Queensland Government
Queensland Health

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ATTACHMENT 2

INFORMATION SUBMISSION

to Cabinet on

TREATING CATEGORY 3 PATIENTS

FROM THE

ELECTIVE SURGERY WAITING LIST

Prepared by the
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Statewide Health and Community Services Branch

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Queensland Health—helping people to better health and well-being.

INTRODUCTION

Elective surgery services in Queensland are at a crossroad. On one hand, it is clear that the Government's initiatives over the past six years via the *Waiting List Reduction Strategy* have delivered significant improvements in care for the more urgent patients, and that costs have been contained. On the other hand, there is evidence that some patients are forced to wait inappropriate time periods for surgery. The future strategy for Queensland's elective surgery services is to build on existing achievements and establish sustainability, while maintaining quality and maximising access.

Background

The Queensland Health Elective Surgery Program commenced in Queensland in 1995/1996, through provision of funding to purchase additional elective surgery over and above what was possible within a Hospital's base budget. Surgery funded under the Program was paid at a marginal rate to take advantage of spare capacity in services where fixed costs were covered in base budgets.

In July 1998, the Government gave a commitment to significantly expand previous strategies to reduce waiting times in Queensland public hospitals by launching the *Waiting List Reduction Strategy*. The *Strategy* originally involved an eight-point plan to reduce elective surgery waiting times, with a further element subsequently added to administer the collection of waiting times for specialist outpatients appointments. In February 2001, the Government's health policy provided further commitments for the enhancement of surgical services in public hospitals *(refer History of the Elective Surgery Program 1995-2005 – Appendix 1).*

CRITICAL ISSUES IMPACING ON ELECTIVE SURGERY

Access to Elective Surgery Services

Access to elective surgery waiting lists is through specialist outpatient services. All referrals received by specialist outpatient clinics are prioritised according to a clinical urgency category, a system similar to that used in elective surgery. The categorisation of referrals facilitates equitable and timely access to appropriate services according to urgency of need.

Although waiting times for outpatient appointments are not corporately collected, it is estimated that there are approximately 84,000 patients waiting to be seen by a surgical outpatient specialist, of which 60,000 patients (approximately) are not booked for a specialist outpatient appointment.

To enhance current specialist outpatient services and maximise existing resources, Queensland Health has recently implemented a *Policy Framework for Specialist Outpatient Services*. The *Policy Framework* provides instruction, information and guidance to all Queensland Health employees and other practitioners involved in the provision of specialist outpatient services. It can be seen as the definitive source of information for the implementation and maintenance of specialist outpatient systems and management processes within Queensland Health.

The volume of the current outpatient waiting list demonstrates that demand for specialist surgical services within the public system is far greater than capacity.

Demand for Specialist Surgical Services

Despite the efforts of the Government to reduce waiting lists, Queensland Health is unable to meet existing demand for elective surgery services particularity in Category 3 (non-urgent) patients. This is demonstrated by an increase in waiting list numbers of approximately 1,000 patients between 2003/2004 and 2004/2005, even with the injection of election commitment funding.

The changes in management of elective surgery waiting services implemented through the *Waiting List Reduction Strategy* has resulted in improved waiting times for higher acuity patients. Improvements for Category 1 and 2 patients were achieved early in the program and have been maintained despite increasing demand for services. While the percentages of Category 3 patients waiting longer than recommended times was initially maintained, deterioration in these waiting times has occurred as elective surgery funds have been progressively used to treat patients with greater clinical need.

The composition of Queensland elective surgery waiting lists varies between facilities, but analysis on a statewide basis is informative. Category 1 patients account for 7% of patients on Queensland lists, while Category 2 and 3 patients comprise 34% and 59% respectively. As at 1 July 2005 more than 1,200 Category 2 patients and 6,000 Category 3 patients are waiting longer than clinically recommended times.

Queensland Health has engaged the private sector to assist with fulfilling activity targets related to specific election commitments for cataracts and joint replacements in

2003/2004 and 2004/2005. This occurred primarily due to the inability of Queensland Health to provide these services in-house. The reasons for this are multifactorial and include limited available capacity, workforce deficiencies and other factors related to non recurrent funding arrangements, for example an inability to appoint staff permanently and therefore plan surgical services.

