

Access to Elective Surgery in Victoria

16 April 2014

Executive Summary

Access to elective surgery is widely used as a proxy for indicating access to timely care in the public hospital system.

Within Victoria there has been significant reporting about waiting list length, time to treatment, the existence of “secret” waiting lists, and the failure of Victorian hospitals to meet national elective surgery targets (NESTs).

The issues affecting reporting and access to elective surgery are complex. In seeking to understand the issues and putting forward recommendations, the VHA has reviewed reporting and access to elective surgery in the following terms:

1. The way we discuss access to elective surgery
2. The way we report access to elective surgery
3. Changes within the health system which would enable existing capacity to be used more productively
4. Increasing capacity in a cost effective way.

The key points and recommendations for each of these areas are described on the following pages.

The **key principles** guiding the discussion and the development of recommendations are:

- Patients will be treated within clinically appropriate times, and the defined time will be based on evidence.
- Patients will expect to receive a similar outcome as a result of having elective surgery, regardless of the hospital that provides the elective surgery.
- Elective surgery will be undertaken in a cost effective manner.

Recommended timeframes for each recommendation are stated. The timeframes represent the relative urgency and acknowledges the degree of difficulty of implementing the recommendation. The recommended timeframes are expressed as:-

- *Now*:- Needs to be addressed in 2014
- *Short term*:- Needs to be addressed in the period 2014 to early 2016
- *Medium term*:- Needs to be addressed late 2016 to early 2018
- *Long term*:- Is required, but not urgent and/or requires significant effort or expense to implement.

Further detail about the recommendations is contained in the body of this paper.

1. The way elective surgery is discussed

Recommendations

Recommendation	Timing
R1. Eliminate waiting list size from a health service’s Statement of Priorities (SOP).	Now

Rationale

- The size of the waiting list is a poor indicator of access to elective surgery within the public health system, and does not tell us whether people are being seen in clinically appropriate times
- A very small waiting list can result in elective surgery being more expensive as surgical lists may not be optimally filled.

2. Reporting of elective surgery

Recommendations

Recommendation	Timing
R2. Expand the scope of procedures reported on the elective surgery waiting list.	Short term
R3. Report the patient journey from acceptance of specialist referral to the point of receiving elective surgery/removed from the list.	Short to medium term
R4. Expand the scope of the Elective Surgery Information System (ESIS) to include all public health services that undertake elective surgery.	Short term
R5. Align referrals to the waiting list with national/state-wide initiatives to uniquely identify patients, such as PCEHR.	Medium term
R6. Report on activity and performance of emergency surgery.	Short to medium term
R7. Standardise definitions of urgency categories and the treatment of people on the waiting list across jurisdictions.	Short term
R8. Provision of comparative information about urgency category information provided to surgical specialty groups, hospitals, local hospital networks and states and territories on a routine basis.	Short term
R9. Review, standardise and expand the use of priority scoring systems for high volume procedures where there is variation in urgency categorisation.	Medium term
R10. Review classification and cost weights for surgical procedures to include the impact of factors such as age, obesity, lifestyle, and the degree to which a patient may be socially disadvantaged.	Short to medium term

Rationale

- The way elective surgery is reported at this time is not telling the complete story as:
 - Many smaller hospitals don’t report on elective surgery demand or activity
 - Many elective procedures are not reported
 - The waiting list and associated waiting times represents only part of the patient’s perspective of their journey from identifying the need for elective surgery to receiving elective surgery

- It doesn't provide a balanced view of demand for resources used for elective surgery
- Patients may be on more than one waiting list.
- Inconsistent categorisation, classification, and approach to treating patients on the waiting list is affecting comparability of reporting – particularly across jurisdictions.
- The classification of procedures through DRG v6.x is not sufficiently granular to permit comparison of costs and performance across the public and private sector.

3. Improving access by increasing productivity

Recommendations

Recommendation	Timing
R11. Review the average cost for surgical procedures typically funded under the Competitive Elective Surgery Initiative (such as Ear, Nose and Throat surgical procedures) to reflect the cost to public hospitals of doing this surgery with a population of more complex patients.	Short term
R12. Provide reporting that enables clinicians to compare their practice with other clinicians within a hospital, and for comparing practice for clinical specialties across health services.	Short to medium term
R13. Improve linkages between surgical procedures and primary health and prevention.	Short to medium term
R14. Review and potentially implement mechanisms for <i>automatic referral</i> based on specified criteria in order to facilitate access to specialised resources and to address blockages affecting patient throughput in the system.	Short to medium term
R15. Review and potentially implement mechanisms for <i>indirect referral</i> as a means of matching supply to demand for elective surgery across the health system.	Medium term
R16. Establish mechanisms for enabling practices and initiatives for improving productivity in elective surgery to be assessed, shared, and implemented in other health services.	Short term

Rationale

- In some cases hospitals are now being inadequately funded for some procedures. This is largely due to increased complexity of patients for some procedures. This has arisen due to factors such as the aging population, increased obesity, and changes in people's lifestyle and living conditions. Additionally, the population of patients treated in the public system is becoming more complex for some procedures as a result of initiatives such as the Competitive Elective Surgery Initiative, which is resulting in less complex patients being treated in the private sector.
- There are a number of initiatives underway in Victoria and other jurisdictions that aim to drive improved productivity, and ultimately throughput, in the provision of elective surgery. This includes initiatives to manage demand, improve referrals and linkages between acute and primary health, and referrals and utilisation of resources between acute services.

- There is a need, and opportunity, to better match capacity with demand across the health system. This is particularly important where capacity may be constrained, but there is capacity elsewhere in the system.

4. Increasing capacity cost effectively

Recommendations

Recommendation	Timing
R17. Further review and address barriers associated with workforce that may be affecting elective surgery access.	Short term
R18. Build capacity into the system by selectively increasing recurrent funding in areas with infrastructure that is currently under-utilised. This may include smaller hospitals with physical capacity to run further lists. However, this would need to be within their scope of practice.	Short term
R19. Review existing capacity, including changing infrastructure needs as a result of changing models of care (such as more day procedures), and demographics (such as more elderly patients who live alone), and selectively invest in further physical and operational capacity. This may also include more dedicated elective surgery facilities in order to quarantine elective surgery.	Medium term

Rationale

- Recent trials of advanced practice endoscopic nursing has demonstrated there are opportunities to increase capacity to perform endoscopic procedures and to significantly reduce waiting times for these procedures.
- There is latent capacity within the public health system that could be utilised at lower marginal cost than investment in construction of further facilities. The two main areas of opportunity are for existing ESIS reporting hospitals to operate outside normal operating hours, and underutilised infrastructure that exists in many small rural health services (including those on Melbourne’s fringe and close to regional centres).
- Purchasing capacity from the private sector may be the most appropriate strategy in the short term, but in the longer term, it may be more cost effective to expand capacity in the public sector.

Table of Contents

1. Introduction.....	1
2. Background.....	1
2.1 Elective surgery in Victorian in facts and figures.....	1
2.2 The relationship of the public sector with the private sector.....	2
2.3 Reporting access to elective surgery.....	4
3. Key principles underpinning access to elective surgery in Victoria.....	7
3.1 The definition of elective surgery.....	7
3.2 Key guiding principles.....	7
4. The way elective surgery is discussed	8
4.1 Overview.....	8
4.2 Shortcomings.....	8
4.3 Recommendations.....	9
5. Reporting of elective surgery.....	9
5.1 What is reported and who reports it.....	9
5.2 Consistency of reporting.....	11
5.3 Comparisons to the private sector.....	13
6. Improving access by increasing productivity	15
6.1 Overview.....	15
6.1.1 Initiatives to manage demand.....	15
6.1.2 Initiatives for increasing productivity.....	16
6.2 Issues experienced by Victorian health services.....	20
6.3 Recommendations.....	22
7. Increasing capacity cost effectively.....	22
7.1 Overview.....	22
7.2 Recommendations.....	25

1. Introduction

Access to elective surgery is widely used as a proxy for indicating access to timely care in the public hospital system.

Within Victoria there has been significant reporting about waiting list length, time to treatment, the existence of “secret” waiting lists, and the failure of Victorian hospitals to meet national elective surgery targets (NESTs).

The issues affecting reporting and access to elective surgery are complex. In seeking to understand the issues and putting forward recommendations, the VHA has reviewed reporting and access to elective surgery in the following terms:

1. The way we discuss access to elective surgery
2. The way we report access to elective surgery
3. Changes within the health system which would enable existing capacity to be used more productively
4. Increasing capacity in a cost effective way.

