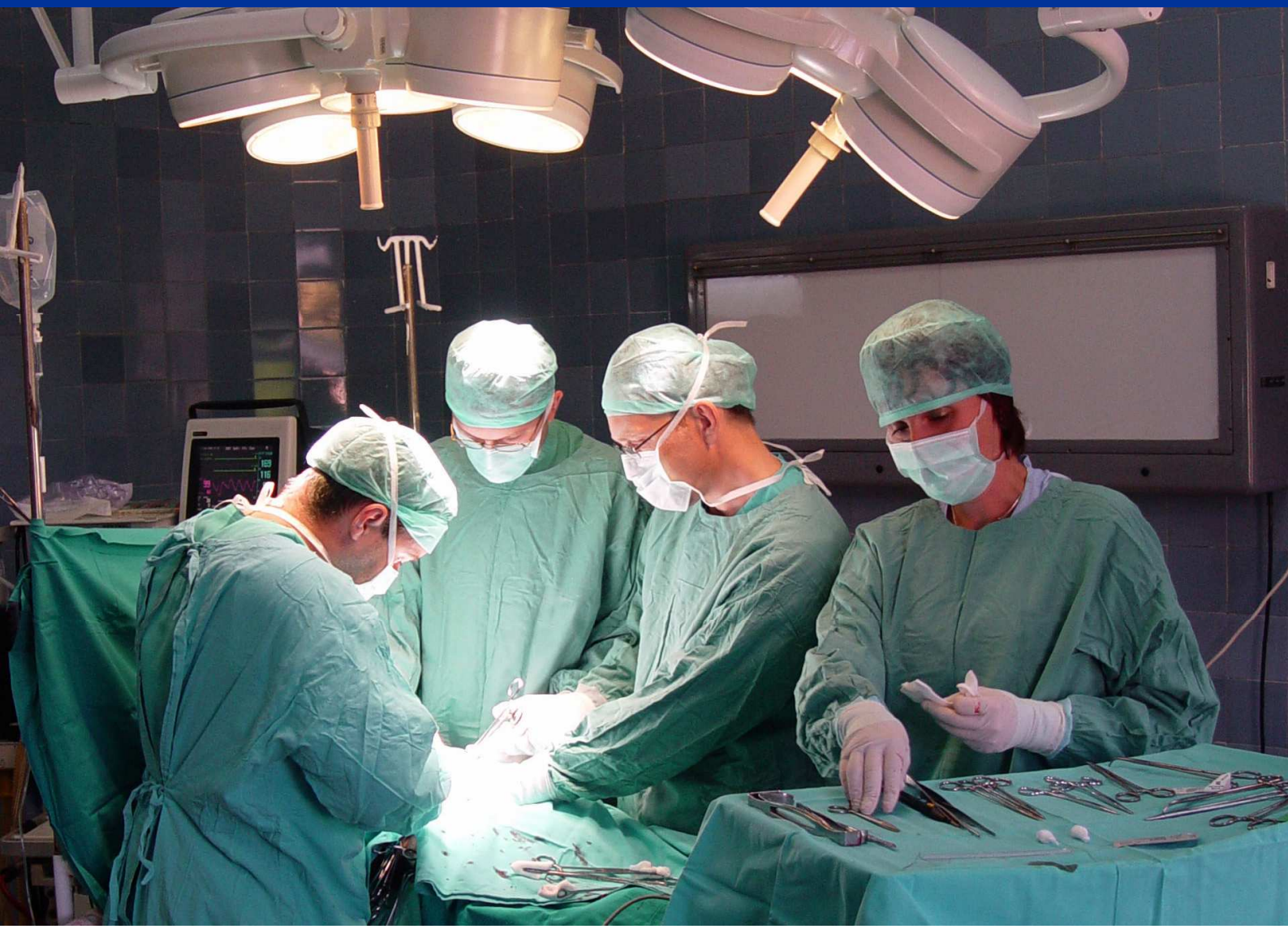
Victorian Healthcare Association

POSITION STATEMENT

VHA 2010 Board Endorsed Position Statement



Elective Surgery Waiting Lists

"Optimising health outcomes for all Victorians"

The Victorian Healthcare Association

The Victorian Healthcare Association (VHA) is the major peak body representing the interests of the public healthcare sector in Victoria. The VHA promotes the improvement of health outcomes for all Victorians from the perspective of its members that include public hospitals, rural and regional health services, community health services and aged care facilities.

