



1. Introduction

This submission outlines the Victorian Healthcare Association's (VHA) response to the *National Partnership Agreement on Improving Public Hospital Services: A Review of the Elective Surgery Targets and National Access Guarantee and the Four Hour National Access Emergency Department Target*

The VHA agrees to this submission being treated as a public document.

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The Victorian Healthcare Association

The VHA is the major peak body representing the public healthcare sector in Victoria. Our members include public hospitals, rural and regional health services, community health services and aged care facilities. Established since 1938, the VHA promotes improvement of health outcomes for all Victorians, from the perspective of its members.

Context

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

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

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

2. The VHA's Response

The VHA is concerned with the way in which elective surgery waiting lists are utilised in Australia. The current elective surgery waiting list process is ineffective as a measure of service access, unreliable as a benchmarking or prioritisation tool, and popularly misused as a measure of how well a health service is performing.

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



2.1 Measurement inaccuracies

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

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

2.1.1 Inconsistent patient categorisation

The practice of assigning public elective surgery patients to urgency categories provides a useful method to prioritise patients, but the current method is too restrictive in its definitions and open to manipulation. Widespread disparity exists between jurisdictions in the percentage of patients in each category.

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

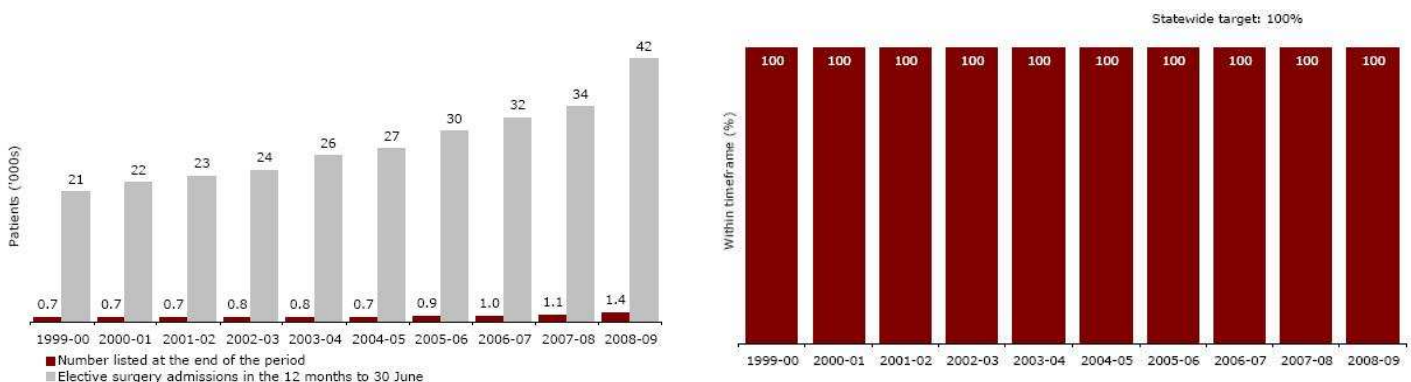
This suggests that the current categorisation system is too subjective and inconsistent, and therefore does not accurately measure actual clinical demand.

Another problem with the current categorisation system is that a patient is not prioritised until they have been assessed by a specialist, regardless of their clinical need. There is no triage system to prioritise access to a specialist to determine surgical urgency. Clinical guidelines must be developed to cover the entire patient referral process (see 2.1.3). This should include measuring referral of patients to specialists and the process by which specialists categorise patients.

2.1.2 The potential for data manipulation

The practice of linking waiting list targets to hospital funding ceased in Victoria in 2009 as it was shown to be detrimental to the accuracy of reporting data, indeed encouraging data manipulation.

In Victoria, the statewide target for category one (urgent) patients is 100 per cent. Over the past 10 years, the percentage of urgent patients seen in the clinically recommended time (30 days) is consistently 100 per cent, despite a doubling of the number of urgent patients admitted annually. This implies that the number of urgent patients has risen in direct proportion to the capacity of the Victorian public system to meet the targets, not clinical need.





2.1.3 Data omission

The current access data fail to reflect the needs of the most vulnerable people and those living in rural and remote Australia. Although the national data already show that people in remote and outer regional areas have longer waiting times for elective surgery than metropolitan residents, access to specialist services is not measured.

If a person who has access to a private specialist consultant, with public hospital admitting rights, is wait-listed for surgery in a public hospital, then that person can access public hospital services before someone who is still waiting to see a specialist in a public outpatient clinic.

Measurement of the time taken to access primary care and specialist appointments is also needed to accurately determine the true waiting times for elective surgery and the capacity of the system to meet increasing demand pressure, and to ensure that disadvantaged communities are not hindered further.

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

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

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

The demand for public elective surgery tends to increase when public waiting times decrease because Medicare removes the financial barrier to access. The only individual "cost" is the opportunity cost in waiting. If the public hospital waiting time decreases, the "cost" decreases making the private hospital option appear to be of lesser "value". This leads to higher public hospital demand.

2.2 Misleading information

2.2.1 Unbalanced focus

Elective surgery is a small percentage of public hospital activity and consequently, the emphasis on waiting lists as a true indicator of healthcare access is distracting and misleading. This was reflected in the National Health and Hospitals Reform Commission (NHHRC) final report, which stated "If we only set National Access Targets for one part of the health system, it is likely that funding (and media interest) will focus on that one issue to the detriment of other important health services".

The VHA reiterates that the amount of attention given to waiting lists, by the media and the political parties, is out of balance with the population's total demand for health services.

The VHA does not dispute the need to inform the public about public access to elective surgery but one of the problems with media snapshots focusing on this data is that they can reinforce the propensity to look at waiting list problems in isolation, rather than looking at the entire system. Media coverage must seek to expose the inadequacies of waiting lists as an effective measure of the health system. Current waiting list data must



be replaced by data that evaluates the effectiveness and efficiency of the whole health system, and is easily understood by the whole population.

2.2.2 Relevant data for benchmarking

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

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

Performance and demand measures must provide more complete data for meaningful improvement activity to occur. Measuring public and private rates of admission and measuring rates of admission according to diagnosis and other information, such as socioeconomic status, would enable more qualitative analysis of the reasons for differences and delays in treatment. For example, people in the most disadvantaged socioeconomic group have twice the rate of admission for Gynaecology and Cardiothoracic surgery than people from the most advantaged groups¹. It is difficult to identify this anomaly if incomplete data is analysed.

2.3 Recommendations

Immediate action must be taken to cease the current spread of misinformation. The Federal Government's key performance indicators (KPIs) for the states and territories must encourage improvement in managing the supply and demand of elective surgery to address waiting times across the health system. Governments should encourage collaborative innovations between the broad range of health services (primary, acute, aged), rather than pure competition and blame.

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

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

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

An alternative model could reward actions taken to improve access to health services rather than just measuring activity². Quality improvement is a continuous process in every hospital, and rather than just focusing on meeting static national benchmarks, problems should be addressed locally with the focus on solving the real issues.



3. Conclusions

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

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

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

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

The VHA welcomes the opportunity to provide further information to the Expert Panel on this or any other issues relating to health in Victoria.

Please contact me on (03) 9094 7777 to clarify any information in this submission.

A handwritten signature in black ink, appearing to read 'Trevor Carr'.

Trevor Carr
Chief Executive Officer

¹ Australian Institute of Health and Welfare (2008) *Elective surgery in Australia: New measures of access.*

² Werner, R.M. and McNutt, R.(2009) *A New Strategy to Improve Quality: Rewarding Actions Rather Than Measures* JAMA 2009; 301(13): 1375-1377