This position has been developed based on extensive consultation with VHA members.

2. Background

2.1 Elective surgery in Victoria in facts and figures

- In 2011-12, there were 199,876 admissions for elective surgery procedures in Victorian public hospitals¹.
- Average annual growth in admissions since 2007/08 to 2011/12 has been 1.7%².
- There is a small decrease in the number of admissions for the last financial year, and for the current calendar year. This is reported as due to changes in Commonwealth funding at the end of 2012 and at the start of 2013³.
- Elective surgery in Victoria is undertaken in both public and private hospitals, with the majority (62% of admissions) being performed in the private sector⁴.
- In Victoria, 86% of emergency surgery is undertaken in a public hospital, and approximately 24% of total surgery is categorised as emergency surgery⁵. In many public hospitals, the same resources (ie staff, theatres etc) are used for both emergency and elective surgery. Emergency

¹ Source: AIHW, “*Australian Hospital Statistics 2011-12*”. Note, this number represents acute care separations reported on NHMD with a “surgical” procedure based on the procedures defined as “surgical” in AR-DRG 6.x. It does not include endoscopic procedures.

² Ibid.

³ Source: Victorian Health Services Performance Database.

⁴ Source: AIHW, “*Australian Hospital Statistics 2011-12*”.

⁵ Ibid.

surgery admissions have been increasing by an average of 3.5% per annum from 2007/08 to 2011/12⁶.

- Median waiting time for elective surgery in Victorian hospitals from 2007/08 to 2011/12 has increased from 32 days to 36 days. In most other states, the median waiting time for elective surgery for this period has decreased or has remained the same. The exception is NSW, where the median waiting time has increased from 38 days to 49 days for the same period⁷.

2.2 The relationship of the public system with the private sector

The private sector plays a significant role in the provision of healthcare in Australia. In 2011-12, individuals, private health insurance, workers compensation and compulsory motor vehicle third party insurance providers contributed 30.3% of health expenditure in Australia, with the majority of this coming from individuals (18.7%), and private health insurance funds contributing 8.4% to expenditure⁸.

Since the introduction of a combination of targeted incentives and penalties in the late 1990s aimed at increasing private health insurance coverage, more than 40% of the population now has private health insurance (up from approximately 30% in the 1990s)⁹, and this has contributed to growth in capacity in the private sector. In Victoria, the average increase in the number of private hospitals for the five year period to 30th June 2011 was 1.9% pa, and Australia wide the number of available beds has increased on average 1.6%pa¹⁰.

More than half of all elective surgery procedures are undertaken in a private hospital. In 2011-12, 62% of all admissions for elective surgery procedures in Victorian hospitals were performed in a private hospital, and this has been increasing on average 4.5% per year since 2007-08¹¹.

The role the private sector plays in Australia is three fold:

1. It potentially facilitates the redistribution of some of the demand for health services from public financed health services to predominately privately financed health services
2. As more patients are able to pay for their own treatment (through their own funds or insurance), then there is likely to be increased privately financed investment into private sector capacity^{12,13}

⁶ Ibid.

⁷ Ibid.

⁸ Source: Productivity Commission, "*Report on Government Services, Volume E: Health*", Table EA.4, 30 January 2014.

⁹ As at December 2013, 46.9% of the population was covered Australia wide, and 44.7% of the population was covered in Victoria. Source: PHIAC, "*Membership and Coverage*", December 2013.

¹⁰ This compares to an increase of 0.5% pa of Victorian public hospitals, and 0.9%pa increase of available beds Australia-wide in the same time period. Source: AIHW, "*Australian Hospital Statistics 2011-12*", Tables 4.1 and 4.2.

¹¹ Source: Australian Institute of Health and Welfare, "*Australian Hospital Statistics 2011-12*", Table 10.3.

¹² Source: Kreindler S, "*Policy strategies to reduce waits for elective care: a synthesis of international evidence*", British Medical Bulletin 2010; 95: 7-32

¹³ "A major contribution of the private hospital sector to the health system is the capacity to raise capital. The private sector, mainly private hospitals, accounts for 60% of the total per annum capital spend in healthcare for facilities and for specialised equipment". Source: Foley M, "*A Mixed Public-Private System for 2020: A paper commissioned by the Australian Health and Hospitals Reform Commission*", Pg 23, July 2008

3. It potentially sets the conditions for innovation and competition, thereby providing improvements in health services for all consumers¹⁴.

There are concerns that a reduction in waiting times for elective surgery, or initiatives such as a guaranteed maximum wait, in Australian public hospitals may see patients switching to public, rather than private, providers. The consequence of this would be that the viability of the private health sector could be undermined, and that costs and demands on publicly financed health services could increase.

The VHA believes that the following points help to mitigate this issue:

- Targeted incentives and penalties introduced in the 1990s through the taxation system aimed at increasing private health insurance coverage have played a significant role in encouraging people to take private health insurance in Australia (particularly with younger people who are currently in good health)¹⁵. Shorter or guaranteed maximum wait times for elective surgery are unlikely to significantly affect people's choices about paying for private health insurance.
- As well as providing shorter wait times than public hospitals, surgical treatment in private hospitals also offers a choice of surgeon, the option for a private room, and an increased ability to plan and schedule the date of surgery¹⁶. These features are attractive to patients who can afford to self-fund their care or are privately insured.
- Where there is spare capacity in the private system, then the initial response can be for the public system to contract capacity from private hospitals. This process already exists in Australia. In Victoria, this is achieved through a funding pool under the Competitive Elective Surgery Initiative¹⁷.

In addition, there is a significant body of research into the effect of the promotion of private health insurance coverage in Australia in the late 1990s on public hospital elective surgery waiting times and lists. This research found that while there was an initial decrease in public waiting times and lists as a result of increased private health insurance coverage, longer term analysis showed there was no evidence that promoting private health insurance reduced either waits or costs in the public system¹⁸. A potential reason that the policy did not result in reduced pressure on the public system is that the new patients and services absorbed by private health insurance were not a source of pressure on the public system in the first place. The increase in privately financed activity was typically from younger,

¹⁴ "Private providers are often better placed to innovate than public authorities. Models which provide greater autonomy to public providers to participate in purchasing opportunities in a competitive environment would also stimulate innovation". Source: Foley M, "A Mixed Public-Private System for 2020: A paper commissioned by the Australian Health and Hospitals Reform Commission", Pg 25, July 2008

¹⁵ Between the March and September quarters 2000 (when the incentives and penalties for promoting increased private health insurance coverage took effect), the greatest increases in private health insurance take up occurred among people aged from 30-49 years, with a significant increase (72%) in the 30-34 years old category. Source: Australian Bureau of Statistics, "4102.0 – Australian Social Trends, 2001", Commonwealth of Australia 2014, Last updated 25 September 2007

¹⁶ In a public hospital, a patient is typically informed 5-10 days before the date of surgery and often needs to rearrange affairs at short notice.

¹⁷ For more information, see: <http://www.health.vic.gov.au/surgery/competitive.htm>

¹⁸ Source: Kreindler S, "Policy strategies to reduce waits for elective care: a synthesis of international evidence", British Medical Bulletin 2010; 95: 7-32

lower risk patients requiring shorter, less complex procedures, leaving the labour intensive and more costly treatments to the public system. It is argued that rather than shifting the demand from the public to the private sector, increased private health insurance coverage may have fuelled new demand for the types of services that are profitable for private hospitals¹⁹.

As well as the public and private sector offering similar services for elective surgery and the potential for patients to shift between public and private hospitals for surgical treatment, other facets of the relationship between the public and private sectors include:

- The public sector contracting with the private sector for capacity to treat publicly funded patients.
- The comparison of public hospital costs and performance with the private sector.

These points are discussed in the relevant sections of this paper.

2.3 Reporting access to elective surgery

In Victoria, elective surgery waiting list information by episode is reported to the Elective Surgery Information System (ESIS). Elective surgery procedures reported to ESIS are those that are surgical procedures in accordance with the therapeutic procedures section of the Medicare Benefits Schedule. Procedures commonly performed by non-surgical clinicians (such as endoscopies) and for which waiting time cannot be controlled (such as caesarean sections and organ transplants) are not required to be reported to ESIS.

As at December 2013 there were 35 hospitals reporting elective surgery performance data to the Victorian Department of Health²⁰. Whilst those services carry out the vast majority of procedures, some smaller rural hospitals, who don't report to ESIS, also deliver elective surgery. Therefore, the reported elective surgery waiting list represents only a proportion of elective surgery conducted in Victoria, both by excluding some hospitals and certain procedures.