Workforce Issues

Hospitals continue to experience difficulties with recruitment and retention of skilled staff – particularly anaesthetists, surgeons and theatre nurses.

A Policy Submission has recently gone to Cabinet (refer Cabinet Decision No 5800 on 27 June 2005), which is the first of a two-part series being prepared for submission to the Commission of Inquiry that looked at future Queensland Health medical workforce requirements, estimated the future overall requirement for the years 2006 through to 2011 and provided some preliminary reform.

The second paper will expand on the analysis and cover the following areas of the medical workforce:

- An analysis of issues including lead time from entry to productive practice/specialisation
- General practice and specialist numbers and projections
- Specialist training positions – history and projections, strategies to increase; comparative performance with other jurisdictions.

The two papers focus on key systemic medical workforce issues and present information and options for consideration by the Commission of Inquiry.

Service Improvement Capability

Throughout the life of the *Waiting List Reduction Strategy*, service improvement has been a hallmark of Queensland Health's clinical services.

The *Waiting List Reduction Strategy* has provided a vehicle through which the following clinical quality and improvement practices have been introduced and implemented across the State:

- Pre-admission clinics;
- Day of surgery admission procedures;
- Discharge planning processes;
- Outpatient and surgical waiting list booking processes;
- Peri-operative management guidelines and procedures;
- Theatre management and utilisation strategies;
- Integrated bed management procedures;
- Post-acute and transitional care services;
- Hospital in the home services.

The Australian Government's Productivity Commission's *Report on Government Services 2005* compares each State and Territory's elective surgery performance. In the latest publication:

- Queensland has the best average waiting time to admission in Australia (at both the 50th and 90th percentiles); and
- Queensland also reported the lowest proportion of patients waiting longer than 12 months for admission for surgery.

A further indicator of the improvements achieved in Queensland elective surgery services is the low average length of hospital stay for elective surgery, at 2.5 days per case. This has been achieved by an increase in the use of efficient practices such as day surgery, to the point where this now accounts for 53.7% of all elective surgery undertaken. The day of surgery admission rate for elective surgery is also among the best in the country, at 76.0%.

While there is some prospect of further marginal improvements in the short-term, repeating the large-scale improvements that have been corporately driven over the past seven years cannot be repeated. Further change is continuing to be driven through the newly established Elective Procedures Program, however efforts must be balanced against the real risk that driving such change relentlessly may actually result in compromised patient safety (eg. unsupported discharge from hospital), increased cost due to adverse events and unplanned re-admissions, or increasing hospital budget deficits.

Funding Model

Historically

The funding model purchases additional elective surgery activity – over and above what is possible within hospital base budgets. In practical terms, the funding is designed to:

- maintain or increase existing levels of elective surgical services and elective procedures;
- establish new programs to treat patients who are unable to access existing surgical services or elective procedures within a reasonable timeframe; and
- ensure that the treatment of patients from the elective surgery wait list is based on prioritisation according to clinical need.

Total recurrent base elective surgery funding currently available under the *Strategy* is $83.7 million. Hospital activity targets associated with this recurrent funding have been maintained each year despite increasing costs of surgery. This means that the same amount of activity (or roughly the same number of patients treated) has been expected from the same pool of funds since 1995/1996.

This situation has resulted in the cross-subsidisation of elective surgery activity from other clinical areas within hospitals. This means that hospitals have been required to make financial decisions on which clinical services will be compromised to ensure that elective surgery targets are met. The other alternative is to maintain clinical service levels at the detriment of budget integrity.

In 2003/2004, this situation was improved by the payment of budget overruns and recurrent adjustment of forward funding.

Currently

A new funding model has been adopted in 2004/2005 under the banner of the *Elective Procedures Program*. This Program consolidates all recurrent funding and associated activity from the previous funds and provides for indexation of new activity in line with increases in costs.

The Government has also provided a non-recurrent allocation of $110 million for the period 1 July 2004 to 30 June 2007. It is expected that this election commitment funding will purchase additional activity on top of that generated currently within base elective surgery budgets.