Definitions:

Elective surgery is surgery that is necessary but for which admission can be delayed at least 24 hours.

Elective surgery waiting lists apply to patients who are waiting longer than 24 hours for a surgical procedure, either for same-day or a multi-day stay.

Urgency categories rate the priority for elective surgery. It is determined on the basis of whether or not a person can afford to wait, with the costs of waiting being based on the risk to the patient of delay. The decision regarding the relevant urgency of the surgery is made by the treating clinician.

Produced by The Victorian Healthcare Association (VHA). This document has been prepared by the VHA with input and feedback from VHA members. While this position statement aims to broadly reflect the views of the health sector in Victoria, it remains the position of the VHA and does not supersede any submission or position stated by any member agency.

Chief Executive Officer: Mr. Trevor Carr
Chair: Mr. Anthony Graham

Level 6
136 Exhibition Street
Melbourne Victoria 3000
Email: vha@vha.org.au
Phone: 03 9094 7777
Fax: 03 9094 7788

Executive summary

Health service performance and access indicators are necessary to measure how well the whole health system is working. However, indicators that are too narrowly focused or poorly monitored not only give a false perception of the performance of the system, but also fail to provide useful information to enable system improvement.

The VHA is concerned that the current elective surgery waiting list process is ineffective as a measure of service access, unreliable as a benchmarking or prioritisation tool, and popularly misused as a measure of how well a health service is performing. This paper aims to outline the need for changes to be made in the design of health service access and performance indicators, and how they should be more appropriately measured and used.

The waiting lists for elective surgery in Victoria, as they are currently applied, do not provide a useful and reliable means to measure the Victorian community's access to health services. That existing measures fail to paint a true picture of access to elective surgery creates inequality in health services provision, and frustration for the Victorian public. The current use of waiting list information also creates undue pressure on some health services to meet unrealistic performance expectations with inadequate resources.

Change is needed to the formulation of access and performance indicators to better reflect the population demand and the performance of health services and the system more broadly. Such improved data will provide reliable and valid information to allow for root cause analysis of problems and thus the development of solutions.

The VHA recommends the following to improve the effectiveness, reliability and usage of elective surgery waiting list data:

1. An immediate review of national performance and access indicators by the Federal Government in collaboration with state and territory governments

2. The development of an elective surgery access indicator to include an accurate measurement of the time taken from general practice referral to any definitive treatment

3. The development of robust clinical guidelines to ensure that the application of waiting list categories is more valid and reliable throughout Australia

4. The use of access indicators as a signaling device to flag areas of need and areas of oversupply to guide strategic planning of services and resources

1. Prefacing comments

Waiting lists for elective surgical procedures will always exist within a health system that has to ration access to acute services[2]. Many governments around the world monitor their waiting list numbers and waiting times for surgery in order to measure the success or failure of their particular health system[3] in meeting the needs of their constituents. The relative availability of medical goods and services can be used to measure the output of a health system; however the process must be valid and reliable if it is to provide any useful information. The VHA is concerned with the way in which elective surgery waiting lists are utilised in Victoria.

1.1 Rationale for the paper

Elective surgery waiting lists in Australia have become a political and media tool. They fail to measure what the planners of health services need to know in order to improve services, and they create undue pressure on health service administrators by creating unrealistic expectations. The performance of a particular health service in meeting their waiting list targets has become synonymous with the performance of the health service as a whole, with little regard to the laws of supply and demand.

The VHA is concerned that the current elective surgery waiting list process is ineffective as a measure of service access, unreliable as a benchmarking or prioritisation tool, and popularly misused as a measure of how well a health service is performing. This paper aims to outline the need for changes to be made in the design of health service access and performance indicators, and how they should be more appropriately measured and used.