Elective surgery is reported according to:

- The number of patients on the waiting list
- The time a patient is on the waiting list by category
- The time a patient is overdue for surgery.

In Victoria, this is agreed in the Statement of Priorities for each health service, and reported in the health service's annual report and broadly on the Victorian Health Service Performance website and in State Budget papers. Nationally, it is reported through the AIHW's Australian Hospital Statistics series of reports, and through the COAG Reform Council's National Healthcare Agreement (NHA) Performance Reports.

As part of the National Partnership Agreement for improving public hospital services, the Commonwealth and the States and Territories have entered into a National Elective Surgery Target (NEST). The Commonwealth will provide up to \$200 million reward funding (\$49.4m in Victoria) until

¹⁹ Ibid.

²⁰ Source: Victorian Health Services Performance Database.

year 2016/17 for achieving targets for stepped improvements in the number of patients treated within the recommended times, and for a progressive reduction in the number of patients who are overdue for surgery (particularly those who have waited the longest beyond the clinically recommended time). The targets for each jurisdiction are different, and they are based on the performance of the jurisdiction in 2010. Victoria's targets are shown in Table 1.

Table 1:- Victorian national elective surgery targets

	Baseline (2010)	2012	2013	2014	2015
Proportion seen on time (%)					
Category 1 (30 days)	100%	100%	100%	100%	100%
Category 2 (90 days)	72.5%	75%	80%	93%	100%
Category 3 (365 days)	91.9%	93%	94.5%	98%	100%
Average overdue wait (days)					
Category 1 (30 days)	0	0	0	0	0
Category 2 (90 days)	129	97	65	32	0
Category 3 (365 days)	165	124	83	41	0
Of the 10% of longest waiting patients who had not had their procedure within the clinically recommended times the previous year, and who have still had their surgery or appropriate treatment options identified by the following year.					
Category 1 (30 days)	NA	0	0	0	0
Category 2 (90 days)	NA	0	0	0	0
Category 3 (365 days)	NA	0	0	0	0

Source: National Health Reform Agreement – National Partnership Agreement on Improving Public Hospital Services




Performance of jurisdictions against their NEST targets in 2012 is shown in Table 2.

Table 2:- NEST performance by jurisdiction, 2012

Urgency categories ->	NEST Part 1 Seen within clinically recommended times (%)			NEST Part 2 Average overdue waiting time (days)			Longest waiting 10% of overdue patients seen by December 2012		
	1	2	3	1	2	3	1	2	3
Victoria	100	68.3	90.3	0	96	144	0	0	0
NSW	95.1	91.0	92.2	11	24	63	0	0	0
Queensland	89.0	77.1	88.7	87	137	136	1	65	12
Western Australia	86.3	82.0	96.4	12	54	67	0	0	0
South Australia	91.0	90.6	96.3	23	38	66	0	0	0
Tasmania	76.1	60.4	72.8	73	287	586	0	56	98
ACT	98.5	57.3	89.3	20	127	109	0	0	0
Northern Territory	87.5	71.3	86.0	24	83	71	0	2	1

This table shows performance against National Elective Surgery Targets by jurisdiction. The shading shows whether the target has been achieved. The numbers refer to actual performance data for the jurisdiction and category.

Legend

 Achieved target	 Partially achieved target	 Did not reach previous year's target or baseline
---	---	---

Source: National Partnership Agreement on Improving Public Hospital Services: Performance Report 2012

Recent developments

1. The Australian Institute of Health and Welfare (AIHW) and Royal Australasian College of Surgeons (RACS) have undertaken an initiative on the national definitions for elective surgery urgency categories. The initiative aims to provide improved consistency of reporting of elective surgery waiting list data across jurisdictions. A summary of the recommendations are shown in figure 1. The report (currently a proposal) is with the Standing Council on Health.
2. A review of elective surgery waiting list management in Victoria was undertaken by an expert panel and a report presented to the Minister of Health in August 2012. The key recommendations concerned expanding the scope of elective surgery procedures reported, and to expand waiting list reporting so it covers the patient journey from initial consultation and referral through to specialist outpatient or elective surgical care and to advocate for this to be adopted nationally.

Figure 1:- AIHW and RACS report recommendations

1. *A statement of overarching principles for urgency category assignment.* The key principle is that the clinical urgency category should be assigned by the treating clinician, appropriate to the patient's clinical situation alone, and not influenced by the availability of hospital or surgeon resources
2. *Simplified, time based urgency category definitions.* The three urgency categories remain, but their definitions are simpler (ie Procedures that are clinically indicated within x days), and a time of 365 days has been placed on Category 3. The timeframe in which the procedures is clinically indicated is as judged by the treating clinician
3. *Feedback and publication of comparative information about urgency categorisation.* This will require establishing arrangements for the feedback of information about comparative urgency categorisation to surgical specialty groups, hospitals, local hospital networks, and states and territories on a routine basis. The information supplied will be applicable for the group. For instance, hospitals would receive comparative urgency categorisation for individual hospitals within their peer group. At a local level, jurisdictional health departments or local health networks may provide individual surgeons or surgeon teams comparative urgency categorisation using local data.
4. *Recommended urgency categories for higher volume procedures.* This will be used as a guide to urgency categorisation by treating surgeons.
5. *"Treat in turn" will be used as a principle for elective surgery management.* In practice, this is likely to be 60-80% of people are treated in turn to accommodate different patient requirements, efficient use of operating theatre times, training of surgical trainees etc
6. *The category "Not Ready for Care" will be called "Not Ready for Surgery".* There will be clarified approaches for patients in this category.
7. *Broader reporting of procedures.* The report recommends broader reporting of procedures, including live donor transplant surgery, endoscopies, and procedures frequently done by non-surgical clinicians.

Does reporting by itself reduce waiting times for elective surgery?

The purpose of reporting is to provide transparency about waiting times for elective surgery so that consumers and participants in the health system can make informed choices about surgery. However, improved reporting in itself does not result in reduced waiting times, although it does provide a foundation for it²¹.

²¹ Source: Kreindler S, "Policy strategies to reduce waits for elective care: a synthesis of international evidence", British Medical Bulletin 2010; 95: 7-32

This is re-enforced by the experience of the Netherlands in the late 1990s, when waiting lists for elective surgery grew exponentially as a result of replacing fee for service payments with lump sum budgeting. Between 1998 and 2000, efforts to reduce waiting time through improved reporting and to resource local wait reduction projects had a limited effect on reducing elective surgery waiting times overall. Waiting lists did not fall until the reinstatement of activity based funding and bonuses for waiting list reduction²².

Similarly, as seen in Sweden and Denmark in the 1990s, targets to reduce waiting times for elective surgery without aggressive performance management appear to have little effect²³.

3. Key principles underpinning access to elective surgery in Victoria

3.1 The definition of elective surgery

Elective surgery is defined as “Surgery that, in the opinion of the treating clinician, is necessary but for which admission could be delayed for at least 24 hours”²⁴.

Several VHA member hospitals noted that surgery classified as “emergency surgery” may be performed more than 24 hours after initial emergency consultation, therefore, this definition is not quite correct, and should change to “Any patient that is treated from the elective surgery waiting list”. Additionally, some VHA members noted that the definition does not encompass all elective interventions, including endoscopy procedures, radiology, and cardiology procedures. A suggestion was that the definition should refer to “elective procedures”, rather than “elective surgery”.

This position statement does not recommend changing the definition of elective surgery. However, it does ask the reader to understand that “elective surgery” is broader than the definition implies, and for many public hospitals it needs to coexist with emergency surgery – which may use the same infrastructure and resources as elective surgery.

3.2 Key guiding principles

The recommendations in this position statement have been developed based on three key principles.

Key Principles

1. Patients will be treated within clinically appropriate times, and the defined time will be based on evidence.
2. Patients will expect to receive a similar outcome as a result of having elective surgery, regardless of the hospital that provides the elective surgery.
3. Elective surgery will be undertaken in a cost effective manner.

²² Ibid.

²³ Ibid.

²⁴ Source: Department of Health, Victoria, “Victorian Health Services Performance, Elective Surgery”, 8 January 2014

4. The way elective surgery is discussed

4.1 Overview

The number of people on the elective surgery waiting list and median waiting time is often used as a measure of whether people's access to elective surgery in the public health system is deteriorating, and as a proxy for the overall performance of the health system. This view pervades discussion by the media, the health sector and also the broader public debate. It is also present in key policy instruments, with waiting list length used as a key performance indicator in a hospital's annual Statement of Priorities.

