AUDITOR-GENERAL
AUSTRALIAN CAPITAL TERRITORY

PA 03/18

The Speaker
ACT Legislative Assembly
Civic Square, London Circuit
CANBERRA ACT 2601

Dear Mr Speaker

I am pleased to forward to you a Performance Audit Report titled '**Waiting Lists for Elective Surgery and Medical Treatment**', conducted under the authority contained in the *Auditor-General Act 1996*.

I would appreciate if you could arrange for the distribution of the Report to each member of the Legislative Assembly, and its tabling in the Legislative Assembly pursuant to Section 17(5) of the *Auditor-General Act 1996*.

Yours sincerely

Tu Pham
Auditor-General
1 December 2004

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ACT Auditor-General's Office

Performance Audit Report

ACT Health

Waiting Lists for Elective Surgery and Medical Treatment

December 2004

Table of Contents

LIST OF ABBREVIATIONS

CUTS	Critical and Urgent Treatment Scheme
CWS	Cost-Weighted Separations
DOSA	Day of Surgery Admission
EEG	Electroencephalogram
ENT	Ear, Nose and Throat
FAQ	Frequently Asked Questions
GP	General Practitioner
MRI	Magnetic Resonance Imaging
NRFC	Not Ready for Care
OECD	Organisation for Economic Cooperation and Development
OPD	Outpatients' Department
PAC	Pre-Admission Clinic
RFA	Recommendation for Admission
TCH	The Canberra Hospital
VMO	Visiting Medical Officer

1. REPORT SUMMARY

INTRODUCTION

1.1 Waiting lists are a key feature of the management of elective surgery in all Australian jurisdictions and many overseas countries. They enable the equitable allocation of scarce resources to patients. Elective surgery lists can also assist in better planning and efficient use of surgical resources.

1.2 Although waiting lists for elective surgery have been a part of the hospital system for many years, they are not as well established for non-surgical cases. With the increasing complexity of medicine, the distinction between surgical and non-surgical can be blurred, and many patients require integrated treatment involving both surgical and medical procedures. This suggests the need to extend the current surgical waiting lists to be more comprehensive and useful.

1.3 The Audit Office chose to conduct an audit of waiting lists because this is one of the key indicators in the provision of health services, and affects the well-being of a large number of people. The issue also reflects considerable public expenditure, and is of interest to the ACT community and the Legislative Assembly.

1.4 The objectives of the audit were to provide an independent opinion to the Legislative Assembly on whether waiting list information is generated and used effectively, and in particular whether:

a) Information on waiting lists published by ACT Health is complete, reliable and timely;

b) Systems to produce the waiting list numbers are efficient;

c) Patient priorities are accurate; and

d) ACT Health uses waiting list information effectively.

1.5 The Audit Office consulted a wide range of medical and administrative staff at The Canberra Hospital, Calvary Hospital and ACT Health, and would like to thank them for their ready and comprehensive assistance. The Audit Office particularly thanks a number of external parties who provided advice and assistance:

- Dr Wayne Ramsey, Senior Fellow in Clinical Governance, ACT Health and ANU Medical School;
- The Australian Medical Association (ACT);
- The Royal Australasian College of Surgeons (ACT Branch);
- The Health Care Consumers Association of the ACT; and
- The ACT Health Services Complaints Commissioner.

AUDIT OPINIONS

1. Waiting times in the ACT were generally worse than for other Australian jurisdictions, and became longer in the last two to three years.

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

   - waiting list data were, at times, neither accurate nor valid;
   - information on surgical waiting lists was more frequent but less comprehensive than in many other jurisdictions;
   - information on non-surgical waiting lists was patchy and inconsistent;
   - systems to produce surgical waiting lists were complex and time-consuming for administrative staff;
   - the process of prioritising patients did not always achieve equity in the treatment of patients;
   - communication with patients waiting for treatment covers essential requirements, but could be improved to provide a better service; and
   - there could be better use of waiting list information to enable patients and General Practitioners to select specialists with shorter waiting lists, and better allocation of resources between surgeons.

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

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

SIGNIFICANT FINDINGS

1.6 The audit opinions are based on the following key findings. Further details behind each significant finding are in Chapters 3 through 6.

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

Waiting List Priorities

- The system of categorising patients into different levels of priority was fundamentally sound but could be improved.
- Reviews of categorisation as recommended by previous reviews have either not proceeded or led to no improvements that Audit could identify.

- Informal practices, for example use of a category higher than Category 1[1], provided more precision and might be incorporated into the formal priority system.
- There was no assurance that priorities were consistently assessed between medical specialties, or between individual specialists.
- The priority system was subject to pressures from surgeons to advance a patient in the list.
- Patients in the 'Not Ready for Care' category were not included in reported waiting list numbers.
- Social factors such as whether others rely on the patient were not taken into account at the time of audit. ACT Health advised that surgeons currently consider social factors and that these issues are included in the new waiting list policy.

The Waiting List Process

- ACT Health had no data on the waiting times between referral by the General Practitioner (GP) and consultation with the specialist.
- Waiting list information by surgeon was not available to GPs and patients. ACT Health plans to provide such information from 2005.
- There were wide disparities between patient waiting times for similar conditions.
- Pooling[2] of patients, to increase equity of waiting times, was attempted by ACT Health on several occasions but with little success. Pooling success depends to a large extent on full cooperation from surgeons.
- Communication with patients on the waiting list, especially long-wait patients, could be improved.
- There was poor control over the placing of patients on, and their removal from, the 'Not Ready for Care' list. ACT Health's new waiting list policy may improve this.
- Actual waiting times did not always reflect the patients' priorities. For example, some 'Category 3' patients were given priority over 'Category 2' patients, and some 'Category 3' patients waited for shorter periods than the equivalent 'Category 2' patients.

Waiting List Performance

- Waiting times for elective surgery were generally worse than for other jurisdictions in Australia, and became longer in the last two to three years.
- Waiting times for non-surgical treatment varied considerably; and were particularly long at TCH for endoscopies and for new referrals to the Outpatients and Neurology Departments.

[1] For discussion of categories, see paragraph 3.7.
[2] For discussion of pooling, see paragraph 4.13

- There was often a lack of evidence for patients entering the 'Not Ready for Care' category.
- There was often a lack of evidence for changes to patients' priority category.
- Like most jurisdictions, information and public reporting on non-surgical waiting times was poor.
- The ACT did not publicly report waiting times by surgeon, thereby reducing the opportunities for GPs and patients to choose surgeons with shorter waiting times. ACT Health proposes to report such data from 2005.

Management of Waiting Lists

- Recommendations of previous reviews pertinent to the management of elective surgery were only partially actioned at the time of audit.
- Flexible resourcing of elective surgery was constrained by factors such as provisions of Visiting Medical Officer contracts.
- Day of Surgery Admission (DOSA) rates can be indicative of surgical efficiency. At the time of audit, ACT Health's DOSA performance was low, but ACT Health advises that the recent setting of targets has led to improvements in performance.
- Postponements of elective surgery were frequent, and there were opportunities to reduce postponements through better planning.
- Information on surgical waiting lists, although containing some errors, was, in broad terms, sufficiently reliable to support management decisions.
- With some exceptions, available funding was appropriately directed to the elective surgery specialties with the longer waiting times.
- No additional funds were directed to endoscopy at TCH despite its very long waiting list.

RECOMMENDATIONS AND RESPONSES TO THE REPORT

1.8 The audit makes 29 recommendations to address issues identified in the report. The more important are recommendations 1, 3, 5, 7, 9, 11, 16, 18, 19, 24, 26 and 28, which are in bold font.

1.9 In accordance with section 18 of the *Auditor-General Act 1996*, a final draft of this report was provided to the Chief Executive of ACT Health for consideration and comment.

1.10 The Chief Executive provided the overall response below:

> *I would also like to make some general comments to ensure that readers of your Report understand the framework in which elective surgery is provided in ACT public hospitals.*

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

The demand for hospital services is increasing, as is the case nation-wide. In 2003-04 ACT Health expanded its inpatient services by more than 8 per cent over the previous year, with over 70,000 admissions recorded for the first time ever. This represents a 60 per cent growth in admissions since the early 1990s. Growth due largely to an ageing population, reduced community access to general practitioners, and rapid advances in medical technology.

In 2003-04 the two public hospital emergency departments in the ACT experienced a 22 per cent growth in high urgency cases. This increase in category 1 and 2 (ED triage scale) emergency department presentations has made the demands of providing timely access to elective surgery an even greater challenge. Patients presenting at ED requiring emergency surgery compete for time and resources with elective surgery. One of the great challenges in our system is achieving a reasonable balance, especially at TCH as a tertiary hospital.

The Report notes that waiting times were generally worse than for other jurisdictions in Australia and became longer in the last 2-3 years. ACT Health accepts that these results are not satisfactory and for this reason the Government will provide more than $20 million over the four years (2003-04 to 2006-07 for additional elective procedures. Orthopaedics, ophthalmology, and general surgery will be the specific areas targeted.

However, on the other hand more people accessed elective surgery at ACT public hospitals in 2003-04 than ever before. For example, the 8,435 admissions to hospitals from the elective surgery waiting list represent an increase of 947 admissions (or 13 per cent) over the total of 7,488 reported for 2002-03.

The number of category 1 (urgent) cases being treated increased 18 per cent in 2003-04 compared to 2002-03, and the result of 98.7 per cent of these patients being treated in less than 30 days is an excellent result. This increase in urgent cases places more pressure on the system when trying to deal with the less urgent surgery. However, even in the face of this increased demand for urgent surgery there was a 16 per cent increase in category 2 (semi-urgent) and a 6 per cent increase in category 3 (non-urgent) surgical procedures performed in 2003-04 compared to 2002-03.

The Report placed particular emphasis on improving the generation and use of waiting list information and the prioritisation of patients placed on the list. ACT Health agrees with these recommendations and has a number of new strategies planned, which will address these particular recommendations in the Report.

There are also resource availability issues that will continue to impact on elective surgery waiting times. The public health system in the ACT is in need of more doctors and nurses to overcome chronic shortages. For example, the shortage of Ear Nose and Throat Surgeons and Plastic Surgeons is impacting on the ability of the public health system to treat patients in these specialties.

As a result of the factors outlined above, ACT Health has had to respond to an increasing level of demand for services, the greater amount being in emergency services which impact on access to elective surgery.

Finally, I would say ACT Health is committed to improvement as shown by the following initiatives: -

- *the improved internal management process of managing the waiting list*
- *the increased public accountability which has occurred with publishing waiting times on the web, and,*
- *our proven track record of providing increasing resources into elective surgery, which based on evidence is directed to areas most in need.*

There has also been significant effort into development of the waiting list policy, which has occurred concurrently with the Auditor-General's Performance review. Many of the issues and recommendations in the Auditor-General's report are addressed in this policy.

In the end this is a very difficult resource allocation issue. ACT Health is committed to looking after the most seriously ill patients first (either emergency or urgent elective). Dealing with less urgent elective surgery needs to be reorganised within these constraints.

1.11 In addition, the Chief Executive provided response to each recommendation, which are included below.

Recommendation 1

ACT Health should work with other jurisdictions to develop better clinical guidelines to improve categorisation. This would also include establishing policy on the extent to which social factors can be used in prioritising within the clinical urgency categories.

ACT Health Response:

Agreed *ACT Health will raise this at appropriate national leadership forums. ACT Health has commenced the development of clinical priority assessment criteria for scoring the severity of a patient's condition. Ophthalmology is planned for the first*

specialty to implement this system. The scoring system places significant weighting on social factors.

Recommendation 2

ACT Health should consider establishing a category intermediate between the current Categories 2 and 3 in order to distinguish between those patients who require treatment in a maximum of one year and those who can wait longer.

ACT Health Response:

Not agreed *This would only increase the complexity of managing the list. ACT Health is investigating options to decrease the complexity of waiting list management.*

Recommendation 3

ACT Health should seek to have all hospital departments with waiting lists use consistent priority categories.

ACT Health Response:

Agreed

Recommendation 4

ACT Health should consider options to get better information on waiting times for specialist consultation.

ACT Health Response:

Agreed in principle *ACT Health cannot conduct a survey without surgeon and GP approval, and will explore this option with surgeons and GPs. The mechanism of referral from GP to surgeon in the ACT is a private referral outside the control of ACT Health.*

Recommendation 5

ACT Health should negotiate with surgeons and review the application of privacy laws with a view to posting wait times by surgeon by procedure on the web, as in NSW and WA.

ACT Health Response:

Agreed *The Elective Surgery Waiting List Management Policy supports this. Action is expected in 2005.*

Recommendation 6

ACT Health should develop and publish material to encourage patients and GPs to consider wait times when selecting their surgeon.

ACT Health Response:

Agreed

Recommendation 7

ACT Health should seek to equalise Category 3 wait times by means such as discouraging Category 3 requests for admission from surgeons with very long (compared to peers) Category 3 waiting time, or by encouraging pooling of Category 3 patients.

ACT Health Response:

Not agreed *ACT Health cannot refuse to accept an admission, as this would constitute a breach of the Australian Health Care Agreement. ACT Health will pursue pooling with cooperative surgeons.*

Recommendation 8

ACT Health should improve information brochures to advise patients that they have a right to know their urgency category and the means by which they can seek to have it changed.

ACT Health Response:

Agreed *A consumer version of the new Elective Surgery Waiting List Management Policy is being developed.*

Recommendation 9

ACT Health should conduct a review of the information needs of patients, GPs and surgeons, such as desired frequency of contact, and preferred mode of contact, with a view to improving communication with stakeholders.

ACT Health Response:

Agreed

Recommendation 10

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

ACT Health Response:

Not agreed *The rules for changing patients to a not-ready-for-care status will be tightened with the implementation of the Elective Surgery Waiting List Policy. All patients who are made not-ready-for-care will be assigned a 'status review date'. When this date becomes current, the patient or surgeon will be contacted to determine the patient's future status. We note that the recent Independent Commission Against Corruption Report did not recommend establishing the rule suggested in the report.*

Recommendation 11

ACT Health should establish, through consultation with the patient or medical practitioner, an expected time that a patient will cease to be NRFC and check status with the patient or medical practitioner at that time.

ACT Health Response:

Agreed *The new Elective Surgery Waiting List Management Policy addresses this, see above.*

Recommendation 12

ACT Health should reiterate the policy that patients should, subject to resource limitations only, be seen in clinical urgency priority: all Category 2 patients should get priority over any Category 3 patient.

ACT Health Response:

Agreed in part *This already occurs with individual doctors lists whenever possible. When there is a space in the list of a specific time, if there is no Category 2 patient available, a Category 3 patient will be substituted. This is required for effective resource utilisation of theatre lists.*

Recommendation 13

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

ACT Health Response:

Agreed *This is addressed in the new Elective Surgery Waiting List Management Policy.*

Recommendation 14

ACT Health should investigate the possibility of better integration of hospital and ACT Health databases in order to produce more flexible, reliable and faster analysis of waiting times.

ACT Health Response:

Agreed

Recommendation 15

ACT Health should improve the accuracy of data entry by means such as training, and conduct of quality assurance checks.

