits. Waiting times also vary widely across the states and territories.[187]

4.31 In the ACT, overall, 68 per cent of public elective surgery patients in 2004-05 were seen within the recommended time. The median waiting time for elective surgery in the ACT was 45 days, sixteen days longer than the national median waiting time.[188]

4.32 According to ACT Health, the median waiting time for category 2 patients dropped to 94 days in June 2006, down from 136 days in June 2005. Further,

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[183] Transcript of evidence, 27 April 2005, p 1.

[184] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 report*, Fact sheet - ACT.

[185] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 report*, Fact sheet - ACT.

[186] ACT Health, *Annual Report 2005-06*, p 11.

[187] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 report*, p 29.

[188] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 report*, Fact sheet - ACT.

the median waiting time for category 3 patients was 176 days in June 2006, compared to 244 days in June 2005.[189]

4.33 Compared to the previous year, the percentage of patients seen within the recommended time in category 1 in the ACT fell from 98 per cent in 2003-04 to 91 per cent in 2004-05.[190]

4.34 When compared with other states and territories for the period 2004-05, the ACT was the worst performer in category 2, admitting only 44 per cent of category 2 patients within the recommended time, a decline in performance compared to the previous year (52 per cent).[191]

4.35 According to ACT Health, there were 4588 people waiting for elective surgery at ACT public hospitals at the end of June 2006.[192]

Recurrent public hospital expenditure[193]

4.36 Worthy of note is that for the period 2004-05, the ACT had the second highest to the Northern Territory ($1355 per person) of public hospital recurrent expenditure per person, weighted Australian population, in the country ($862, an increase of 52 per cent from 1998-99).[194]

Limitations of statistical comparisons

4.37 The Committee understands that, as a performance measure, statistical comparisons across jurisdictions have the following limitations:

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[189] ACT Health, *Annual Report 2005-06*, p 12.

[190] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 report*, p 28.

[191] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 report*, p 28.

[192] ACT Health, *Annual Report 2005-06*, p 11.

[193] Recurrent expenditure – is expenditure on goods and services which are ongoing, for example expenditure on wages and salaries, medical and pharmaceutical supplies, and domestic services (Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 report*, p 59).

[194] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 report*, Fact sheet - ACT.

- **elective surgery waiting times by urgency category** are not comparable across jurisdictions because clinicians have systematically different approaches to categorisation by urgency[195]; and
- **overall elective surgery waiting times** are not comparable across jurisdictions because of variations in the method used to calculate waiting times for patients who transfer from a waiting list, managed by one hospital, to a waiting list managed by a different hospital. In some jurisdictions, the time waited on the first list is included in the waiting time reported. The ACT reports the total time waited on all lists. According to the AIHW, this approach may have the effect of increasing the apparent waiting times for admission in the ACT compared with other jurisdictions[196].

4.38 Notwithstanding the limitations of statistical comparison as a performance measure, the Committee believes demand for elective surgery continues a steady trend of growth in recent years with supply struggling to keep up with the increasing demand.

Whole systems thinking

4.39 The Committee acknowledges that health services are complex systems comprising other complex systems: health economies, hospitals, departments, and specialities. How elective surgery operates is best understood by considering it, not as a distinct issue but as part of other systems.

4.40 The Royal College of Nursing Australia (RCNA) commented that:

> The management of waiting lists involves a complex interplay of consideration for the availability of human and material resources of a health care facility, clinical need of the client, and personal circumstances of that client.[197]

4.41 Further, the Committee notes that the Chief Executive of ACT Health in response to the Auditor-General's report stated that:

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[195] Productivity Commission, Report *on Government Services 2007*, pp 9.24-9.25.

[196] AIHW, *Australian Hospital Statistics*, Canberra, 2006.

[197] Submission No. 5, August 2005, p 2.

> …elective surgery is only one of a range of health services provided by the public health system. Other comprehensive services include ambulatory care, mental health services, community health services, aged care programs and other public health services. We need to balance elective surgical services with other demands.[198]

4.42 Whole systems thinking draws upon open systems theory, an approach that begins by identifying and mapping the repeated cycles of input, transformation, output, and renewed input which comprise the organisational pattern.[199] The Committee emphasises that open systems thinking aims to gain insights into the whole by understanding the links, interactions and processes between the elements that make up the system as a whole.

4.43 The Committee understands that traditional organisational theories have tended to view human organisations such as hospitals as closed systems. This tendency has led to a disregard of differing organisational environments and the nature of organisational dependency on its environment. It has also led to an over concentration on principles of internal organisational functioning, with consequent failure to develop and understand the processes of feedback which are essential to survival.[200]

4.44 In its inquiry, the Committee considered the context within which the elective surgery system operates by using whole systems thinking. In this report the Committee uses it to represent the:

- **whole hospital system** – within the hospital, elective surgery is part of a wider system providing a number of other services, of which the most important is emergency care. In most hospitals, staff, beds, operating theatres and diagnostic equipment are to a greater or lesser degree shared facilities. It follows that the capacity of the hospital to provide elective surgery depends on the extent to which these shared resources are required for other uses[201]; and

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[198] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 7.

[199] Katz & Kahn, *The Social psychology of organisations*, 1978, p 33.

[200] Katz & Kahn, *The Social psychology of organisations*, 1978, p 34.

[201] Appleby, J., Boyle, S., Devlin, N., et al., 'Sustaining Reductions in Waiting Times: Identifying Successful Strategies', *King's Fund*, January 2005, p19.

- **wider health economy** – in which the hospital is located, including the private sector and social care facilities. This includes policies that might bear on the demand for care, as well as its provision[202].

4.45 The Committee is of the view that the elective surgery system is itself complex, and how it works is also determined by the wider system in which it operates. Any strategies to improve its performance must take into account the way the elective surgery system responds to changes in waiting times, the way in which other demands on the hospital system are dealt with, and the whole system within which the hospital operates.[203]

Fundamental determinants of elective surgery access and management

4.46 The Committee is of the view that the efficiency, effectiveness and economy of the management of elective surgery are underpinned by the determinants of waiting times and waiting lists.

4.47 Using whole systems theory, these determinants can be divided into those which affect the:

- **demand for treatment or inflows to the waiting list**. The inflow of (demand for) elective surgery is determined by the health status of the population and state of medical technology, which determines the range of conditions that are treatable and patient's expectations. Various financial incentives, such as the extent of cost sharing by public patients, the proportion of the population with private health insurance and the price of private surgery, are also likely to be factors influencing demand[204]; and

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[202] Appleby, J., Boyle, S., Devlin, N., et al., 'Sustaining Reductions in Waiting Times: Identifying Successful Strategies', *King's Fund*, January 2005, p 20.

[203] Appleby, J., Boyle, S., Devlin, N., et al., 'Sustaining Reductions in Waiting Times: Identifying Successful Strategies', *King's Fund*, January 2005, pp 19-20.

[204] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003.

- **supply of treatment or outflows from the waiting list**. The outflow (supply) of elective surgery depends on both public and private surgical capacity and the productivity with which capacity is used[205].

4.48 Submissions and witnesses appearing before the Committee highlighted areas of concern and issues in connection with the various determinants of waiting times and waiting lists.

4.49 Part three of the Committee's report (Chapters 5 to 7) provides comments on the efficiency, effectiveness and economy of elective surgery management in Australia and the ACT. It includes the Committee's examination of significant issues raised with it in relation to the determinants underpinning the demand and supply for elective surgery treatment.

4.50 Part four of the Committee's report (Chapters 8 to 9) provides comments on supply and demand strategies for short term and sustainable reduction of waiting times.

[205] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003.

5 DEMAND FOR ELECTIVE SURGERY

5.1 A number of factors influence demand for elective surgery treatment in Australia. As stated earlier, demand for elective surgery is determined by the health status of the population and state of medical technology, which determines the range of conditions that are treatable and patient's expectations. Various financial incentives, such as the extent of cost sharing by public patients, the proportion of the population with private health insurance and the price of private surgery, are also likely to be factors influencing demand.[206]

5.2 The factors contributing to an increasing demand for elective surgery in the ACT include:

- ageing of the population;
- burden of chronic disease;
- increased consumer knowledge and health expectations;
- advances in technology; and
- jurisdictional issues

Ageing of the population

5.3 Australia's changing age profile will significantly increase health expenditure as a result of structural, demand and supply pressures. As outlined in the Productivity Commission's report on the *Economic Implications of an Ageing Australia*, health spending on the over 65s is currently around four times more per person than on those under 65.[207]

5.4 The Committee understands that while private hospitals in Australia have been funded to significantly increase elective surgical activity, the private

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[206] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003.

[207] Productivity Commission, *Australia's Health Workforce*, 19 January 2006, p xvii.

sector, in general, offers very little in the way of elective medical services for the type of patient that is placing pressure on public hospitals. That pressure comes increasingly from older persons with multidisciplinary problems, who require a significantly sized and skilled team to manage their condition effectively. The same comment is relevant for acute medical admissions to Australia's public hospitals.[208]

Burden of chronic disease

5.5 The World Health Organization (the WHO) has stated that the biggest burden of disease and cause of death and disability globally is chronic disease.[209] Further, the WHO argues that chronic diseases are all preventable and governments need to prioritise investment in evidence-based preventative policies to tackle the burden of chronic disease.[210]

5.6 It has been estimated that the burden of chronic disease accounts for approximately 75% of annual healthcare costs in developed countries.[211]

5.7 According to the Australian Health Care Reform Alliance (the AHCRA), because not enough is being done to prevent illness in the community, the increasing burden of chronic disease on the public hospital system undermines its ability to perform elective surgery.[212]

5.8 The Executive Director of the Australian Healthcare Association has also stated:

> Demand is increasing due to the ageing population and technological advances. New medical technologies and new drugs allow us to keep people alive much longer…what we need to do to keep up with the demand is actually keep

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[208] Submission No. 6, April 2006, p 2.

[209] World Health Organization (WHO), 'Global chronic illness burden', *WHO,* 21 October 2005.

[210] World Health Organization (WHO), 'Global chronic illness burden', *WHO*, 21 October 2005

[211] Australian Institute of Health and Welfare (AIHW), 'Health system expenditure on chronic disease', *AIHW*, 23 June 2005, pp 1-2; Hardy, G.E., 'The Burden of chronic Disease: The Future of Prevention', *Public Health Research, Practice and Policy*, April 2004, pp 1-4.

[212] Dwyer, J., in Stafford, A., 'Longer wait for elective surgery', *Australian Financial Review*, 30 June 2005, p 7.

people out of hospitals by concentrating on health promotion and prevention of disease.[213]

Increased consumer knowledge and health expectations

5.9 Public expectations of health care availability have increased markedly in recent years. At the community level in Australia, the electorate expects access to all that medical science has to offer. At the individual level, there has been an increase in advocacy on behalf of patients/consumers, public expressions of patients' rights in the form of charters and customer contracts, and pervasive demands for more patient-centred services.

5.10 Further, public expectations have a considerable influence on the total amount that any society allocates to health care, for what goods and services, and how. As a general rule society's expectations of health care services are increasing. As people lead longer and healthier lives their experience of ill health is reduced and diseases and disability become increasingly unacceptable.[214]

5.11 As a consequence, expectations placed on the health system to prevent mortality and morbidity rise. Similarly, as medical information has become more freely available to the general public through the media, including television, magazines and the Internet, the asymmetry of knowledge between patient and doctor has begun to diminish, further raising consumers' expectations.[215]

Advances in technology

5.12 An explanation put forward for the increasing elective surgery waiting times lies in advances in surgical technology and in anaesthesia over the last two or three decades. These advances have improved greatly the range, the safety and the effectiveness of the surgical procedures that can be offered by modern

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[213] Pirani, C., 'Patients are waiting longer for elective surgery, despite a significant increase in government spending on public hospitals', *Age*, 31 January 2007.

[214] Somjen in Bloom et al., *Health Reform in Australia and New Zealand*, 2000, p 59.

[215] Somjen in Bloom et al., *Health Reform in Australia and New Zealand*, 2000, pp 58-60.

health systems. Many procedures can now be carried out at a lower unit cost, as day cases rather than involving one or more overnight stays in hospital.[216]

5.13 As a consequence, there have been significant increases in the demand for surgical procedures, especially elective (non urgent) procedures, such as cataract surgery, hip replacements and coronary artery bypass surgery, in all OECD countries.[217]

Jurisdictional issues

5.14 During its inquiry the Committee was told that growth in numbers on elective surgery waiting lists in the ACT is entirely in the NSW population. The ACT resident figures on the waiting list are stable.[218]

5.15 In evidence to the Committee, the Minister for Health drew the Committee's attention to aspects of the increase in growth from NSW patients on the ACT's elective surgery waiting lists, stating:

> In ophthalmology, the change in the number of New South Wales residents who were seeking ophthalmology procedures…in Canberra public hospitals, in Calvary public and the Canberra Hospital, it was 99 per cent. There was a 99 per cent increase in the number of New South Wales residents seeking ophthalmology procedures…in contrast, there was a net decrease in the number of ACT residents seeking the same procedures of three per cent. Another example is vascular surgery. The change in the number of New South Wales residents seeking vascular surgery was 55 per cent. There was a 55 per cent increase. In the same time, there was only a 10 per cent increase in the number of ACT residents seeking the same types of procedures or needing the same types of procedures…overall, there has been a growth in the number of New South Wales patients added to the list of 40 per cent—40 per cent—during 2002-03 and 2003-04. ACT patients increased by zero per cent during the same period.[219]

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[216] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003, p 10.

[217] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003, p 10.

[218] Transcript of evidence, 27 April 2005, p 9.

[219] Transcript of evidence, 27 April 2005, pp 5-6.

