

Elective Surgery Waiting Lists: What are we trying to achieve?

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Sponsored by: the Central Northern Adelaide Health Service

Lies, damned lies — and elective-surgery waiting lists

The Age
Carol Nader
November 23, 2006

Five years of hell seeking surgery in state's hospitals

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August 09, 2009 (Sunday Mail)

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Minister 'made hospitals fudge data'

A WHISTLEBLOWER has alleged political interference in Victoria's health system as the scandal over fudged hospital figures worsens.

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This Programme of Research

Research Aims

1. To map the systems used to manage patients waiting for elective THR/TKR surgery.
2. To identify factors that impact on the delivery of elective THR/TKR surgery.
3. To identify strategies to improve the systems used to manage patients waiting for THR/TKR surgery.

Research Methods

- Semi-structured interviews with stakeholders
 - Four public hospitals
 - 19 interview participants
- Observation of how patients are booked for surgery
- Systematic reviews of the literature

Elective Surgery Waiting Lists

What are we trying to achieve?

"To ensure optimal management of elective surgery across the public hospital system in order to minimise waiting times, maximise patient satisfaction and promote health outcomes for individual patients and the community in general."

(South Australian Department of Health, 2006)

But that's not the whole picture...

"... so I think that you know, it needs to be fair and equitable across the board ..."

"I take care of their theatre bookings, I work off a waiting list, so I like to be fair with all patients..."