4.2 Shortcomings

The size of a waiting list is a poor indicator of access to elective surgery within the public health system as:

- a) Reducing elective surgery waiting times should occur only when the benefits of doing so exceeds the costs:- Studies on optimal waiting times for elective care have shown there is a point of equilibrium where the marginal cost of providing shorter waiting times exceeds the marginal benefits of the reduced waiting time^{25,26}. For example, the marginal benefit to patients of a shorter waiting time begins to diminish when the personal costs (e.g., organising time away from work at short notice) become more acute²⁷. Similarly, there are costs for reducing waiting lists. Some of these costs can be small (for example organisation and process change), however, others can be significant (for example, building infrastructure and staffing further capacity). As waiting times are reduced, then the cost of treating patients rises as more capacity, some of which will be idle part of the time, has to be kept available to deal with variations in demand²⁸.
- b) The size of the waiting list does not tell us whether people are being seen in clinically appropriate times:- The size of the waiting list does not tell us about the needs of the people on the waiting list. This includes considerations about when surgery is required for their condition before there is deterioration, whether they are in pain, or whether their condition is, or will, significantly impacting on their quality of life (for instance whether it affects their ability to live in their own home). This is supported by the fact that there are differences across jurisdictions and over time in the make-up of elective surgery waiting lists based on clinical urgency. Table 3 shows differences in the make-up of elective surgery waiting lists by jurisdiction. The report by AIHW and RACS on the National Definitions for Elective Surgery Urgency Categories suggests some of these variations may be as a result of differences in interpretation of categories by clinicians²⁹. However, some of

²⁵ Source: Xavier, A, "Hospital competition, GP fundholders and waiting time in the UK internal market: The case of elective surgery", International Journal of Health Care Finance and Economics, Mar 2003.

²⁶ Source: Harrison A et al, "Optimising waiting: a view from the English National Health Service", Health, Economics, Policy and Law, 2010.

²⁷ Ibid

²⁸ Ibid

these variations are also likely to be as a result of differences between the clinical needs of different populations over time.

Table3:- Relative proportion of admissions from elective surgery waiting lists in 2011-2012

	Vic	NSW	Qld	WA	SA	Tas	ACT	NT	Australia
Category 1	30%	25%	41%	23%	27%	39%	39%	39%	30%
Category 2	47%	32%	45%	35%	33%	44%	49%	41%	39%
Category 3	23%	43%	14%	42%	40%	17%	21%	20%	32%

Source: "National Definitions for Elective Surgery Urgency Categories – Proposal for Standing Committee on Health", AIHW & RACS, 2013

Therefore, discussing access to elective surgery in terms of the proportion of people who receive treatment within clinically appropriate times is a better way of expressing access to elective surgery.

4.3 Recommendations

R1. Eliminate waiting list size from a health service's Statement of Priorities (SOP).

5. Reporting of elective surgery

The way information is collected and reported can be misleading. Factors to consider are:

- What is actually reported and who reports it?
- Is reporting done in such a way that comparisons can be made between different hospitals and jurisdictions?
- Is it valid to compare cost and performance with hospitals in the private sector?

The following sections explore each of these questions in detail.

5.1 What is reported and who reports it

5.1.1 Overview

What is represented on the elective surgery waiting list

As described in Section 2.2, the elective surgery waiting list of Victorian public hospitals is sourced from reporting of elective surgical procedures to the Elective Surgery Information System (ESIS). Currently 35 hospitals report to ESIS. Smaller rural health services performing elective surgery procedures do not report to ESIS. Further, it is only mandatory for ESIS reporting hospitals to report episodes for reportable procedures. While ESIS does allow health services to report episodes for non-reportable procedures, these are not mandatory and are not represented on the elective surgery waiting list³⁰.

²⁹ Source: AIHW and RACS, "National definitions for elective surgery urgency categories – Submission information paper", March 2012

³⁰ Source: Department of Health Victoria, "Elective Surgery Information System (ESIS) manual", 16th edition 2013-14, Version 1.0

The Australian Institute of Health and Welfare and the Royal Australasian College of Surgeons have developed a proposal for Health Ministers which includes recommendations for expanding the scope of elective procedures that are reported and mechanisms for standardising the categorisation of patients on the elective surgery waiting list³¹.

Representation of the patient journey

Only a part of the patient journey for elective surgery is represented in the reporting of elective surgery waiting times. Patients are put on the elective surgery waiting list by a specialist (e.g., the orthopaedic surgeon). The time a patient waits to see the specialist is not reported.

A review of elective surgery waiting list management in Victoria was undertaken by an expert panel, and a report was presented to the Minister of Health in August 2012. The report included recommendations for expanding waiting list reporting to cover the patient journey from initial consultation and referral through to specialist outpatient or elective surgical care³².

Since the release of the report, the *Specialist clinics in Victorian public hospitals: Access policy*³³ has been developed. This policy describes processes and reporting associated with access to specialist clinics in Victorian public hospitals. Health services are expected to be compliant with this policy by 1 July 2015. While this policy describes access to specialist clinics to be reported differently and separately to waiting lists for elective surgery³⁴, there is potential for reporting to be aligned.

5.1.2 Shortcomings with current arrangements

The way elective surgery is reported at this time is not telling the complete story as:

- a) Many elective procedures are not reported.
- b) From the patient's perspective, it represents only part of their journey. This means it is possible that while a patient may wait a short time for a hip replacement from the time they saw an orthopaedic surgeon, they may have waited a much longer time to see the surgeon in the first place. Current reporting of elective surgery waiting times would show the waiting time for the elective procedure, but not the waiting time to see the surgeon.
- c) It doesn't provide a balanced view of demand for resources used for elective surgery. In particular, in most hospitals emergency surgery competes with elective surgery. For several hospitals with a relatively high proportion of emergency surgery and constrained capacity this can adversely impact elective surgery throughput.
- d) Many smaller hospitals don't report on elective surgery demand or activity, although these services represent a very small proportion of all procedures.

³¹ Source: Australian Institute of Health and Welfare & Royal Australasian College of Surgeons, "National definitions for elective surgery urgency categories – Draft proposal for Health Ministers", 24 September 2012.

³² Source: Victorian Government Appointed Expert Panel, "Expert Panel on Waiting List Management", August 2012

³³ Source: Department of Health Victoria, "Specialist clinics in Victorian public hospitals: Access policy", 2013

³⁴ For example, the clinical priority categories for specialist clinics are different to the clinical priority categories for elective surgery waiting lists

5.1.3 Recommendations

R2. Expand the scope of procedures reported on the elective surgery waiting list.

Note:- The recommended scope of procedures reported includes organ and tissue transplant procedures, procedures associated with obstetrics, cosmetic surgery (ie when the procedure will not attract a Medicare rebate), biopsies, bronchoscopy, peritoneal and renal dialysis surgical procedures, gastrointestinal endoscopy, colonoscopy, dental procedures, endoscopic retrograde cholangiopancreatography, in-vitro fertilisation procedures and other diagnostic and non-surgical procedures (ie procedures frequently performed by non-surgical clinicians)³⁵.

R3. Report the patient journey from acceptance of specialist referral to the point of receiving elective surgery/removed from the list.

- a) *Short Term*:- Continue implementation of the *Specialist Clinics in Victorian Public Hospitals: Access Policy*³⁶.
- b) *Medium Term*:- Expand the policy to support reporting of patient journey from acceptance of specialist referral to the point of receiving elective surgery/removed from the list, and implement this policy.

Note:- As part of this recommendation, consideration needs to be given to the treatment of models of care, such as pre-assessment clinics, bariatric clinics, and more conservative approaches to treatment when reporting the patient journey.

R4. Expand the scope of the Elective Surgery Information System (ESIS) to include all public health services that undertake elective surgery³⁷.

R5. Align referrals to the waiting list with national/state-wide initiatives to uniquely identify patients, such as PCEHR.

R6. Report on activity and performance of emergency surgery.

5.2 Consistency of reporting

5.2.1 Overview

In order for reporting on access to elective surgery to tell the complete story, the capture of information needs to be comparable.

The main areas that are subject to variation are urgency categorisation of patients, and the use of the “Not Ready for Care” category.

A project undertaken by the Australian Institute of Health and Welfare (AIHW) and the Royal Australasian College of Surgeons (RACS) reviewed national elective surgery urgency category

³⁵ List of procedures sourced from list of procedures defined as excluded in the current definition of elective surgery (Source: AIHW & RACS, “*National definitions for elective surgery urgency categories – Draft proposal for Health Ministers*”, 24 Sept 2012). Note, the proposal recommended live donor transplant surgery is in scope, and further discussion needs to occur for other procedures not currently reported.