5.16 As part of the agreement on payments for interstate patients treated in the Territory's public hospitals, NSW provided over $53.7 million in 2003-04 to cover the cost of its residents' care.[220]

5.17 The Committee understands that the ACT Government is working with NSWs Greater Southern Area Health Service (GSAHS) to stem the flow of patients across the border.[221]

5.18 As a strategy to respond to the growth in NSW residents on the elective surgery waiting list, the Minister for Health advised that ACT Health had identified reversing patient flows:

> …or trying to get patients from New South Wales to utilise, wherever possible, services in New South Wales, as a key strategy. We are doing that in a range of areas. At the moment, I am advised, Greater Southern Area Health Service is looking at data from the ACT elective surgery waiting list on New South Wales patients, particularly in the areas of gynaecology, ophthalmology and general surgery procedures, to identify what can be done to enable those people to get those procedures in their local area, rather than coming to the ACT.[222]

5.19 Further, the Minister for Health stated:

> It is important to make the point that, under the Australian health care agreements, all public hospitals around the country, including ours, are obliged to accept people without fear or favour if they indicate that they wish to have surgery performed at one of those hospitals, and we are compensated, obviously, through bilateral agreements, in particular between ourselves and the New South Wales government, for that. The quantum is always a matter of some dispute. The territory believes that we are not adequately compensated for the costs of providing care for those New South Wales residents. However, we are obliged to take them and we do take them.[223]

5.20 The Committee is of the view that the value of cross border flows requires a debate more around money than future clinical directions based on demographic need. Further, the Committee understands that the capacity of

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[220] Cronin, D., 'NSW funding exacerbates cross-border patient row', *Canberra Times*, 15 March 2006,

[221] Cronin, D., 'Waiting list a symptom of the lack of hospital beds', *Canberra Times*, 3 March 2005, p 5.

[222] Transcript of evidence, 27 April 2005, p 9.

[223] Transcript of evidence, 27 April 2005, p 9.

TCH and, to a lesser extent, Calvary, to evolve their regional referral potential is hampered by the annual disagreements about payments for patient flow.[224]

5.21 The Committee notes that the *ACT Health Review 2002* (the Review), commented that the AHCA could provide a vehicle to have improved longer term arrangements with NSW to accommodate cross border payments for hospital care.[225]

5.22 According to the Review, these longer term arrangements could be achieved by NSW and the ACT agreeing to a five year program whereby financial transfers parallel the bilateral AHCA negotiations.[226]

RECOMMENDATION 2

5.23 **The Committee recommends, to the extent that work is not already taking place, that ACT Health should use the renegotiation of the 2008-2013 Australian Health Care Agreements to negotiate a five year arrangement with NSW regarding cross border payments for hospital care.**

5.24 In evidence the AHCRA noted that there was a need for better cooperation between the ACT and NSW services:

> …fused into a single entity providing seamless care across the jurisdictions. Although an autonomous territory, the ACT is entirely contained within New South Wales and its citizens do not have vastly different health needs to New South Wales citizens.[227]

5.25 The AHCRA believes that there could be an opportunity for the ACT and NSW, where there is a local geographic connection, to lead the way with trialling some ways of sharing responsibility in the area of an integrated health system.[228] Whilst noting that, practically, an integration of the two services without some interim stages was unrealistic, the AHCRA suggested:

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[224] Reid, M., et al., *ACT Health Review*, May 2002, p 49.

[225] Reid, M., et al., *ACT Health Review*, May 2002, p 49.

[226] Reid, M., et al., *ACT Health Review*, May 2002, p 49.

[227] Transcript of evidence, 28 July 2006, p 84.

[228] Transcript of evidence, 28 July 2006, pp 86-87; Submission 6A, July 2006.

> One option is to fund a pool across a range of specific programs—the example that you cite in relation to Queanbeyan Hospital that you have contributions from both jurisdictions to that hospital. Instead of having jurisdictional control of the services or the determination of service delivery in that area, you could arrange for a citizens panel to be constituted in order to determine the service priorities within that area. So the accountability would then come back to the panel and then, via that panel, to the respective health ministers.[229]

5.26 The Committee believes that planning by demographic need is more efficacious than by jurisdiction and that there are cost efficiencies and service improvements to be gained by integrating health service delivery.

RECOMMENDATION 3

5.27 **The Committee recommends that ACT Health explore the feasibility of trialling further ways of sharing responsibility with NSW in the area of an integrated health system.**

5.28 In making the above recommendation, the Committee recognises that there are some good examples of collaboration currently in place. For example, a joint renal nurse appointment with the former Southern Area Health Service (SAHS) coordinates renal care. Similarly, there has been collaboration between the former SAHS and ACT Health in planning the enhancement of orthopaedic services for the south coast in NSW.[230]

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[229] Transcript of evidence, 28 July 2006, p *86*.

[230] Reid, M., et al., *ACT Health Review*, May 2002, p 49.

6 CAPACITY OF THE SYSTEM

6.1 The outflow (supply) of elective surgery depends on the surgical capacity of the system and the productivity with which this capacity is used.[231]

6.2 The supply of elective surgery is primarily determined by budget allocations, but is also influenced by practical factors such as the availability of surgeons, operating theatres, beds and nurses, and also by the efficiency with which these factors are brought together to provide elective surgery.[232]

6.3 The Committee is of the view that the challenge to policy makers and health providers is to find the right balance of resources to the system and waiting list management procedures that produce both optimal surgery rates and optimal waiting times.

6.4 Fundamentally this requires policy makers and health providers to be clear about the level of capacity of elective service provision that is potentially available, and the factors affecting this capacity.

6.5 The Committee regards the attributes of ACT's two public hospitals as a key factor affecting the level of capacity of elective surgery provision. In evidence, the Acting Chief Executive of ACT Health stated:

> The difference between TCH and Calvary is that Calvary have less emergency surgery, less break-ins, so they are able to plan their lists a lot better, have less interruptions. Also, they tend to focus on less complex cases, and less complex cases can be planned better. You can get more in to, say, a four or six-hour theatre session and that is why Calvary are able to get roughly 90 per cent of their patients—it varies a bit from month to month—in on the day of surgery because they know that they are unlikely to be bumped, which is the term we use, by an emergency surgical patient.
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> TCH is a different kettle of fish. It is a 24-hour major trauma hospital. We do cardiothoracic surgery, major vascular surgery, major hip and knee, trauma,

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[231] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003.

[232] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 16.

> plastics, paediatric surgery. It is a much more complicated environment. Therefore, we believe setting a target at between 70 and 80 per cent is probably about as good as it is going to get there under the current circumstances.[233]

6.6 In evidence presented to the Committee the following were raised as key factors affecting the level of capacity of elective surgery provision:

Division of responsibilities for funding and providing services

6.7 As specified in the Australian Constitution, responsibility for health is divided between the Commonwealth and individual state governments. As mentioned previously, the states/territories run the public hospitals, with the Australian, state and territory governments financing over 90 per cent of expenditure on public hospitals in 2004-05. Further, every five years, the states/territories and the Commonwealth meet to negotiate the AHCA as to how much the Commonwealth grants to run the hospitals will be worth.[234]

6.8 In evidence presented to the Committee there is a view that these spilt responsibilities undermine the ability of public hospitals across Australia to respond effectively to the demands placed on them, of which elective surgery is but one of many.

6.9 The federal/state dichotomy of funding and responsibility for planning and design of health care can lead to cost-shifting, the Commonwealth can say that elective surgery waiting lists are not their responsibility, all these problems are state problems. Equally the states can say we don't have to fix these problems, the Commonwealth caused them. The split of funding between federal and state governments in Australia also encourages the states and hospitals to shift costs out of hospital budgets and into the federal budget.[235]

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[233] Transcript of evidence, 28 September 2006, pp 95-96.

[234] Lavelle, P, 'Hospital funding – a dog's breakfast', *ABC Online*, 7 October 2005.

[235] Somjen in Bloom et al., *Health Reform in Australia and New Zealand*, 2000, pp 62-63

6.10 As a consequence, according to many, these inefficiencies are responsible for poorer health outcomes than would otherwise be the case.[236]

6.11 In evidence to the Committee, the AHCRA noted:

> Equity of access and equity of health outcomes is essential. The alliance firmly believes that jurisdictional inefficiencies associated with Australian and state governments being responsible for different segments of our health care system have produced a major problem. The solutions to these problems have been sought for the last 20 years. The current arrangements are now widely recognised as a serious impediment to the delivery of quality, equitable and cost-effective health care. They represent a major historical mistake. Were we to design a health care system from scratch we would not make that mistake again.[237]

Resource availability

6.12 The following resource availability issues continue to impact on the capacity of elective surgery provision:

Health workforce

6.13 Workforce shortages are one of several factors placing pressure on Australia's health care system and consequently resource availability issues impact on elective surgery waiting times. The public health system needs more doctors and nurses to overcome chronic shortages. Whilst the specialist workforce shortage is the responsibility of the Federal Government, state and territory jurisdictions also have a role to play to do what they can to attract more medical staff to their respective health systems.[238]

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[236] Freebairn, J., in Dawkins & Steketee (eds), *Reforming Australia – New Policies for a New Generation*, Melbourne University Press, 2004, p 107.

[237] Transcript of evidence, 28 July 2006, p 84; Submission No. 6, April 2006.

[238] NSW Auditor-General, *Performance Audit Report – NSW Dept of Health: Waiting times for elective surgery in public hospitals*, September 2003, p 6.

6.14 Further, the preference for some specialists in demand to work in the private sector means that there are larger numbers of patients waiting for treatment for certain conditions in the public hospital sector.[239]

6.15 A study commissioned by the Australasian College of Surgeons into surgeon shortages indicates that elective surgery is becoming very difficult to access in public hospitals. The Report predicts that by the year 2021 there will not be enough surgeons to cope with demand. The College says an increase of at least 30 per cent in surgical training positions in Australia's public hospitals is needed over the next few years to keep up with the increasing demand for elective surgery.[240]

6.16 The Productivity Commission's report on *Australia's Health Workforce*[241] examining issues impacting on the health workforce including the supply of, and demand for, health workforce professionals found that, despite a growing reliance on overseas trained health professionals that made up 25 per cent of the workforce compared with 19 percent a decade ago, the states and territories had workforce shortages across a number of specialties.[242]

6.17 During its inquiry, the Committee was told that an ACT Health 2005 report revealed that 2247, or more than half of ACT Health's permanent workforce, was likely to leave in the next five years. Further, according to the report, the problem was most pronounced in nursing.[243]

6.18 In evidence to the Committee, AHCRA commented that:

> We simply do not have the workforce to maintain all services that are nominally on offer at so many public hospitals across the nation.[244]

6.19 Further, the AHCRA added that:

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[239] NSW Auditor-General, *Performance Audit Report – NSW Dept of Health: Waiting times for elective surgery in public hospitals*, September 2003, p 6.

[240] Birrel, B., et al., *The outlook for surgical services in Australasia*, Centre for Population and Urban Research, Monash University, 2003.

[241] Released 19 January 2006

[242] Productivity Commission, *Australia's Health Work Force*, 19 January 2006

[243] Cronin, D., 'Agency calls for Health Reforms', *Canberra Times*, 19 January 2006.

[244] Submission No. 6, April 2006, p 1.

> While the Prime Minister has just announced (April 8, 2006) a most welcome addition in the number of HECS funded places in Australian Universities for the training of doctors and nurses, it will be many years before this injection of capital eases our workforce problems.[245]

6.20 The Chief Executive of ACT Health commented that the public health system in the ACT is in need of more doctors and nurses to overcome chronic shortages.[246]

6.21 In contrasting evidence, the ACT VMOA stated:

> Appointment of more doctors to the ACT public hospitals would do nothing to reduce waiting lists unless there are more operating sessions and beds. The doctors currently available in the ACT could do more public hospital work if more operating sessions and beds were made available. Everything else is of secondary consideration.[247]

6.22 Further, the ACT VMOA stated:

> What the government is doing is rationing public hospital services by keeping waiting lists long in the ACT….[248]

6.23 The Committee notes that the Productivity Commission's annual reporting on public hospitals from 2007 will include an indicator on workforce sustainability. The Committee understands that this indicator will assist with systematic workforce planning to help build and sustain the capacity of the health workforce.[249]

6.24 The Committee understands that health workforce outcomes are strongly influenced by government policies relating to: workforce planning; the number of funded training places; education and training curricula; regulation of professional groups; and job design. Further, these outcomes are also influenced by broader health care system settings, including the division of responsibilities for funding and providing services between: individuals; the

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[245] Submission No. 6, April 2006, p 1.

[246] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 8.

[247] Submission No. 1, March 2005, p 1.

[248] Transcript of evidence, 15 June 2005, p 40.

[249] Productivity Commission, *Report on Government Services 2007*, p 9.11.

public and private sectors; institutions within governments; and levels of government.[250]

Emergency department workloads

6.25 Emergency presentations to public hospitals are increasing all over Australia and the consequent increase in emergency workload undermines the ability of the public system to treat elective surgery patients.[251]

6.26 In 2004-05, more than 4.3 million people were treated in an emergency department, an increase of approximately 200,000 from the previous year. In 2004-05, the ACT had the second highest rate of emergency presentations to the Northern Territory.[252] This may be in part due to a greater reliance on public hospitals, general practitioner numbers, and access to general practitioners after hours, in the ACT.

6.27 The Committee is of the view that such an increase in emergency workload is an influential factor in the ability of the public health system to treat elective surgery patients.

6.28 In evidence to the Committee, the ACT VMOA stated:

> At the Canberra Hospital there is the additional problem that they do almost all of the emergency orthopaedic surgery and the biggest problem there is getting those patients to theatre expeditiously…that immediately produces a problem of bed block. So, in some sense, Canberra Hospital need to address their problem with being able to deal with their emergency cases expeditiously…the waiting list gets pushed back because the elective lists are being earmarked and turned into non-elective lists. So, for a lot of the elective cases at Canberra Hospital, the lists are being taken out of the elective category and made into non-elective lists in some sort of effort to cope with the problems from the trauma load….[253]

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[250] Productivity Commission, 'The Health Workforce', *Productivity Commission Issues Paper*, May 2005, p 9-10.

[251] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 report*.

[252] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 report*, p 38.

[253] Transcript of evidence, 15 June 2005, pp 45-46.