ACT Health Response:

Agreed *Both hospitals are implementing improved staff training.*

Recommendation 16

ACT Health should maintain records of assent to patients joining the NRFC list, ideally in writing by the patient or specialist, but at least keeping a signed and dated note of conversation with the patient or specialist.

ACT Health Response:

Agreed in part *Not-ready-for-care patients will be assigned a status review date and will have their status reviewed at this time. There is a need to reduce the complexity of managing the waiting list, not increase its complexity. Record keeping is covered in the new Elective Surgery Waiting List Management Policy. Included in this is a reference to documenting any change in clinical priority on the RFA and waiting list database.*

Recommendation 17

ACT Health should conduct regular independent audits of the NRFC list to minimise errors in NRFC categorisation and subsequent errors in statistical results.

ACT Health Response:

Agreed *This activity is documented in the new Elective Surgery Waiting List Management Policy.*

Recommendation 18

ACT Health should ensure that all changes to category are based on sound medical reasons and are recorded appropriately.

ACT Health Response:

Agreed

Recommendation 19

ACT Health should request that each hospital review its medical services to establish what services are subject to waits, and establish appropriate systems to measure and report to ACT Health on those waits.

ACT Health Response:

Agreed

Recommendation 20

ACT Health should combine reporting for the two hospitals so that an overall report on the health system is produced

ACT Health Response:

Agreed *This is already in place with the monthly Access to Elective Surgery Report.*

Recommendation 21

ACT Health should publish the number of patients in the NRFC category as a supplement to the waiting list statistics. Ideally, this would be split into their former category, for example NRFC: used to be Category 1.

ACT Health Response:

Agreed in part *The number of people on the not-ready-for-care list will be published. Splitting the group into previous categories would require considerable personnel resources and would not represent good value for money. New hospital systems will report the patient's current clinical priority as 1, 2 or 3 and whether they are 'Ready for Care' or 'Not Ready for Care'.*

Recommendation 22

ACT Health should publish waiting time performance calculated at the date of admission, to improve the relevance and internal consistency of data.

ACT Health Response:

Agreed *Quarterly waiting times reported on the publicly available web page are calculated on waiting time to admission.*

Recommendation 23

In addition to the monthly reports, ACT Health should produce a more comprehensive analysis of waiting list trends on at least an annual basis.

ACT Health Response:

Agreed *This will be done in the Annual Report.*

Recommendation 24

ACT Health should work towards including reporting on elective medical procedures in regular public statistical reports.

ACT Health Response:

Agreed

Recommendation 25

ACT Health should consider the cost-effectiveness of means such as increased Day of Surgery Admission, same-day surgery and evening and weekend surgery in addressing waiting lists.

ACT Health Response:

Agreed in part *This is already in hand. DOSA rates are improving. Evening and weekend surgery is not cost-effective due to high penalty payment rates for staff, so is not supported.*

Recommendation 26

ACT Health should encourage each hospital to review the causes of postponements with a view to reducing them, and in particular request The Canberra Hospital to take steps to improve planning so as to reduce postponements.

ACT Health Response:

Agreed *This is already occurring.*

Recommendation 27

ACT Health should encourage each hospital to offer surgical sessions that become available, either permanently or through the temporary unavailability of a surgeon, to the surgeons with the longest Category 1 and Category 2 waits.

ACT Health Response

Agreed *This is already done if the surgeon is available.*

Recommendation 28

ACT Health should complete implementation of agreed recommendations of the Standing Committee on Health and Community Care's 1999 inquiry into waiting lists.

ACT Health Response:

Agreed *ACT Health has progressively implemented responses to these recommendations.*

Recommendation 29

ACT Health should consider the feasibility and cost-effectiveness of acquiring services from private providers to address excessive waiting lists.

ACT Health Response:

Agreed *ACT Health will consider the use of private providers where appropriate.*

2. INTRODUCTION

THE NATURE OF THE WAITING LIST PROBLEM – DEMAND EXCEEDING SUPPLY

2.1 Waiting lists for elective medical procedures exist because demand for elective surgery exceeds supply, and therefore a rationing process is necessary. For most products and services in our economy, the rationing process is achieved by price, so that if there is a shortage, price rises restore the balance by reducing demand and increasing supply. However, it is not appropriate for public health to be subject to such price considerations, and so another form of rationing is required for a service that is effectively free but valuable.

2.2 Demand for elective surgery in the ACT has fluctuated, but shown no consistent trend, over the last two years. Some 45 000 people are admitted to public hospitals in the ACT for elective (non-emergency) admissions, of which almost 9000 are for elective surgery. Public hospital admissions rose from 53 000 in 1993-94 to 61 900 in 2001-02. With an ageing population, a more significant growth trend might have been expected. From 1993 to 2003, the ACT population aged 65 years and over increased by 47% and the population aged 85 years and over more than doubled. This rate of ageing is more than the comparable rate for all of Australia. However, the increasing use of private facilities has reduced demand on the public system.

2.3 The supply of elective surgery is primarily determined by budget allocations, but is also influenced by practical factors such as the availability of surgeons, operating theatres, beds and nurses, and also by the efficiency with which these factors are brought together to provide elective surgery. Supply has also fluctuated in recent years, but increased in 2003-04 compared to the previous year.

2.4 Waiting lists help to balance supply and demand. Acquiring the service depends on firstly the criticality of the condition, and if the condition is not serious, on the willingness to wait. The inconvenience of the operation, its assessed benefit, the alternative cost and timeliness of seeking private treatment are weighed by patients, and the result is a system that can be in balance, as those patients faced with a long wait may decide to cancel the operation or obtain private treatment.[3] That the system is in balance does not necessarily mean that it is optimum. If a free market achieved a balance through a high price that most people could not afford, this would be seen as undesirable. Similarly, rationing by waiting lists where the waiting list is very long would also be undesirable.

2.5 Waiting lists fulfil two main functions. Firstly, as a formal record of patients registered as requiring admission for treatment, they ensure that patients do not get overlooked. Secondly, they provide a statement of known demand for treatment to

[3] S Martin & PC Smith, *Rationing by Waiting Lists*, J. Pub. Econ. 1999; 71:141-164

assist the planning of hospital resources, thereby increasing efficiency. No waiting list would imply that at times surgeons, nurses and operating theatres would be unoccupied.

2.6 The optimum length of waiting lists, from the point of view of overall costs and benefits to society, is therefore not zero. The challenge to policy makers and health providers is to find the right balance of resources to the system and waiting list management procedures that produces the optimum length of waiting lists. As an Organisation for Economic Cooperation and Development (OECD) report noted: 'if clinical prioritisation is working well, it is the least needy who will wait longest'.[4]

SURGERY AND OTHER FORMS OF TREATMENT

2.7 Most audits of waiting lists have focused on elective surgery. While noting that this is a key component of non-urgent treatment, Audit became aware early in the audit planning process that there were many other medical procedures not involving surgery that were also subject to resource limitations leading to the need for patients to wait.

2.8 Audit also became aware that the division between surgery and non-surgical treatment is becoming increasingly indistinct. There are some procedures that are formally defined as surgery according to the Medicare Benefits Schedule, such as angioplasty, that are not included in the ACT statistics.[5] Other procedures can be invasive, such as taking gastroenterological biopsies, but are performed as a day procedure that is not counted in the elective surgery statistics. Similarly, a procedure such as fitting of a coronary pacemaker, once a significant surgical operation, is now performed under local anaesthetic as one of the procedures in the cardiac catheter laboratory, and not counted as surgery.

2.9 Further, a combination of surgical and non-surgical treatment is often essential. For example, a typical course of treatment of breast cancer involves surgery followed by chemotherapy and radiotherapy. If the initial surgery is timely, but the follow up therapies are not, then the whole course of treatment can have a degraded outcome.

2.10 For some conditions, there may be a choice between a surgical and non-surgical intervention; and this will be partially influenced by the availabilities (including waiting times) of these interventions. Also, the availability of early medical management of a progressive disease, for example renal failure, may delay or prevent the need for surgical treatment such as to provide for dialysis or to perform a transplant.

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[4] Hurst, Jeremy and Luigi Siciliani, *Tackling Excessive Waiting Times for Elective Surgery: A Comparison of Policies in Twelve OECD Countries*. OECD Health Working Papers No. 6, 2003, p.41

[5] A perusal of the waiting lists on the web indicated that this procedure is counted as elective surgery in WA, but not in NSW

2.11 For these reasons, this audit included a review of the non-surgical component of waiting lists.

REASONS FOR CONDUCTING THE AUDIT

2.12 There has been no previous performance audit of waiting lists in the ACT, although significant issues have been discovered by audits conducted in other jurisdictions such as NSW, WA and UK. Addressing waiting lists issues is of significant cost. Total costs for acute services in ACT hospitals (which include most hospital care, including emergency as well as elective procedures) are budgeted for $431.6m in 2004-05. In 1998, the Government estimated that the surgical waiting list contributed to less than 10% of public hospital workload.[6] In 2003-04, elective surgery accounted for approximately 13% of hospital admissions.

2.13 Waiting lists are of significance as their effective management contributes to the efficient operation of hospitals, and can minimise the pain and discomfort felt by a large number of patients. As ACT Health has noted, the management of elective surgery is a major indicator of the effectiveness of the public hospital system. In September 2004, there were 2723 cases on the waiting list for elective surgery at TCH and 1954 at Calvary Public Hospital. In addition, waiting lists are issues of considerable interest to the community. The topic has been raised in the Legislative Assembly several times and has been the subject of frequent press comment.

AUDIT OBJECTIVES AND SCOPE

Audit objectives

2.14 The objectives of the audit were to provide an independent opinion to the Legislative Assembly on whether waiting list information was generated and used effectively, and in particular whether:

a) information on waiting lists published by ACT Health was complete, reliable and timely;

b) systems to produce the waiting list numbers were efficient;

c) patient priorities were accurate; and

d) ACT Health used waiting list information effectively.

Scope – audit coverage and entities involved

2.15 The scope of the audit was limited to elective procedures conducted on public patients at an ACT hospital. It did not deal with waiting for emergency services or waiting as an in-patient for additional procedures or surgery. Nor did the

[6] *Government Submission to the Standing Committee on Health and Community Care Inquiry Into Public Hospital Waiting Lists (Both Surgical and Non-Surgical), 1999*, p.5

audit deal with waiting for procedures that are performed outside the hospital system or outside the ACT.

2.16 Section 12 of the *Auditor-General's Act 1996* provides that in the conduct of a performance audit, the Auditor-General shall, where appropriate, take into account environmental issues relative to the operations being reviewed or examined, having regard to the principles of ecologically sustainable development. For this audit, the Auditor-General determined that it was not appropriate to take into account environmental issues because there were no issues of substance that were relevant to the topic.

Focus – matters for consideration

2.17 The audit considered accuracy and reliability of waiting list information as well as measures taken to address waiting list issues.

2.18 The audit approach and the criteria used are described in Appendix 1.

WAITING LISTS AND REVIEWS ELSEWHERE

2.19 Waiting lists for elective surgery are a common feature of many public health systems throughout the world. The OECD, in an analysis of waiting lists, reported that they were a concern in almost half the OECD countries; for example, in Australia, New Zealand, UK and Canada, but not in USA, France, Germany or Japan. The study showed that the availability of doctors most strongly influenced waiting lists, and also that an overall health expenditure increase of US$100 per head reduced waiting times by 6.6 days.[7] Countries that did not report waiting times were characterised by a higher level of capacity (doctors and beds), and a higher level of spending, which translated into higher production (more surgery).[8] In countries with waiting times, GPs often acted as gatekeepers by referring patients to surgeons, whereas in countries without waiting times patients tended to have direct access to surgeons. The OECD report had no clear explanation for this correlation.[9]

2.20 Most Australian jurisdictions regularly publish information on surgical waiting lists. However, they do not generally publish, or gather centrally, good information on non-surgical waiting lists.

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[7] Siciliani, Luigi and Jeremy Hurst, *Explaining Waiting Time Variations for Elective Surgery Across OECD Countries*, OECD Health Working Papers No. 7, 2003 p.4
[8] ibid, p. 26
[9] ibid, p. 36

3. WAITING LIST PRIORITIES

INTRODUCTION

3.1 Before describing the waiting list process in detail, it is useful to discuss the processes used in setting patient priorities. The chapter starts with an overview of waiting list priorities, and then describes the system in the ACT.

3.2 Australian States and Territories have taken a consistent approach to elective surgery waiting lists. The main features are the establishment of a three-way priority scale of urgent (30 days) semi-urgent (90 days) and not urgent (ideally within one year). Each State aims for a degree of centralisation of waiting lists, normally at the Area level. Although there is a principle that public patients do not have the right of choice, there is in practice a good deal of choice made by patients on the surgeon they prefer. States do not generally include procedures other than elective surgery in their published waiting lists.

3.3 Major variations are that NSW has a wider spread of priorities, including a one-week very urgent priority, and also reports some non-surgical procedures. Also, NSW and WA have published on the internet waiting lists by surgeon and hospital.

3.4 Canada, New Zealand and Oregon in the USA use more formalised approaches with priority scoring systems.[10] New Zealand regulates its system so that patients are either admitted within six months or not listed at all, but sent back to GPs for 'active review'.

3.5 The Western Canada Waiting List adopted a system that gives a score (of 0 to 100) to patients and thereby places them in a priority order.[11] A similar system was trialled in New Zealand and showed promise in giving due priority to the more urgent patients.[12] However, it also attracted criticism and did not get full support of management or surgeons.[13]

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[10] Hurst and Siciliani op. cit. p.37; Oregon Department of Human Services, '*The Prioritized List – a History* downloaded from www.dhs.state.or.us/healthplan/priorlist/history.html

[11] McGurran, John, Western Canada Waiting List Project, *Prioritising Elective Surgery Patients*, paper presented to Meeting Patient Needs Conference Series: Managing Hospital Demand, Melbourne, March 2003

[12] MacCormick, Andrew D, Lindsay D. Plank, Elizabeth M. Robinson and Bryan R. Parry, *Prioritizing Patients for Elective Surgery: Clinical Judgement Summarized by a Linear Analogue Scale*, ANZ J. Surg. 2002; 72: 613-617

[13] Roake, Justin, *New Zealand's Experience of Elective Surgery Prioritisation Systems*, paper presented to Meeting Patient Needs Conference Series: Managing Hospital Demand, Melbourne, March 2003

SIGNIFICANT FINDINGS

3.6 The audit found that:

- The system of categorising patients into different levels of priority was fundamentally sound but could be improved.
- Reviews of categorisation as recommended by previous reviews have either not proceeded or led to no improvements that Audit could identify.
- Informal practices, for example use of a category higher than Category 1, provided more precision and might be incorporated into the formal priority system
- There was no assurance that priorities were consistent between medical specialties, or between individual specialists.
- The priority system was subject to pressures from surgeons to advance a patient in the list.
- Patients in the 'Not Ready for Care' category were not included in reported waiting list numbers.
- Social factors such as whether others rely on the patient were not taken into account at the time of audit. ACT Health advised that surgeons do consider social factors and that these issues are included in the new waiting list policy.