³⁶ Source: Department of Health Victoria, “*Specialist clinics in Victorian public hospitals: Access policy*”, 2013

³⁷ This will require additional funding and support to establish and operate reporting in health services that are not currently reporting to ESIS.

definitions (including not ready for care) to facilitate consistent application of these categories across all states and territories.

The report produced by AIHW and RACS identified variation in urgency categorisation of patients across jurisdictions as well as atypical recording practices for waiting times for elective surgery for staged patients in some public hospitals. For indicator procedures (ie high volume elective surgery procedures) for which patient mixes would be expected to be relatively uniform, such as total hip replacement surgery, the project found there was significant variation. For example, the proportion of patients admitted for total hip replacement in urgency category 2 was 25% in New South Wales, and 74% in Victoria. Similarly, the proportion of patients admitted for myringoplasty in urgency category 3 was 86% in New South Wales and 29% in Queensland³⁸.

The VHA has observed that some of these inconsistencies could be as a result of differences in approach and interpretation of the urgency categories and elective surgery management, as a result of perverse incentives arising from funding arrangements, or possible gaming from clinicians.

AIHW and RACS recommended that assignment of patients to urgency categories remain the responsibility of the treating clinician, but to improve consistency they also recommended simplified, time based urgency category definitions, feedback and publication of comparative information about urgency categorisation, and recommended urgency categories for higher volume procedures. These and some other commentary received through our consultation process with VHA members, but not necessarily recommended, as part of their work to improve the consistency of reporting are described below.

[Recommended clinical priority categories for specific procedures](#)

This is currently used in both New South Wales and Western Australia for assignment of categories for procedures. The AIHW and RACS proposal recommended that guidelines for clinical priority categories are developed for higher volume procedures (such as joint replacement). A key criticism of clinical priority categories is that they are developed based on very few inputs – ie procedures to be undertaken. They don't take into consideration factors such as a patient's current circumstances which, when considered, may place the patient in a different clinical priority category.

[Priority scoring systems](#)

Both Canada and New Zealand have developed methods of prioritisation for different specialties based on physician-scored point based tools. The tools assess the patient based on broad criteria relevant to the condition, such as clinical factors and considerations relevant to patient experience and social factors. The tools promote increased consistency in prioritising patients and provide a framework for audit. However, significant investment is often required to develop the tools and their effectiveness has been criticised³⁹. Participants interviewed for a study in South Australia indicated

³⁸ Source: Australian Institute of Health and Welfare & Royal Australasian College of Surgeons, "National definitions for elective surgery urgency categories – Submission information paper", March 2012

³⁹ Source: AIHW and RACS, "National definitions for elective surgery urgency categories – Submission information paper", March 2012

that the introduction of a priority scoring system in order to improve the consistency of prioritisation and the capacity of the system to achieve tasks would be resisted by surgeons⁴⁰.

Priority scoring system – used in Victoria:- A Multi-Attribute Prioritisation Tool (MAPT) which includes 11 clinical and psychosocial domains was developed for joint replacement and piloted at several Victorian hospitals in 2008/2009⁴¹ and is still used by many Victorian hospitals⁴².

5.2.2 Shortcomings with current arrangements

Inconsistency in the categorisation, classification and treatment of patients on the waiting list (e.g., the use of the Not Ready for Care category) affects the comparability of reporting – particularly across jurisdictions. Comparisons made in the media using this data can, therefore, be misleading.

5.2.3 Recommendations

R7. Standardise definitions of urgency categories and the treatment of people on the waiting list across jurisdictions (as per the AIHW and RACS proposal)⁴³.

R8. Provision of comparative information about urgency category information provided to surgical specialty groups, hospitals, local hospital networks and states and territories on a routine basis (as per the AIHW and RACS proposal)⁴⁴.

R9. Review, standardise and expand the use of priority scoring systems (like MAPT) for high volume procedures where there is variation in urgency categorisation.

Note:- In order for these tools to be relevant and used as intended, then it is imperative that the establishment and management of the priority scoring system(s) are independently clinician led.

5.3 Comparisons to the private sector

5.3.1 Overview

More than half of elective surgery procedures in Victorian hospitals are performed in a private hospital. Further, private hospitals are contracted by the public system to perform elective surgery procedures for publicly funded patients⁴⁵.

For this reason, it is tempting to make comparisons of the costs and performance of elective surgery in the public sector with that in the private sector.

⁴⁰ Source: Walters et al, "Snakes and ladders: the barriers and facilitators of elective hip and knee-replacement surgery in Australian public hospitals", AHHA, 18 March 2013, 37, 166-1712

⁴¹ Source: Curtis et al, "Waiting lists and elective surgery: ordering the queue", MJA, Vol 192 No 94, 15 February 2010

⁴² Feedback from a VHA member hospital noted that a few hospitals are using Oxford Score in favour of MAPT as a basis for scoring the relative urgency for surgery.

⁴³ See: Australian Institute of Health and Welfare & Royal Australasian College of Surgeons, "National definitions for elective surgery urgency categories – Draft proposal for Health Ministers", 24 Sept 2012

⁴⁴ Ibid.

⁴⁵ For example, private hospitals may contract for providing surgery for a defined population of patients by tendering for a proportion of funds made available through the Competitive Elective Surgery Initiative. For further information, see: <http://www.health.vic.gov.au/surgery/competitive.htm>

5.3.2 Shortcomings in making comparisons between public and private hospitals

There are several reasons why such comparisons can be misleading, including:

- *Public hospital obligations and the resulting costs are different to those in the private sector.* For example:
 - Public hospitals have obligations that don't exist in the private system, including the responsibility for training clinical staff, including surgical registrars. This may affect surgical throughput, which may cause a teaching hospital to appear less efficient than a hospital that does not have teaching obligations, such as a hospital in the private sector.
 - Private hospitals do not generally have the allied health and resident medical staff structures of public hospitals, rather the model is geared around a patient being admitted by an individual, specialised VMO who is responsible for the required procedure. Similarly, salaried multidisciplinary teams as found in public hospitals are not financially supported in the same way in private hospitals.
- *The patients receiving surgical treatment in the public system are typically more complex than those treated in private hospitals, and the DRG classification system is not sufficiently granular to accurately report to this degree of detail.* For example, under the Competitive Elective Surgery Initiative, private hospitals will contract with an ESIS provider to do elective surgery for a defined procedure (such as ENT surgery) for a defined population of patients (e.g., younger patients with a BMI < 28). This means the patient mix for public patients will include a higher proportion of more complex patients (based on factors such as age, obesity, lifestyle and the degree of social disadvantage), which do result in increased time and resources, but complexity is not captured in the current DRG classification system⁴⁶. This affects the relative throughput and cost of performing a surgical procedure in a public hospital, compared to a private hospital.

5.3.3 Recommendations

R10. Review classification and cost weights for surgical procedures to include the impact of factors such as age, obesity, lifestyle, and the degree to which a patient may be socially disadvantaged.

Note:- While further development of AR-DRG classification system is largely a responsibility of IHPA, it is the role of the State to work with IHPA to make these changes, and for reporting of Victorian hospitals to be represented appropriately.

⁴⁶ Refers to the AR-DRG v6.0 classification system. Examples of factors that can result in further time and resources for a surgical procedure (including hospital length of stay) includes age, obesity, alcohol use, smoking, and whether the patient is socially disadvantaged.

6. Improving access by increasing productivity

6.1 Overview

Redesigning and reorganising healthcare delivery in order to make the most of existing capacity makes sense. Access to elective surgery is optimised when people who need elective surgery treatment are treated within clinically appropriate times, when throughput is maximised and cost is minimised through using existing capacity productively.

Some recent initiatives concerning improving access to elective surgery are described below.

6.1.1 Initiatives to manage demand

Health services have implemented a number of approaches for managing demand.

For example, many health services are increasingly implementing pre-assessment processes to triage patients and/or to divert to non-surgical approaches of care where appropriate for the patient. An example of a physiotherapist led shoulder clinic recently established at a hospital in Melbourne is shown in Figure 2. It should be noted, that while many hospitals have implemented orthopaedic pre-assessment clinics and processes, some have stated that their experience was that while it did initially divert demand for elective surgery to more conservative approaches of treatment (such as physiotherapy), in many cases the patient would eventually require surgery.