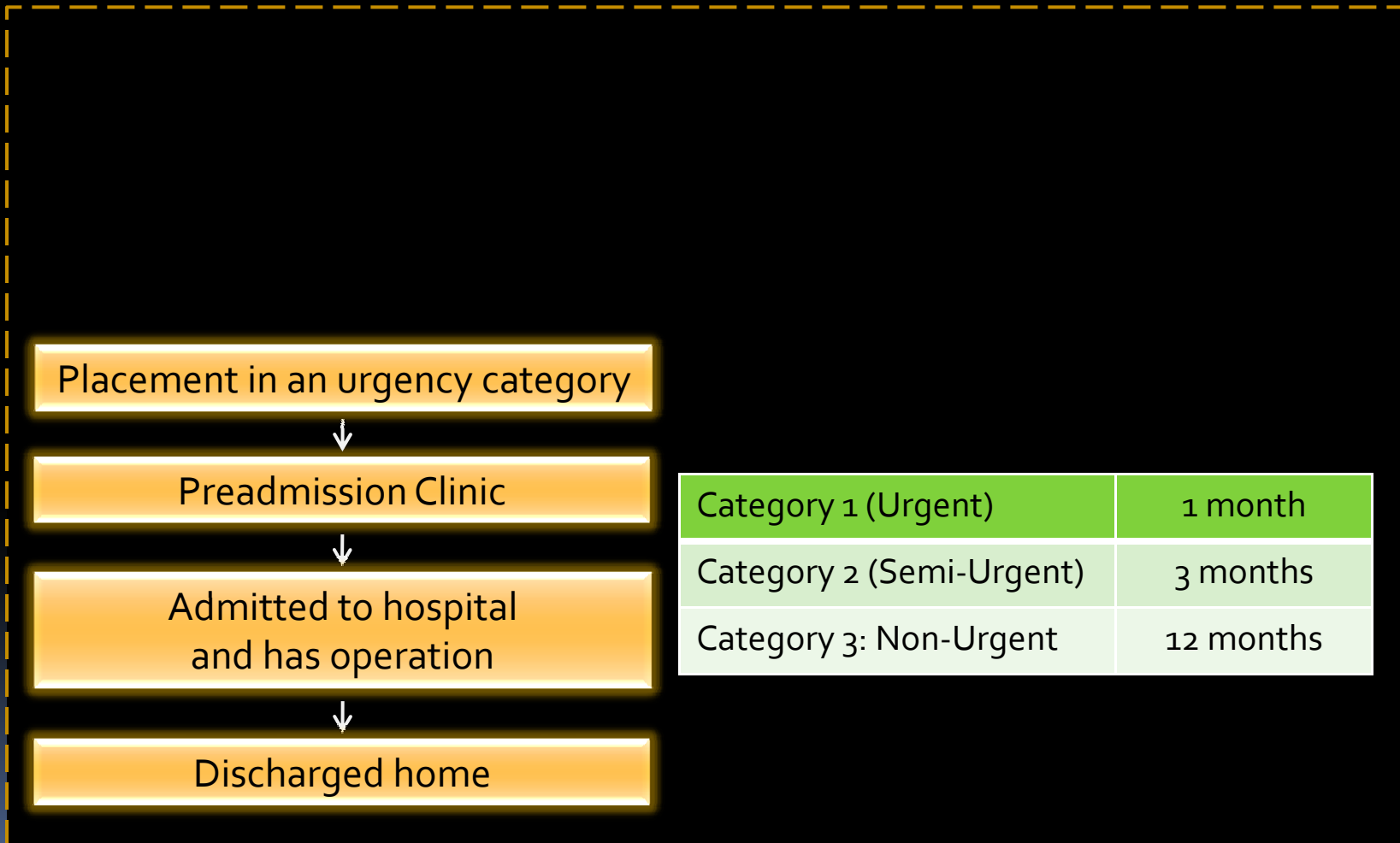
Clinical Urgency Categories

Urgency Category	Description
Category 1 (Urgent)	Very early admission desirable for a condition that has the potential to deteriorate quickly and become an emergency or is life threatening. Admission within 30 days desirable
Category 2 (Semi-Urgent)	A condition causing some pain, dysfunction or disability which is not likely to deteriorate quickly or become an emergency. Admission within 90 days desirable
Category 3 (Non-Urgent)	Admission at some time in the future for a condition causing minimal to no pain, dysfunction, or disability, that is unlikely to deteriorate quickly and that does not have the potential to become an emergency. Admission within one year desirable

What are we trying to achieve?

1. Efficient system function
2. Maximal patient satisfaction
3. Promotion of healthy outcomes for the patient and the community
4. Equitable access to elective surgery, within a 1,3,12 month timeframe depending on urgency