Availability of beds

6.29 The number of beds[254] immediately available for use is a basic measure of a hospital's capacity to provide care, particularly for patients needing to stay overnight. However, it does not measure capacity to provide care for same day procedures, hospital in the home, emergency departments, and outpatient services.[255]

6.30 A bed is considered immediately available for use if it is located in a suitable place with nursing and auxiliary staff on hand within a reasonable period.[256] In 2004-05, the total number of public hospital beds reported as available was 54, 665 or about 2.6 per 1,000 weighted population.[257] For the 2004-05 period, bed numbers in the ACT were below the national figure.[258]

6.31 According to the ACT President of the Australian Salaried Medical Officers' Federation (ASMOF) the ACT has the lowest number of public hospital beds per capita in Australia. Further, the ACT President believed:

> …100 more public hospital beds were needed across the ACT to cope with demand at Canberra and Calvary Hospitals.[259]

6.32 The Committee understands that on any given day across Australia there can be a significant number of aged people occupying acute care beds in public hospitals, simply because there are not enough nursing home beds available.[260] In the ACT, according to the ACT President of the ASMOF, this can equate to 60 to 80 beds.[261]

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[254] The concept of an available bed is becoming less important in the overall context of hospital activity, particularly in light of increasing same day hospitalisations and the provision of hospital-in-the-home care (AIHW, *Australian Hospital Statistics*, 2006).

[255] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 report*, p 11.

[256] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 report*, p 11.

[257] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 report*, p 11.

[258] Australian Government, Dept of Health & Ageing, *The state of our public hospitals, June 2006 report*, Fact sheet - ACT.

[259] Cronin, D., 'Waiting list a symptom of the lack of hospital beds', *Canberra Times*, 3 March 2005, p 5.

[260] NSW Auditor-General, *Performance Audit Report – NSW Dept of Health: Waiting times for elective surgery in public hospitals*, September 2003, p 5.

[261] Cronin, D., 'Waiting list a symptom of the lack of hospital beds', *Canberra Times*, 3 March 2005, p 5.

6.33 The Committee is aware that one of the issues facing patients waiting for planned surgery in our public hospitals is an inadequate number of overnight beds available to many institutions, which make it impossible to quarantine beds to run an efficient elective surgery program.[262]

6.34 However, the Chief Executive of John James Memorial Hospital (JJMH) stated:

> …there is no shortage of beds in the ACT: today nearly half of the National Capital Private Hospital beds are empty. That would be approximately 30 to 40 beds. I have my Deakin ward closed, which is 24 beds. TCH has 6 per cent of its beds with private patients and possibly up to 5 per cent more with DVA-funded patients.
>
> There is, of course, an issue with labour appropriately skilled to staff more beds. If we all had all the beds open, there would not be adequate labour. There have been known and emerging skills shortages for many years. There has been rhetoric more than there has been action.[263]

6.35 Notwithstanding the differing views on the availability of beds in the ACT, the Committee understands that to reduce pressure on ACT public hospitals, the Government has set targets for increasing the overall number of hospital beds. Further, it has developed programs designed to make better use of the existing bed stock by encouraging more rapid discharge of patients from both emergency and elective beds.

Funding for planned surgical services

6.36 The health policy debate in Australia is driven by the equity objective of universal access for all, and then by the efficiency objective of the provision of medically effective health care at least cost. On most assessments, including international comparisons, Australia scores well on the equity objective, but there are pressures for more resources to be allocated to health. These are associated with new technology and rising community expectations, with an

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[262] Submission No. 6, April 2006, p 2.

[263] Transcript of evidence, 1 September 2005, p 58.

ageing population, and with the consequences of the heavily subsidised prices faced by consumers.[264]

6.37 According to the AHCRA, an important factor facing patients waiting for elective surgery in our public hospitals, particularly, major tertiary institutions[265], is a lack of adequate funding for planned surgical services:

> In metropolitan areas there is no shortage of orthopaedic surgeons willing to operate in the public hospital system on a far more frequent basis than is currently possible. Theatre and recovery time is restricted for budgetary reasons. Often when new and talented young surgeons are appointed to a hospital they can only be given operating time if the existing surgical workforce agrees to share a fixed amount of theatre time with the newcomer.
>
> Around the country, particularly at election time, the boom and bust cycle is played out with a short injection of funds, making it possible to reduce temporarily politically unacceptable waiting lists. It is generally not appreciated by health care systems that people trapped on long waiting lists ultimately involve the system in far more expense than would be the case if they were operated on in a timely fashion. Drug treatments, medical complications, time lost from work and many other factors contribute to the cost ineffectiveness of not having an adequate planned surgical service available for long wait patients. [266]

6.38 In evidence, the ACT VMOA submitted that unless the Government is prepared to spend more money on allocating surgery time, the problem with waiting lists will not be dealt with, and concluded:

> ...that the government is comfortable with the number on the public hospital waiting list and has no intention of spending more money to reduce the public hospital waiting list.[267]

6.39 The VMOA also informed the Committee that the basis on which it had reached this conclusion was informed by:

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[264] Freebairn, J., in Dawkins & Steketee (eds), *Reforming Australia – New Policies for a New Generation*, Melbourne University Press, 2004, p 107.

[265] Major tertiary institutions are teaching hospitals that usually have a full component of services including paediatrics, general medicine, various branches of surgery and psychiatry.

[266] Submission No. 6, April 2006, pp 3-4.

[267] Submission No. 1, March 2005, p 1; Transcript of evidence, 15 June 2005, p 48.

> The Visiting Medical Officers Association and the AMA in the ACT have made numerous submissions to the government for more money for regular elective sessions and additional sessions to reduce the waiting time and these sessions have not come, have not appeared…Extra sessions can be provided if the government puts up the funding for that, and they are not prepared to put up the funding. They have not increased the funding for this purpose and it has not happened.[268]

6.40 The Committee heard that some surgeons contracted to work in public hospitals completed their allocated quota of operations before June 30 and had to stop work due to the practice of cost weight limitations. The Committee heard evidence of dissatisfaction amongst many surgeons due to this practice at Calvary Hospital:

> This is a system where, because there is only a certain amount of public work allocated to a hospital, the administration then delegates that limit to individual clinicians in the sense that Dr A will have 130 cost weights allocated for that year and Dr B will have 200 cost weights. If you use up that number of cost weights, you are prevented from operating on any public patients, unless they are category 1 or emergencies, for the rest of the financial year, which in effect means that surgeons like me and a few others will have two months or three months of theatre time prevented. Theatres will lie fallow, unused, and we will not be in a position to help shorten the waiting lists whilst there are actually some resources available.[269]

6.41 The Committee was told that the rationale for cost weight limitations is a technique of working to a budget by transposing the responsibility for cost cutting onto the clinicians. Further, the Committee understands that such a practice is in breach of the contracts respective VMOs have with ACT Health.[270]

6.42 The Committee understands that if the volume of elective surgery is not considered adequate, waiting times can be reduced through supply side policies such as increasing the productivity of public hospitals by adequately funding planned surgical services.

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[268] Transcript of evidence, 15 June 2005, pp 48-49.

[269] Transcript of evidence, 15 June 2005, pp 42-43.

[270] Transcript of evidence, 15 June 2005, pp 48-49.

Theatre utilisation

6.43 The Minister for Health told the Committee that whilst the Government would continue to focus strongly on elective surgery it would also be focusing on system improvements in terms of the management of theatres and other systems within the hospitals to make sure that they work as efficiently as possible:

> …I can also flag that the government will also be focusing on other areas of systems within public hospitals to make sure that operation of our theatres is as efficient as it can be to ensure that we are able to maximise the throughput in our public hospitals.[271]

6.44 The capacity of an elective surgery system depends primarily on the availability of operating theatres[272], and of clinical and other staff necessary for the performance of the operation.

6.45 As existing capital stock, operating theatres use a significant portion of the total resources of the hospital. It costs around $1.6 million (US) to build and equip one operating theatre to which an annual budget for recurrent and non-recurrent funding is added.[273]

6.46 The Auditor-General found:

> Surgical theatres for elective surgery are used only during normal working hours Monday to Friday. Calvary operates from 9:00am to 5:00pm, with, on most occasions, the same surgeon operating all day. TCH is trying to work towards this more efficient schedule. TCH theatres currently start with a morning session from 9:00am to 1:00pm, followed by an afternoon session from 1:00pm to 4:00pm. Audit was informed that on occasions, they close much earlier than 4:00pm, and an ACT Health consultant's report stated that the three hour surgical session in the afternoon is 'quite dysfunctional'. TCH informed us that this shorter period is a consequence of agreements with operating theatre

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[271] Transcript of evidence, 27 April 2005, pp 2-4.

[272] The major difference between TCH and Calvary Hospitals is the nature of the workload and the casemix. Calvary has six operating theatres and can pretty much predictably run these six theatres all the time. TCH has ten and they have to set aside one theatre, sometimes up to three, at any one time for what is called non-elective surgery, which is, very urgent work, or emergency work (Transcript of evidence, 28 September 2006, p 96.)

[273] UK Audit Commission, *Operating Theatres: Review of National Findings*, 2003.

> staff, which are being updated as staff are replaced. The review of surgical services recommended a theatre session period of 8:00am to 6:00pm.[274]

6.47 The Committee understands that several OECD countries have progressively reduced elective surgery waiting times by increasing the throughput of operating theatres, i.e. increasing productivity through more efficient use of theatre sessions within existing resources.[275]

6.48 Several submissions to the Committee highlighted that operating theatre capacity, in particular at TCH, could be reorganised to absorb extra work within existing resources.

6.49 The Committee understands that the Auburn Elective Surgery Program used an existing single six and a half hour shift of nursing staff to man the operating theatre lists as compared to the usual practice of two half-day lists. The improved utilisation of recurrent costs in theatre avoided the 'on-cost' of commencing a new shift of staff at midday or earlier. Further, the institution of a single, daylong list resulted in an earlier start for emergency cases.[276]

6.50 The Committee believes that it would be beneficial to explore the merit of rationalising operating theatres to a single six and a half hour list with one shift of theatre staff. In response, the Acting Chief Executive of ACT Health stated:

> We are looking at a whole range of options for improving the efficiency of the theatres. We are focusing this year mainly on TCH and we see some merit in extending the overall length of the operating times, and that could well include consideration of an unbroken six-hour list. So we are very open to that suggestion, but at this point in time we are doing a piece of redesign work under the access improvement program and that will give us greater guidance on how we can structure those theatre lengths and durations.[277]

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[274] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 56.

[275] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003.

[276] Singh, N. et al., 'The Auburn Elective Surgery Pilot Project', *Australia New Zealand Journal of Surgery*, 2005, 75: 768-775.

[277] Transcript of evidence, 28 September 2006, p 96.

RECOMMENDATION 4

6.51 **The Committee recommends that ACT Health explore, in conjunction with the Canberra and Calvary Hospitals, the rationalisation of operating theatre lists to a single six and a half hour list, with a single shift of staff.**

6.52 The Committee was disturbed to learn that TCH and Townsville Hospital are the only two facilities in the country that had three rather than four hour theatre sessions for elective surgery in the afternoon.[278]

6.53 Regarding TCH's practice of stopping operating lists at 4:00pm, the ACT VMOA told the Committee:

> That applies at Canberra Hospital, and it is one of only two hospitals in the whole of Australia that stop their operating lists at 4.00 pm. In every other hospital it is 5.00 pm or later…We have been told by the department of health that it is a problem getting the nurses to do what they want…It is a rostering problem, they keep saying, which they do not seem to be able to control.
>
> They will not start a case that will not finish before 4 o'clock in the afternoon, so there is no capacity for the list to run over time at all. So the effective finishing time for those lists may be as early as 2:30…the elective operating lists are strongly underutilised. They are now going into a situation where some of the morning operating lists will not commence until 9.00 am. Again, that reduces those operating lists by 30 per cent, with the same problem of being reluctant to start any case that will not finish before midday…At no other hospital in Canberra do those restrictions apply. It is just normal practice at all the other hospitals for the lists to go on until they are finished. If the lists are seriously overbooked, the particular surgeon making the bookings will be instructed to be less ambitious with how many cases he can do. But normally we will finish every case that is booked on those lists, and that may mean going until 6:30 or 7 o'clock some nights.[279]

6.54 The Committee was also told by the Chief Executive of JJMH that the:

> …public operating theatres are fundamentally less efficient than the private sector. They have afternoon sessions at TCH that go for only three instead of four hours; few theatres have the flexibility of working late on demand; they do

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[278] Cronin, D., 'Calls for urgent health reform as elective surgery lists escalate', *Canberra Times*, 22 March 2005, p 2.

[279] Transcript of evidence, 15 June 2005, pp 40-41.

> not do as many operations in the time available; and there is no elective weekend operating. The scheduling of emergency cases, I will admit, often leads to cancellation and re-booking of elective cases, most of which then form part of the ongoing waiting list numbers.[280]

6.55 Further, the Chief Executive of JJMH added that:

> Afternoon lists are a known problem with TCH. They run an hour shorter than the standard session times of the other hospitals, including Calvary, and it obviously has an overall impact. If you multiply 10 theatres by an hour a day, there is 10 hours a day less operating time available… It is not something that I would do as an administrator. Three-hour sessions are very difficult, given a lot of operations run for two hours, and you have got to have fill-in operations for 20 or 30 minutes. There is a reported tendency of the operating sessions to cut off fairly sharply if the patient is not going to be ready to go in before 5 o'clock, so they would not put them in at 4 o'clock.[281]

6.56 The ACT VMOA attributed the Canberra Hospital's inability to secure rostering with nursing staff as:

> Basically, it seems to be an industrial issue, that people work at the Canberra Hospital because they finish at a particular time and they can be confident of finishing on time, and it seems to be the administration's policy to enforce that.[282]

6.57 The Chief Executive of JJMH commented that industrial practices at the Canberra Hospital:

> …are such that there is fundamental inefficiency in the utilisation of capital infrastructure and strong resistance to change. At times there would appear to be a lack of political will to support management in dealing with the necessary changes.[283]

6.58 In evidence to the Committee, the ACT VMOA stated that its members would be quite happy to work outside the timeframes currently utilised at TCH.[284]

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[280] Transcript of evidence, 1 September 2005, p 59.