Another approach utilised by a Victorian health service, and increasingly being adopted in other parts of Melbourne, is to improve linkages between surgical procedures and primary health and prevention. This health service worked with their Medicare Local to implement these linkages through *HealthPathways*. The tools and mechanisms embedded within *HealthPathways* enables GPs, specialists and allied health professionals

to come together to discuss the optimal assessment and management of common medical conditions, and when and where to refer patients. Through the provision of relevant and evidence based information accessed by GPs at the point of care, the health service has found improvements in the appropriateness of patients referred for elective surgery at their health service.

Figure 2 – Physiotherapist Led Shoulder Clinic

A hospital implemented a physiotherapist led shoulder clinic in order to assess whether patients referred for surgery require surgery or the skills of an orthopaedic surgeon, or whether the patient can be managed effectively by a skilled musculoskeletal physiotherapist.

In its first year of operation, the hospital found:

- Of the new patients seen in its clinic, 40% required no further appointments and were discharged from the orthopaedic service.
- A survey of patients, orthopaedic surgeons and referrers showed that despite nearly half of the patients expecting to see an orthopaedic surgeon in the clinic, all patients were satisfied with the outcome of their visit.
- Most orthopaedic surgeons felt that the appropriateness of referrals had improved, and most felt the overall experience of working in the outpatient service had improved since the commencement of the clinic.

6.1.2 Initiatives for increasing productivity

Increasing productivity requires the system to work more efficiently so that patients can receive elective surgery within a given level of capacity and resources. Approaches for increasing productivity include:

- i. Process redesign, organisational change, and reporting infrastructure
- ii. Managing the balance between elective and emergency surgery
- iii. Reducing variation in clinical practice
- iv. Mechanisms for matching capacity with demand.

Each of these is discussed in further detail below.

(i) Process redesign, organisational change, and supporting infrastructure

“The root cause of wasted operating theatre time can be a result of one or a combination of factors that may include inappropriately prepared patients, unavailability of surgeons, delay in transport to the operating room and/or surgical cases running longer than their scheduled time”⁴⁷.

Internal changes within a hospital can address these issues and improve the efficiency of the operating theatre.

Process changes at a large metropolitan hospital in outer Melbourne saw a 38% improvement in start times.

Similarly, as part of the development of the Alfred Centre, the Alfred Hospital redesigned the surgical care model in order to streamline the patient journey for elective surgery. The changes include separating surgical care into three streams, and implementing changes including: patient screening and allocation to an appropriate ward by the perioperative coordinator; one day attendance at a pre-admission clinic for pre-surgical evaluation and investigations; and coordination of individually tailored discharge support before admission. The clinical process redesign is reported as resulting in a sustained downtrend in the number of elective surgery patients waiting longer than national recommended waiting times, reduction of HIP rates to 1% in the dedicated elective surgery facility, and a significant reduction in the length of stay for most common surgical procedures⁴⁸.

Automatic referrals

A large metropolitan hospital has been investigating the use of *automatic referrals*. Automatic referrals provide a hospital with the ability to automatically transfer a patient to another hospital based on predefined criteria, such as type of procedure, clinical characteristics, stability of the patient etc.

It is used to access specialised resources, including surgeons, who are able to perform the surgical procedure more efficiently and often more safely than would be the case in a hospital without the specialised resources. However, as part of the agreement, the referring hospital needs to accept the

⁴⁷ Source: Winbroum et al, “*Efficiency of the operating room suite*”, The American Journal of Surgery, 2002

⁴⁸ Source: Lowthian et al, “*Streamlining elective surgery care in a public hospital: the Alfred experience*”, MJA, Vol 194 No 9, 2 May 2011

patient after the surgical procedure for the remainder of the post-operative acute care, and for post-acute care.

In order for automatic referrals to work effectively, two way agreements with clear criteria for referral (and acceptance) must exist, and bed availability cannot exist as part of these criteria.

Further, funding arrangements may need to be reviewed. For instance, the patient may still require acute care when the referring hospital accepts the patient post-surgery, but the way the care is funded may not sufficiently cover the cost of acute care.

Supporting best practice

There are many examples of countries that have selectively funded service improvements and/or made significant efforts to disseminate and support best practices (such as the NHS Institute for Innovation and Improvement⁴⁹), however, while it is reported that these initiatives have shown some local impact, it has often been difficult to determine how they have affected elective surgery waiting times at a national level⁵⁰.

(ii) Managing the balance between elective and emergency surgery

The Victorian Department of Health undertook a literature review in 2010 on good practice in management of emergency surgery. In this report, approaches both in Australia and overseas were reviewed for their impact on the operational management of emergency surgery and more effectively balancing elective and emergency surgery demand⁵¹.

In respect to more effectively balancing elective and emergency surgery demand, a number of different approaches were discussed, including:

- Using dedicated emergency surgery lists or theatres
- Reserving capacity in elective surgery lists to allow flexibility in the schedule for expected emergency cases
- Balancing in-hours and out-of-hours work by using twilight lists or out-of-hours operating theatre sessions for emergency surgery
- Clearly separating elective and emergency surgery resources to reduce the impact that emergency cases have upon elective sessions (and vice versa)⁵².

The approach varies according to the size of hospital, resourcing, and the number of emergency surgery cases. However, where there is sufficient size and caseload, there has been an increasing trend to quarantining elective surgery. Both the Alfred and Austin hospitals have achieved this through purpose built elective surgery facilities. Some Melbourne based metropolitan hospitals have achieved this through setting aside theatres for emergency surgery and making changes to how all

⁴⁹ See: <http://www.institute.nhs.uk/>

⁵⁰ Source: Kreindler S, "Policy strategy to reduce waits for elective care: a synthesis of international evidence", British Medical Journal 2010: 25: 7-32

⁵¹ Source: Victorian Department of Health, "Good practice in management of emergency surgery: a literature review", October 2010

⁵² Ibid

theatres are used based on analysis of past activity. However, some large hospitals with a high proportion of emergency surgery are reporting there is insufficient theatre capacity within their hospitals to implement this approach and are at a size and scale that requires dedicated elective surgery facilities.

(iii) Reducing variation in clinical practice

Variation in clinical practice is cited in reports both in Australia and overseas, even where agreed clinical practice guidelines exist⁵³. In New South Wales, the Special Commission of Inquiry into Acute Services in NSW Public Hospitals (the Garling Report) identified variation in practice, and observed that much clinical care reflected clinician or organisational preference, not patient needs⁵⁴.

Variation in clinical practice can refer to whether a patient undergoes a particular surgical procedure, or may be related to differences in how a procedure is performed. For example, the NSW Clinical Excellence Commission found differences in hysterectomy rates in non-cancer cases across different districts in NSW⁵⁵.

Reducing unwarranted clinical practice variation is important from a quality and safety perspective. It encompasses care that is patient focused, is appropriate, reduces mortality and morbidity, and improves efficiency in the face of spiraling health care costs⁵⁶.

Kennedy et al state, “The most common initiative to reduce unwanted variation in clinical practice is the development and implementation of clinical practice guidelines, evidence based pathways and clinical protocols. However, development is not enough, implementation of guidelines needs to be supported by education, infrastructure, data support, promotion, endorsement, and, if applicable, incentives or penalties to encourage uptake”⁵⁷.

One approach to achieving this is through the provision of information that shows differences in practice amongst clinicians within a hospital, and comparison of practice for clinical specialties across health services. This may be performed at an organisation level through access to information by surgeon and procedure, including length of stay and complexity. It may be useful for some hospitals to receive information from an independent external source that compares information about procedure rate and factors such as length of stay for a particular hospital against de-identified peers.

(iv) Mechanisms for matching capacity with demand

Pooled waiting lists

Theoretically, pooling waiting lists is one way of distributing demand across providers in such a way as to increase equity in waiting times across a geographic area, and to reduce overall waiting times.

⁵³ Source: Kennedy P et al, “*Clinical practice variation*”, MJA, Vol 193, No 8. 18 October 2010

⁵⁴ Ibid

⁵⁵ Source: Clinical Excellence Commission (CEC), “*Safety and Quality of Healthcare in NSW – Chartbook 2010*”, Sydney: CEC (Information Management Series No. 8), 2011

⁵⁶ Source: Kennedy P et al, “*Clinical practice variation*”, MJA, Vol 193, No 8. 18 October 2010

⁵⁷ Ibid

An evaluation was undertaken of strategies to reduce waiting times for total joint replacement in Ontario. The evaluation was performed using a simulation model based on seven years of historical data. The simulation found that a single waiting list (as opposed to each region managing their own waiting list) had the same effect as reducing demand by 5% each year. This was attributed to increased resources to treat patients with greater clinical need, and because there were fewer instances of an allocated surgery not being used⁵⁸.