PATIENT PRIORITY CATEGORIES

Categories 1, 2 and 3

3.7 In the ACT, surgeons allocated a priority category (1, 2 or 3) to each patient as follows:

> Category 1: urgent admission is desirable within 30 days for a condition that could deteriorate;
>
> Category 2: semi-urgent admission is desirable within 90 days for a condition that may influence the person's health status over the longer term;
>
> Category 3: admission at some stage in the future for a condition that is causing minimal or no pain, dysfunction or disability.

3.8 In addition, patients could be placed in a fourth category, 'Not Ready for Care' (NRFC). This can arise from patients' own choice; for example, they may be

away on holidays, or for medical reasons, such as another illness, that makes surgery inadvisable.

3.9 Priority can be considered to be made up of severity (the degree of pain or lack of functionality caused by the condition) and urgency (the propensity for the condition to deteriorate if not treated).[14] For example, a painful and debilitating, but stable, hip condition may be severe but not urgent, and early-stage cancer may be urgent, but not severe. Categories can be revised by the specialist if considered medically necessary.

3.10 Some non-surgical specialties also used this three-category system, while others used a more informal classification into urgent and routine cases. Radiotherapy at TCH established a three-way system different to elective surgery.

3.11 Category 3 does not have a clinically determined time limit, although a benchmark of 12 months is set. There is some ambiguity as to whether patients can expect treatment within 12 months or not. In 1996, the target waiting time for Category 3 patients in the ACT was six months. The 2004 Elective Surgery Waiting List Management Policy stated that there will be a Key Performance Indicator of 'patients waiting longer than 6 months' and that patients must have the option of being admitted within 12 months.

Reviews of the category system

3.12 In 1999, the ACT Government commented in a submission to the Standing Committee on Health and Community Care's inquiry into waiting lists that there can sometimes be little or no differences in clinical need between patients classified 1, 2 or 3, and that the categorisation tool was subjective and could lead to inequities. Therefore, a trial was being conducted for a few indicator procedures where the surgeon included other clinical indicators. The Committee supported the Government's move to refine the categorisation system. However, there was no recorded outcome from this trial, and it had no impact on the process of categorisation.

3.13 A review of elective surgery waiting lists in Victoria in 1998 recommended retention of the current categorisations, but also recommended development of clinical guidelines to improve categorisation.[15] However, a 2003 Victorian review showed that clinicians appeared to be inconsistent in their approach to categorisation of urgency for individual conditions, possibly because criteria are very subjective. The conclusion was that the urgency prioritisation system would seem unlikely to

[14] Based on Hadorn, David C., and the Steering Committee of the Western Canada Waiting List Project, *Setting priorities for waiting lists: defining our terms*, CMAJ, October 3, 2000; 163(7) p. 858.

[15] Clarke, Dr Bernard, and Emeritus Professor Richard Bennett, *Review of Elective Surgery Waiting Lists*, Report to Victorian Minister for Health, September 1998

provide equity of access to patients.[16] Similarly, a recent audit in NSW found that surgeons differ markedly in the clinical priority that they give to patients undergoing the same procedure. Further, there were no state-wide assessment tools, guidelines or criteria to assist surgeons in allocating patients a priority category.[17] In addition, a WA audit found that there were no guidelines for specialists to help ensure a more consistent categorisation of patients into the various urgency categories.[18]

Need for additional categories

3.14 Audit observed that there was an informal categorisation of 'Category 1+' where surgeons could request patients be scheduled for surgery as soon as possible; normally within a week. Booking staff were responsive to these requests. Given the significant difference between a one-day admittance (the definition of emergency) and the 30 days of Category 1, an intermediate category of admittance in 7 days seems useful. NSW uses such a category. The 2000 Surgical Services Review conducted for ACT Health also identified a category of patients who require surgery within a week, but cannot wait to be done on the surgeon's next elective list.

3.15 Some medical patients require to be admitted soon, but do not rate emergency admission – effectively a Category 1+ as discussed above. It was often difficult to get access to a bed for these patients. The Audit was informed that some new patients who would be a 'Category 1+' were added to the emergency surgery list. However, this was not consistent with the emergency definition of needing treatment within 24 hours. There may be some merit in codifying current practice to provide for these semi-emergency patients to receive appropriate priority.

3.16 There may also need to be an additional category at the non-urgent end of the scale. For example, audit was informed that there were Category 3 patients who were unlikely to receive surgery in many years, if at all. Indeed, the longest wait as at 30 June 2004 was 1785 days or almost five years. At the same time, Audit was also informed that some of these patients were not currently suffering degradation of life style due to their condition. This is consistent with the Category 3 definition that refers to a condition that is causing minimal or no pain, dysfunction or disability, and the lack of a formal target date for treatment. Also, a research project across three countries showed a high tolerance for long waits for non-urgent cases (in this case, ophthalmology). For example, only about one third of patients said the wait (one to 18 months) was too long, and only 1.7% paid the approximately $1000 to have the surgery done privately.[19]

[16] Russell, Colin. *Measuring & Meeting Demand: The Victorian Experience*. Paper presented to Meeting Patient Needs Conference Series: Managing Hospital Demand, Melbourne, March 2003

[17] NSW Auditor-General's Report: *Waiting Times for Elective Surgery in Public Hospitals: NSW Department of Health*, September 2003, p.5, p.77

[18] Auditor General for Western Australia: *Patients Waiting: Access to Elective Surgery in Western Australia*, Report No. 11, December 2003 p.37

[19] *CentrePiece*, (Canada) Issue 6, Fall 1998.

3.17 However, many patients in Category 3 do require treatment within a year at most. Audit was informed that for specialities for which Category 3 patients could wait years, surgeons sometimes artificially upgrade the patient to Category 2 to ensure their surgery takes place. Such patients may require a category intermediate between the current Categories 2 and 3. ACT Health has agreed with ophthalmologists (who have many long-wait patients) that some type of prioritisation is needed but it has not been implemented yet.

Accuracy and consistency of categorisation

3.18 There was a risk that surgeons elevate priorities for their own patients without a justifying medical reason. Surgeons could also exert pressure by making strong requests to place a patient on a specific early list, even if they were of lower category, and audit was informed that these requests were often acceded to. This could also distort priorities.

3.19 The priority generally worked well within each surgical type, but not between types of surgery (there was no way of knowing if a Category 2 neurosurgery case was of similar criticality to a Category 2 orthopaedic case). There was no independent clinical review on whether the priorities of individual cases are reasonable. Occasionally surgeons were queried by ACT Health, but their decisions were not then subject to review or change.

3.20 One way of assessing the consistency of categorisations is to consider the variations between States, as in Table 1 below.

Table 1: Classification of patients to clinical urgency categories, 2001-02 (per cent)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT
Category 1	na	20.7	33.8	Na	27.0	na	30.7	34.6
Category 2	na	46.0	45.8	Na	20.4	na	41.4	33.0
Category 3	na	33.3	20.4	Na	52.6	na	27.9	32.4
Total	na	100.0	100.0	Na	100.0	na	100.0	100.0

Note: Data refers to patients admitted from waiting lists

Source: Productivity Commission, *Report on Government Services,* 2004

3.21 There is a high level of variation in Table 1, for example over half of South Australian patients, but not much more than a quarter of patients in the ACT, were rated as Category 3. Such variations are unlikely to be due to different health levels between the States. This high degree of inconsistency of categorisation after averaging across a State suggests that the level of variation between individual surgeons is likely to be quite high.

Social factors in setting priorities

3.22 The 1995 ACT waiting list policy stated that social and geographic circumstances should be considered. However, the current ACT system has put patients in priority order solely on the basis of medical need, and then waiting time within each category of need and any previous postponements. The 2004 Elective Surgery Waiting List Management Policy states that 'if all other things are equal, priority must be given … to those in disadvantaged social situations (e.g. … the elderly living on their own).' In addition, there has been a recognised but informal priority given to children. Attempts were made not to postpone at short notice out-of-town patients. The impact of the health condition on others (such as dependants) was not taken into account.

3.23 In New Zealand, social factors such as the ability to work, to give care to dependants and to live independently were explicitly considered.[20] A Canadian paper discussed these issues as follows:

> Is it right, for example, that a person who is working or caring for an elderly parent should receive higher priority than another (clinically comparable) patient who is unemployed or not caring for a parent? In New Zealand, this issue was addressed by the National Advisory Committee on Core Health and Disability Support Services, which convened 2 formal public hearings focused on this subject. The committee found cautious support for the social factor, provided that the number of points assigned to it was not large compared with the clinical factors.
>
> The experience of the Western Canada Waiting List Project is that, at least in the setting of elective surgery, doctors were generally comfortable with the inclusion of such a social factor. Preliminary experience in the United Kingdom appears to be similar.[21]

Conclusions on the priority-setting process

3.24 The current set of priorities adopted in the ACT has the virtue of simplicity. However, there were instances where the available priorities did not adequately describe clinical need, and this applied both to medical and surgical specialties. There also were some inconsistencies in application that might be addressed by establishing better guidelines for use by specialists. Use of a consistent set of priority descriptions across the hospital system, including medical waiting lists, would enable ease of comparison of waiting list pressures.

[20] Hurst and Siciliani, op. cit p.38

[21] Hadorn, David C., and the Steering Committee of the Western Canada Waiting List Project, *Setting Priorities for Waiting Lists: Defining our Terms*, CMAJ, October 3, 2000; 163(7) p. 859.

Recommendation 1

ACT Health should work with other jurisdictions to develop better clinical guidelines to improve categorisation. This would include establishing policy on the extent to which social factors can be used in prioritising within the clinical urgency categories.

Recommendation 2

ACT Health should consider establishing a category intermediate between the current Categories 2 and 3 in order to distinguish between those patients who require treatment in a maximum of one year and those who can wait longer.

Recommendation 3

ACT Health should seek to have all hospital departments with waiting lists use consistent priority categories.

4. THE WAITING LIST PROCESS

INTRODUCTION

4.1 The waiting list process starts when a patient consults a General Practitioner (GP) who decides that the condition warrants referral to a surgeon or other medical specialist. This specialist may send a Recommendation for Admission (RFA) to a public hospital.

4.2 Every surgical patient is the patient of a specific surgeon, even though public patients do not have the right to choose their doctor, and may have their surgery conducted by a registrar under the supervision of their admitting specialist. Whether a patient is a public or private patient does not affect their priority of access to a public hospital; however, it enables them to choose their doctor.

4.3 RFAs for public surgery were managed centrally by each hospital's surgical bookings team. The bookings team sorted patients by priority, kept track of the resulting waiting lists, created surgical lists in conjunction with the surgeon, informed patients when they should come to the hospital for treatment, and handled any unexpected postponements by either the patient or the hospital. Patients on the list eventually receive surgery or otherwise leave the waiting list.

4.4 Non-surgical waiting lists were each managed in a separate part of each hospital. Areas where patients may have had to wait for scheduled services included the following:

- Oncology;
- Endocrinology;
- Gynaecology (PAP smears);
- Renal clinic services;
- Neurology;
- Cardiology (Angiograms and angioplasty);
- Gastroenterology (Endoscopies); and
- Dentistry.

SIGNIFICANT FINDINGS

4.5 The audit found that:

- ACT Health had no data on the waiting times between referral by the GP and consultation with the specialist.
- Waiting list information by surgeon was not available to GPs and patients. ACT Health plans to provide such information from 2005.
- There were wide disparities between patient waiting times for similar conditions.
- Pooling of patients, to increase equity of waiting times, was attempted by ACT Health on several occasions but with little success. Pooling success depends to a large extent on full cooperation from surgeons.
- Communication with patients on the waiting list, especially long-wait patients, could be improved.
- There was poor control over the placing of patients on, and their removal from, the 'Not Ready for Care' list. ACT Health's new waiting list policy may improve this.
- Actual waiting times did not always reflect the patients' priorities. For example, some 'Category 3' patients were given priority over 'Category 2' patients, and some 'Category 3' patients waited for shorter periods than the equivalent 'Category 2' patients.

REFERRAL BY GENERAL PRACTITIONER TO A SPECIALIST

4.6 From the overall health system perspective, the process starts when a patient seeks an appointment with a GP. Where the condition warrants it, the GP will refer the patient to a specialist. The patient must then wait for a consultation with the surgeon. This interval was not known by ACT Health, except for the small minority of cases where the specialist was a staff specialist at TCH. It is believed that this time can be substantial, of the order of 3-6 months, unless the GP seeks priority consideration for more seriously ill patients.

4.7 This wait between GP and specialist is measurable, at least with respect to referrals to specialists in outpatient clinics, in jurisdictions such as WA and the UK. Audits in both these jurisdictions recommended reporting or managing the total time waited from seeing a GP to being admitted. The ACT Standing Committee on Health and Community Care recommended in 1999 that ACT Health investigate the usefulness and feasibility of collecting data on the length of time it takes patients to

see specialists. The Government accepted this recommendation, but then decided it was not practicable to measure this wait.

4.8 It would be very useful to estimate waiting times for patients to see a specialist, as this is a leading indicator of future demand for elective hospital treatment. Possible approaches to collecting data include conducting a survey of specialists to determine their waiting time for a routine appointment, or to hold consultations with medical and surgical colleges or other professional bodies to assess the size of the waiting lists.

Recommendation 4

ACT Health should consider options to get better information on waiting time for specialist consultation.

4.9 Waiting list information by surgeon was not available from the waiting list system to GPs or patients, with the result that it was more difficult to take into account the prospective waiting time in selecting a surgeon. The absence of information was based on a legal opinion that assessed that identity of the surgeon was personal information and thereby should not be disclosed under the Privacy Act. ACT Health was advised in 2001 to seek express consent from each surgeon. However, they did not do so, and instead ceased distributing information on surgeons' waiting lists to GPs. The 2004 Elective Surgery Waiting List Management Policy stated that the elective surgery internet site will provide data according to surgeon.

Recommendation 5

ACT Health should negotiate with surgeons and review the application of privacy laws with a view to posting waiting times by surgeon by procedure on the web, as in NSW and WA.

Recommendation 6

ACT Health should develop publicity material to encourage patients and GPs to consider wait times when selecting their surgeon.

RECOMMENDATION FOR ADMISSION

4.10 Following consultation with patients, the specialist will decide whether to recommend admission to hospital for surgery or other treatment. This process itself may involve a delay while diagnostic tests are carried out. The waiting list from ACT Health's point of view commences when the hospital receives a Recommendation for Admission.

4.11 Surgical booking clerks in each hospital then add patients to waiting lists by speciality, for example orthopaedics or ophthalmology. The specific procedures planned are also recorded.

4.12 Waiting lists for patients with similar procedures can vary markedly. For example, the mean waiting time in 2003-04 for cataract extraction varied from a minimum of about 30 days for one surgeon to a maximum of about 520 days for another.