There are many different policy solutions suggested in the literature, and by service providers, for addressing the problem of inadequate access to elective surgery, and thus decrease the wait times. However, these solutions will only work once there are valid measures to determine the true extent of the problem. The VHA proposes that the key issue is to change community and political understanding that the current methods of measuring elective surgery waiting lists creates neither a valid indicator of overall access to Victoria's healthcare services nor a gauge of the performance of an individual health service.

1.2 The current situation

The Victorian Government considers the availability of timely and high quality elective surgery as critical to the successful functioning of the public health system[4]. According to the Victorian Auditor-General's 2009 report, *Access to Public Hospitals: Measuring Performance* access indicators (both emergency and elective surgery waiting) are critically important as they provide the main measure of assurance to the public that hospital services are accessible and provided in a timely manner[5].

Public hospital services account for approximately 29 per cent of the expenditure for all health services in Australia[6]. Victorian public hospitals provide a variety of services within inpatient and outpatient settings. Elective surgery accounts for approximately 15 per cent of all public hospital admissions[7].

Elective surgery is undertaken at 63 public hospitals throughout Victoria. However, publically reported elective surgery waiting lists only apply to certain types of elective surgery included in the Elective Surgery Information System (ESIS) and performed at 29 ESIS participating hospitals: 22 metropolitan hospital sites, five regional health service sites, and two sub-regional health service sites.

An ESIS hospital's waiting list comprises the number of patients waiting for a particular ESIS reportable procedure, at that particular hospital on a particular day. The list is a measure of the difference between the demand and supply of surgical services at that particular hospital.

Table 1: Urgency categories

Clinical urgency categories	**National standards - desirable treatment times**
1 Urgent • Has the potential to deteriorate quickly to the point it may become an emergency	Admission within 30 days
2 Semi-urgent • Causes some pain, dysfunction or disability • Unlikely to deteriorate quickly	Admission within 90 days
3 Non-urgent • Causes minimal or no pain, dysfunction or disability • Unlikely to deteriorate quickly	Admission some time in the future *There is no national standard but 365 days is used as a guide*

(Source: Your Hospitals http://www.health.vic.gov.au/yourhospitals/elective/about.htm)

These waiting lists also include the percentage of patients admitted within a certain timeframe, depending on their urgency categorisation. The time is measured from when a procedure is registered onto the elective surgery waiting list to the day that the procedure takes place. The factors determining elective surgery priority are:

- How quickly the patient's condition may deteriorate to become an emergency
- How much pain, dysfunction and disability their condition causes them

The decision regarding the relevant urgency of the surgery is made by the treating specialist clinician[8].

In Australia, patients are assigned to one of three categories: urgent cases that need to be seen within 30 days; semi-urgent cases that need to be seen within 90 days; and non-urgent cases that can be seen some time in the future, preferably within 365 days. Table 1 provides a summary of National Standards for each category.

Waiting lists for elective surgery exist as an indicator of the performance of an ESIS hospital in providing a service to the public, and are reported every six months in Victoria. The practice of rewarding a health service financially for achieving waitlist targets was removed in 2009 due to an issue with data integrity[9]. However, poor waiting list performance may still result in punitive sanctions with the Department of Health (DH) increasing scrutiny by placing the health service under "close watch"[10].

The public reporting of access indicators can allow a patient to be moved between hospitals by the Elective Surgery Access Service (ECAS) coordinators, but only if there is a choice of public hospitals in the region (such in as the metropolitan region), and if the referring surgeon agrees.

Importantly, waiting lists do not include the time taken for a patient to see a specialist with referral rights to a public hospital surgical list after being referred by their general practitioner (GP), or the time between seeing a specialist and being registered onto an ESIS waiting list[11]. This latter time is mandated by DHS to be less than three days[12], but it is not always recorded by the hospital.