[281] Transcript of evidence, 1 September 2005, pp 61-62.

[282] Transcript of evidence, 15 June 2005, p 42.

[283] Transcript of evidence, 1 September 2005, p 59.

[284] Transcript of evidence, 15 June 2005, p 41.

6.59 In relation to experiences of operating theatre practices at other ACT hospitals, the ACT VMOA stated:

> It would be fairly typical for the lunch hour to be shortened to 20 minutes or so because the morning list had gone on a bit longer and it would be quite reasonable for a list with a scheduled finishing time of 5.00 pm to finish between 5.30 and 6.00 pm.[285]

6.60 When asked whether other hospitals would ever initiate an operation at 3.00 or 4.00pm, the ACT VMOA commented:

> The lists tend to be better structured, or the lists are well structured in that sense. But yes, they would do. I know of cases where the operating lists have gone on until 8 or 9 o'clock at night with the same staff just being held back on overtime until the work is completed.[286]

6.61 Further, the ACT VMO Association stated:

> All of these problems with late starts, early finishes and not enough sessions are often in a setting where the physical theatre is available, the surgeon is available and the anaesthetist is available but there is no nursing staff available to open that theatre. Although I am not right in the midst of the nursing staff, the overall impression of many of us working in theatres is that the rate-limiting step in being able to open up theatres is largely lack of nursing staff, more than lack of surgeons, for example.[287]

6.62 On the available evidence, the Committee concludes that TCH should be able to increase productivity by improving the efficiency of its operating theatres and surgical units. In addition the Committee believes that the provision of better information on monitoring theatre performance and the subsequent analysis of waiting list trends would be useful.[288]

6.63 The Committee understands that as part of future directions for 2006-07, a major initiative at TCH within the operating suite will be to extend the operating theatre time to a 5pm finish. According to ACT Health this will

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[285] Transcript of evidence, 15 June 2005, p 41.

[286] Transcript of evidence, 15 June 2005, p 42.

[287] Transcript of evidence, 15 June 2005, p 49.

[288] UK Audit Commission, *Operating Theatres: Review of National Findings*, 2003.

align TCH with national standards.[289] Further, the Committee notes that as part of ACT Health's priorities for 2006-07 there will be further refinement of theatre utilisation reporting at TCH.[290]

RECOMMENDATION 5

6.64 **The Committee recommends, to the extent that work is not already taking place, that the Canberra Hospital routinely produce and analyse theatre performance information falling under the following headings: capacity utilisation ratios in terms of hours and sessions; average number of cases per hour; cancelled schedule lists; cancelled operations; utilisation of scheduled theatre hours; review of list start and finish times; numbers of patients operated on compared with planned numbers; incidence of out-of-hours operating; theatre incident rates and patterns; and break up of public, private and Department of Veteran's Affairs patients.**

Perverse incentives

6.65 In evidence presented to the Committee a number of issues were highlighted as factors that may affect the capacity for elective surgery provision. These included:

- Private health insurance initiatives
- Spending public monies pursuing private patients

Private health insurance initiatives

6.66 Proponents of private health insurance initiatives argue that additional support for the private sector will take the pressure off the public sector and reduce waiting times for public patients.

6.67 However, health researcher, Professor Stephen Duckett contends that policies supporting private health insurance may actually increase waiting times for

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[289] ACT Health, *Annual Report 2005-06*, p 17.

[290] ACT Health, *Annual Report 2005-06*, p 12.

hospital treatment.[291] According to the findings of a study of how private financing affects public health care systems, OECD countries with parallel public and private health care systems have the longest waiting times.[292]

6.68 Further, researchers have also looked at the variation in waiting times within countries, based on the co-existence of public and private care. Studies in both Australia and England have found that the more care provided in the private sector in a given region, the longer the waiting times for public hospital patients.[293]

6.69 However, the researchers of these studies also stress that this methodology, of comparing countries or areas with different levels of private and public health is inadequate. They explain that:

> Firstly, it is not enough to draw comparisons across nations at a given point in time, although such comparisons may be suggestive. What is more important (and more challenging) is to look for the dynamic effects of changes over time within given systems. ... Second, it is not enough to look at the level and the share of public and private spending per se – we need also to consider how the relationship between public and private finance is structured.[294]

6.70 Moreover, others have dismissed Professor Duckett's claims, with the Australian Medical Association (AMA) stating that the following evidence refutes his argument:

> The Federal Government policies that support private health insurance (the 30% PHI rebate, Lifetime Health Cover and the Medicare Levy surcharge) have together been responsible for lifting coverage from 30 per cent of the population (and falling fast) to 43 per cent (and steady). Were it not for these policies, the private health sector would have been in terminal decline and the pressure on the public system (and Budgets) would have been intolerable…large numbers of patients have been able to access the private sector, including patients who would otherwise have encountered long waits for access as public patients. The

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[291] Duckett, S.J, 'Private care and public waiting', *Australian Health Review*: 29(1): 87-93.

[292] Hughes Tuohy et al., 'How does private financing affect public health care systems? Marshalling the evidence from OECD nations', *Journal of health Politics, Policy and Law*; 29(3): 359-396.

[293] Duckett, S.J, 'Private care and public waiting', *Australian Health Review*: 29(1): 87-93; Besley et al., 'Public and private health insurance in the UK', *European Economic Review*; 42(3-5): 491-497.

[294] Hughes Tuohy et al., 'How does private financing affect public health care systems? Marshalling the evidence from OECD nations', *Journal of health Politics, Policy and Law*; 29(3): 360-361.

> transfer of work is very striking, between 1995-96 and 2002-03, private hospital separations grew by 63 per cent and public hospital separations by 14 per cent.[295]

Spending public monies pursuing private patients

6.71 The Chief Executive of JJMH expressed a view that there would be immediate relief on the system by utilising private hospitals as the primary vehicle for private and DVA patient care, stating:

> Certainly our view is that a lot of the patients who are privately insured, particularly DVA patients, could be removed from the system tomorrow and that would clearly unblock those chronic co-morbid beds because most veterans present with co-morbidities; they are an older age group generally than the rest of the patient population. Their own data shows that within TCH; so there would be some relief. It will only ever be part of the solution; so it is a short-term solution to take pressure off. There will have to be other systemic reforms in the efficiency and deployment of the resources.[296]

6.72 The Committee notes the view expressed by JJMH that a significant reason why patients were overdue for elective surgical treatment was that TCH was busy pursuing the dollars it could get from DVA or private patients and that, potentially, public patients, who were a less profitable customer group were in fact losing out on this equation in the quest to compete for dollars.[297]

6.73 Further, the Committee notes that this is also the position of the Australian Private Hospitals Association (APHA), which has published material on this issue.[298] In its submission to the Commonwealth government's *Review of the Regulatory Framework for Private Health Insurance*, the APHA commented that:

> there is some anecdotal evidence emerging that public hospitals in some States may be using the 'patient election' provisions of the Australian Health Care Agreements to pressure patients with private health insurance to be treated in

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[295] Glasson, B., Australian Medical Association Media release: 'The Truth About Private Health Care – AMA Buckets Duckett', February 2005.

[296] Transcript of evidence, 1 September 2005, p 65

[297] Transcript of evidence, 1 September 2005, p 65.

[298] Transcript of evidence, 1 September 2005, p 65; APHA, Submission to the Commonwealth government's *Review of the Regulatory Framework for Private Health Insurance*, May 2002.

> the public hospital as a private patient. This is of great benefit to the public hospital which saves the money it has been paid by the Commonwealth through the AHCAs for the treatment of public patients and also receives revenue from health insurance funds for hospital accommodation of the patient. In these cases, the patient receives little or no benefit compared to a public patient.[299]

6.74 In evidence to the Committee it was expressed that the active pursuit of private and DVA patients as a fund raising source for public hospitals was questionable. The Chief Executive of JJMH stated:

> I do not think someone has done a proper economic examination, including all subcosts, like your cost of capital and your long-term cost of capital replacement, as to whether in fact chasing private revenue, which is the cream on the top, actually is a benefit financially or not. It certainly is for the incentives from the hospital administrators' point of view because they are already being funded for the members of the public once; then, on top of that, if they can pick anything else up, it is an advantage…I did a submission that suggests that, on the back-of-envelope figures, from what we can glean, it may in fact be less cost effective to do it in the public sector than in the private. That is an area that we think should be looked at but not looked at by ACT Health itself.[300]

6.75 The Committee is of the view that whilst the practice of pursuing privately insured patients may increase revenue for the public hospital sector, when viewed in the context of funding extra capacity in the public sector and paying market price in the private sector to increase supply of elective surgery, its cost effectiveness in the long term may be questionable.

6.76 Further, the Committee notes that the desirability of the active pursuit of private and DVA patients is indicative of broader issues in the funding context.

RECOMMENDATION 6

6.77 **The Committee recommends that ACT Health commission an independent economic evaluation of The Canberra Hospital's practice**

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[299] APHA, Submission to the Commonwealth government's *Review of the Regulatory Framework for Private Health Insurance*, Ma 2002, p 13.

[300] Transcript of evidence, 1 September 2005, p 64.

of pursuing privately insured patients from a whole system perspective.

7 WAITING LIST MANAGEMENT

7.1 In order to improve elective surgery efficiency, there needs to be a coordinated approach to efficient supply and management of all relevant resources. To support this, there needs to be adequate performance information provided to hospital management to manage the supply of elective care and waiting times.[301]

7.2 Reduction in waiting times can be achieved by encouraging improvements in the management of the waiting list. The idea is that, in eliminating inefficiency in the management of the list, the number of treatments for a given level of personnel and capital endowment, can be increased.[302]

7.3 The AESP has shown that efficiency gains can be obtained by developing a methodology for the administrative management of elective surgical patients distinct from that of emergency surgical patients.

7.4 Hospital waiting list data has long been regarded as an important performance indicator for the public hospital system.[303] Further, the ICAC-NSW concluded that waiting lists needed to adequately reflect the importance of waiting list data as a performance indicator for the public hospital system.[304]

7.5 ACT Health's *Elective Surgery Waiting List Management Policy* states:

> Waiting time information is complex and is constantly changing. The accuracy of the information system depends on staff correctly updating information…if changes are not recorded accurately by staff, the actual waiting times that patients experience may be quite different to that recorded on the waiting list. If the staffing level is inappropriately low, or staff training is inadequate, clerical

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[301] ACT Auditor-General's Report No. 8 of 2004: *Waiting Lists for Elective Surgery & Medical Treatment*, p 55; Corden & Luxmoore in Bloom et al., *Health Reform in Australia and New Zealand*, 2000, pp 293-295.

[302] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003, p 29.

[303] ICAC, *Investigation into Alleged Misreporting of Hospital Waiting List Data*, February 2004, p 5.

[304] ICAC, *Investigation into Alleged Misreporting of Hospital Waiting List Data*, February 2004, p 4.

> errors can occur in the system, which may not become apparent for some time.[305]

7.6 The Committee notes that medical sociology has tended to concentrate only on the professionals in the health care system such as the clinicians and the managers. Research has demonstrated that work on low level bureaucrats in medical settings has been neglected, yet lower level staff are crucial to an understanding of how the organisation actually works and the meanings associated with waiting lists.[306]

RECOMMENDATION 7

7.7 **The Committee recommends, to the extent that work is not already taking place, that ACT Health should specifically incorporate into induction programs for all new staff, training and education in relation to the management of waiting lists and compilation and reporting of waiting list data.**

Analysis, forecasting, monitoring & planning

7.8 Evidence demonstrates that effective and efficient management of waiting lists requires information that is reliable, detailed, comparative and continuous (daily or even hourly).[307]

7.9 The Committee welcomes ACT Health's clerical audit initiative, a routine program of audit to ensure that the ACT elective surgery waiting list is as up to date as possible. In evidence, the Acting Chief Executive of ACT Health stated:

> Because people on the waiting lists can, unfortunately, be there for a long time, we need to make sure that we continually update their details. We need to make sure that they still need their surgery, because we do find that some people might have their name on a list here, they might have their name on a list in New South Wales, they might have their name on a list in Victoria, and then, if

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[305] ACT Health, *ACT Elective Surgery Waiting List Management Policy*, November 2004, p 2.

[306] Hughes in Pope, C, 'Trouble in store: some thoughts on the management of waiting lists', *Sociology of Health & Illness*, Vol. 13, No. 2, 1991, p 197.

[307] Appleby, J., 'Cutting NHS Waiting Times', *King's Fund*, February 2005, p 6.

> they get fed up with all three, they may just use their private health insurance and get it done privately. We don't automatically know that.[308]

7.10 The Committee is of the view that it is hard to overstate the importance of good, frequent and reliable information for managing the supply of elective surgery.

RECOMMENDATION 8

7.11 **The Committee recommends, to the extent that work is not already taking place, that ACT Health model elective surgery activity using a capacity planning model to plan for changes in demand and consequent changes in capacity. This should include not only matching capacity prospectively with planned workload, but also undertaking retrospective reviews of activity, and subsequent analysis of reasons for any discrepancies.**

ACT Elective Surgery Waiting List Management Policy

7.12 As mentioned earlier in this report, subsequent to the Auditor-General's Report, ACT Health stated that a number of the audit recommendations would be addressed by the effective implementation of the *ACT Elective Surgery Waiting List Management Policy*.[309]

RECOMMENDATION 9

7.13 **The Committee recommends that ACT Health should state in its *Elective Surgery Waiting List Management Policy* that compliance with the Policy is mandatory.**

7.14 Whilst the Committee found no evidence of failure to comply with ACT Health's *Elective Surgery Waiting List Management Policy*, the Committee is of the view that the development of a specific disciplinary code to reinforce the importance of compliance with the Policy should be considered.

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[308] Transcript of evidence, 28 September 2006, pp 101-102.

[309] Submission No.2, April 2005, p 1.