4.13 One approach to removing waiting time inequities is to put all patients in a common pool, from which each surgeon treats next the patient who has been waiting longest. The Standing Committee on Health and Community Care recommended in 1999 that the Government work towards developing a trial for pooling public patients, and also consult with a view to encouraging GPs to provide the option of being referred to a specialist with shorter waiting times. ACT Health agreed at the time, and noted that some pooling had already occurred for urology in 1999 and would be extended to ophthalmology in 2000.[22] However, advice from ACT Health was that this pooling did not in fact occur at that time. Audit was informed that attempts at pooling failed as surgeons were not supportive, most patients preferred to stay with their initial surgeon, and changing surgeons required an additional consultation for the new surgeon to become familiar with the case. However, ACT Health states that pooling is now occurring in general surgery and ophthalmology.

4.14 Since the audit, ACT Health is now implementing a policy that will provide for patients to be offered the ability to switch to a doctor with a shorter waiting list. Waiting list coordinators would identify a surgeon with a shorter waiting time, and after consultation with the clinicians, offer this option to the patient. This option relies on the goodwill of the clinicians and the willingness of the patient to move, and still requires a further clinician consultation.

4.15 Recognising the obstacles above, Audit suggests that the solution lies in trying to equalise waiting lists at the time patients are first referred to specialists. One approach that could be considered is for ACT Health to work with specialists and their professional bodies with a view to reducing Category 3 recommendations for admission from specialists with very long waiting lists compared with their peers. This might be achieved by persuading specialists not to accept such referrals from GPs, and instead encouraging GPs to refer their patients to specialists with shorter waiting times.

Recommendation 7

ACT Health should seek to equalise Category 3 wait times by means such as discouraging Category 3 requests for admission from surgeons with very long (compared to peers) Category 3 waiting time, or by encouraging pooling of Category 3 patients.

[22] *ACT Government Response to the Report on the Inquiry into Public Hospital Waiting Lists,* 2000

COMMUNICATION WITH PATIENTS AND GPS DURING THE WAITING PERIOD

4.16 A 1999 qualitative research study commissioned by the ACT Government showed that consumers were not so much concerned about waiting times as they were about lack of information about the system and inadequate notice of surgery dates.[23] Further, an ACT survey of inpatients in 2002-03 showed that although 81% of patients were satisfied with their service, communication from staff to patients and family members was identified as an area for improvement.[24] This audit also identified communication with patients on the waiting lists as an area that could be further improved.

4.17 When patients were included on the list, they were informed by a standard letter, accompanied by a pamphlet on the elective surgery waiting list. This letter did not state the patient's clinical priority or any estimate of the possible waiting time. General information was provided on the 'Frequently Asked Questions (FAQ)' page on the website. For those patients without internet access or who are not familiar with on-line services, it may be better to include this information in an extended pamphlet. Neither the pamphlet nor the FAQ discussed the option of switching surgeons to expedite surgery.

4.18 Should patients' conditions deteriorate, they can contact their GP and then the specialist to seek an upgrade in priority, but this depends on the patient's initiative. The FAQ raised this possibility, but the brochure did not. Of those patients who had surgery in 2003-04, 269 or 3.2% were upgraded in priority during their wait.

4.19 Some patients, especially the elderly and those not familiar with government systems, may suffer in silence when their condition deteriorates, on a mistaken belief that they have to wait their turn. The ACT Health Services Complaints Commissioner quoted a case in his 2002-03 Annual Report as follows:

> A man was concerned that his wife might have to wait up to 14 months for spinal surgery. His wife used a wheelchair, was reliant on large doses of morphine, and was suffering severe constipation from medication prescribed to relieve pain. After six weeks of enormous anguish the man booked his wife into a private hospital utilising money set aside for their funerals. He and his wife were aged pensioners. He sought an explanation for the delay in surgery under the public system. Written responses were received from the hospital and it was explained how the waiting list system worked and that the woman had been identified as a patient to whom priority should be given. The hospital explained that during the time the woman was waiting there were larger than usual numbers of category one patients, who took priority. The hospital apologised for the distress the woman had experienced. The man was satisfied with the explanation and the Commissioner felt that the hospital provided a fair and reasonable response.

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[23] *ACT Government Response to the Report of Inquiry into Public Hospital Waiting Lists,* 2000

[24] Productivity Commission, *Report on Government Services,* 2004, p. 9.28

4.20 GPs were not routinely told the urgency category into which their patient was placed. Surgeons did not routinely receive a copy of the list of their patients recorded on the waiting lists, but Calvary instituted from August 2004 a process of sending surgeons a copy of their list every three months. However, the hospital did not propose to seek confirmation from the surgeon that the list is complete and details are correct.

4.21 Patients (or doctors) could also telephone the Elective Surgery Access Team. This team consisted of coordinators at each hospital and a central coordinator at ACT Health. The Access Team received about 3000 calls from early 2002 to April 2004. Patients could be informed of the estimated waiting time, and were advised to consult their GP if they felt their condition had deteriorated.

4.22 At approximately six-monthly intervals, the Access Team sent patients letters to determine whether or not they still required surgery and that their contact details remained correct. If there was no reply they sent a follow-up letter and then attempted telephone contact. If there was still no reply, then the patient was removed from the list; but could be re-instated if there was sufficient reason. The letters did not provide an option for the patient to state that they required surgery, but were not currently available – the NRFC category.

4.23 While patients are waiting on the list, especially Category 3 patients who may wait in excess of a year, there was little communication. Audit's view, based on complaints reviewed and feedback from the Health Care Consumers Association, is that better communication can alleviate some of the uncertainty that can add to the stress of waiting for treatment. There may be benefit in consulting patients on better ways of communicating with them.

4.24 Few complaints reached the Health Services Complaints Commissioner regarding access to elective surgery; five in each of 2002-03 and 2003-04. There were also only a small number of complaints arriving via letters to the Minister. Most of these referred to long waits. Often the response was that a patient at low priority had to wait. On one occasion, an orthopaedic patient was informed by the Minister that 'As a Category 2 patient you can expect to wait a minimum of 90 days'; however, this was inconsistent with the definition of Category 2, which states that admission is *desirable* within 90 days. Sometimes, ACT Health suggested specific measures to reduce the wait, such as transfer of hospital.

4.25 Both hospitals invited customer feedback, with TCH launching a new Customer Feedback program on 16 June 2004. TCH reported only eight complaints in 2003-04 relating to elective surgery. Some raised issues such as long periods of being left uninformed of progress or of options to expedite surgery, but none raised the length of wait suffered.

Recommendation 8

ACT Health should improve information brochures to advise patients that they have a right to know their urgency category and the means by which they can seek to have it changed.

Recommendation 9

ACT Health should conduct a review of the information needs of patients, GPs and surgeons, such as desired frequency of contact, and preferred mode of contact, with a view to improving communication with stakeholders.

'NOT READY FOR CARE' CATEGORY

4.26 Patients could be placed in the 'Not Ready for Care' (NRFC) category at any point in their waiting period. NRFC status could arise for several reasons, namely:

- patients being scheduled to undergo surgery at a future date; they do not require surgery now, but will require it at a predetermined time;
- patients being too ill due to other medical conditions to undergo surgery; and
- patients preferring for personal reasons to postpone surgery.

4.27 Placement of patients in the NRFC category was made by elective surgery coordinators. The decision was made based on evidence that one of the above factors apply, but did not require specific authorisation. This is in contrast, for example, to the initial placement on the list, which required authorisation by a medical specialist.

4.28 Some patients postpone surgery several times for non-medical reasons. Audit concurs with the new ACT Health policy whereby patients may be removed from the list if they decline admission on two occasions.

4.29 Elective Surgery coordinators did not record a predicted time at which the patient would again be ready for care; it was the responsibility of the patient to let the coordinator know when they became ready for care. Due to lack of communication, patients could remain in the NRFC category when they actually thought they were on the list for surgery. Audit observed several cases of patients transiting from a lower category, to NRFC, and then coming back on the active waiting list as a Category 1 patient, indicating that the condition had significantly worsened while they were 'Not Ready for Care'. The new Elective Surgery Waiting List Policy now calls for recording a reason for NRFC and setting a status review date. However, it does not include telling the patient that they are now on the 'Not Ready for Care' list.

4.30 Patients requiring surgery at some time in the future were also put in the NRFC category until their surgery is required. This typically referred to exploratory surgery to ensure that cancer has not returned. Often the surgeon's suggested time was imprecise, such as 'end of September or October'. The surgical bookings team

then chose and recorded a date for clinical review, normally the first of the month. The procedure then was to ensure at the clinical review date that the patient is scheduled for surgery.

Recommendation 10

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

Recommendation 11

ACT Health should establish, through consultation with the patient or medical practitioner, an expected time that a patient will cease to be NRFC and check status with the patient or medical practitioner at that time.

REMOVAL FROM ELECTIVE SURGERY WAITING LIST

4.31 This section discusses the way in which patients were allocated a surgery date and subsequently removed from the list after having their surgery. It also discusses mechanisms for removing patients from the list for reasons other than having surgery, such as leaving the Territory or no longer requiring treatment.

4.32 Patients in Category 1 were scheduled into an operating theatre session immediately the RFA arrived. Lower category patients filled up the session if there was capacity. Patients were (on most occasions) asked to attend a pre-admission clinic (PAC). At this PAC, they would be further assessed for readiness for surgery and post-operative care would be discussed. If patients failed to attend a PAC, or they were assessed as not well enough, their surgery would be postponed.

4.33 Patients were asked if they wished to be considered for short-notice surgery. Patients on this list attended a PAC in case a vacancy arose. Advice from TCH was that this system did not work as well as expected, in that many patients were not actually ready for short notice surgery.

4.34 At TCH, long wait Category 3 patients were sometimes given priority over Category 2 patients. Calvary claimed that Category 2 patients always had higher priority. For both hospitals, some Category 3 waiting times were less than for Category 2. For example, in July 2003, Category 2 patients waited 204 days for General Surgery at TCH, and Category 3 patients waited 107 days. In June 2004, Category 2 patients waited 353 days for orthopaedic Surgery at Calvary, and Category 3 patients waited 136 days. Overall, there were 32 instances in 2003-04 where for a particular hospital, for a particular specialty and a particular month, the Category 2 waiting time was longer than for Category 3 patients.

4.35 Audit recognises that there can be several practical reasons for treating a Category 3 patient when there are still patients waiting who are in Category 2. These include instances where a small interval of theatre time is available, sufficient for a Category 3 but not a Category 2 operation; and instances where there is no bed available, but the Category 3 patient can be treated as a day patient. ACT Health commented that some category 2 cases, especially joint replacement cases, can be very expensive and so treatment of these is subject to budget constraints.

4.36 Nevertheless, Audit is concerned that the apparent lack of priority for Category 2 means that the *average* waiting times are sometimes longer than for Category 3. For 25 of these instances, the *average* Category 2 waiting time was longer than the maximum desirable wait of 90 days. ACT Health noted budget limitations for some specialities; but instances of Category 2 waiting times being more than Category 3 covered most surgical specialties. Of the 25 instances mentioned earlier in this paragraph, only four referred to orthopaedics.

4.37 The 2004 Elective Surgery Waiting List Management Policy states that 'in some cases, it may be appropriate that long-wait patients have priority of access over all other patients, regardless of priority category'. Audit does not understand how this is consistent with the definitions of the priority categories.

4.38 Once the surgery has been conducted, the details were immediately entered into the hospital's database (Caresys for TCH; Hospital Administrative System (HAS) for Calvary). If the surgery was cancelled at the last minute, there was a risk that the patient may not be properly recorded as needing rescheduling. In its review of data accuracy, Audit found one case where a patient who refused surgery after admittance was counted as having received surgery.

4.39 There were many reasons why people left the waiting list in addition to receiving surgery. These included no longer requiring surgery, left the area, had surgery elsewhere, now medically unsuitable, could not be contacted, and died.

4.40 Removal of patients from the lists for reasons other than surgery needs to be carefully justified. Guidelines for this purpose are included in the 2004 waiting list policy developed by ACT Health. Prior to these guidelines, the previous guidelines and policy statement was dated December 1995. The new guidelines are very similar to those of Victoria and were assessed by Audit as being reasonable. As at September 2004, the policy had been endorsed within ACT Health, but was subject to ongoing consultation with surgeons on implementation.

Recommendation 12

ACT Health should ensure that patients are, subject to resource limitations only, seen in clinical urgency priority: all Category 2 patients should get priority over any Category 3 patient.

5. WAITING LIST PERFORMANCE

INTRODUCTION

5.1 This Chapter discusses systems used to produce statistical information on waiting lists and includes an analysis of waiting list performance based on that information, including comparisons with other jurisdictions. The Chapter also discusses the extent of public reporting on waiting list performance.

SIGNIFICANT FINDINGS

5.2 The audit found that:

- Waiting times for elective surgery were generally worse than for other jurisdictions in Australia, and became longer in the last two to three years.
- Waiting times for non-surgical treatment varies considerably; and were particularly long at TCH for endoscopies and for new referrals to the Outpatients and Neurology Departments.
- There was often a lack of evidence for patients entering the 'Not Ready for Care' category.
- There was often a lack of evidence for changes to patients' priority category.
- Like most jurisdictions, information and public reporting on non-surgical waiting times was poor.
- The ACT did not publicly report waiting times by surgeon, thereby reducing the opportunities for GPs and patients to choose surgeons with shorter waiting times. ACT Health proposes to report such data from 2005.

COLLECTING AND ANALYSING SURGICAL WAITING LISTS INFORMATION

5.3 Surgical lists were comprehensive, in that they covered all relevant procedures, with the exception of some ambiguous procedures such as angioplasties. Despite being on the Medicare Benefits Schedule as a surgical procedure, angioplasties are not included on surgical waiting lists as the procedure is not generally performed in an operating theatre. Surgical lists should also exclude non-clinical surgery such as cosmetic surgery, and ACT Health's new waiting list policy provides for this. ACT Health informed Audit that all apparently cosmetic procedures have been reviewed by their surgeon who states they are clinically indicated and are therefore not cosmetic.