2. The VHA position

2.1 Measurement inaccuracies

There are several shortcomings in the measurement of elective surgery access that undermine the reliability of waiting lists as a reflection of the population demand. These include:

- Inconsistent patient categorisation, especially across jurisdictions and across specialties
- The potential for data manipulation
- Inaccurate data due to data omission

2.1.1 Inconsistent patient categorisation

The practice of assigning public elective surgery patients to urgency categories provides a useful method to prioritise patients, but the current method is too restrictive in its definitions and open to manipulation[13]. Widespread disparity exists between the different states in the percentage of patients in each category. This suggests that the current categorisation system is too subjective and inconsistent[14], and therefore does not accurately measure actual clinical demand[15].

For example, in mid-2006 the proportion of patients in category 1 (urgent) in NSW was four times higher than in Victoria (9.4 per cent of all patients on the waiting lists, compared to 1.9 per cent respectively)[16].

Another inconsistency with the current categorisation system is that a patient is not prioritised until they have been assessed by a specialist, regardless of their clinical need. This means that there is no priority system to measure access to a specialist to determine surgical urgency. Clinical guidelines must be developed to cover the entire patient referral process[17]. This should include measuring referral of patients to specialists and the process by which specialists categorise patients. These additions would help to ensure patients are reliably and effectively prioritised in a timely way, with indicators to measure the time taken for high priority patients to see a specialist[18].

2.1.2 The potential for data manipulation

The practice of linking waiting list targets to hospital funding ceased in Victoria in 2009 as it was shown to be detrimental to the accuracy of reporting data, indeed encouraging data manipulation[19]. Although the pressure of financial reward has been removed, other pressures to report perfect waiting list targets remain[20].

For example, the most recent Victorian Department of Health "*Your hospitals*" report illustrates that despite a 100 per cent increase in the annual number of urgent patients admitted, over the past 10 years (see figure 1), the percentage of the urgent patients seen in the allowable time (30 days) is consistently 100 per cent[21](see figure 2).

This implies that the number of urgent patients has risen in direct proportion to the capacity of the Victorian public system to treat urgent patients.

Figure 1: Access to elective surgery—urgent patients

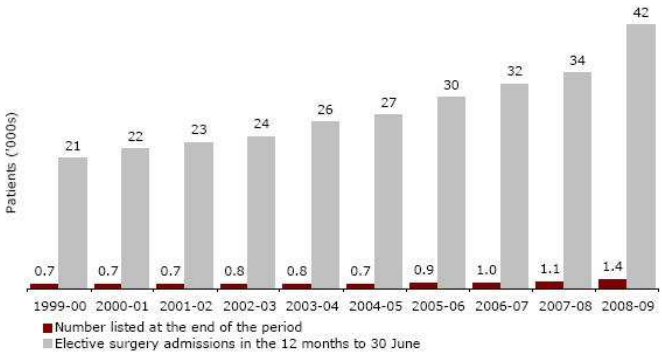
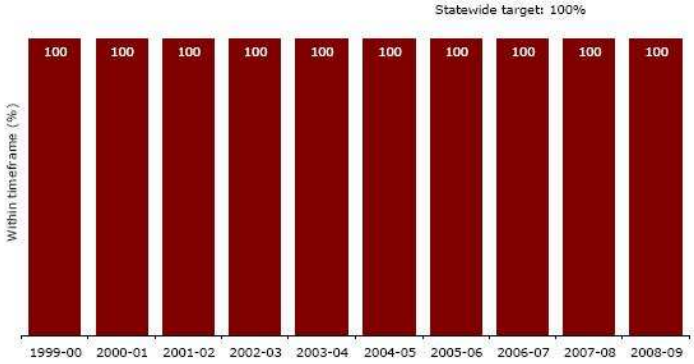


Figure 2: Percentage of urgent patients seen in 30 days



In some cases, data is not manipulated but reported inaccurately due to a misunderstanding of the health service elective surgery access policy. More explicit definitions for the assessment of access to elective surgery are needed in the policy to measure this in a more standardised way, without increasing the administrative burden on health services.