RECOMMENDATION 10

7.15 **The Committee recommends that ACT Health should consider devising a specific disciplinary code identifying appropriate actions to be taken where it is proven that there has been a failure to comply with ACT Health's *Elective Surgery Waiting List Management Policy*.**

7.16 The Committee understands that ACT Health considers the review of *its Elective Surgery Waiting List Management Policy* as a priority for 2006-07.[310]

RECOMMENDATION 11

7.17 **The Committee recommends that ACT Health give consideration to a public review of the *Elective Surgery Waiting List Management Policy* after three years of operation.**

Information for consumers on the ACT Elective Surgery Waiting List

7.18 As mentioned previously in this report, ACT Health publishes online elective surgery waiting times for ACT surgeons to enhance accountability and provide consumer information and choice.[311]

7.19 The Committee notes that research suggests that patients consulting internet-based information may be misled if sufficient guidance is not provided to users. In particular, it is suggested that webpages should highlight that waiting times measurements indicate average waiting times for previous surgeries and do not necessarily imply that these will be the waiting times for future patients. Moreover, the research suggests that users should be provided with some user-friendly measurements of the statistical significance of waiting times differences across providers.[312]

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[310] ACT Health, *Annual Report 2005-06*, p 12.

[311] ACT Health, *Annual Report 2005-06*, p 12.

[312] Cromwell, D.A., et al., 'Surgery dot.com: the quality of information disseminated by web-based waiting time information services', *Medical Journal of Australia*, 2002, p 177.

RECOMMENDATION 12

7.20 **The Committee recommends that ACT Health provide, on the relevant webpage, some user-friendly measurements of the statistical significance of waiting times differences across providers.**

7.21 The Health Care Consumers' Association of the ACT (the HCCA-ACT) noted that:

> Since the performance audit report was published, ACT Health has attempted to make its rational, 50-page policy on managing elective surgery waiting lists more comprehensible to the average patient by preparing a two-page consumer version. We don't know whether it is currently in use or whether it has helped staff as well as consumers to understand how the system is supposed to work, but here are some of our comments about it at the time it was proposed earlier this year.[313]

7.22 The Committee was pleased to see that the some of the recommendations put forward by the HCCA-ACT (see Appendix C) have been responded to in the *Access to Elective Surgery Information for Consumers on the ACT Elective Surgery Waiting List Policy*.

7.23 In its submissions to the Committee, COTA-ACT expressed a view that the Auditor-General's Report focused primarily on methods of providing better quality information on waiting lists and its subsequent dissemination to assist consumers in more informed decision making. Further, COTA-ACT was of the view that much of this information was already available through informal processes and that simply improving the quantity and quality of information was likely to be accompanied by an increase in community frustration.[314]

7.24 The COTA-ACT was of the view that:

> We are not saying that we justify a system of reduced information to patients. The broad analysis of the system is that information flows are fairly reasonable and used in a reasonable way and not particularly distorted, although not perfect, and there are significant problems. What we say is that the causality of the problems is the length of the waiting list.

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[313] Transcript of evidence, 7 December 2005, pp 74-75.

[314] Submission No. 3, May 2005, p 8.

> So, while we would encourage more information and greater transparency, and that is a natural thing for consumers, if we had a significantly reduced waiting list, then the cost of those things would be significantly reduced, too. We are concerned that a large number of resources will be used to upgrade the information and that is all they are doing. They are not actually helping to reduce the time that people wait and so the burden of the problem on the general population.[315]

7.25 The COTA-ACT believes that the system of providing more information on the elective surgery system provides a justification for longer waiting times.[316]

Management of 'Not Ready for Care' Patients

7.26 A not ready for care patient can be defined as a patient who is not available for treatment, but is expected to become available at some time in the future. This can be for medical or other (personal or social) reasons.[317]

7.27 During its inquiry the Committee heard evidence of patients delaying surgery for personal reasons, on multiple occasions, without an adequate reason. The Chief Executive of JJMH stated:

> … in the Hunter, where the hospital I was running was doing waiting list reduction surgery for the public sector, we were extraordinarily disappointed at the quality of waiting lists there, in that we would get patients that we would offer an operation to on Saturday morning and they would say, "No, I'm going to bowls" and not turn up. You would offer them twice and then you would have problems when you would suggest they then be removed from the waiting lists, and they were not, and things like that. I got a phone call one day from a businessman, "I've got a business meeting; I'm going to be late to surgery; reschedule me to 2 o'clock, please," instead of the 12 o'clock slot we had him in. We were appalled at some of the attitudes of public members who were on the waiting lists and their expectations of the system too. So it is not entirely a one-way street.[318]

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[315] Transcript of evidence, 15 June 2005, p 55.

[316] Transcript of evidence, 15 June 2005, p 56.

[317] ACT Health, *ACT Elective Surgery Waiting List Management Policy*, November 2004, p 43.

[318] Transcript of evidence, 1 September 2005, pp 68-69.

7.28 Notwithstanding that there are genuine personal circumstances which would preclude patients from accessing surgery, the situation of patients declining to take up dates offered to them on multiple occasions delay opportunities for others who (generally) want to have their surgery carried out.

7.29 The Committee understands that NSW Health's Surgical Services Taskforce has introduced a 'two-strikes' policy to target its NRFC list. Under the two strikes rule, people who delay surgery without an adequate reason are removed from the waiting list to free up space for others. These people can rejoin the queue if they are referred by their specialists. According to the NSW Health's Surgical Services Taskforce, the policy has resulted in a 31 per cent reduction of people on the list.[319]

RECOMMENDATION 13

7.30 **The Committee recommends that ACT Health consider the development of a 'Not Ready for Care' policy to respond to people who delay surgery repeatedly without an adequate reason. This policy should stress to patients the consequences of failure to attend for scheduled surgery.**

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[319] "NSW 'not ready' lists cut by a third", *Age*, 17 December 2006.

8 STRATEGIES TO REDUCE WAITING TIMES

8.1 Part four of the Committee's report (Chapters 8 and 9) provides comments on supply and demand strategies for reducing waiting times and sustainable reduction of waiting times.

Short term and sustainable reduction of waiting times

8.2 Strategies to reduce waiting times are not always the same (or of the same importance or scale) as those needed to sustain reductions. For example, the need to protect resources used for elective activity, or to manage demand, for example, by referral protocols, is less relevant once waiting times are low. As a consequence, once optimum demand and supply management is in place, it would be reasonable to conclude that referrals can be processed more quickly.[320]

8.3 Several governments have tried to address high waiting times by providing extra funds to existing hospitals to perform extra activity (for a given capacity), raising the productivity of the hospitals (in terms of the number of treatments per surgeon or per bed).[321] This policy making view supports the premise that a waiting list is a backlog of patients that can be eliminated through the one off introduction of temporary dedicated funding. However such a perspective ignores the dynamic nature of waiting times and waiting lists and the continuous nature of technological change. That is, waiting time is affected not only by the number of patients on the list at one point in time but also by the number of patients that are continuously added to the list.[322]

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[320] Appleby, J., 'Cutting NHS Waiting Times', *King's Fund*, February 2005, p 5.

[321] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003.

[322] Worthington, D.J., 'Hospital waiting list management models', *Journal of Operational Research Society*, 1991, 42(10), 833-843; Worthington, D.J., ' Queuing models for hospital waiting list', *Journal of Operational Research Society*, 1987, 38(5), 413-422.

8.4 Temporary increases in capacity are essential as a short-term strategy to meet targets, however, research has shown that they are often wasteful and expensive in the long term, and prevent the same money being invested in a permanent capacity. Further, research has shown that such strategies do not lead to sustainable reductions in waiting times.[323]

8.5 Short-term initiatives or temporary policies for reducing waiting lists run the risk of providing only temporary relief and do not address the underlying problem of ensuring that waiting lists operate as an efficient and equitable price rationing mechanism.[324]

8.6 In contrast, research has shown that scrutinising the logistics of hospital care processes is more effective in reducing waiting lists. This involves looking at patients' routes through different interventions and attempting to simplify and shorten them; identifying bottlenecks for patients, and then using the whole-hospital system perspective to work out, for example, the best way of handling the interaction between elective and emergency flows.[325]

8.7 Further, a range of smaller measures to improve efficiency, including the careful management of beds, maximising day-case activity, ensuring the full use of theatres, and effective discharge planning, including investment in convalescent step-down facilities to free up beds for elective cases have also been effective in reducing waiting lists.[326]

8.8 The Committee is of the view that short term supply and demand policies to reduce waiting times are essential[327], however, this needs to be combined with supply and demand policies that lead to sustainable reductions in waiting times.

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[323] Appleby, J., 'Cutting NHS Waiting Times', *King's Fund*, February 2005, p 7.

[324] Edwards, 'Points for pain: waiting list priority scoring systems', *British Medical Journal*, 1999, 13 February, 318(7181): 412-414.

[325] Appleby, J., 'Cutting NHS Waiting Times', *King's Fund*, February 2005, p 8.

[326] Appleby, J., 'Cutting NHS Waiting Times', *King's Fund*, February 2005, p 8.

[327] Research has shown that the use of short-term initiatives such as weekend working to reduce waiting lists were unsustainable in the long run and expensive in terms of cost per case (Appleby, J., 'Cutting NHS Waiting Times', *King's Fund*, February 2005, p 8).

Supply side policies

8.9 If the volume of surgery is not considered adequate, waiting times can be reduced through supply-side policies – classified into three main categories:

- increasing productivity of public hospitals (funding for extra activity, encouraging day surgery);
- increasing capacity (via the public sector, via the private sector); and
- changing incentives (increasing choice for patients).

8.10 Different ways of increasing supply will have different costs and will require different time scales. In the short term it may be possible to purchase extra activity from public facilities at low marginal cost if there is spare capacity. If public facilities are already working close to full capacity, it will be possible to purchase extra activity only at a high marginal cost in the short term. In these circumstances, purchasing from the private sector may be a better solution in the short to medium term, depending on relative prices. In the medium to longer term, it may well be cheaper to expand activity by expanding public capacity.[328]

Demand side policies

8.11 If the supply of publicly funded surgery is considered to be adequate (or the highest that can be afforded) and if waiting times are higher than the minimum necessary to avoid unused capacity, policymakers can intervene to reduce waiting times on the demand side, thus generating a reduction in the demand for public treatments.[329]

8.12 Throughout its inquiry, the Committee heard and considered evidence in relation to a number of short term supply and demand strategies for reducing elective surgery waiting times. These include :

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[328] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003.

[329] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003.

Increasing productivity by funding extra activity

8.13 According to the ACT Health Minister, as part of a new range of initiatives to improve access to elective surgery and reduce waiting times, in the 2006-2007 Budget, the ACT Government allocated a $10.4 million increase over the next four years for elective surgery which will provide an increase of approximately 350 elective surgery operations a year.[330] The Committee understands that $2.5 million will be allocated to Calvary Hospital and The Canberra Hospital for additional elective surgery in 2006-07.[331]

8.14 The Committee notes research findings conclude that several incentive issues arise from the types of funding for extra activity. If additional funding is allocated to hospitals with higher waiting times and lists, hospitals may not have sufficient incentive to reduce waiting times because of the expectation that the additional resources will be withdrawn once the waiting time has been reduced.[332]

8.15 In the case that additional funding is allocated to hospitals conditional on the delivery of extra activity, two problems may be identified. First, it may be difficult to distinguish between 'ordinary' and 'extra' activity and the hospital has an incentive to shift 'ordinary' activity into 'extra' activity. Second, there may be an increase in the demand for surgery if the waiting time decreases. The impact in terms of reductions in waiting times may then be small or non-existent.[333]

8.16 In the case that additional funding is allocated to hospitals conditional upon the delivery of extra activity and an agreed reduction in waiting times, then the hospital has an incentive to increase activity and, at the same time, it has an incentive to increase the number of additions to the list (by allowing

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[330] ACT Minister for Health, *Media release*: 'New initiatives to reduce long waiting times for elective surgery', 11 September 2006; ACT Minister for Health, *Media release*: '$10 million elective surgery injection targets priority areas', 27 June 2006.

[331] ACT Minister for Health, *Media release*: '$10 million elective surgery injection targets priority areas', 27 June 2006.

[332] Iverson, T., 'A theory of hospital waiting lists', *Journal of Health Economics*, 1993, 12:55-71.

[333] Gonzlez-Busto, G., 'Waiting lists in Spanish public hospitals: a system dynamic approach', *System Dynamics Review*, 1999, 15(3), 203-224.

thresholds to fall). Such a dual approach seems to be the most appropriate to obtain significant reductions in waiting times.[334]

Increasing productivity by raising the use of day surgery

8.17 Due mainly to technological and medical innovations, such as less invasive surgery and better anaesthetics, there has been a steady growth in day only surgery in many OECD countries. The Committee understands that day surgery reduces the unit cost of treatment, which is driven by the length of stay. For a given endowment of beds, the availability of less invasive surgery can increase the volume of treatments performed and free up hospital beds.[335]

8.18 In the ACT, ACT Health's *Elective Surgery Waiting List Management Policy* sets the benchmark for the performance of day surgery at 60 per cent:

> This is that 60% of all booked surgery should be performed on a day only basis.[336]

8.19 The Committee understands that NSW Health's key performance indicator for day surgery is also set at 60 per cent.[337]

8.20 According to ACT Health:

> Hospital management must ensure that pre-admission clinics, theatre time, surgical, anaesthetic and nursing time, equipment and other infrastructure essential to the efficient operation of day surgery are in place, to allow for the appropriate use of same-day surgery. [338]

8.21 The Committee welcomes ACT Health's uptake of day only surgery, however, it notes that research has found that if increases in day-surgery utilisation are accompanied by a contemporaneous reduction in the number of hospital beds

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[334] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003.

[335] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003; ACT Health, *ACT Elective Surgery Waiting List Management Policy*, November 2004, p 7.

[336] ACT Health, *ACT Elective Surgery Waiting List Management Policy*, November 2004, p 7.

[337] MacLellan, D., 'NSW Health Predictable Surgery Program', *NSW Health*, July 2006, p 8.