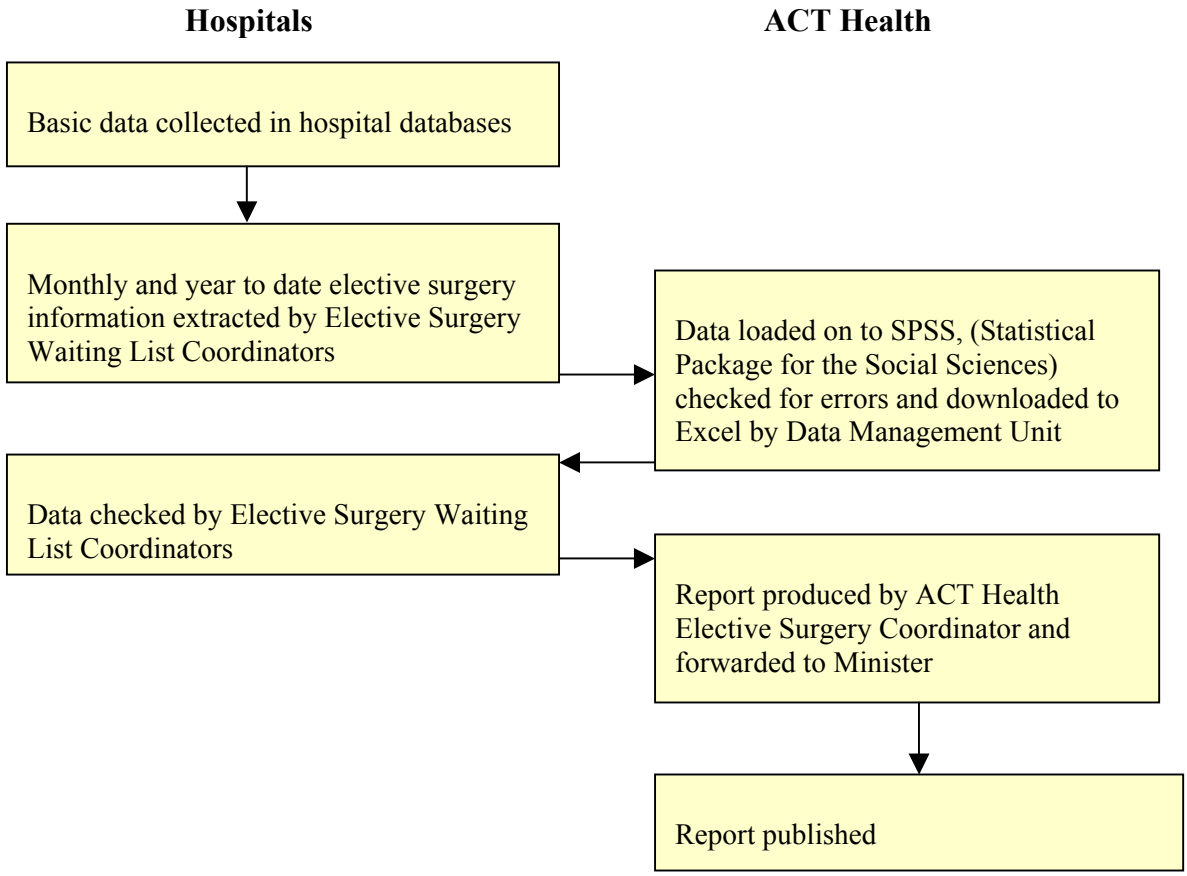
Recommendation 13

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

5.4 The system for collecting information on surgical waiting times was based on dated Recommendations for Admission (RFA) from specialists addressed to the hospital, which were then entered into databases. Waits were determined by comparing the RFA date with the date recorded for surgery.

5.5 The systems to produce public waiting list reports were complex, as indicated in Figure 1 below. Audit observed that end-of-month processing was a significant resource commitment for staff of the Elective Surgery Access Team, requiring several days. ACT Health advised that funding was made available for more effective data processing in July 2004 for the Enterprise Reporting Project. This is now in the process of implementation.

Figure 1: Flows of Waiting List Data



Recommendation 14

ACT Health should investigate the possibility of better integration of hospital and ACT Health databases in order to produce more flexible, reliable and faster analysis of waiting times.

5.6 Validity checks are run on data to cover a wide range of potential errors such as duplicates and invalid data.

5.7 Surgeons were not asked to check details on their lists. This was done in NSW, although few doctors provided feedback.[25]

5.8 Audit conducted a review of data on the ACT Health database. This was done by checking the data against medical records for a sample of patients. Audit was particularly interested in occasions where the ACT Health database recorded waits for elective surgery as being less than the clinically indicated period (30 days for Category 1; 90 days for Category 2), but the hospital records indicated the waits were longer than these periods. We also counted the converse. The results are in Table 2 below.

5.9 Table 2 also reports the proportion of occasions where there was insufficient evidence to determine whether the true figure was above or below the indicated benchmark for the category (30, 90 or 365 days). There were many occasions where there were discrepancies that did not change the assessment of whether the figure was above or below the benchmark. These cases were counted as valid. Some of these latter discrepancies were minor variations of a few days. However, some were significant, for example recording substantial waits as zero waits because the date of going on the waiting list had been incorrectly copied from the date of surgery.

Table 2: Validity and accuracy of waiting list data

Assessment	Category 1	Category 2	Category 3
Valid	76.5%	87.9%	83.3%
Error: waiting time should be more than 30, 90 or 365 days	1.7%	5.2%	2.3%
Error: waiting time should be less than 30, 90 or 365 days	1.0%	3.3%	0
Insufficient evidence to show that waiting time is correctly above or below the benchmark	20.7%	3.6%	14.3%
Total	100.0%	100.0%	100.0%

Note: Totals may not add to 100% due to rounding.

[25] NSW Auditor-General's Report: *Waiting Times for Elective Surgery in Public Hospitals: NSW Department of Health*, September 2003 pp. 85-86

Completeness of patient data

5.10 Audit tested for completeness of data by comparing lists of patients operated on according to the hospitals and comparing them with the lists from the ACT Health database. This comparison was done for a sample of categories, months and surgical specialties. Results were as follows.

Table 3: Completeness of elective surgery data

	Number of cases according to hospital	Cases missing from ACT Health statistics	Missing cases as a percentage of total cases
Calvary	157	3	1.9%
TCH	86	1	1.1%

Note: In addition, ACT Health recorded an additional six cases to those recorded by TCH for the sample months and specialties chosen.

5.11 ACT Health and hospital staff are aware that data quality requires improvement and have proposed actions, such as those described in the new waiting lists policy, designed to improve data quality.

Recommendation 15

ACT Health should improve the accuracy of data entry by means such as training, and conduct of quality assurance checks.

Changes to categories contributed to poor data validity

5.12 Many of the data problems concerned the Not Ready for Care (NRFC) category. There was often a lack of evidence of patients moving into the NRFC category, and of the timing of their return to ready for care. There were many occasions where the overall period between joining the waiting list and being operated on exceeded the benchmark, but because for part of that time the patient was NRFC, the period was not counted as exceeding the benchmark. For many of these cases, the NRFC episode was not well documented; these cases are listed in Table 2 as 'insufficient evidence'. Audit was informed that Category 1 patients who are displaced by higher priority Category 1 patients were put in the NRFC category, even though their medical condition remained Category 1 and they were ready for care. In examining of a sample of 20 Category 1 cases, Audit observed this on one occasion.

5.13 The new Elective Surgery Waiting List Management Policy provides appropriately that if a doctor's absence would lead to a Category 1 patient not being treated within 30 days, the patient should be transferred to the list of another doctor who can perform the surgery within 30 days. The doctor can also be invited to revise the Category. However, the provision for Category 1 patients to be deferred and waiting time not counted during a doctor's leave seems inappropriate.

5.14 Clerical audits of patients (i.e. contacting the patients and asking them to confirm their current status) will act to confirm or correct NRFC status. On some occasions, we observed that an audit had recorded a patient as claiming to be ready for care, but they continued on the list as NRFC. We were informed that sometimes such patients are then approached with a surgery date, but then refuse it, i.e. become NRFC again. However, this was not documented.

5.15 Similarly, cases where a patient's priority category was increased from Category 3 or 2 to Category 2 or 1 were often poorly documented and led to instances where the recorded waiting time was unable to be validated.

5.16 The current lack of good quality data to validate categories, especially the NRFC category, should be addressed when the new waiting list policy is fully implemented. Independent audits would provide more assurance that errors in NRFC categorisation and subsequent errors in statistical results have been reduced. The new policy provides for such audits to occur.

Recommendation 16

ACT Health should maintain records of assent to patients joining the NRFC list, ideally in writing by the patient or specialist, but at least keeping a signed and dated note of conversation with the patient or specialist.

Recommendation 17

ACT Health should conduct regular independent audits of the NRFC list.

Recommendation 18

ACT Health should ensure that all changes to category are based on sound medical reasons and are recorded appropriately.

WAITING LIST PERFORMANCE - SURGERY

5.17 For 2001-02, the ACT performance was below the national average, as indicated in Table 4 below.

Table 4: Elective surgery waiting times, public hospitals, 2001-02

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Days waited at 50th percentile (50% of patients wait no more than this time)	28	28	23	25	34	34	40	29	27
Days waited at 90th percentile (90% of patients wait no more than this time)	220	210	132	217	203	339	268	230	203
Proportion who waited more than 365 days (%)	5.0	4.4	3.6	4.1	3.6	9.0	6.8	4.4	4.5
Estimated coverage of surgical separations (%)[a]	100	70	98	72	61	99	100	100	84

a The separations with a surgical procedure for hospitals reporting to the National Elective Surgery Waiting Times Data Collection as a proportion of the separations with a surgical procedure for all public hospitals.
Source: Productivity Commission, *Report on Government Services*, 2004, p. 9.37

5.18 More recent performance is in the table below. This is based on those States for which comparable information was readily available from the Internet.

Table 5: Comparative median waiting times (days)

	ACT (July 2004)	SA (June 2004)	WA (July 2004)
Category 1	17	13	20
Category 2	106	51	84
Category 3	258	77	169

5.19 Some other key indicators of performance included hospital-initiated postponements, number of patients on waiting lists admitted via emergency for a related condition; number of deaths from related conditions while on waiting lists, and the proportion of patients leaving the list for reasons other than having surgery.

5.20 ACT Health did not keep statistics of those patients who were on elective surgery lists who subsequently received their surgery as an emergency patient. Emergency admissions tend to increase as the length of the wait increases, at least in one Canadian study.[26] However, this can also be distorted by doctors advising patients with long waits to go to emergency when next the condition flares up and complain until treated. Postponements of elective surgery, and departures from the elective surgery list for 2003-04 are listed below. Further discussion of the management of elective surgery postponements is in Chapter 6.

[26] B Sobolev *Emergency Admissions while Awaiting Elective Cholecystectomy*. December 5 2002, downloaded from www.surgery.ubc.ca/files/resroundarch/sobolev2002.pdf

Table 6: Postponements of elective surgery 2003-04

	Number	% of admissions
TCH	1260	25.9
Calvary	199	5.0
Total	1459	16.5

Table 7: Departures from the elective surgery waiting list, 2003-04

Category	2003-04 numbers	2003-04 percentages
Admitted as elective patient for procedure (any hospital)	8852	88.2
Could not be contacted (includes death)	190	1.9
Treated elsewhere but not as patient of this waiting list	307	3.1
Surgery not required or declined	602	6.0
Not known	81	0.8
Table Total	**10032**	**100.0**

Note: This table excludes those transferred between ACT public hospitals. In 2003-04, there were 1090 such transfers

Source: ACT Audit Office table based on data provided by ACT Health

5.21 There has been some increase in waiting time over past three years, especially in Categories 2 and 3. This is depicted in Figures 2 to 4 below.

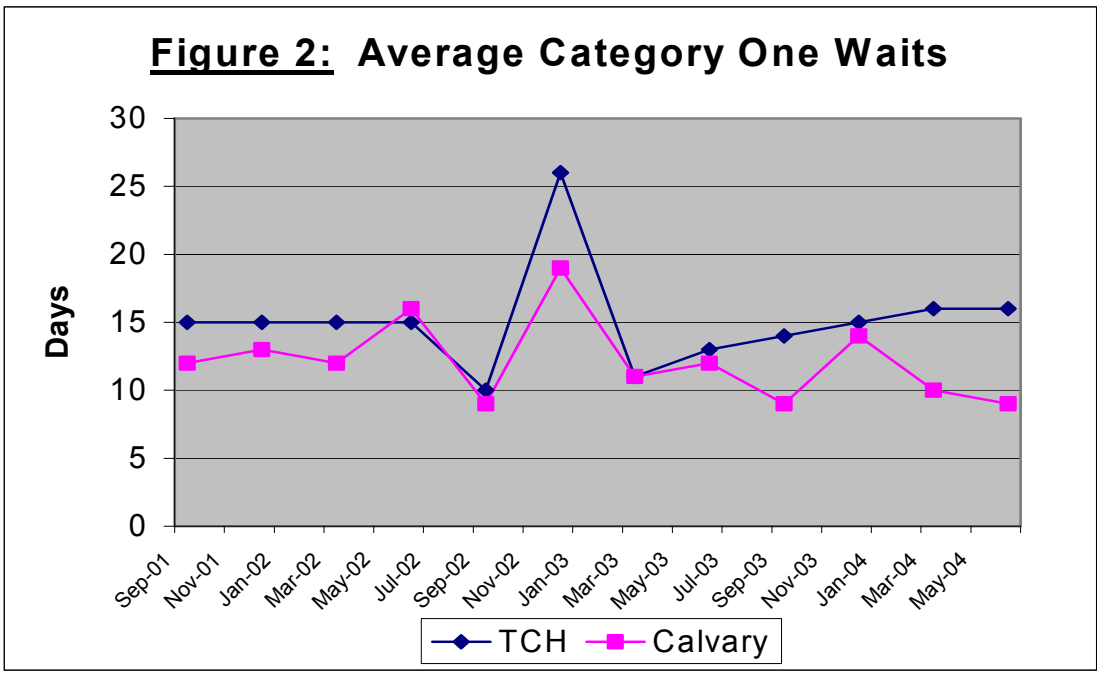


Figure 3: Average Category Two Waits

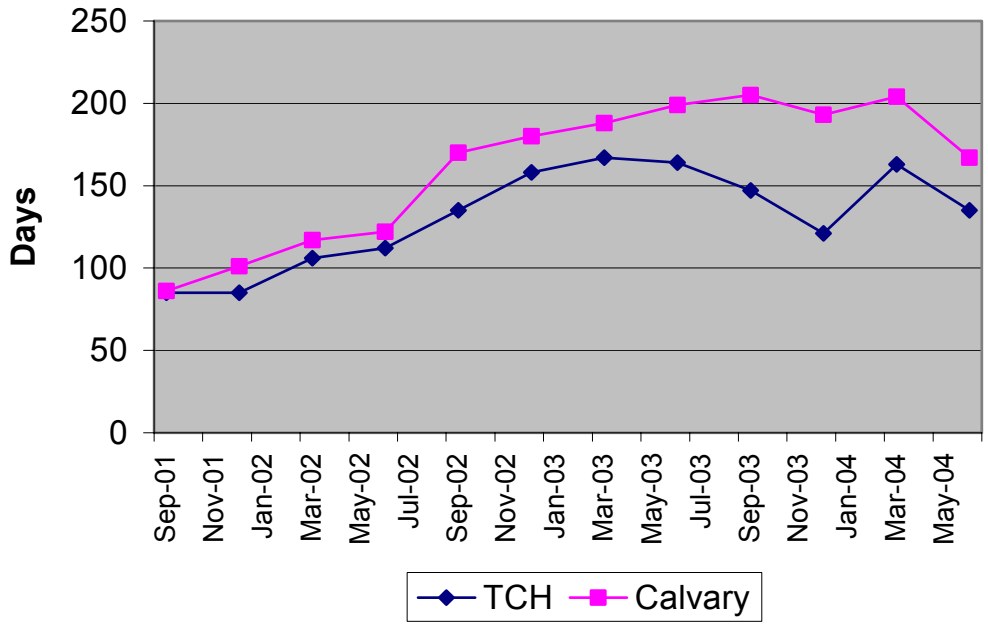
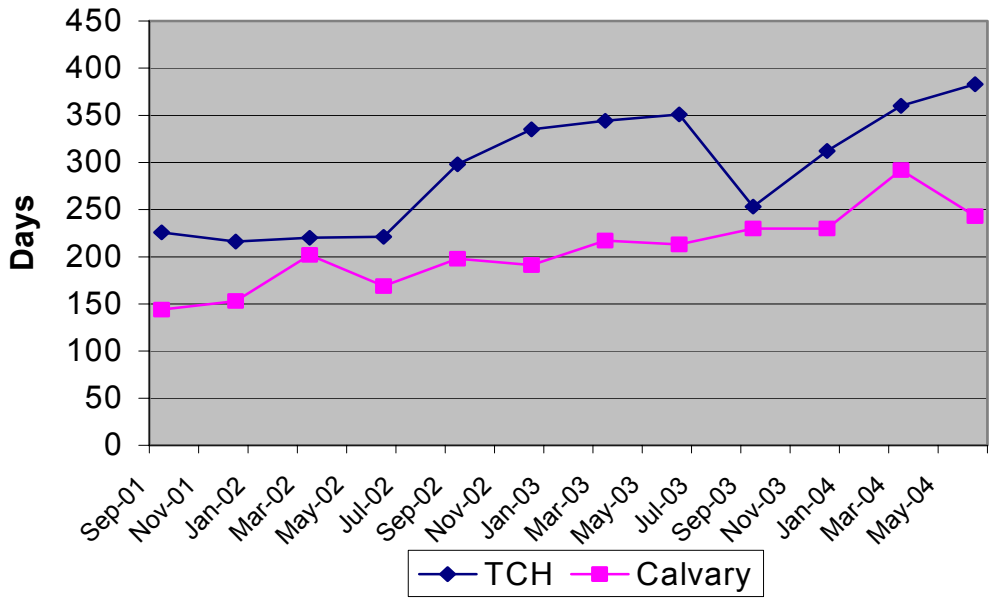