In 2004/2005, $32.2 million was directly attributed to providing elective surgery activity statewide, and $7.8 million was allocated towards capital and staffing initiatives. Within the $32.2 million, new election commitment funding pools have been established for joint replacements ($5 million), cataract surgery ($2.2 million), and other elective surgery procedures ($25 million) at phase 8 pricing. This means Hospitals are paid the most current price for surgery under the Public Hospital Cost Benchmarks *(refer Information Paper on Measuring Elective Surgery – Appendix 2).*

In 2004/2005, Queensland Health has spent over $5 billion delivering health services, of which $2.7 billion is attributed to inpatient services. Of this, Medicine accounts for 60% or $1.6 billion and Surgery accounts for 40% or $1.1 billion. In this regard, the election commitment funding constitutes 1.2% of total inpatient services costs or 3% of total surgery costs.

Analysis of elective surgery throughput and waiting times indicate that continuing the current funding strategy will result in an increase in hospital deficits if throughput and waiting times targets are maintained, or a reduction in throughput and worsening waiting times if budgets are controlled.

STRATEGIES TO IMPROVE ACCESS TO ELECTIVE SURGERY

Future Direction

Improving consumer access to elective surgery services in Queensland public hospitals has been a major commitment of the Government, and one which has been supported at all levels of Queensland Health.

The future direction for elective surgery services must be made within the context of issues that impact on hospitals, on Queensland Health as a whole, and on the Government. Determining the most appropriate course of action to deliver improved access to elective surgery services in Queensland must align with key elements of the *Health 2020* strategic plan, including integrating patient-focused health services; shaping future workforce; and paying for health.

To improve access to elective surgery, consideration must also be given to the impacts on the existing health system – specifically the system's capacity to maintain or increase elective surgery throughput without comprising other services and quality of care.

Access Options

Specialist outpatient services perform an important gate-keeping role with respect to being placed on an elective surgery waiting list. The conversion of specialist outpatient referrals to the elective surgery waiting list must be managed according to available resources to ensure surgical waiting times are not compromised.

Waiting times for a specialist outpatient appointment vary considerably throughout the State and are dependent on the demand in a particular specialty and the availability of specialist staff. The number and period of time that patients are waiting for a specialist outpatient appointment are not corporately reported – this is recognised as the 'hidden waiting list'.

Any option to improve access to elective surgery, either within the public or private sector, will need to factor availability of specialist outpatients services. It is evident that any further increase in public specialist outpatient capacity is highly unlikely. The more appropriate option is to partner with the private sector. However, any large scale transfer of public outpatients to the private sector may be complicated due to current funding agreements with the Australian Government. To proceed with this option will require further investigation.

Treatment Options

Further development of partnerships with private sector health services may present opportunities for mutually beneficial elective surgery arrangements in areas of identified need. Private health services in Queensland have substantial infrastructure and workforce resources, capable of delivering elective surgery services. In areas where public sector capacity is not sufficient to meet the elective surgery demand, Queensland Health has successfully negotiated to use spare capacity in private services at competitive rates.

Category 3-type procedures including joint replacement and cataract surgery currently place an enormous strain on the public system. Evidence reveals that lengthy delays in the treatment of these types of patients will contribute to a reduction in quality of life, increase cost to community and increased cost of treatment in the future. By redirecting less urgent patients to the private sector Queensland Health will be able to focus attention towards the more urgent and complex patients.

Option 1 – Treat existing 'long wait' Category 2 and 3 patients in the private sector

The existing 7,200 'long wait' Category 2 and 3 patients are waiting for procedures that would be suitable for treatment within the private sector. These include cataract surgery, hip or knee replacements, cystoscopies, varicose vein surgery, cholecystectomy, hernia repair and various ENT procedures such as tonsillectomy. There are more than 14,000 patients with these types of procedures currently waiting for surgery - if not treated they will add to the existing 'long wait' position.