[338] ACT Health, *ACT Elective Surgery Waiting List Management Policy*, November 2004, p 7.

(as in most OECD countries), then the net impact on activity may be lessened.[339]

Funding extra capacity in the public sector

8.22 The Committee understands that in the three years to 2005-06, the ACT Government commissioned a new operating theatre to boost capacity for elective surgery.[340]

8.23 Further, according to the Minister for Health, additional surgeons have been employed in specialties where there is significant and increasing demand for care, such as general surgery.[341]

8.24 The Committee understands that, as part of the 2006-07 Budget, funding has been allocated to provide additional acute care capacity across the ACT public hospital and health care system to meet growing demand, in particular the funding and commissioning of additional bed capacity across the sector. This new capacity to be introduced in 2006-07 will include the commissioning of up to an additional eight beds to cater for the demand for surgery with particular emphasis on post-surgical care. According to the Minister for Health, this extra capacity will reduce the overflow of urgent patients into beds allocated for elective surgery.[342]

Using capacity in the private sector

8.25 The demand on public hospitals to accommodate medical admissions through public hospital emergency departments means that public hospitals are forced to deal with patients requiring surgery and other procedures as the balancing factor, hence the problem of public hospital waiting lists. Private hospitals and private day-surgery clinics are an important source of supply for these services.[343]

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[339] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003.

[340] Minister for Health, *Media release*: 'New initiatives to reduce long waiting times for elective surgery', 11 September 2006.

[341] Minister for Health, *Media release*: 'New initiatives to reduce long waiting times for elective surgery', 11 September 2006.

[342] Minister for Health, *Media release*: 'Acute care capacity - $12 million to enhance acute bed capacity in the ACT', 29 June 2006.

[343] Foley in Bloom et al., *Health Reform in Australia and New Zealand*, 2000, pp 112-114.

8.26 At the same time, the capacity of the private sector to tender for and operate public hospital services has increased the significance of private sector capital and management capability in considerations of public policy.[344]

8.27 During its inquiry, the Committee was told that ACT Health was exploring options for contracting out specific low cost, low acuity, high volume procedures to private providers.[345]

8.28 In March 2006, the ACT Government struck a deal with the National Capital Private Hospital (NATCAP) to reduce the waiting list for varicose vein operations. The Committee was interested to ascertain whether a premium had been paid for the 50 operations. The Chief Executive of ACT Health told the Committee:

> We pay market price for those procedures. The arrangements between the private health insurers and the private hospitals, as you can appreciate, are commercial contracts. We do not have access to those on a micro basis, but we go out to the marketplace and the marketplace gives us a price. If we believe that the benefits can be achieved at that price, then we buy…What we are trying to do, above all, is to improve timely access to elective surgery for public patients. If we do not have the capacity immediately available to us to do that, the private sector has at times got slack capacity available and we take advantage of that.[346]

8.29 Notwithstanding the Chief Executive's assertion that the varicose vein operations were obtained at market price, when asked if the Government paid more to conduct the procedures at NATCAP instead of TCH, he replied:

> Yes, we certainly did last year, but that is not necessarily going to be the case in the future. We may take a different approach. It is not all about money, though, as I think you would appreciate.[347]

8.30 The Committee reiterates its earlier comments that different ways of increasing supply will have different costs and will require different time scales. If public

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[344] Foley in Bloom et al., *Health Reform in Australia and New Zealand*, 2000, pp 113.

[345] ACT Minister for Health, *Media release*: 'New initiatives to reduce long waiting times for elective surgery', 11 September 2006; Cronin, D., 'Surgery to be handed to private hospitals', *Canberra Times*, 12 September 2006, p 2; Transcript of evidence, 28 September 2006, p 100.

[346] Transcript of evidence, 28 September 2006, p 100.

[347] Transcript of evidence, 28 September 2006, p 100.

facilities are already working close to full capacity, it will generally only be possible to purchase extra activity at a higher marginal cost in the short term.

8.31 Buying from the private sector may present some advantages. First, it may be the quickest way to increase capacity compared to other options (for example by constructing new theatres, which may take years and may imply a high initial investment cost). Second, contracting with private providers may introduce an element of competition with private providers.

8.32 A potential disadvantage is that if the supply of specialists is limited and specialists work in both the public and private sector, an increase in activity in the private sector may necessitate a reduction in the activity performed in the public sector.[348]

Speciality programs

8.33 In response to managing people in category 2 and 3 with extended waits, the ACT Health Minister advised of her intention for ACT Health to continue to utilise capacity in the private sector as a way of targeting reduction in long-wait surgery.

8.34 The Acting Chief Executive of ACT Health informed the Committee that:

> We are actually in the process as we speak of preparing for some expressions of interest from the private sector to provide some targeted procedures…we are mainly focusing on those sorts of procedures that, first of all, are in long-wait categories, that is, category 2 or category 3 that are well past the benchmark time. So the first criterion is to identify who is waiting the longest. We also need to bear in mind that we don't want to inadvertently give priority to a person who has been waiting longer over a person who may have more clinically urgent needs. So we have to balance that…if we can get a good price for that from the private sector, that helps us to do a lot of the reforms that we mentioned before and focus greater attention on improving the efficiencies at both TCH and Calvary.[349]

8.35 Further, the Minister for Health added:

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[348] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003.

[349] Transcript of evidence, 28 September 2006, p 99.

> I have made it clear that I am open to looking at and investigating ways of dealing with certain types, particularly long-wait patients, through private providers, that I have had representations from the private health insurance sector—in fact, I met with it last week—which is concerned about this. So I think it's steady as we go.[350]

Categorisation - explicit guidelines to prioritise patients on the waiting list

8.36 Categorising patients according to need on elective surgery waiting lists serves to pursue an 'efficiency goal' (reduce excessive waiting times) but also an 'equity goal' (making waiting fair).[351]

8.37 Policy makers accept that some waiting time may be optimal (in order to fully utilise surgical capacity), and as a consequence patients wait according to some explicit and equitable criteria. Most countries have limited themselves to establishing broad criteria for prioritising patients. However, other countries such as New Zealand and Canada have been proactive in establishing more explicit 'priority scoring systems' at procedure level.

8.38 In New Zealand, social factors have been explicitly considered, such as the 'ability to work', 'to give care to dependants' or 'to live independently'.[352] A similar approach was adopted by the Western Canada Waiting List project.[353]

8.39 Submissions to the Committee expressed concern about the inadequacy of the standard approach of categorising elective surgical patients into three strata, according to perceived clinical urgency, at the time the patient is booked for surgery and that differences exist in the proportions of patients allocated to the three categories.[354]

8.40 Research has shown that variations in elective surgery rates cannot be explained by variations in the demographic or epidemiological characteristics

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[350] Transcript of evidence, 28 September 2006, p 100.

[351] Siciliani, Luigi & Hurst, J., 'Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries', *OECD Health Working Papers No. 6*, July 2003.

[352] Hefford, B. & Holmes, A., 'Booking systems for elective services: the New Zealand experience', *Australian Health Review*, 1999, 22, 4, 61-73.

[353] Western Canada Waiting List Project, 2001.

[354] Transcript of evidence, 1 September 2005; Stoelwinder & McNeil, 'Public hospital waiting lists – can a necessary evil be better managed?', *New Matilda*, 10 August 2005, p 2.

of the populations being served or by local resource variations. Rather, it appears likely that they are a consequence of surgeons' leading role in deciding surgery rates and the variation in clinical opinion.[355]

8.41 Research reports that the phenomenon of 'gaming' or documenting higher urgency categories to ensure that patients are moved up on a wait list has been recently reported and contributes to abuse of the wait list system.[356] Similarly, less urgent wait categories may not reflect subjective patient morbidity.[357] Thus the wait list system is only as good as the information entered into it; if this information has been influenced in any direction, inappropriate allocation of resources ensues.

8.42 The HCCA-ACT has noted that the process for setting and revising patient priority is mostly clinician driven. Just as health care is a complex process for administrators, managers and clinicians, it is also a complex process from the consumer perspective.[358]

8.43 The Committee welcomes the Minister for Health's undertaking that ACT Health was developing an improved clinical priority scoring system and working with surgeons to improve the management of the elective surgery waiting list.[359]

8.44 In its submission to the Committee, the RCNA called for a review of the process of categorisation for different levels of priority leading to greater equity in the treatment of clients on the waiting list. This includes better evidence for changes to clients' priority category.[360]

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[355] Mc Pherson, K., et al., 'Small area variations in the use of common surgical procedures: an international comparison of New England, England and Norway', *New England Journal of Medicine*, 1982, 307, 21, 1310-1314; Wennberg, J.E., & Gittelsohn, A., 'Variations in medical care among small areas', *Scientific American*, 1982, 246, 1000-1112.

[356] MacCormick, A., et al., 'Priority assessment of patients for elective general surgery: a systematic review', *Australian New Zealand Journal of Surgery*, 2004, 74:143-145.

[357] Fitzpatrick, R., et al., 'Equity need when waiting for a joint hip replacement', *Journal Evaluation Clinical Practice,* 2004, 10:3-9; MacCormick, A., et al., 'Prioritising patients for elective surgery: a systematic review', *Journal Evaluation Clinical Practice 2005.*

[358] Transcript of evidence, 7 December 2005, pp 73-74.

[359] ACT Minister for Health, *Media release*: 'New initiatives to reduce long waiting times for elective surgery', 11 September 2006; Cronin, D., 'Surgery to be handed to private hospitals', *Canberra Times*, 12 September 2006, p 2; Transcript of evidence, 28 September 2006, p 100.

[360] Submission No. 5, August 2005, p 1.

8.45 The RCNA also called for a system which was fair and transparent in determining priority clients and individual specialists being able to bring pressure to bear to have their client's priority rating changed.[361]

RECOMMENDATION 14

8.46 **The Committee recommends that ACT Health undertake more research to better understand variations in clinical priorities and treatment thresholds, as part of a more systematic program of demand management.**

8.47 Research supports priority scoring systems, such as those developed for elective health care in New Zealand, Canada, and Sweden.[362] In Sweden, a central register established to ensure guaranteed maximum waiting times for cataract surgery found that centres using formal priority scoring systems were more successful in adhering to maximum waiting time guarantees than centres without such systems.[363]

8.48 The main arguments in favour of introducing priority point scoring systems are that they make the management of waiting lists transparent; the criteria by which priority is given to patients are explicit; and they should lead to patients being treated in order of clinical need, rather than according to arbitrary waiting time guarantees. They also make it possible to set minimum thresholds of clinical need for referral onto waiting lists.

8.49 The Committee believes that there is merit in using waiting lists as a rationing mechanism for elective health care only if the waiting lists are managed efficiently and fairly. Consideration of priority scoring systems may offer an opportunity for policies which promote the treatment of patients in order of clinical need and thus promote clinical effectiveness.

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[361] Submission No. 5, August 2005, p 1.

[362] Hadorn & Holmes, 'The New Zealand priority criteria project', *BMJ*, 1997; 314:131-134;Naylor et al., 'Assessment of priority for coronary revascularisation procedures', *Lancet*, 1990; 335:1070-1075; Lundstrom et al., 'Assessment of waiting time priority setting by means of a national register', *International Journal of Technology Assessment of Health Care*, 1996; 12:136-140.

[363] Lundstrom et al., 'Assessment of waiting time priority setting by means of a national register', *International Journal of Technology Assessment of Health Care*, 1996; 12:136-140.

RECOMMENDATION 15

8.50 **The Committee recommends that ACT Health evaluate the dynamic effects of priority scoring systems over time on case mix, distribution of waiting times, and patterns of resource use.**

Efficiency of the production process

8.51 The AESP sought to improve the effectiveness and efficiency of administrative and clinical aspects of elective surgery by: using spare operating theatre capacity at Auburn Hospital; the use of a new booking and waiting list system, managed by a nurse co-ordinator, which offered suitable patients a definite date for surgery; increasing surgical sessions by paying surgeons on a fee for service basis (however surgery could be performed by a surgeon other than their treating surgeon); re-structuring elective surgical sessions to eliminate meal breaks; and planning post discharge care so that surgery could be performed on a day only basis.[364]

8.52 The Committee was pleased to hear during its inquiry that ACT Health was committed to improving operating theatre scheduling systems.[365] Further, in evidence, the Acting Chief Executive of ACT Health informed the Committee that some of the features of the AESP had been considered or were being considered:

> …one of the other features of the Auburn model is the focus on day-of-surgery admission. We have made some very substantial gains, particularly at TCH, over the last 18 months. Yes, we have adopted a number of good principles there. In fact, we will continue to look at those in our current redesign work. Chair, you mentioned before the longer list duration, and that is certainly something that we are exploring as a worthwhile initiative to pursue for some sorts of cases.[366]

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[364] Pollicino, C., et al., 'Economic Evaluation of the proposed Surgical Scheme at Auburn Hospital', *Centre for Health Economics Research and Evaluation (CHERE), Project Report 19*, August 2002.

[365] ACT Minister for Health, *Media release*: 'New initiatives to reduce long waiting times for elective surgery', 11 September 2006; Cronin, D., 'Surgery to be handed to private hospitals', *Canberra Times*, 12 September 2006, p 2; Transcript of evidence, 28 September 2006, p 100.

[366] Transcript of evidence, 28 September 2006, pp 101-102.

Pooling of patients

8.53 A feature of the AESP was centralised pooling throughout the serviced area matching the patient to the resources available (in the form of the facility and the operating list) rather than to the VMO, who is dependent upon his or her hospitals' bed capacity and theatre list times.[367] The Committee was interested in the extent to which pooling of patients takes place in the ACT, to which the Minister advised:

> …pooling of patients within specialities. This is a difficult issue. Some specialities and surgeons are prepared to consider this and contemplate it. Others are not. The approach ACT Health is adopting is, wherever possible, where there is agreement between surgeons within specialities or groups of surgeons within specialities, to pool patients. Pooling is already occurring, I am advised, in relation to general surgery at the Canberra Hospital amongst some general surgeons and also in relation to the ophthalmology speciality at Calvary Hospital. So pooling is a desirable practice, wherever possible. It is certainly my view that we should pursue that. That is the department's approach. But it does rely on the consent and the agreement of individual surgeons and their preparedness to see other surgeons' patients. Some surgeons are prepared to do that and some are not.[368]

8.54 The Committee notes that pooling of patients necessitates some shift in the concepts regarding patient referral for elective surgery. This includes the concepts: of consultant 'ownership' of public patients; that of sharing one's referral base with colleague surgeons; and standardised criteria for surgery.[369]

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[367] Pollicino, C., et al., 'Economic Evaluation of the proposed Surgical Scheme at Auburn Hospital', *Centre for Health Economics Research and Evaluation (CHERE), Project Report 19,* August 2002.