There would need to be consideration as to how this works in practice. In a study on the barriers and facilitators of elective joint replacement surgery in South Australia, participants interviewed for the study had supported a recommendation to introduce a generic or pooled surgical waiting list to replace the practice of allocating patients to a particular surgeon at the time of their initial consultation. However, they anticipated resistance from orthopaedic surgeons as individual surgeons could not be confident in a course of treatment if they had not been involved in the initial decision making⁵⁹.

This view has been supported by several large Victorian health services who believe that a common waiting list could result in a “doubling up” of initial outpatient consultations which would represent unnecessary expense both for the system and the patient. A couple of Victorian health services noted that for some clinical specialties they had effectively pooled their waiting list over a broad geographic area for hospitals within their service. They stated that it worked for smaller specialties, such as neurology, where there was a fairly well defined group of surgeons that work as a unit. However, it is unlikely this could be expanded over a broader geographic area, or even the entire state. A large regional health service believed this may be applicable for metropolitan Melbourne, but would not work across regional areas.

Accountability is a further consideration. Specifically, the governance arrangements in Victoria make Victorian hospitals responsible for the delivery of services to meet the demands of the population their area serves. The management of individual waiting lists is a part of this.

Interhospital referral

Victorian hospitals consulted during this process have suggested mechanisms for *Interhospital Referral* as a means of matching capacity with demand.

Interhospital Referral is for situations where a patient is referred to a hospital that is operating at capacity. Through *Interhospital Referral*, the hospital can refer the patient to another hospital that has capacity. There would need to be policy and procedures governing how this works, there needs to be patient consent, and there would need to be appropriate governance mechanisms to ensure that perverse behaviours (e.g., non-acceptance of less profitable patients) are dealt with. Two clear benefits of *Interhospital Referral* are that patients would have the option of receiving elective surgery in an area that has capacity, and issues with clinical accountability and post-surgical follow up are overcome.

⁵⁸ Source: Cipriano et al, “An evaluation of strategies to reduce waiting times for total joint replacement in Ontario”, Medical Care, Vol 46, No 11. 11 November 2008

⁵⁹ Source: Walters et al, “Snakes and ladders: the barriers and facilitators of elective hip and knee-replacement surgery in Australian public hospitals”, AHHA, 18 March 2013, 37, 166-1712

Elective Surgery Access Service (ESAS) exists as part of Victoria's statewide surgical services program⁶⁰. ESAS was established to provide a streamlined system for transferring elective surgery patients from health services that are unable to treat them within clinically appropriate timeframes, to health services with the capacity to provide rapid treatment. As at 2009-10, four hospitals were identified as receiving ESAS centres, including St Vincent's (orthopaedic surgery), the Royal Victorian Eye & Ear Hospital (ear, nose and throat surgery), the Royal Women's Hospital (gynaecology), and The Alfred Centre⁶¹.

Victorian health services consulted by the VHA reported that ESAS is not widely used, and where it does tend to be used, it is for joint replacements. Health services felt the scope of procedures were very limited, and it was not embraced by patients as it would usually require further outpatient consultation before being placed on another waiting list for surgery.

For this reason, a system of *Interhospital Referral* would need to be determined as a hospital reviews their capacity and, with the patient's consent, organises for the patient to be transferred to another hospital prior to initial outpatient consultation.

Giving patients choice

Another approach for matching capacity and demand is to give patients a choice of providers, on the assumption they will choose the provider with the shorter waiting list. However, the experience in Denmark, Sweden and the Netherlands suggests there are limitations with this approach. Specifically, only a small number of patients (5% in Denmark) exercised their right to choose, and choices were often based on factors other than waiting time (e.g., reputation, doctor's opinion)⁶².

The English NHS implemented a "Choose & Book" system that offered patients a choice of at least four hospitals and their appointment date and time, however, it is unclear how many patients are actually offered these choices, especially choice of date and time. Additionally, English wait times for elective surgery were already falling before this scheme was introduced, therefore, it is unclear the degree to which this initiative is contributing to the trend⁶³.

6.2 Issues experienced by Victorian health services

Key issues experienced by Victorian health services in the provision of elective surgery include:

(i) Increasing demand for elective surgery in an increasingly challenging environment

Overall demand for surgery is increasing. This is driven by population growth, the ageing population, the increasing burden of chronic disease, technological advances, and increasing community expectation. While shorter stays in hospital are possible as surgical procedures for many conditions have become less invasive, the degree that this is realised is affected by a greater proportion of

⁶⁰ See: <http://www.health.vic.gov.au/surgery/policies.htm>

⁶¹ Source: Department of Health Victoria, "*Elective Surgery Access Service (ESAS) Business Rules*", October 2011

⁶² Source: Kreindler S, "*Policy strategies to reduce waits for elective care: a synthesis of international evidence*", *British Medical Journal*, 2010; 95: 7-32

⁶³ Ibid.

patients that are older and have significant comorbidities⁶⁴.

Specific issues include:

- Hospitals are reporting increased complexity and comorbidity. This is increasing the time and resources required by a patient for an elective surgery procedure. However, this is often not acknowledged through funding arrangements.
- There is an increasing impact of demographic and socioeconomic factors on access to elective surgery and throughput. Examples reported include:
 - An increasingly ageing population that is less conditioned than in the past gives rise to complications of care and a heightened risk of surgery.
 - Many of the older patients seen for endoscopy procedures cannot manage bowel preparation on their own, so are admitted the day prior to their operation.
 - For patients that live alone, the need for overnight stay post-operatively increases.
- Increased screening (particularly bowel and breast screening) and cancer gene testing is increasing the identification of patients requiring surgical intervention. Some of these procedures, such as elective mastectomies and reconstruction can require 8 hours surgery for one patient.
- An increase in the available treatment options, growing patient awareness of treatment available and expectations are also placing increased pressure on hospitals and waiting lists.

(ii) Changes in the patient mix

Changing demographics, including an ageing population, increased obesity, and increased incidence of chronic disease is changing the mix of patients receiving surgery to a mix that includes more complex patients requiring more time and resources for their surgical procedure and care.

Recent policy changes, particularly elements of the Competitive Elective Surgery Initiative, are also making the mix of patients receiving elective surgery in many public hospitals more complex. This is occurring as private and smaller hospitals are successfully bidding to undertake specified elective surgery for a defined population of patients. While this is enabling increased capacity to be purchased, and a concurrent reduction in an ESIS reporting hospital's waiting list, the mix of patients receiving elective surgery at the ESIS reporting public hospital for specialties, such as Ear Nose and Throat surgery, often becomes more complex. As hospitals are funded based on the average cost for surgical procedures for a specified DRG, when the population on which the payment is based changes, the hospital is not adequately reimbursed for the procedure. Related to this issue, AR-DRGv6.x is not sufficiently granular to recognise factors such as age, obesity, lifestyle factors, and social disadvantage contributing to the increased complexity (and hence time and cost) of performing surgical procedures for these patients.

⁶⁴ Source: Department of Health Victoria, "Patient Centred Surgery – Strategic Directions for Surgical Services in Victoria's Public Hospitals 2010-15", October 2009

6.3 Recommendations

- R11.** Review the average cost for surgical procedures typically funded under the Competitive Elective Surgery Initiative (such as Ear, Nose and Throat surgical procedures) to reflect the cost to public hospitals of doing this surgery with a population of more complex patients.
- R12.** Provide reporting that enables clinicians to compare their practice with other clinicians within a hospital, and for comparing practice for clinical specialties across health services.
 Note:- The information recommended to be reported is beyond the mortality and morbidity information currently reported. It includes information that enables clinicians to understand differences in practice compared to peers (e.g., for a hip replacement, there will be factors about the patient, outcomes/outputs such as LOS and degree of functionality, but also factors relating to the model of care, such as the implant used, medication prescribed, rehabilitation undertaken, home support services received etc). Similarly, there also needs to be reporting of clinical indicators, such as hysterectomy rates for a defined population of patients by health service. This type of reporting is currently produced in NSW by the Clinical Innovation and Excellence Commission⁶⁵. This information should be compiled by an independent source.
- R13.** Improve linkages between surgical procedures and primary health and prevention.
 Note:- This may be through mechanisms and tools for providing further support and direct engagement with primary health, such as *HealthPathways*.
- R14.** Review and potentially implement mechanisms for *automatic referral* based on specified criteria in order to facilitate access to specialised resources and to address blockages affecting patient throughput in the system.
- R15.** Review and potentially implement mechanisms for *indirect referral* as a means of matching supply to demand for elective surgery across the health system.
- R16.** Establish mechanisms for enabling practices and initiatives for improving productivity in elective surgery to be assessed, shared, and implemented in other health services.