It is estimated that $42 million (on top of existing election commitment funding) is required to treat these 7,200 'long wait' patients within the private sector. This would clear the existing backlog of 'long wait' patients, but will not fix the problem as the public sector is at capacity and the waiting list will continue to grow. It should be noted that the cost of treating the backlog of 'long wait' patients increases each month as more patients are added to the waiting list.

Risks

- One-off funding of $42 million is an interim fix for current 'long wait' patients
- Elective surgery waiting list will continue to grow
- This option will only be successful if access to specialist outpatient services remains static – any increases may push demand beyond the public sector's capability

Option 2 – Treat Category 3 patients in the private sector

To continue to maintain the urgent Category 1 workload, improve Category 2 waiting times, and reduce 'long waits' in the public sector, existing election commitment funding will need to be made recurrent, and Category 3 activity will need to be significantly reduced.

It is estimated that approximately 15,000 Category 3 procedures will need to be outsourced on an annual basis which will cost in the vicinity of $88 million per year. This is in addition to providing election commitment funding of $33.2 million on a recurrent basis.

This option will enable total available capacity within the public sector to be dedicated to the treatment of more urgent patients. In this regard, overall supply of elective surgery services is expected to remain static.

Risks

- Substantial recurrent costs incurred ($88 + $33.2 million)
- This option will only be successful if access to specialist outpatient services remains static – any increases may increase demand beyond the public sector's capability

Implementation Options

Outside of expanding public capacity, options available to Queensland Health to treat additional elective surgery/procedures include:

1. Contracting services to the private sector (including non-Queensland Health Visiting Medical Officers);
2. Contracting services to the private sector exclusively to Queensland Health Visiting Medical Officers; or
3. Contracting fee-for-service sessions within Queensland Health facilities to Visiting Medical Officers in addition to their existing rostered arrangements.

A similar arrangement to the voucher system utilised within Oral Health Services could be expanded to the elective surgery program.

Prior to proceeding with either implementation option, further negotiation with the relevant private providers, medical officers and specialist colleges will need to occur to mitigate any level of associated risk.

A dedicated multidisciplinary team will need to be established to coordinate, manage, and outsource the treatment options within the private sector.

Summary

The options suggested provide real opportunity to improve access and waiting times for treatment and will have a positive impact on the quality of life for many Queenslanders. However the options provided must not be seen as an overall solution for meeting the ongoing demand for elective surgery services.

APPENDIX 1
History of the Elective Surgery Program
1995-2005

Name *Strategy for managing elective surgery in Queensland public hospitals*
Period *November 1995 – February 1996*
Party *Labor Government*

The *Strategy for managing elective surgery in Queensland public hospitals* was released by the Minister for Health, Peter Beattie in November 1995. It provided a framework for improving access to elective surgery in Queensland public hospitals in conjunction with a number of funding strategies to reduce waiting times for elective surgery.

The Strategy complemented a range of other initiatives introduced by the State Government to reduce the times that patients in public hospitals wait for elective surgery. These initiatives included:

- Investment to reduce the backlog in elective surgery ($64 million over three years);
- Incentives to attract and retain specialized personnel ($42.1 million over three years);
- Accelerated rebuilding of the major metropolitan hospitals so that they can be used to their full potential (an additional $40 million over two years); and
- A specialist equipment program to ensure that our specialist areas maintain world class standards (an additional $35 million over two years).

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Name *Surgery on Time*
Period *February 1996 – June 1998*
Party *Coalition Government*
Team *Elective Surgery Project*

In February 1996, the Government gave a commitment to significantly expand previous strategies to enhance elective surgery services in public hospitals in Queensland through the *Surgery on Time* plan. The plan involved a coordinated approach to managing the major elements that impact on elective surgery services, with strategies to target increased throughput in conjunction with active management of waiting times (rather than the size of the waiting list).

A dedicated Project Team was formed in March 1996 to develop and implement an action plan for enhancing elective surgery services in Queensland's public hospitals. The team was known as the Elective Surgery Project and was headed by a senior clinician. The action plan was developed after extensive consultation with medical and nursing colleges, societies and associations as well as with District Managers and key medical and nursing personnel from the participating hospitals.