[368] Transcript of evidence, 27 April 2005, p 27.

[369] Transcript of evidence 28 September 2006, p 103; Singh, N. et al., 'The Auburn Elective Surgery Pilot Project', *Australia New Zealand Journal of Surgery*, 2005, 75: 768-775.

9 STRATEGIES FOR SUSTAINABLE REDUCTION

9.1 Sustainable reductions, as opposed to temporary or short-term reductions, must rely on long-term policies designed to respond to a range of factors. They must meet a level of demand that rises in response to technical change, demography, rising user expectations, and changes in clinical behaviour.[370]

9.2 The Committee is of the view that the following policies and strategies might prove successful in sustaining reductions in waiting times:

Clinical ownership and involvement

9.3 The Committee is of the view that systemic impediments in workplace arrangements that reduce efficiency, effectiveness and responsiveness can impact on the provision of elective surgery. Notably, this has been the focus of reform programs in many other sectors. The Productivity Commission has stated:

> Improving the productivity and effectiveness of the available workforce, and its responsiveness to changing needs and pressures, will increase the level and quality of the workforce services that can be supported by any given level of spending. This in turn will help to reduce the rate of growth in future health care expenditure, without compromising safety and quality.[371]

9.4 Experience during the 1980s and 1990s in Australia suggests that not only are clinicians, as providers of health services, key targets of many reform processes, but also they can and do play a significant role in bringing about change. Indeed, it is unlikely that anyone involved in health reform would ignore the role of clinicians[372], or fail to harness their energies and ideas in the interest of change. To do otherwise would be a recipe for failure.[373]

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[370] Appleby, J., 'Cutting NHS Waiting Times', *King's Fund*, February 2005, p 3.

[371] Productivity Commission, *Australia's Health Workforce*, 19 January 2006, p xviii.

[372] The term 'clinician' can be applied to doctors, nurses, and allied health professionals.

[373] Alexander in Bloom et al., *Health Reform in Australia and New Zealand*, 2000, pp 161-162.

9.5 During its inquiry, the Committee was told that ACT Health was pursuing three initiatives to enhance clinical ownership and involvement to improve the productivity and effectiveness of service delivery. These opportunities are:

9.6 Firstly, the establishment of a Surgical Services Taskforce to enhance and improve dialogue with surgeons:

> The surgical services task force will be a fairly large group. There will probably be up to a dozen surgeons, a couple of anaesthetists, and obstetricians. We are asking them to work with us to roll out a surgical services plan for the ACT across both hospitals. It will also engage the private sector as well. That surgical services task force will look at overseeing the changes we want to put in place, particularly in the TCH operating theatre, so that their needs are met. They clearly are key stakeholders here. They know what works. They understand their patients' needs. We are setting up this forum for them to do that[374].

9.7 Secondly, the Access Improvement Program (AIP) which commenced in 2005-06 aimed at reducing Emergency Department (ED) access block, reducing acute bed occupancy in hospitals, reducing cancelled elective surgery, and focusing on the special needs of older Canberrans needing access to hospital and community care in a timely manner.[375] The AIPs objectives are designed to identify and remove barriers to accessing care, including redesign of care and administration systems in surgery at TCH:

> We have three groups guiding that process, and surgeons are actively involved and taking the lead in a number of those groups[376].

9.8 Thirdly, exploring the appointment of a number of clinical directors who are practicising clinicians to play a more active role in the management decisions of TCH:

> The third area is subject to some consultation at the moment and we haven't made a decision on it. It is just really looking at giving not just surgeons but other clinicians a more prominent role in the management structure of TCH. We are looking at appointing a number of clinical directors who are practising

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[374] Transcript of evidence, 28 September 2006, p 104

[375] Minister for Health, *Media release*: 'Acute care capacity - $12 million to enhance acute bed capacity in the ACT', 29 June 2006.

[376] Transcript of evidence, 28 September 2006, p 104

> surgeons, anaesthetists, physicians, obstetricians, et cetera, to play a more active role in the management decisions of the hospital.[377]

9.9 There are several important lessons from more than a decade of experience in involving clinicians in management in Australia. In an editorial in the *Medical Journal of Australia* on doctors and health reform, Professor Duckett stated:

> the medical profession (and other health professionals) must be given the opportunity to engage in the reform process.[378]

9.10 The Committee notes that research has suggested that:

> Doctors have had a long history of obstructing processes of reform, or even stopping them outright. They should be encouraged to use their powers to support reform. This is most likely to occur when the clinicians themselves are included in the development of the agenda for change, where they have developed a broader vision for health, and where they already have a significant management role.[379]

9.11 Whilst no discussion of health sector reform can ignore the importance and potential contributions of doctors, who are now central to reform in the health arena, the same opportunities for involvement need to be provided to other members of the multidisciplinary care team or clinician groups, such as nurses and allied health professionals.

9.12 In its submission, the RCNA commented that with nurses forming the largest single component of the health care workforce in Australia, and practising across all areas in which health care is delivered:

> …our College is well aware of the competing demands within the health care system. It is therefore imperative that systems for improvement in one area – waiting lists – be undertaken in genuine consultation with all stakeholders across the system.[380]

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[377] Transcript of evidence, 28 September 2006, p 104.

[378] Duckett, S.J., 'Doctors and Health Care Reform', *Medical Journal of Australia*, 167:184-5

[379] Alexander in Bloom et al., *Health Reform in Australia and New Zealand*, 2000, pp 172-173.

[380] Submission No. 5, August 2005, p 2.

RECOMMENDATION 16

9.13 **The Committee recommends that ACT Health ensure that membership of the Surgical Services Taskforce is representative of all members of the multidisciplinary care team.**

Increasing emphasis on primary care and prevention

9.14 An approach to address the pressures facing the Australian health care system should be on reducing the underlying demand for health care by increasing emphasis on primary care and prevention.[381]

9.15 According to the AHCRA:

> Primary care is the only way we will effectively contain rising health care costs, especially through support for preventive care, health promotion and improvements in chronic disease management and the management of co-morbidities. Investment in primary care services will reduce the burden on acute services and reduce or delay the need for surgical intervention. Non-invasive intervention should be offered to patients in the community, with elective surgery reserved as a last resort.[382]

9.16 In its submission the AHCRA stated that by reorienting our health care system to a wellness model with major emphasis on prevention and early diagnosis of potentially chronic problems the demand for surgical services of an elective nature in our public hospital system would significantly decrease.[383]

9.17 The Productivity Commission's report on *Australia's Health Workforce*[384] found that strategies which improve preventative health care would assist in relieving the pressure on Australia's health care systems.[385]

9.18 The AHCRA further commented:

> …in terms of the impact on the waiting list, poor chronic disease management is a very, very high indicator for presentation in an emergency department.

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[381] Productivity Commission, *Australia's Health Workforce*, 19 January 2006, p xviii.

[382] Transcript of evidence, 28 July 2006, pp 83-84.

[383] Submission No. 6, April 2006, p 3.

[384] Released 19 January 2006

[385] Productivity Commission, *Australia's Health Workforce*, 19 January 2006.

> Presentation in an emergency department and a patient subsequently being admitted to hospital is a factor in elective waiting lists blowing out, because that person being admitted to hospital can mean that a person waiting for elective surgery no longer has a bed available for them. So if we can actually stop the person with a chronic disease presenting to emergency then the person who is on the elective waiting list is more likely to have a bed.[386]

9.19 The Committee is aware that ACT Health recently launched its *Primary Health Care Strategy*[387] which, according to the Minister for Health,:

> …is the first time that we have actually put down on paper a focus on primary health care as a key part of meeting the expectations of our community over the next few years. That document does set out keys areas of focus, key areas of actions, what are our principles, and the need to make sure that our promotion of primary health care isn't lost in the mix of secondary and tertiary health care.[388]

9.20 Further, the Minister acknowledged that perhaps, politically, primary health care:

> …does not get the right level of attention that it should. I am keen to work with the division of general practice and all the other providers in the primary area to make sure that we do stick to that plan, implement it, and make sure that we are, as much as possible, stopping people coming into hospital in the first place, because that is a key part of meeting the demand of our community in the future so that, as the population grows, we age and we get sicker, we can be fixed more often. Preventing admission to hospital will be one part of providing the hospital of the future. There will have to be more beds and there will have to be more services at the hospital, but trying to keep people out will be a key focus, certainly for me.[389]

9.21 The Committee was pleased to hear that ACT Health has articulated a commitment to primary health care in the development of its *Primary Health*

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[386] Transcript of evidence, 28 July 2006, p 91.

[387] Primary health care involves health promotion, early intervention, prevention, diagnosis and management of health. All jurisdictions in Australia and New Zealand recognise the need for primary health care review as part of a broader system of health reform. An efficient and effective primary health care system underpins the effective functioning of the health system as a whole.

[388] Transcript of evidence, 28 September 2006, pp 107-108.

[389] Transcript of evidence, 28 September 2006, pp 107-108.

Care Strategy. The Committee notes that research has shown that countries with strong primary care have lower overall health costs, generally have healthier populations and adverse effects of social inequality are reduced.[390]

9.22 The Committee is aware of the ability of well-designed health education, health promotion, and self-management programs to improve health, reduce health risks, and decrease medical care costs.[391] Several reviews describe recent progress with the use of these programs.[392] Cost savings in the first year of effective programs appear to be due largely to an increased use of self-management techniques and increased personal self-efficacy. Subsequently, a reduction in illness burden due to the postponement or prevention of costly, chronic illness can lead to further savings.[393]

9.23 The Committee believes that hospitals play an important role in promoting health, preventing disease and providing rehabilitation services. Some of these activities have been an essential part of hospital work, however, the increasing prevalence of lifestyle-related and chronic diseases require more expanded scope and systematic provision of activities such as health promotion/education and effective communication strategies to enable patients to take an active role in chronic-disease management.

Geriatric units of excellence

9.24 Australia's changing age profile is significantly increasing health expenditure through structural, demand and supply pressures. As outlined in the Productivity Commission's report on the *Economic Implications of an Ageing Australia*, health spending on the over 65s is currently around four times more per person than on those under 65. Further, through its impact on the

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[390] Menadue, J., 'The patient journey: unravelling the maze', *Australian Policy Online*, November 2006, pp 1-3.

[391] Fries, J. & McShane, D., 'Reducing Need and Demand for Medical Services in High-risk persons', *WJM*, October 1998, Vol 69, No. 4. pp 201-206.

[392] Pelletier, K., 'A review and analysis of the health and cost-effective outcome studies of comprehensive health promotion and disease prevention programs', *American Journal of Health Promotion*, 1991; 5: 311-315; Chapman, L., *Proof positive: analysis of the cost-effectiveness of worksite wellness (* 3rd ed) 1991.

[393] Fries et al., 'Reducing health care costs by reducing the need and demand for medical services', *N Eng J Med*, 1993: 329:321-325.

incidence of chronic disease, ageing will also be a major contributor to changing care needs.[394]

9.25 Collectively, the Committee understands that these demand and supply pressures will have a growing impact on health care spending in the future. Indeed, by 2044-45, such spending could account for at least 16 per cent of GDP, with government outlays equivalent to about 10 per cent of GDP.[395]

9.26 As mentioned previously, according to the AHCRA, while private hospitals in Australia have been funded to significantly increase surgical activity, that sector in general offers very little in the way of elective medical services for the type of patient that is placing pressure on public hospitals. That pressure comes increasingly from older persons with multidisciplinary problems, who require a significantly sized and skilled team to manage their condition effectively. The same comment is relevant for acute medical admissions to Australia's public hospitals.[396]

9.27 In its submission, the AHCRA stated that:

> All jurisdictions should be examining the possibility of creating geriatric units of excellence, offering elective and acute services, with acute services offering the early stages of rehabilitation in specifically planned units. These should be remote from principal referral hospitals that are resourced to offer sophisticated medical and surgical services that are currently under utilised because of the pressure to offer secondary aged care services.[397]

9.28 The Committee understands that research in Australia and the United Kingdom has shown that with ageing populations some 60 to 70 per cent of acute geriatric admissions to public hospitals which so pressurise the system and compromise careful planning of bed utilisation could have been avoided if

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[394] Productivity Commission, *Australia's Health Workforce*, 19 January 2006, p xvii.

[395] Productivity Commission, *Australia's Health Workforce*, 19 January 2006, pp xvii-xviii; Bloom et al., *Health Reform in Australia and New Zealand*, 2000, p 4.

[396] Submission No. 6, April 2006, p 2.

[397] Submission No. 6, April 2006, p 2.

there had been an effective community intervention[398] within a reasonable time period prior to that individual presenting at an ED.[399]

9.29 The Committee understands that, in this instance, an effective community intervention would involve structural reform to support caring for patients in the community who currently must be sent to hospital, as the primary care physician does not have the resources to look after such individuals at home.[400]

9.30 The Committee was pleased to hear that ACT Health had undertaken the construction of a psychogeriatric facility at Calvary Hospital, the Minister for Health told the Committee:

> We also have capital works money right now to build an additional 60-bed subacute and psychogeriatric facility at Calvary Hospital. That project is in the detailed design stage and we will shortly be seeking development approval.[401]

9.31 The Committee understands that this facility has been completed and opened.

Community engagement

9.32 One of the factors contributing to increased demand for health services in Australia is increased consumer knowledge and expectations for health care.[402]

9.33 The HCCA– ACT has noted:

> There should be appropriate sources of information to allow people to make rational decisions about any action they take in this regard. Certainly, some people have greater expectations of the system than the system is ever likely to be able to deliver.[403]

9.34 In evidence to the Committee, the AHCRA stated:

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[398] Community intervention – the delivery of an appropriate program response to a particular priority health issue, including the establishment of minimum requirements in structures and skills, such as strengthening agency/system infrastructure ('Health promotion interventions and capacity building strategies', Victorian Government Health Information, p 1, December 2006).