7. Increasing capacity cost effectively

7.1 Overview

Although access to elective surgery can be improved through mechanisms for better managing demand, increasing productivity, and better matching supply to demand, there will continue to be areas where further capacity is required in order to meet demand.

Increasing capacity does not necessarily require investment in further infrastructure – however, this is sometimes the case. Sometimes capacity can be increased through workforce change, and using latent infrastructure that exists in the public and private sector. These approaches are currently used both in Victoria and other jurisdictions in Australia and internationally, and are discussed in further detail below.

⁶⁵ For an example, see: Clinical Excellence Commission, “*Chartbook 2010 – Safety and quality of healthcare in NSW*”, July 2012, Sydney: CEC (Information Management Series no. 08).

7.1.1 Workforce initiatives for increasing capacity

Health Workforce Australia (HWA) initiated a program to develop and put in place programs to introduce advanced practice in endoscopy nurses in sites across Australia⁶⁶.

Implementation sites in Victoria include Austin Health, Western Health, Southern Health and Alfred Health. The Logan and Beaudesert Hospital (two campuses) was the implementation site in Queensland. Six nurse endoscopists were trained as part of the program. The evaluation found that over a one year period, the nurse endoscopists completed 1,259 colonoscopies with a 0.8 per cent rate of adverse events/complications. Further, both Victorian and Queensland governments have allocated funding to develop initiatives to train more nurse endoscopists⁶⁷.

The evaluation cited a case study from hospital that said it had reduced its seven year waiting list for routine endoscopic procedures to a maximum of 40 days⁶⁸.

Advanced care practice nursing, including advanced practice endoscopy nursing, has been trialed and deployed in many different ways across the world. An evaluation of the clinical outcomes of diagnostic endoscopy performed by doctors and nurses found that, based on reports from participants, there was little significant difference in clinical outcomes between those procedures performed by a doctor compared to those performed by a nurse. Further it was found there was no significant difference between the number of immediate or delayed complications identified after endoscopy by a doctor or a nurse⁶⁹.

7.1.2 Obtaining capacity from the private sector

Contracting capacity from the private sector has been used widely in Australia and internationally as a way of quickly increasing capacity compared to other options (such as constructing further infrastructure in the public sector). It is also sometimes used to introduce an element of competition with public providers⁷⁰.

The use of the private sector to provide elective surgery to publicly funded patients is part of the Victorian government's Competitive Elective Surgery Initiative. In 2013-14, \$101 million was allocated to this initiative, and the funds were split over three funding pools:

- A pool of ESIS reporting public providers (\$77 million)
- A pool of the private and public providers currently providing surgery under the 2013 Elective Surgery Services Deed of Agreement (\$9 million)

⁶⁶ See: <http://www.hwa.gov.au/our-work/expanded-scopes-practice-program/introducing-advanced-practice-endoscopy-nursing>

⁶⁷ Source: Health Workforce Australia, "Expanded Scope of Practice and Aged Care Workforce Reform Progress Report", 2014

⁶⁸ Ibid.

⁶⁹ Source: Williams J et al, "Effectiveness of nurse delivered endoscopy: findings from randomised multi-institution nurse endoscopy trial (MINuET)", *BMJ* 2009, 338:b231

⁷⁰ Source: Hurst J and Siciliani L, "Tackling excessive waiting times for elective surgery: A comparison of policies in twelve OECD countries", *OECD Health Working Papers*, OECD, 2003

- A pool of private and public providers to be awarded via a competitive request for submission (RFS) process (\$15 million) in 2013-14, with options for future years to a maximum contract value of \$165 million⁷¹.

The purpose of the initiative is: to use competition to maximise the value of Victorian government funding for elective surgery for public patients; to improve access and maximise the number of public patients treated; and to encourage partnerships between the private and public sector for the delivery of public elective surgery.

The views of this initiative from Victorian public hospitals have been mixed. Some, such as smaller rural health services with latent capacity, have benefited from the initiative. Generally speaking, ESIS reporting hospitals can see benefits in the initiative as a means of treating less urgent patients faster than would have been the case without the initiative. However, the following issues have been noted:

- a) The initiative is increasing the proportion of complex patients treated within the public sector, as less complex patients are treated in the private sector through this initiative. The view is that complex patients require more time (therefore, throughput is slower), and are more costly (and not adequately funded when the concentration of more complex patients within the patient mix has increased)
- b) Variable levels of funding from initiatives such as this, increases the challenge associated with workforce, demand and capacity planning.

Research about whether the purchase of private capacity has made a major contribution to any country in reducing waiting times for elective surgery in the medium to longer term is inconclusive⁷².

An OECD study on policies for tackling excessive waiting times for elective surgery noted that there are different ways to increase supply, including purchasing from the private sector. It noted that the different ways of increasing supply will generally have different costs and will require different time scales. So purchasing from the private sector may be the most appropriate strategy in the short term, but in the longer term, it may be cheaper to expand activity by expanding capacity in the public sector⁷³.

7.1.3 Access to further capacity in the public sector

The marginal cost for accessing unused physical infrastructure in the public sector is less than the cost of constructing and operating new facilities.

The main opportunities for accessing further capacity is for existing ESIS reporting hospitals to operate outside normal operating hours, and to use under-utilised physical infrastructure in smaller rural health services.

⁷¹ Source: Department of Health Victoria, "*Competitive Elective Surgery Initiative - \$15 million public and private pool: Frequently Answered Questions*", 19 September 2013

⁷² Source: Kreindler S, "*Policy strategies to reduce waits for elective care: a synthesis of international evidence*", British Medical Journal 2010, 95:7-32

⁷³ Source: Hurst J and Siciliani L, "*Tackling excessive waiting times for elective surgery: A comparison of policies in twelve OECD countries*", OECD Health Working Papers, OECD, 2003, p45

The main issue raised by ESIS reporting hospitals providing elective surgery out of normal operating hours is that funding does not adequately cover the costs of staffing sessions during these hours. This seemed to be a bigger issue for smaller hospitals than was the case for larger hospitals with a larger proportion of emergency surgery as part of their total surgical workload.

Several smaller rural health services (some on Melbourne's fringe or close to regional centres) reported their theatres are currently under-utilised and there is an opportunity to increase their operational capacity to provide further surgery for people in their area. The main benefits of this are:

- These health services have the physical infrastructure, but in many cases the current funding only allows the theatres to be operated a couple of days a week
- Some of these hospitals are reporting that the waiting time for some procedures (e.g., Endoscopy procedures, orthopaedic procedures) can be long, however, they receive insufficient recurrent funding to reduce the waiting times
- Based on self-sufficiency data used by these health services, they have noted that some people from their area are going to Melbourne or regional centres for surgery, where this shouldn't be the case as they are for procedures which are performed by the health service
- It was noted that further increasing the operating capacity of the smaller rural health services to undertake further elective surgery would also enable the health services to more effectively provide services to their community and makes it easier to attract and retain nursing staff.

The key challenge with this approach is concerned with reporting. Currently some smaller rural health services have successfully bid for additional elective surgery through the Competitive Elective Surgery Initiative. They report on the status of elective surgery patients on the waiting list of an ESIS reporting hospital. They do this as they treat elective surgery patients from the ESIS reporting hospital waiting list through the Competitive Elective Surgery Initiative.

It is possible for this to continue in this way. However, in order for there to be increased transparency and accountability for individual hospitals and also across the system (see earlier recommendation), then these health services also need to report through ESIS. Generally speaking, the current burden of ESIS reporting for a health service is reported to be about 2-4 hours per week. However, there is significant effort for small health services to establish the necessary systems, and this would need funding to support establishment.

Some smaller rural health services are successfully bidding for additional elective surgery through the Competitive Elective Surgery Initiative and/or contracting with larger ESIS reporting hospitals to perform the surgery. However, as noted in the previous section, the variable nature of this funding makes it difficult for hospitals to build the capacity to perform the additional surgery. This issue is more acutely experienced in smaller rural health services.

7.2 Recommendations

R17. Further review and address barriers associated with workforce that may be affecting elective surgery access.

- R18.** Build capacity into the system by selectively increasing recurrent funding in areas with infrastructure that is currently under-utilised. This may include smaller hospitals with physical capacity to run further lists. However, this would need to be within their scope of practice.
- R19.** Review existing capacity, including changing infrastructure needs as a result of changing models of care (such as more day procedures), and demographics (such as more elderly patients who live alone), and selectively invest in further physical and operational capacity. This may also include more dedicated elective surgery facilities in order to quarantine elective surgery.