The implementation of the *Surgery on Time* plan aimed to achieve:

1. Better information and reporting to aid monitoring and performance management;
2. Appropriately qualified and trained clinical staff in our hospitals;
3. Enhanced capital infrastructure to support increased surgical throughput;
4. Better utilisation of our operating theatres;
5. Strategies to increase day surgery rates and reduce the need for hospitalisation;
6. Improved transitional care in the community to promote reduced hospital lengths of stay;
7. The development of better clinical practices; and
8. Extra funding packages to ensure that our objectives are achieved.

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Name	*Waiting List Reduction Strategy*
Period	*July 1998 – January 2005*
Party	*Labor Government*
Team	*Surgical Access Team (changed to Surgical Access Service in 2002)*

In 1998, the Government gave a commitment to significantly expand previous strategies to reduce waiting times in public hospitals in Queensland. The Waiting List Reduction Strategy involves an eight-point plan to cut waiting lists and includes a commitment to:

i) publish the waiting list for each hospital every three months so that money can be channelled to where the real need is;
ii) supply general practitioners with quarterly briefings on waiting lists to help them when referring people for surgery;
iii) even out waiting lists by moving people in appropriate cases to a hospital where their procedure can be performed more speedily;
iv) provide additional funding of $6.0 million per year to finance extra surgery for complex procedures;
v) work with the specialist colleges to expand training places for new specialists to meet the demand of the next century;
vi) use holiday times to keep operating theatres working for the benefit of those waiting for surgery;
vii) benchmark waiting times for accident and emergency departments to reduce excessive waits; and
viii) increase levels of day surgery across the State to reduce the length of waiting times for elective surgery.

A further element was added to the eight-point plan, being the collection of waiting times for specialist outpatient appointments to assist in clinical prioritisation for surgery and appointments.

In achieving these elements, the Surgical Access Team's objectives were to:

- Develop policy directions to inform the effective delivery of services into the future;

- Develop and implement systems to improve efficiency, appropriate practice and equity of access to emergency department, specialist outpatient and elective surgery services on a statewide basis;
- Provide information, both at a strategic and operational level, to guide the forward planning and ongoing management and of emergency department, specialist outpatient and elective surgery services across Queensland public hospitals;
- Benchmark performance of emergency department, specialist outpatient and elective surgery services in Queensland public hospitals;
- Provide expert advice and analysis relating to emergency department, specialist outpatient and elective surgery services; and
- Consult and communicate with key stakeholders including the major medical and nursing colleges and associations.

In 2001, the Government's election commitments provided for the enhancement of surgical services in public hospitals, including:

- injecting an additional $20 million over two years, into funding for elective surgery so that more people can have their operations faster;
- continuing to work towards a target of 50% of elective surgery performed as day surgery and setting a target of 80% for day of surgery admissions within two years;
- establishing a central elective surgery booking bureau that will be more patient-focused and more responsive to providing services to people where they live; and
- strengthening clinical protocols to ensure appropriate and timely treatment of patients based on clinical need.

In 2004, the Government's election commitments included a $110 million program aimed at reducing waiting lists throughout the State, with funding for areas with the highest need and longest waiting lists over three and a half years. The Government has also committed significant funding to support initiatives to ease the pressure on public hospital emergency departments.

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Name	*Waiting List Reduction Strategy*
Period	*February 2005 - current*
Party	*Labor Government*
Team	*Zonal Management Units and Health Systems Development Unit*

In February 2005, the Surgical Access Service was mainstreamed and the responsibility for overseeing the *Waiting List Reduction Strategy* was given to the Zonal Management Units. The responsibility for reporting against the *Strategy* was given to the Health Systems Development Unit (within Statewide Health and Community Services Branch).