Figure 4: Average Category Three Waits



5.22 Table 8 below provides more detail on the waits experienced as at 30 June 2004.

Table 8: Details of waiting times as at 30 June 2004

Length of wait	Number of people waiting	Percentage
Category 1		
Under 30 days	147	98.7%
30-44 days	2	1.3%
Over 45 days	0	0.0%
Category 2		
Under 3 months	938	46.5%
3-6 months	455	22.5%
6-9 months	273	13.5%
9-12 months	141	7.0%
Over 12 months	212	10.5%
Category 3		
Under 12 months	1731	68.9%
12 to 18 months	437	17.4%
18 months to 2 years	166	6.6%
2-3 years	122	4.9%
Over 3 years	56	2.2%

5.23 Waiting time performance has been mostly satisfactory over the past three years for the highest priority patients, those in Category 1.

5.24 There has been generally declining performance in the less urgent categories:

- the average delay in Category 2 has risen over the three year period to June 2004 from just below the clinically indicated 90 days to well above it (167 days for Calvary and 135 days for TCH); and

- for Category 3, performance has fluctuated, but has generally declined over the three-year period to June 2004, with the average wait increasing from 226 to 383 days for TCH, and from 144 to 243 days for Calvary.

5.25 Significant numbers of patients wait for lengthy periods:

- at June 2004, 1081 patients or 54% of Category 2 on the waiting list were waiting more than the clinically recommended three months; and 212 patients or 10% were waiting more than 12 months; and

- at June 2004, 781 or 31% of all Category 3 patients were waiting more than the benchmark of 12 months, and 178 or 7% were waiting more than two years.

5.26 ACT Health has stated that the key issue to be addressed is long Category 2 waits, and Audit agrees. Although Category 3 waits are also long, the definition of Category 3 implies that these patients can wait a significant length of time without adverse consequences.

NON-SURGICAL WAITING TIMES

Introduction

5.27 Most jurisdictions do not have good information on non-surgical waiting lists, and this includes the ACT. Queensland established guidelines for the management of specialty outpatient clinic waiting lists. These guidelines called on each hospital to maintain central waiting list for each specialist outpatient clinic. They also recommended a three-way urgency category system similar to that used for elective surgery.[27] In NSW, numbers of elective medical patients were about one fifth of elective surgical patients in 2003.[28]

5.28 The 1995 ACT waiting lists policy stated that it was intended to include elective medical admissions by 1 July 1996; however, this did not happen. In 1999, the Government commented that collection and reporting of waiting times and waiting lists for non-surgical patients was not required nationally, and there were no uniform data definitions or benchmarks. At that time, the areas of increasing demand were endoscopic procedures ranging from 12 to 20 weeks, catheterisation procedures and exercise tolerance tests with waiting periods of 3 to 8 weeks, and radiotherapy between 6 to 8 weeks waiting.[29]

5.29 In its performance measures report for December 2002, TCH reported that it had put reporting systems for radiotherapy, chemotherapy and endoscopy in place. Endoscopy reporting used similar approaches to that used in elective surgery, with recording of recommendations for admission and subsequent treatment on the CareSys system. Radiotherapy reporting used a different system and format of reporting. In both cases, there were reports prepared for hospital management on the numbers on the list and the proportion treated within the clinically advised times. For other non-surgical treatments, reports on volumes of services are provided to hospital management.

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[27] Queensland Health, *Guidelines for the Management of Specialist Outpatient Clinic Waiting Lists*, 1999, p.1-2

[28] NSW Auditor-General's Report: *Waiting Times for Elective Surgery in Public Hospitals: NSW Department of Health*, September 2003

[29] Government Submission *to the Standing Committee on Health and Community Care Inquiry Into Public Hospital Waiting Lists (Both Surgical and Non-Surgical), 1999*, p.18

5.30 There were many departments for which waiting lists apply. At TCH, audit visited the Cardiac Catheter Laboratory, the Outpatients' Department and the Neurology, Renal, Gastrointestinal and Radiation Oncology units. At Calvary, Audit visited the Zita Mary Clinic, which provides primarily oncology services. As processes varied for each department, the remainder of this section is organised by department.

Cardiac Catheter Laboratory

5.31 Patients were first referred by their GPs for a consultation with a specialist at the cardiac unit. Waits were recorded using a diary system. This wait for an initial consultation could be of the order of two months. If called for by the specialist, the patient underwent an angiogram to collect further diagnostic information. The wait for this was normally about two weeks. This procedure might lead to the need for angioplasty or similar treatment. If urgent, this was done immediately; otherwise there was a further wait which is on a single list, first-come, first-served. The wait for this was also reasonably short, with a maximum of three weeks at the time of audit. There was no formal reporting of waiting list performance to hospital management.

Radiation Oncology

5.32 By 2002, significant waiting lists had developed for radiation oncology services. This was due primarily to a shortage of radiation therapists and radiation oncologists. In October 2002, patients at TCH were experiencing up to a 10-week delay for standard treatment. As a short-term measure, some patients were sent to other hospitals in Wagga Wagga or Sydney. The Government also attempted to recruit the required staff and appointed a Patient Liaison Officer to manage the waiting list. In May 2004, the Minister for Health reported that waiting lists for radiation oncology had dropped significantly; however, there is no regular public reporting on this list as there is for elective surgery.

5.33 Detailed reports were prepared and presented to hospital management on radiation oncology waiting lists, among other things to assist in benchmarking with similar hospitals. The table below shows some basic data.

Table 9: Average waiting times for radiotherapy

Category	June 2003	December 2003	March 2004	October 2004
Urgent (3 days)	Immediate	One day	Immediate	5 days
Semi-urgent (ideally 2 weeks, definitely 4 weeks)	17.5 days	23 days	12 days	21 days
Standard Category A (6 weeks)	72 days	32 days	28 days	23 days

Zita Mary Clinic

5.34 Calvary's Zita Mary Clinic is a satellite service of oncology at TCH. Resources for Zita Mary were capped through an agreement with ACT Health, and at the time of audit, the clinic was managing within this limit. The booking process used a paper-based diary system. New appointments were triaged, with those requiring treatment given priority over those coming in for a regular review. The referral process was very complex, with most chemotherapy referrals coming after surgery. On some occasions, treatment starts with chemotherapy or with radiotherapy (referred to TCH or elsewhere if necessary). Calvary has arrangements with TCH for cross-referral, which help to manage the workload and keep within clinical parameters.

5.35 Data on bookings were entered into a hospital administrative system known as IBA. This system is later used to produce data on costs and workload, but there are no performance measures related to waiting lists.

Endoscopies

5.36 The gastrointestinal unit at TCH conducted endoscopies and related procedures for inspecting and taking biopsies from the gastrointestinal tract. The waiting list management process started with a GP referring a patient to a specialist in the unit. The typical wait to see the specialist was about three months, but less if the GP negotiated. Following this consultation, the urgency criterion was set and the formal waiting period commenced. The unit used the categories 1, 2 and 3 as for elective surgery, and also used a category 4 for scheduled patients.

5.37 The proportions of waits that exceeded clinically indicated periods in 2003-04 are listed in Table 10 below. Times for TCH in particular were very long. To increase capacity, a balanced increase of resources in the form of beds, physicians, nurses and support staff would be required.

5.38 Very few Recommendations for Admission for Category 3 endoscopy patients were being received at TCH (because, according to TCH, patients choose private treatment). Private specialists could conduct a wide range of endoscopic procedures in their rooms, but not the more serious or emergency cases.

Table 10: Proportion of patients waiting in excess of clinically indicated periods for endoscopies: 2003–04

	TCH	Calvary
Category 1 waits over 30 days	71%	9.1%
Category 2 waits over 90 days	70%	28.0%
Category 3 waits over 365 days	46%	0.7%
Total number of patients on list	738	260

Renal Unit

5.39 Waiting lists at the Renal Unit were managed through a combination of paper diaries and the CareSys system for recording outpatient visits. The unit did not record data on waiting times.

5.40 Patients are first referred by GPs to the unit or a specific physician for outpatient assessment. New referrals are booked within two weeks and almost all are seen in three months, and sick patients sooner. If patients are assessed as needing dialysis, they require vascular surgery to arrange for this. This surgery becomes part of the surgical waiting list for vascular surgery.

5.41 As for many of the medical specialties, the Renal Unit provides ongoing care to patients over many visits. It is estimated that patients are seen on average every 6-8 weeks. When in stable dialysis, outpatient visits are required every three months or so.

5.42 The rate of renal disease is increasing. Combined with good care to extend life and few transplants, this means demand is increasing rapidly. Steps have been taken to increase renal services in response to demand, through the establishment of new satellite dialysis units at Goulburn, Moruya and northern Canberra, and through increased staffing of the clinic and better bed management.

Neurology Unit

5.43 The neurology unit sees patients with conditions including dementia, multiple sclerosis, epilepsy and the after effects of a stroke. Delays in treating inpatients, often through waiting for services such as MRI scans, can lead to situations where patients who need to be in hospital cannot be admitted because no beds are available. Some patients need a bed urgently (less than a week) and it is difficult to achieve this. Numbers of patients waiting for beds are low, but are expected to increase.

5.44 Outpatient waiting lists are based on the backlog of cases, and are not formally recorded, and there are no resources currently available to produce formal statistics. Waits include about 2-4 weeks for an EEG (considered satisfactory) and 4-8 weeks for nerve conduction tests. Waits for general consultations have built up to about five months; these are sorted into urgent and non-urgent cases. Because of the

long wait, the unit was not accepting new referrals until another staff member joined. A small number of time slots each week are kept for urgent cases, which are filled if not needed by telephoning more routine patients to come in.

5.45 In October 2004, resourcing was increased through the opening of a new Stroke Unit.

Other Outpatients' Departments

5.46 The outpatients' department (OPD) at TCH covered both surgical and non-surgical areas. Surgical areas included general surgery, urology, vascular, plastics, orthopaedics, ophthalmology and ENT (ear, nose and throat). Non-surgical services included rheumatology, infectious diseases, diabetes, dermatology and clinical pharmacology–toxicology. Surgical outpatients services were entirely related to follow-up visits after surgery. Most non-surgical patients were also seen as a follow-up to in-patient treatment, and for both of these types of patients, appointments were made at the recommended period after in-patient treatment.

5.47 There was some scope to see new non-surgical patients who had been referred by their GP to outpatients. However, these patients waited a long time. The exact duration of the wait was not known as the OPD only accepted bookings up to three months ahead. Because of this limit, patients were told to contact the OPD three months before the desired date of their next consultation in order to set up an appointment.

5.48 Monthly statistics on OPD activity by speciality and specialist were prepared based on the CareSys database and submitted to hospital management as part of the monthly Information Bulletin. However, no information on the waiting list was produced.

5.49 The Health Action Plan 2002 referred to a review of outpatients to 'ensure such services are provided in an optimal manner'. However, action on implementing the recommendations of this review has not progressed.

5.50 Calvary has no Outpatients' Department as such, but a number of outpatient clinics. The only surgical outpatients service other than pre-admission clinics is a small orthopaedic clinic.

Conclusion

5.51 Audit's review of a sample of non-surgical departments has shown that several different types of waiting list management approaches were used, but all were somewhat more informal than for elective surgery. None were consistently reported publicly. Actual performance of the departments ranged from service that was well within clinical guidelines to very long waits for others. Audit's view is that a more consistent regime in defining and publishing waiting lists would tend to improve overall performance and accountability.

5.52 Audit also supports the development of appropriate systems for managing waiting lists. In some smaller departments with straightforward booking and scheduling requirements, 'appropriate systems' could be as simple as a booking diary.

5.53 As suggested in Recommendation 3, priority categories should also be consistent across surgical and non-surgical departments.

Recommendation 19

ACT Health should request that each hospital review its medical services to establish what services are subject to waits, and establish appropriate systems to measure and report to ACT Health on those waits.

PUBLIC REPORTING IN THE ACT

Reporting standards

5.54 A report for the Council of Europe[30] stated that:

> Patients and consumers of health care are entitled to have adequate general information on waiting lists and waiting times in specific settings. This should include access to individualised information about their own ranking on waiting lists. Information at an institutional level should be transparent - but without allowing individuals to be identified to third parties - and available to the general public, consumers, patients, governments and decision makers as well as insurance companies and health care providers. As well as the management and planning uses for such information … there is great potential to use waiting list/time information to enable consumers to make deliberate choices about the options available to them for treatment.

5.55 In NSW, the Independent Commission Against Corruption recommended that for completeness, waiting list statistics should explicitly define procedures and categories of patients not included in statistics.[31] For example, procedures such as cosmetic surgery, and patient categories such as 'not ready for treatment' should be defined.

5.56 Most States produced public reporting on the state of their elective surgery waiting lists. Other States provided a single report for the health system, while the ACT reported separately for each hospital. Also, most States reported quarterly, while the ACT reported monthly. Some of the State reports showed good use of graphics to facilitate understanding of information.