[399] Submission No. 6, April 2006, p 4.

[400] Dwyer, J., 'Reform of health care delivery not tackled by COAG: Prof Dwyer', ABC Radio PM transcript, p 3, February 2006; Submission No. 6, April 2006, p 4.

[401] Transcript of evidence, 27 April 2005, p 27.

[402] Bloom et al., *Health Reform in Australia and New Zealand*, 2000, p 4.

[403] Transcript of evidence, 7 December 2005, p 76.

> Experience overseas and more recently in Western Australia shows that when asked to take a community focus, presented with balanced evidence, and given time to discuss and deliberate, citizens juries are able to identify and debate issues of broad principle such as equity. They make sensible decisions that allow politicians to change service priorities with the support of the community. Citizens' juries in Western Australia have supported a move from acute services to primary care, which, in the medium term, will have a positive impact on waiting times.[404]

9.35 The AHCRA further commented that there is a need to have a transparent conversation with the Australian public to explain the need to limit services at specific sites in order to make sure that where services are offered for a particular problem they are as good as possible given the current workforce shortage.[405]

9.36 The Committee notes that studies in NSW have shown that patients are more than willing to travel beyond their local hospital to get quality service in a timely fashion once the imperatives are explained to them.[406]

9.37 The Committee is aware that an element of the British reform of public services has been concerned with placing greater emphasis on the end users of public service with a view to engaging in dialogue about service provision and service priorities.[407]

9.38 The Committee is aware that there is a growing interest in involving the public in decisions about health care provision. Further, health care spending decisions made within tight budgetary constraints are not, as a rule, made in close consultation with the community. However, above the level of individual clinical decisions, there are questions about resource allocation and policy that are very much social choices.[408]

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[404] Transcript of evidence, 28 July 2006, p 84; Submission No. 6A, July 2006.

[405] Submission No. 6, April 2006, pp 1-2.

[406] Submission No. 6, April 2006, p 2.

[407] Sturgess, G., *Public Sector Informant*, October 2006, p21.

[408] Mooney, G. & Blackwell, S.H., 'Whose health service is it anyway? Community values in healthcare', *MJA* 2004; 180 (2): 76-78.

9.39 The Committee believes that engaging informed citizens in a dialogue about service provision and service priorities is a sustainable strategy for reducing hospital waiting lists. Community and patient engagement through models such as citizens' juries is such a strategy. Without taking the decision-making role away from Ministers, community engagement can better inform Ministers when making decisions about priority spending.[409]

Role delineation for hospitals

9.40 The AHCRA has called for role delineation for hospitals, with a particular emphasis on having some hospitals not run emergency departments, but taking pride in offering superbly efficient planned surgical service. In Western Sydney many planned surgical services are focused at Auburn Hospital, under the AESP, with patients coming from a very large geographic area to have surgery at a guaranteed time. This service has achieved a 94 per cent satisfaction rating from patients even though they may have had to travel 30 or more kilometres to attend the hospital offering the service.[410]

9.41 The AESP has demonstrated that patients are more than willing to have the first available surgeon provide them with the care that they need, and every effort should be made to balance out the waiting times for individual surgeons.[411]

9.42 The Committee notes that one of the fundamental principles behind the AESP approach was the treatment of elective surgical admissions as predictable events conducive to cultivation as separate business events as compared with emergency surgical admissions. The Committee is of the view that the concept of role delineation for hospitals supports this fundamental principle.[412]

9.43 The Committee welcomes the Minister for Health's undertaking that role delineations between TCH and Calvary will be reviewed to ensure that where

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[409] Menadue, J., 'The patient journey: unravelling the maze', *Australian Policy Online*, November 2006, pp 1-3.

[410] Submission No. 6, April 2006, p 3.

[411] Submission No. 6, April 2006, p 3.

[412] Singh, N. et al., 'The Auburn Elective Surgery Pilot Project', *Australia New Zealand Journal of Surgery*, 2005, 75: 774.

possible, most elective surgery will occur at Calvary, where there is less chance of postponement of surgery due to emergency cases.[413]

9.44 Given that a ninth operating theatre was commissioned at TCH during 2004-05, the Committee hopes that the review of role delineations between TCH and Calvary will ensure that existing operating theatre capital stock will not be underutilised.[414]

[413] ACT Minister for Health, *Media release*: 'New initiatives to reduce long waiting times for elective surgery', 11 September 2006; ACT Health, *Annual Report 2005-06*, p 12.

[414] ACT Health, *Annual Report 2005-06*, p 13.

10 CONCLUSION

10.1 The Committee acknowledges the views presented and conclusions made in the Auditor-General's Performance Audit Report No. 8 of 2004.

10.2 The Committee acknowledges that maintaining an appropriate focus on elective surgery in the context of growing hospital demand is a challenge for all health services.

10.3 The Committee is of the view that the elective surgery system is itself complex, and how it works is also determined by the wider system in which it operates. Any strategies to improve its performance must take into account the way the elective surgery system responds to changes in waiting times, the way in which other demands on the hospital system are dealt with, and the whole system within which the hospital operates.

10.4 The Committee has made 16 recommendations in relation to its inquiry into Auditor-General's Performance Audit Report No. 8 of 2004: *Waiting Lists for Elective Surgery and Medical Treatment.*

Dr Deb Foskey MLA

Chair

13 September 2007

APPENDIX A: List of submissions

List of written submissions received by the Committee

No. 1	Dr Peter Hughes, FRCS, FRACS, President, ACT VMO Association
No. 2	Minister for Health, Mr Simon Corbell MLA, Government submission
No. 3	Mr Paul Flint, Executive Director, COTA National Seniors (ACT)
No. 4	Mr Phil Lowen, Chief Executive Officer, John James Memorial Hospital
No. 4a	Mr Phil Lowen, Chief Executive Officer, John James Memorial Hospital
No. 5	Ms Rosemary Bryant, FRCNA, Executive Director, Royal College of Nursing Australia
No. 6	Professor John M Dwyer AO, FRACP, Chair, Australian Health Care Reform Alliance
No. 6a	Ms Kerren Clark, Chair (from April 2006), Australian Health Care Reform Alliance

APPENDIX B: List of witnesses

List of witnesses who appeared before the Committee at public hearings

Public hearing of Wednesday 27 April 2005

- Mr Simon Corbell MLA, Minister for Health
- Dr Tony Sherbon, Chief Executive, ACT Health
- Mr Mark Cormack, Deputy Chief Executive, ACT Health

Public hearing of Wednesday 15 June 2005

- Ms Tu Pham, ACT Auditor-General
- Mr Graham Smith, Audit Manager
- Dr Peter Hughes, President, ACT VMO Association
- Dr Geoffrey Stubbs, ACT VMO Association
- Dr James Lim, ACT VMO Association
- Mr Paul Flint, Executive Director, COTA National Seniors (ACT)

Public hearing of Thursday 1 September 2005

- Mr Phil Lowen, Chief Executive Officer, John James Memorial Hospital

Public hearing of Wednesday 7 December 2005

- Mr Russell McGowan, President, Health Care Consumers Association of the ACT

Public hearing of Friday 28 July 2006

- Ms Kerren Clark, Chair, Australian Health Care Reform Alliance
- Professor Michael Kidd, Executive Member, Australian Health Care Reform Alliance

Public hearing of Thursday 28 September 2006

- Ms Katy Gallagher MLA, Minister for Health
- Mr Mark Cormack, Acting Chief Executive, ACT Health

APPENDIX C: Comments by the Health Care Consumers Association of the ACT

Excerpt from Transcript of Evidence, 7 December 2005, pp 72-75

Waiting times for hospital care have become a political issue. Waiting times are affected by many factors, including the supply of health care practitioners, referral patterns and the availability of operating room time or other resources. We recognise that, whilst the health care system is beginning to show the strain created by factors like an ageing population, capital-intensive medical technology, innovative treatment in care practices and the tighter financial constraints by government—and patient wait times are merely one initial indicator of this pressure—some of the waiting times experienced by patients in the ACT seem to be well beyond the national benchmarks. And the management of them needs improvement.

Research teams commissioned by Health Canada to study this issue in 1998 concluded that, with rare exceptions, waiting lists in Canada, as in most other countries, are non-standardised, capriciously organised, poorly monitored and, according to most informed observers, in grave need of retooling. Where waiting list data are carefully and accurately compiled and routinely monitored, the public clearly benefits.

We would like to highlight in this submission three of the findings of the performance audit: the inaccuracy of waiting list data, the inequities in the current processes for prioritising patients and the need to improve communication with consumers about their status on the waiting lists. We would also like to stress the need to take social factors into account when deferring access for those not ready for care when offered it.

In our original submission to the audit, we noted that waiting times are one of the most common complaints consumers have about elective surgery and invasive medical procedures. We also know that people are less likely to complain when they are given explanations and communication about what to expect or, in this case, what not to expect. A person may already be in pain and discomfort, and the lack of certainty about the wait time will add to their concern about their health.

In saying this, we acknowledge the recent attempts by ACT Health to improve its performance and accept that most of its responses to the audit findings are reasonable. However, we feel that the current system still does not deal well enough with how a person on the list is treated, whether or not they are kept informed about

their place on the waiting list and whether they have adequate health care while they wait or are given other options to try. These are key issues for consumers.

The following observations, derived from HCCA consultations with consumers, may be helpful in drawing this out: firstly, communication about process times and delays is important to consumers and can mitigate perceptions of staff inefficiency or insensitivity. Secondly, satisfaction is linked to consumers' perceptions of the appropriateness of time spent waiting. If consumers are not informed of the reasons for their wait, they and their family members might fear that they have been forgotten or that their medical problem is not being taken seriously. Finally, time spent waiting may be perceived as appropriate if there is an explanation by nurses and staff about the wait. Informing patients of the expected length of the wait can also mitigate the negative influence of waiting time.

We have concerns that the process for setting and revising patient priority is mostly clinician driven. For example, the consumer experience of waiting for hip replacement, which has resulted in limited mobility and pain, could be far greater than another procedure like cataract surgery which is deemed more urgent but is easier to program.

Just as health care is a complex process for administrators, managers and clinicians, it is also a complex process from the consumer perspective. As consumers, we need to coordinate different aspects of our lives in order to access the health services on the date we are given. This means not only changing commitments such as work, family and community activities but also our responsibility as carers—to our children, friends or ageing relatives.

We need to consider the support we may need on discharge and for the days and weeks to follow. This support may also require others to change their commitments. There is a strong ripple effect. By receiving timely and accurate information about what we can expect, we can better prepare ourselves, our family and our support people.

Service standards need to be in place and closely monitored for the management of waiting lists, that is, the service provider must agree to contact potential patients at agreed time points to advise progression on the list and seek updates on the patients' condition and any personal constraints that may impact on their access to surgery. This should be easier for ACT Health now it has centralised management of its services.

Published information hasn't helped many people until now. ACT Health's recent move to publish information on the internet, about which surgeon or proceduralist

and which hospital has capacity and when, may help consumers to make decisions more easily to wait, go interstate or seek private access, et cetera. Problems will continue to be magnified for those patients confined to the public system, particularly where there are cross-border issues. This needn't be the case in a public health system.

As part of the national health system reforms in the UK, we understand they have managed to introduce a system which allows them to make firm bookings for people to have elective surgery, at a time to suit them, not just at a time which suits the hospitals. This approach may be worth exploring further here.

We understand that in other places, like New Zealand, they have a wait list category that ensures certainty that treatment will take place within the next six months. They also have a care and review category which applies to patients with conditions that are likely to deteriorate in the foreseeable future, who have been assessed as likely to benefit significantly from surgery but cannot be offered certainty of public-funded treatment due to the clinical priority and current financial constraints. These patients have an individualised care plan, predominantly private primary care, including a program or process for regularly reviewing their priority for surgery.

Another point of view with some currency is that anyone on a list with an expected wait time of more than 12 months shouldn't be on the list at all; rather they should be monitored and placed on the list when their properly assessed need warrants it. We have sympathy with this approach, especially if it helps to de-politicise the publication of waiting lists, which are notoriously inaccurate because of duplications and failed maintenance and should just be used as administrative mechanisms, not political footballs.

Since the performance audit report was published, ACT Health has attempted to make its rational, 50-page policy on managing elective surgery waiting lists more comprehensible to the average patient by preparing a two-page consumer version. We don't know whether it is currently in use or whether it has helped staff as well as consumers to understand how the system is supposed to work, but here are some of our comments about it at the time it was proposed earlier this year.

There are some elective surgery procedures which cannot be performed in ACT hospitals. The full policy uses the term "eligible elective surgery". Examples of procedures that are not eligible include some forms of cosmetic surgery. Thus the statement in the draft that "elective surgery patients will have their names added to the elective surgery waiting list" is not completely correct. The consumer version should at least make reference to this.

The full policy has a much more comprehensive description of the term “priority”. The consumer version has very little information, other than “clinical need” and “social factors”. The consumer version should at least include the comment: “If all other things are equal, the treatments will be on a next-in-line basis.” This is different to being given “special consideration”, which is what the consumer version says.

Consideration should be given to including a section on removal from the waiting list and the ability for a person to defer their surgery. The consumer version makes no reference to the fact that people can be removed from the waiting list or why, in particular if contact is lost with the person, for example, because they have moved. It would be useful for people to know that this could happen and that it is important for them to inform the hospital of any change of contact details.

The document should make reference to the ability of people to appeal decisions—for example, the category of clinical urgency or removal from the waiting list and information on complaints processes. The final version should be made available in community languages and in different formats.