2.1.3 Data omission

The current data regarding patient access to elective surgery fail to reflect the needs of the most vulnerable people and those living in rural and remote areas. Although the national data already show that people in remote and outer regional areas have longer waiting times for elective surgery than metropolitan residents[22], access to specialist services is not measured. Measurement of the time taken to access primary care and specialist appointments is also needed to accurately determine the true waiting times for elective surgery and the capacity of the system to meet increasing demand pressure[23], and to ensure that rural communities are not further disadvantaged.

The practice of reporting the number of patients on each health services waiting list also provides inaccurate data. It does not account for people registered at multiple hospitals, or people waiting for their convenience rather than inadequate capacity[24]. Unique patient identifiers may help to overcome this problem.

The omission of non-ESIS participating public hospitals and private hospitals from elective surgery waiting list data means that the recorded waiting list data do not provide a full picture of the health system capacity or the population demand for elective surgery. Additional capacity in rural public hospitals and private hospitals is not captured and utilised to decrease waiting times. Measurement of the clinical need of emergency patients taking precedence over elective surgery patients would also provide insight to the health system capacity.

There is also no record of any movement of patients seeking private surgical services to public hospitals when public hospital waiting lists decrease. Yet when the federal government spends more money on elective surgery "blitzes" to increase the numbers of public elective procedures performed, the demand for public hospital services rises[25].

"Demand responds positively to reductions in waiting times."[26]

Medicare removes the financial barrier to access, therefore the demand for public elective surgery tends to increase when public waiting times decrease. The only individual "cost" is the opportunity cost in waiting. If the public hospital waiting time decreases, the "cost" decreases making the private hospital option appear to be of lesser "value"[27]. This leads to higher public hospital demand. Since a person who has access to a private specialist consultant with public hospital admitting rights can be referred for surgery in a public hospital with their doctor of choice, then that person can access the public hospital services before someone who is still waiting to see a specialist in a public outpatient clinic.

2.2 Misleading information

2.2.1 Unbalanced focus

When one considers that elective surgery is a small percentage of public hospital activity (see 1.2), the emphasis on waiting lists as a true indicator of healthcare access is distracting and misleading. This was reflected upon by the National Health and Hospitals Reform Commission (NHHRC), that stated in its final report, "If we only set National Access Targets for one part of the health system, it is likely that funding (and media interest) will focus on that one issue to the detriment of other important health services"[28]. The amount of attention given to ESIS waiting lists, by the media and the political parties, is out of balance with the population's total demand for health services.

The VHA does not dispute the need to inform the public about public access to elective surgery but one of the problems with media snapshots is that they can reinforce the propensity to look at waiting list problems in isolation, rather than looking at the full picture. Media coverage must seek to expose the inadequacies of waiting lists as an effective measure of the health system. Current waiting list data must be replaced by data that evaluates the effectiveness and efficiency of the whole health system[29], which is easily understood by everyone.

The current representation of waiting lists through the media dilutes the real story of system access, demand and performance, and can sometimes exacerbate the excessive pressure placed on hospitals to manage elective surgery waiting lists. For example, recent reports of "cheating" when an audit revealed one hospital was incorrectly putting people on a "not-ready-for-surgery (NRFS)" list while waiting to attend a pre-admission clinic[30] has resulted in an increase in administrative paperwork for all ESIS hospitals[31], rather than simple clarification of the policy.

2.2.2 Relevant data for benchmarking

Measures for health service demand and performance need to be relevant and useful at a local level to have any opportunity to improve access and quality. Benchmarking is more meaningful when fed back to service providers throughout the system. The further health services are distanced from the data, the less likely it is that data will impact the decisions they make. This is true both for clinicians and the public alike.

Benchmarking can be used as a tool to stimulate continual practice improvement, not just as a static marker by which to judge individual performance. Missing indicator targets should be embraced as an opportunity to learn and adjust practices, not routinely treated as a black mark with a potentially punitive outcome. The system should reward innovation for continual improvement and best practice, as opposed to over-emphasis on hitting a target number as a significant performance measure.