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[30] Council of Europe, *Criteria for the Management of Waiting Lists and Waiting Times in Health Care*, 1998. Downloaded from www.coe.int

[31] Independent Commission Against Corruption (NSW), *Investigation into the Alleged Misreporting of Hospital Waiting List Data*, 13 February 2004. Downloaded from www.icac.nsw.gov

5.57 NSW and WA reported individual waiting time by surgeon and procedure on the web. Denmark reported maximum waiting times for each hospital for 25 common medical problems on the Internet, including maximum waiting times for patients.[32] Ontario in Canada was developing a system that integrated both public provision of waiting times and specific information on individual patients to surgeons.[33]

ACT reporting on elective surgery

5.58 The ACT reported publicly data on the flow of patients into and out of the surgical waiting lists, by hospital, surgical specialty and priority category. It also enumerated the number and percentage of overdue patients. A summary report also included graphical data such as the total numbers on the waiting list, a comparison of the additions and removals form the list, and the percentages of long waits, much of it graphically presented.

5.59 This information is in one quarterly report and three separate monthly reports. The quarterly report gives waiting times for the most common operations, and a summary for each of the specialities (all categories combined). Of the monthly reports, one 'Access to Elective Surgery' gives information on total numbers and overall waits for each category. Two more reports, one each for Calvary and TCH, give more detailed reports, in similar but slightly different formats, for waiting time performance for each surgical specialty. It may be more convenient for the users of this data to produce a single report, at least quarterly, that will include, for example, system-wide data at the same level of detail as is currently provided for Calvary and TCH separately.

Recommendation 20

ACT Health should combine reporting for the two hospitals so that an overall report on the health system is produced

Recommendation 21

ACT Health should publish the number of patients in the NRFC category as a supplement to the waiting list statistics. Ideally, this would be split into their former category, for example NRFC: used to be Category 1.

5.60 Elective surgery waiting time performance statistics published on the web were based on those waiting beyond the clinically indicated period *at the census date*. However, the performance measure reported in the annual report was based on those waiting beyond the clinically indicated period *at the date of admission for surgery*. Reporting at census date provides a more favourable view. For example, consider a

[32] National Audit Office (UK) *Inpatient and Outpatient Waiting in the NHS*, 26 July 2001, p. 4

[33] White, Julie, *Tracking Elective Surgery Waiting Times on the Web*. Hospital Perspectives, November 2002. Ontario Hospital Association. Downloaded from www.oha.com

hypothetical patient added to the waiting list in Category 1 on the 10th of February, but not operated on until the 20th of March. This patient has clearly exceeded the 30 days criterion for Category 1. However, at the census date at the end of February they have not exceeded the 30-day criterion. At the census date at the end of March, they have received their operation. Therefore, they will not be reported in the monthly statistics reported on the web as exceeding 30 days. For Category 1 in 2003-04, only two cases failed the 30-day criterion by the census definition, but about 65 waited more than 30 days for their surgery. Internal reports to the hospitals also used the more favourable definition, although decisions on scheduling patients were based on actual elapsed time between referral and date of surgery.

5.61 In their public reporting, other States varied between using the census date approach or the waiting time at admission approach.

Recommendation 22

ACT Health should publish waiting time performance calculated at the date of admission, to improve the relevance and internal consistency of data.

5.62 The ACT did not report publicly waiting time by surgeon, as was done in WA and in NSW. There were variable comments made by medical staff consulted by the audit as to whether such information was useful to GPs. Many said that it would be not helpful or even potentially misleading. Others commented that in a small city such as Canberra, GPs were generally aware of the length of surgeons' waiting lists. Nevertheless, as there was some interest from GPs, releasing this information may have the impact over time of equalising waiting lists. Recommendation 5 above states that ACT Health should negotiate with surgeons and review the application of privacy laws with a view to posting waiting times by surgeon on the web.

5.63 There is currently only one performance measure that is included in the statement of performance produced by ACT Health, namely the proportion of patients in Category 1 who are operated on within the guideline period of 30 days. For 2002-03, reported performance was 91%, compared with a target of 95%. This increased to 96% in 2003-04. When TCH produced its own Annual Report (up to December 2002) it produced a wider range of performance measures, namely:

- percentage of long waiting times for each of the three categories of elective surgery;
- percentage of patients where booked surgery is cancelled; and
- reporting systems for radiotherapy, chemotherapy and endoscopy in place.

5.64 However, subsequent annual reports for ACT Health (which absorbed TCH in December 2002) did not report waiting list data for these matters, except to note in 2002-03 that there were long waiting lists for radiotherapy.

Recommendation 23

In addition to the monthly reports, ACT Health should produce a more comprehensive analysis of waiting list trends on at least an annual basis.

ACT reporting on elective non-surgical treatment

5.65 There was no consistent reporting on non-surgical waiting lists. Occasional public reports were made on the status of the radiotherapy list, but even in annual reports, there was no overall view presented.

Recommendation 24

ACT Health should work towards including reporting on elective medical procedures in regular public statistical reports.

CONCLUSIONS

5.66 Available statistics indicated that the timeliness of elective surgery in the ACT is worse than that in most other jurisdictions. There was scope for improvement, especially for Category 2 (semi-urgent) patients.

5.67 Audit found that waiting list statistics were, at times, neither accurate nor valid. There were problems in documenting and recording reasons for changes in category, especially the 'Not Ready for Care' category. The processes for collecting, analysing and reporting data were also complex and time-consuming.

5.68 Systems for reporting on non-surgical waiting lists were sketchy. Some areas had short and well-managed lists, while waiting times for some other areas, such as endoscopy at TCH, were excessive.

5.69 In providing monthly public reports, ACT provided more frequent reporting than most jurisdictions. However, there was inconsistent reporting of on-time surgery performance, and there was scope for providing a whole-of-system report in addition to the reports for Calvary and TCH separately.

6. MANAGEMENT OF WAITING LISTS

INTRODUCTION

6.1 This section discusses internal reporting of waiting list issues and the various measures taken to limit or control the waiting experienced. It focuses on decision-making at both the Government (ACT Health) level and the hospital level. For the latter, emphasis is on The Canberra Hospital as Calvary is managed outside the Government system.

SIGNIFICANT FINDINGS

6.2 The audit found that:

- Recommendations of previous reviews pertinent to the management of elective surgery were only partially actioned at the time of audit.
- Flexible resourcing of elective surgery was constrained by factors such as provisions of Visiting Medical Officer contracts.
- Day of Surgery Admission (DOSA) rates can be indicative of surgical efficiency. At the time of audit, ACT Health's DOSA performance was low, but ACT Health advises that the recent setting of targets has led to improvements in performance.
- Postponements of elective surgery were frequent, and there were opportunities to reduce postponements through better planning.
- Information on surgical waiting lists, although containing some errors, was, in broad terms, sufficiently reliable to support management decisions.
- With some exceptions, available funding was appropriately directed to the elective surgery specialties with the longer waiting times.
- No additional funds were directed to endoscopy at TCH despite its very long waiting list.

HOSPITAL-LEVEL MANAGEMENT ISSUES

6.3 There are a number of constraints to the carrying out of elective surgery procedures, some of which are under the control of hospitals, and some of which are not. They include:

- Availability of surgeons and anaesthetists. This includes both their presence in Canberra, and their willingness to perform surgical sessions for public patients. This availability is limited by surgeons' and anaesthetists' illnesses, recreation leave and attendance at conferences.

- Availability and efficiency of use of staffed surgical theatres. This includes the physical structure and equipment, and also the necessary ancillary staff such as theatre nurses to enable the theatres to be used.

- Availability of prostheses. For some procedures, the availability of prostheses such as artificial heart valves or joints may be a factor. This in turn may be due to the budget allowed for these items.

- Availability of staffed hospital beds. This includes the physical space plus the nursing and other staff to care for the patient. Some procedures will require a period of intensive care followed by general ward care, some will require general ward care only, some will require only a day-bed.

- Emergency demand. Any of the above resources can become unavailable for elective surgery if required to treat emergency patients.

- Availability of patients. It seems redundant to mention this as a possible constraint when there are extensive waiting lists, but it is possible, for reasons such as late cancellations or operations being performed more rapidly than expected, that there are not enough patients on the surgical list to fill the surgical session.

6.4 In order to improve elective surgery efficiency, there needs to be a coordinated approach to efficient supply and management of all relevant resources. To support this, there needs to be adequate information provided to hospital management. For example, Calvary did a short-term projection of future waiting lists in early 2003. TCH prepared monthly summaries of surgical activity for each specialty. These reviews included waiting list data for each surgeon. TCH also prepared a quarterly Theatre Management Report, which among other things tracked surgical theatre utilisation, Day of Surgery Admission rates and day surgery rates.

Efficiency of elective surgery

6.5 As noted in ACT Health's Elective Surgery Waiting List Management Policy, hospitals must optimise the use of theatre time and beds. In response to a recommendation in the 1999 Assembly inquiry that the Government examine ways of improving theatre utilisation, a review of surgical services was initiated. Many suggestions, such as those around staffing and management of operating theatres were taken up, but issues concerning length of operating theatre sessions, pooling of surgery and referral by GP to surgeons with shorter lists have not been actioned. In addition, the document tracking implementation of suggestions was years out of date.

6.6 Surgical theatres for elective surgery are used only during normal working hours Monday to Friday. Calvary operates from 9:00 a.m. to 5:00 p.m., with, on most occasions, the same surgeon operating all day. TCH is trying to work towards this more efficient schedule. TCH theatres currently start with a morning session from 9:00 a.m. to 1:00 p.m., followed by an afternoon session from 1:00 p.m. to 4:00 p.m. Audit was informed that on occasions, they close much earlier than 4:00, and an ACT Health consultant's report stated that the three-hour surgical session in the afternoon is 'quite dysfunctional'. TCH informed us that this shorter period is a consequence of agreements with operating theatre staff, which are being updated as staff are replaced. The review of surgical services recommended a theatre session period of 8:00 a.m. to 6:00 p.m.

6.7 There was no evening or weekend elective surgery, with the exception of a monthly Saturday session for one specialty at Calvary. Extra costs would be involved, but overall cost-effectiveness of such out-of-hours sessions should be investigated compared to, for example, building more theatres.

6.8 Another approach to increasing efficient use of bed resources is to increase use of day surgery and Day of Surgery Admission.[34] Up to December 2002, TCH was not achieving the benchmark rate of 60% day surgery. TCH achieved 65.7% DOSA in March 2004, compared with 76.7% at the John Hunter Hospital at Newcastle, and 88.6% across all NSW public hospitals in January 2004. Recently, measures have been taken to try to improve the DOSA rate. ACT Health set a new target of 90% DOSA in June 2004, and for that month, Calvary achieved 86% and TCH 64%.

6.9 The total number of beds available at TCH has declined in recent years, although it increased slightly in 2003-04, as shown in Table 11 below. Bed occupancy remained high, at 96.6% in 2003-04 compared with 95.0% in 2002-03. The number of surgical operations at TCH was down by 2.9% in 2003-04 compared with 2002-03 as at May 2004.

Table 11: Available beds at TCH

Year ending	Available Beds
June 2001	504
June 2002	498
June 2003	493
June 2004	498

Source: TCH Information Bulletins on Patent Activity Data

6.10 TCH has also sought to increase efficiency, for example through a coordinated joint-replacement program that reduced hospital length of stay.

[34] Day surgery: a patient is admitted, operated on and discharged within one day. Day of Surgery Admission: a patient is admitted and receives surgery on the same day, but the operation is followed by at least one night's stay in hospital.

Recommendation 25

ACT Health should consider the cost-effectiveness of means such as increased Day of Surgery Admission, same-day surgery and evening and weekend surgery in addressing waiting lists.

6.11 In each of the last two years, Calvary has spent its funds for elective surgery in such a way that several surgeons have run out of funds to operate on elective patients well before the end of the financial year. Surgeons subsequently seek additional funds. ACT Health has limited control over the way in which Calvary distributes its expenditure over the year.

Postponements of surgery

6.12 Postponements of surgery cause inconvenience to patients and require additional work for the hospital, especially if the patient is already admitted. The overall ACT figure of 16.5 postponements per 100 admissions for 2003-04 (25.9 for TCH; 5.0 for Calvary) seemed high, but was comparable to the 20.85 postponements per 100 admissions for South Australia in the six months to March 2004.

6.13 Some postponements are unavoidable, e.g. unexpected emergency cases. However, during 2003-04 over 400 cases at TCH (about 8% of all elective surgery, or about a third of all postponements) were postponed essentially due to inadequate planning: Session cancelled by Surgical Services, VMO leave session cancelled, Elective List Overrun, or Operating Theatre decided list too full. The equivalent figure at Calvary was 26 postponements, less than 1% of elective surgery cases.

6.14 Each of the complaints to TCH concerning elective surgery referred to postponement of surgery, indicating the significance of this aspect. (ACT Health does monitor and report to the Minister on hospital initiated postponements.)

Recommendation 26

ACT Health should encourage each hospital to review the causes of postponements with a view to reducing them, and in particular request TCH take steps to improve planning so as to reduce postponements.

Equity of access to elective surgery

6.15 As noted in ACT Health's Elective Surgery Waiting List Management Policy, hospitals must 'review the distribution of resources between clinical disciplines on a regular basis, to ensure patients are admitted according to clinical urgency across all disciplines'. This review is to include consideration of the doctor's contract, and theatre session allocation, which in turn should be based on waiting time and theatre utilisation.

6.16 In 1999, the Government stated that surgeons with longer waiting lists were given greater opportunity to access theatre time, but they did not always avail themselves of the opportunity.

6.17 Visiting Medical Officer (VMO) contracts have added some rigidity to the system. The standard contract provided that the operating room sessions for the VMO would be based on an average of the three previous years' sessions, which can only be reduced by the Territory if the VMO is unavailable or does not use his or her allocated lists. The agreement further stated the Territory would not cancel more than 10% of the VMO's annual workload for non-budgetary reasons and none of the workload for budgetary reasons without the agreement of the VMO. These provisions are not consistent with the waiting list management policy discussed above.

6.18 There was some scope for reallocation of time to those with long lists when other surgeons are not available due to taking leave. TCH sought to reallocate time to those with long lists when other surgeons are not available due to taking leave. The Operating Theatre Management Committee at TCH proposed in August 2004 that waiting list in specialty and for individual surgeon should be a factor in allocating surgical lists.

Recommendation 27

ACT Health should encourage each hospital to offer surgical sessions that become available, either permanently or through the temporary unavailability of a surgeon, to the surgeons with the longest Category 1 and Category 2 waits.

Action on non-surgical lists

6.19 Only basic census data on the numbers of endoscopy patients in the three urgency categories, plus activity data, were presented to hospital management (i.e. not the percentages of patients waiting beyond clinical limits). There have not been any proposals submitted recently for increased resourcing of endoscopy. On the contrary, in early 2003, TCH considered capping the number of scopes.

6.20 ACT Health states that additional funding has not been allocated to endoscopy due to higher priorities elsewhere, and that there are numerous community-based private services, as well as a new service to be established soon at Queanbeyan Hospital.

DEPARTMENT-LEVEL MANAGEMENT ISSUES

Policy and guidelines

6.21 As noted in earlier chapters of this report, there has been unsatisfactory implementation of the recommendations of the Standing Committee on Health and Community Care's 1999 inquiry into waiting lists. Although there was an action plan created at the time, there was no record of its completion available until late 2004.