In March 2005, the Elective Procedures Program Steering Committee was activated comprising membership from Statewide Health and Community Services Branch, Zonal Management Units, and the Health Services Directorate office. The role of the Elective

Procedures Program Steering Committee is to oversee the Elective Procedures Program in line with the Government's *Waiting List Reduction Strategy*. This includes:

- Developing the business rules for the Elective Procedures Program;
- Providing recommendations to the Senior Executive Director, Health Services Directorate (SEDHSD) regarding the allocation of funding and activity targets to Districts for the Elective Procedures Program;
- Monitoring performance against agreed funding and target allocations;
- Developing the methodology for incorporating elective procedures and elective surgery into the Elective Procedures Program; and
- Governance of the Policy Framework and Management Guidelines for the Elective Surgery Program

APPENDIX 2
Information Paper on Measuring Elective Surgery

BACKGROUND:

The Statewide Health and Community Services Branch is responsible for monitoring and reporting on elective surgery performance to the Queensland Health Executive and the Minister on a monthly and quarterly basis.

The information provided is sourced from two different corporate collections.

1. **Queensland Hospital Admitted Patient Data Collection (QHAPDC)**
   This collection is managed by the Queensland Health - Health Information Centre (HIC) and facilitates reporting of the number of patients discharged (separated) from hospital in weighted and unweighted separations. The data is sourced from District Health Services via the Hospital Based Corporate Information System (HBCIS) Admissions Transfers and Discharges Module (ATD).

2. **Elective Admission Monthly Summary Report**
   This reporting process is managed by the Statewide Health and Community Services Branch and facilitates:
   - The number of patients waiting at each hospital by urgency category/specialty at the census date including the number and percentage of 'long waits'.
   - The number of elective procedures 'treated' from the waiting list for the reference month.

   The data is sourced from District Health Services via the Hospital Based Corporate Information System (HBCIS) Elective Admissions Module (EAM).

KEY ISSUES:

Funding and monitoring of elective surgery activity

- Each year elective surgery targets and associated funding for District Health Services are allocated via consultation between the Elective Procedures Steering Committee and the Senior Executive Director, Health Services Directorate.
- The targets are developed and measured in terms of weighted separations sourced from the QHAPDC. The associated funding is calculated using the cost weights from the Queensland Health Hospital Benchmarking Prices Model.
- The information reported under the above arrangements is used solely for the purpose of financial management of the elective surgery program. This information is not reported in the public arena for reporting progress with elective surgery election commitments.

Queensland Hospital Admitted Data Collection (QHAPDC)

- Due to its functionality as a live system for managing waiting lists and patient bookings, EAM is unable to support the complexity of data validation required of Queensland Health's formal data collection on public hospital admissions known as the QHAPDC. The Health Information Center is responsible for managing the QHAPC and generating hospital morbidity data.
- The term 'weighted separation' applies to a methodology used internationally to quantify the relative cost of one patient admission to another.
- The process for determining weighted separations for a hospital separation is as follows;
  - After discharge from hospital the patient's medical record is reviewed and the details of relevant clinical diagnoses and procedures performed on the patient are coded and captured in the HBCIS Admissions, Transfers and Discharges Module (ATD). This process is carried out within the hospitals medical records department by staff qualified in using the International Classification of Diseases (ICDv10) to assign morbidity codes.
  - Software then assigns the patient admission a classification known as a Diagnosis Related Group (DRG). DRGs group patients that are similar in terms of their diagnosis/treatment and also the costs/resources typically consumed.
  - The timeframes associated with processing hospital weighted separation data are such that it is typically several weeks from the end of a month before data is finalised.
  - The release of final activity data is dependent on the data validation processes of the Health Information Centre. The close-off date for finalisation of data is 30 September each year.
  - Weighted separation data allows the monitoring of elective surgery operations in terms of relative cost and is a more robust method for negotiating and monitoring activity under the elective surgery program.

Queensland Health Public Hospital Cost Benchmarks 2004/2005 (PHCB)

- The PHCB is the vehicle whereby Queensland DRG costs are developed using information from the National Hospital Cost Data Collection (NHCDC).
- Under the PHCB each DRG is assigned a cost weight to reflect the cost of each patient admission relative to the average.
- As an example, an admission for knee arthroscopy would be classified to the DRG *I24Z – Arthroscopy* with a cost weight of 0.69 (cost $690), while a total hip replacement would be classified to the DRG I03C with a cost weight of 5.27 (cost $5,270).
- New phases of the PHCB are developed each year and Queensland Health is currently using Phase 8 benchmark costs.