Performance and demand measures must provide more complete data for meaningful improvement activity to occur. Measuring public and private rates of admission and measuring rates of admission according to diagnosis and other information, such as socioeconomic status, would enable more qualitative analysis of the reasons for differences and delays in treatment. For example, people in the most disadvantaged socioeconomic group have

twice the rate of admission for Gynaecology and Cardiothoracic surgery than people from the most advantaged groups[32]. It is difficult to discover this anomaly if only ESIS data is analysed.

3. Action plan

Immediate action must be taken to cease the current spread of misinformation. The Federal Government's key performance indicators (KPIs) for the states and territories must encourage improvement in managing the supply and demand of elective surgery to address waitlist times across the regions, and encourage collaborative innovations between health services, rather then pure competition and blame.

Recommendation 1:

An immediate review of national performance and access indicators by the Federal Government in collaboration with state and territory governments.

Waiting times must include the time spent waiting for specialist consults, and the time spent waiting for all diagnoses at all hospitals. Monitoring the capacity of smaller public hospitals would also be of benefit to understand the full capacity of the healthcare system. This information could then be used to formulate solutions aimed at increasing access to public elective surgery.

Recommendation 2:

The development of an elective surgery access indicator to include an accurate measurement of the time taken from general practice referral to any definitive treatment

The system for assigning an urgency category to a patient must be standardised and be made more explicit in order to increase reliability and validity[33]. The recommended waiting times for each procedure must be clinically appropriate and evidence based.

Recommendation 3:

The development of robust clinical guidelines to ensure that the application of waiting list categories is more valid and reliable throughout Australia.

Elective surgery access indicators must be used as a screening tool, rather than a definitive diagnostic of poor hospital performance[34]. Indicators can be designed to identify where undersupply and oversupply is evident in order to guide a no-blame solution to inequitable access. Access indicators can be used as a lag indicator to highlight areas where further investigation is needed to address a problem.

An alternative model could reward actions taken to improve access to health services rather than just measuring activity[35]. Quality improvement is a continuous process in every hospital, and rather than just focusing on meeting static national benchmarks, problems should be addressed locally with the focus on solution.

There are some innovative strategies that have worked in a range of contexts to reduce waiting times. These include: mobile consultants; the use of excess capacity in private hospitals or small rural hospitals; paying for rural and remote patients to travel for services further away; or creating a stand-alone service for elective surgery with its own infrastructure and funding, away from emergency presentations.

Reliable data is required to enable adequate qualitative analysis to determine the correct action to take, rather than ad-hoc, temporary funding "blitzes".

Recommendation 4:

The use of access indicators as a signaling device to flag areas of need and areas of oversupply to guide strategic planning of services and resources.

4. Conclusion

Performance and access indicators are necessary to measure how well the whole health system is working. However indicators that are too narrowly focused or poorly monitored not only give a false impression of the performance of the system, but also fail to provide any information to enable system improvement.

The waiting lists for elective surgery in Victoria, as they are currently applied, are unable to provide a useful means to measure health services' performance or the Victorian community's access to services. They also create undue pressure on some healthcare providers to meet unrealistic expectations with inadequate resources. The inability of existing measures to paint a true picture of access to elective surgery creates further problems of inequality of health services provision, and frustration for the Victorian public.

There is a need to develop new access and performance indicators to better reflect population demand and health system performance. These indicators would allow for root cause analysis of systemic problems to drive long term solutions. Governments must provide more timely financial and logistical support to struggling health services. There is a need to reward for innovation and quality improvement to address infrastructure and workforce issues before these issues affect health outcomes.

The NHHRC final report suggests the application of three measures of success in a health system. These include: performance of the health services, the public's confidence in the health system, and the satisfaction of those working within it. The current undue focus on hospital waiting lists provides unreliable measures of the health services' performance and is eroding public confidence and increasing workforce dissatisfaction.

The Victorian Government and the Federal Government must take the opportunity to reform the health and hospital performance indicators at the forthcoming COAG meetings.

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Level 6 | 136 Exhibition Street | Melbourne | VIC | Australia | 3000 www.vha.org.au

Tel: (03) 9094 7777 Fax: (03) 9094 7788 Email: vha@vha.org.au ABN: 54 004 228 111