Even this document referred to some actions, such as publishing waiting times by surgeon, as to be achieved in 2005. Further, some action stated in 1999 as being current (e.g. progress in pooling patients) did not actually happen.

Recommendation 28

ACT Health should complete implementation of agreed recommendations of the Standing Committee on Health and Community Care's 1999 inquiry into waiting lists.

6.22 The ACT has established guidelines for managing elective surgery. These guidelines have been developed after review of guidelines in other jurisdictions and are soundly based.

6.23 There has been a trend to establish Calvary as the primary elective surgery hospital, supplementing TCH as the primary emergency care hospital, which was one of the reasons to allocate funds direct to Calvary. This approach has worked in other jurisdictions, e.g. a trial at Auburn Hospital in Sydney showed that conducting elective surgery at a smaller hospital could lead to efficiencies in the management of elective surgery. One example of this trend has been the move of most elective ophthalmology surgery to Calvary.

6.24 One aspect of decision-making that might be taken into account is the cost of waiting in terms of increased suffering and lack of amenity. One estimate in Britain was that the cost was about £75 per month per patient in 1999; this did not take into account the use of sick leave, or the chance that the condition would deteriorate.[35] This is in the middle of a range of C$1100 to C$5600 per year quoted in Canada.[36]

6.25 In some jurisdictions, performance measures relating to elective surgery have been used to assess the performance of senior executives in discharging their functions. In NSW, Area CEO performance agreements contained seven measures (out of about 100) relating to elective surgery;[37] and a WA audit recommended introducing performance agreements including elective surgery targets.[38] These practices can focus management's attention on achieving good performance. However, there are also risks such as incentives to artificially influence measures in order to achieve desired results. This has led in the UK, for example, to deliberate distortions of results.[39]

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[35] National Audit Office (UK) *Inpatient and Outpatient Waiting in the NHS*, 26 July 2001p.32

[36] The Frasier Institute, *Waiting Your Turn: Hospital Waiting Lists in Canada*, 2001. Downloaded from http://oldfrasier.lexi.net p.3

[37] NSW Auditor-General's Report: *Waiting Times for Elective Surgery in Public Hospitals: NSW Department of Health*, September 20031 p. 82

[38] Auditor General for Western Australia: *Patients Waiting: Access to Elective Surgery in Western Australia*, Report No. 11, December 2003 p. 10

[39] National Audit Office (UK) *Inappropriate Adjustments to NHS Waiting Lists*, 2001

Allocation of funding to address elective surgery waits

6.26 Agreements were reached by ACT Health with Calvary Hospital and TCH to provide overall surgical services. Targets were not split between emergency and elective surgery.

6.27 Resources available for elective surgery have fluctuated in recent years. Funds were boosted through the Federal Government's Critical and Urgent Treatment Scheme (CUTS), which provided $6.5m to Calvary over the four years 1998-1999 to 2001-02. The cessation of this funding in 2002-03 resulted in cutbacks to elective surgery at Calvary.

6.28 Subsequently, $500 000 was allocated in late 2002-03 to Calvary Hospital for orthopaedic surgery. In 2003-04, the ACT Government increased expenditure by $2m ($8.3m over four years) to increase access to elective surgery. The funds were to target the areas with the longest waiting lists, including orthopaedics, ophthalmology, general surgery, plastic surgery and ear, nose and throat surgery. Calvary Public Hospital was invited to provide the additional surgery detailed in Table 12 below in 2003-04 for a total of $2m.

Table 12: Additional elective surgery for Calvary, 2003-04 (targets)

Procedure type	Cost ($)	Cost-weighted separations (CWS)[40]	People treated
Orthopaedics (major joint procedures)	500 000	189	38
Orthopaedics (excluding joints)	200 000	75	63
Ophthalmology	500 000	189	270
Ear, nose and throat surgery	200 000	75	151
General surgery	400 000	151	60
Plastic surgery	200 000	75	94
TOTAL	2 000 000	755	676

6.29 Progress against achieving these targets has been monitored. The target was publicly announced variously as 'an extra 600 patients' and 'approximately 590 additional people' compared to the 676 agreed with Calvary as shown above. An internal review in December 2003 noted that an increase of 430 had been achieved, but this was put as 71.6% of 600, rather than comparing it to the real target (676). By April, it was stated that the target of 600 had already been achieved.

[40] Cost-weighted separations (CWS) refer to occasions of service, i.e. separations from hospital, weighted by the estimated cost of treating the condition. Each cost-weighted separation is funded to the same dollar value.

6.30 In January 2004, the Acting Health Minister was quoted as saying 'We accept the Category 2 long waits are unacceptably high and are rectifying this situation by injecting additional funds into elective surgery targeting Category 2 long waits, especially ophthalmology and orthopaedics'. A further sum of $1.8m became available during 2003-04, for hospital projects generally, not necessarily only elective surgery. Proposals were received from Calvary and from TCH, and the advantages and disadvantages of the various proposals were analysed by ACT Health.

6.31 From this sum, ACT Health allocated $0.85m for joint replacement (400 CWS), which is predominantly elective surgery, to TCH. This was based on a business case that proposed 500 CWS for a cost of $1.025m. This represented a cost per CWS less than that offered by Calvary.

6.32 A sum of $0.3m was offered to TCH for 260 CWS for cardiac surgery in 2003-04, some of which may reflect elective surgery. However, the funds were not expended because the relevant surgeon was not available to perform the planned additional surgery. The business case presented for the additional cardiac surgery referred to length of waiting lists and avoiding adverse effects of long waits, but had no quantification. Cardiac surgery had a short waiting list.

6.33 The 2004-05 budget provided $3.225m for increased general surgery in order to increase access to elective surgery. The budget also provided $1m to increase access to joint and cataract elective surgery, and also provided for two more VMOs and a ninth operating theatre. This funding is for surgery generally, rather than just for elective surgery.

Table 13: Action in response to long Category 2 waiting times

Specialty	Average time on list July 2003*	Action taken for 2003-04	Average time on list June 2004*	Action planned for 2004-05
Plastic surgery	460	$0.2m plus move to recruit plastic surgeon	241	
Ear, nose and throat surgery	366	$0.2m	127	
Orthopaedic surgery	240	$1.55m	175	Extra $1m (total with ophthalmology)
Other	217	-	379	
General surgery	155	$0.4m	151	Allocation of new theatres to general surgery. Extra $3.225 (for all general surgery, not just elective surgery)
Neurosurgery	103	-	162	
Ophthalmology	90	$0.5m	101	Extra $1m (total with orthopaedics)

Specialty	Average time on list July 2003*	Action taken for 2003-04	Average time on list June 2004*	Action planned for 2004-05
Urology	83	-	112	
Gynaecology	77	-	67	
Vascular surgery	122	-	201	
Cardiothoracic surgery	36	$0.3m	24	

Source: ACT Audit Office analysis of ACT Health data
Notes * Simple average of Category 2 waiting times at Calvary and TCH

6.34 From the above table, actions appear to have addressed Category 2 waiting lists lengths, with the exceptions of:

- no additional action on 'other' surgery';
- ophthalmology investment is more related to Category 3 waiting lists, which are high; and
- there was additional investment in the best-performed waiting list, cardio-thoracic surgery.

6.35 Similarly, the 2004-05 budget addressed Category 2 waiting lists towards the end of 2003-04, except that that there was no specific action to address the long and increasing lists in 'other' surgery, neurosurgery and vascular surgery.

6.36 One approach to reducing waiting lists is to contract-in services outside the public hospital system. This has been used in the past for ophthalmology, and is currently being used for public dental services, where $0.5m annually is being injected into the dental health program to reduce a long waiting list by funding the private treatment of public patients. This approach may be cost-effective if facilities in private hospitals were available at a competitive price.

Recommendation 29

ACT Health should consider the feasibility and cost-effectiveness of acquiring services from private providers to address excessive waiting lists.

Appendix 1: Audit Approach and Criteria

AUDIT APPROACH

The audit approach comprised the following steps:

- research including a review of other States' approaches to this issue;
- mapping of the flow of information used to produce the waiting lists;
- analysis of the completeness, reliability and timeliness of the waiting list data;
- discussions with key stakeholders on the effectiveness of the waiting list information and the extent to which it is used. These stakeholders included:
  - the Legislative Assembly through the Standing Committee on Health;
  - ACT Health;
  - hospital staff; and
  - representatives of surgeons, GPs and patients;
- review of data provided by ACT Health and outside bodies such as the Australian Institute of Health and Welfare, the Productivity Commission and the Australian Bureau of Statistics; and
- analysis of funding and other relevant health policy decisions to determine the extent that waiting list information was taken into account.

AUDIT CRITERIA

Audit criteria are presented below, according to the audit objective to which they relate.

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

Criterion 1.1 All relevant elective surgical cases are covered by waiting lists

Criterion 1.2 All hospital-based medical procedures involving substantial waiting times are covered by waiting lists

Criterion 1.3 Collection systems are reliable (both manual and automated elements)

Criterion 1.4 Procedures for storing and analysing data are reliable (both manual and automated elements). For example, there is adequate validity checking.

Criterion 1.5 Excessive waiting times are clearly defined and are based on sound medical practice

Criterion 1.6 Published data can be traced back to original documentation

Criterion 1.7 Lists are published within a period after the end of the month that meets good practice standards

Objective 2. Systems to produce the waiting list numbers are efficient.

Criterion 2.1 Data are only handled once

Criterion 2.2 There is appropriate automation of data handling

Criterion 2.3 The number of errors requiring manual intervention is small

Objective 3. Patient priorities are accurate

Criterion 3.1 There is a consistent process for prioritising urgency of patient treatment

Criterion 3.2 Patient priorities are subject to review by qualified persons and changed where necessary

Objective 4. ACT Health uses waiting list information effectively

Criterion 4.1 Information is provided to General Practitioners and patients to assist in selection of surgeons

Criterion 4.2 Where appropriate, patients are given the option to move to a doctor with a shorter waiting list.

Criterion 4.3 Doctors are allocated resources (such as theatre time) according to their waiting list lengths

Criterion 4.4 The difference in waiting list lengths is used to allocate resources between specialities, e.g. in decisions on which doctors to recruit in to the system and in capital investment decisions.

Criterion 4.5 Overall waiting times are stable or reducing with the longer waiting times by doctor and by speciality reducing in length. Incidences of unwanted medical outcomes due to excessive waiting are small and reducing.

Criterion 4.6 ACT Health analyses and uses waiting list information on incidence of medical treatment.

PREVIOUS AUDIT REPORTS[41]

Reports Published in 2004

1. Administration of Policing Services
2. Travel Arrangements and Expenses
3. Revenue Estimates in Budget Papers 2002-03
4. Data Reliability for Reporting on the ACT 'No Waste by 2010' Strategy
5. Leave Management
6. Workers' Compensation Supplementation Fund
7. Annual Report 2003-04

Reports Published in 2003

1. Effectiveness of Annual Reporting
2. Belconnen Indoor Aquatic Leisure Centre
3. Emergency Services
4. Management of Fraud and Corruption Prevention in the ACT Public Sector
5. Lease of FAI House
6. Allegations of Financial Mismanagement University of Canberra Union
7. Compliance Performance Audit – Recruitment Processes
8. Financial Incentive Package for Fujitsu Australia Ltd (FAL)
9. Annual Management Report for the Year Ended 30 June 2003
10. Financial Audits with Years Ending to 30 June 2003

Reports Published in 2002

1. Special Purpose Review of Part of the Commission of Audit Report on the State of the Territory's Finances at 31 October 2001
2. Operation of the Public Access to Government Contracts Act
3. Governance Arrangements of Selected Statutory Authorities
4. Frameworks for Internal Auditing in Territory Agencies
5. V8 Car Races in Canberra – Costs and Benefits
6. Annual Management Report for the Year Ended 30 June 2002
7. Financial Audits with Years Ending to 30 June 2002

Reports Published in 2001

1. Financial Audits with Years Ending to 30 June 2000
2. Enhancing Professionalism and Accountability
3. Market Research and Marketing (Second Report)
4. Peer-Based Drug Support Services Tender – 1998
5. The Administration of Payroll Tax
6. Annual Management Report for the Year Ended 30 June 2001
7. Managing Canberra Urban Parks and Open Spaces
8. Canberra Tourism and Events Corporation – Relocation to Brindabella Business Park
9. Agents Board – Financial Administration of Training Grant Program
10. Corrective Services – Review of Certain Allegations
11. Financial Audits with Years Ending to 30 June 2001
12. The Freedom of Information Act

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[41] 57 Reports were issued prior to 1997. Details can be obtained from the ACT Auditor-General's Office or the ACT Auditor-General's homepage: http://www.audit.act.gov.au.

Reports Published in 2000

1 Bruce Stadium Redevelopment — Summary Report
2 Bruce Stadium Redevelopment — Value for Money
3 Bruce Stadium Redevelopment — Costs and Benefits
4 Bruce Stadium Redevelopment — Decision to Redevelop the Stadium
5 Bruce Stadium Redevelopment — Selection of the Project Manager
6 Bruce Stadium Redevelopment — Financing Arrangements
7 Bruce Stadium Redevelopment — Stadium Financial Model
8 Bruce Stadium Redevelopment — Actual Costs and Cost Estimates
9 Bruce Stadium Redevelopment — Market Research and Marketing
10 Bruce Stadium Redevelopment — Stadium Hiring Agreements
11 Bruce Stadium Redevelopment — Lawfulness of Expenditure
12 Bruce Stadium Redevelopment — Governance and Management
13 Annual Management Report for the Year Ended 30 June 2000

Reports Published in 1999

1 Stamp Duty on Motor Vehicle Registrations
2 The Management of Year 2000 Risks
3 Annual Management Report for Year Ended 30 June 1999
4 Financial Audits With Years Ending to 30 June 1999

Reports Published in 1998

1 Management of Preschool Education
2 Lease Variation Charges - Follow-up Review
3 Major IT Projects - Follow-up Review
4 Annual Management Report for Year Ended 30 June 1998
5 Management of Housing Assistance
6 Assembly Members' Superannuation and Severance Payments to Former Members' Staffers
7 Magistrates Court Bail Processes
8 Territory Operating Losses and Financial Position
9 Financial Audits with Years Ending To 30 June 1998
10 Management of Schools Repairs and Maintenance
11 Overtime Payment To A Former Legislative Assembly Member's Staffer

Reports Published in 1997

1 Contracting Pool and Leisure Centres
2 Road and Streetlight Maintenance
3 1995-96 Territory Operating Loss
4 ACT Public Hospitals - Same Day Admissions
Non Government Organisation - Audit of Potential Conflict of Interest
5 Management of Leave Liabilities
6 The Canberra Hospital Management's Salaried Specialists Private Practice
7 ACT Community Care - Disability Program and Community Nursing
8 Salaried Specialists' Use of Private Practice Privileges
9 Fleet Leasing Arrangements
10 Public Interest Disclosures - Lease Variation Charges and Corrective Services
11 Annual Management Report for Year Ended 30 June 1997
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