Elective Surgery Patient Pathway



Patient consults his GP about his hip/knee



GP sends a referral to the hospital



Patient's referral is triaged by hospital staff



Patient has first appointment with his surgeon at the OPD



Patient is given urgency category



Patient attends preadmission clinic



Patient is admitted to hospital and has his operation



Patient is discharged home

Patient consults his GP about his hip/knee



GP sends a referral to the hospital



Patient's referral is triaged by hospital staff



Patient has first appointment with his surgeon at the OPD



Patient is given urgency category



Patient attends preadmission clinic



Patient is admitted to hospital and has his operation



Patient is discharged home

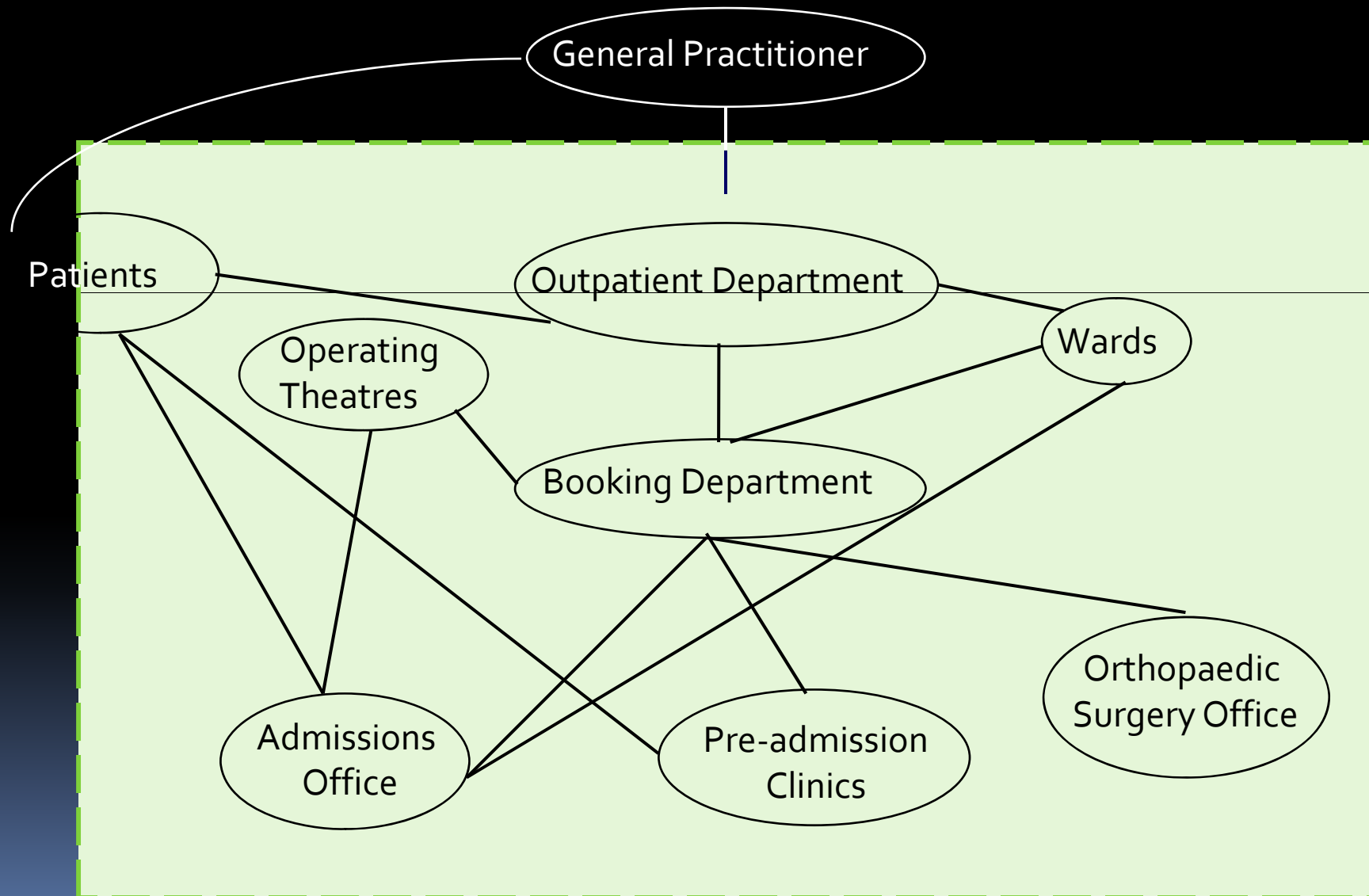
12 – 24 months



12 – 15 months



The Elective Surgery System





System Function

Are we achieving our objectives?

Objective 1: Optimal System Function

- Barriers to System Efficiency

Barrier 1: Demand for Joint Replacement Surgery

Total Hip and Knee Replacement Surgery in Australia
2000-2009



Barrier 2: Resource Constraints

“We have gaps (in theatre), we don’t have enough anaesthetists here, there’s never an anaesthetist.”

“Beds are our significant problem and emergency patients.”

“You’d have a hip on there and then you’d have an emerge come in, you know someone with a fractured NOF, had to go to theatre, knock off, your major off.”

Barrier 3: Workforce Issues

“There are slightly different objectives about waiting list management between [person who works in system] and what we’re trying to manage in terms of targets.”

“That’s because of lack of anaesthetists, you know, [staff members] don’t want to work overtime, um and it’s about them trying to manage their department.”

Barrier 4: Variability in Clinical Decision-making

- The literature tells us that there is no consensus related to clinical indicators of *need* for THR/TKR surgery

“But what I find is that, you know, one lot of criteria for one surgeon isn’t the same as another surgeons ...”

“... everyone's a little bit different with the way they assess their patients.”

Objective 2: Maximise Patient Satisfaction

“You get your regulars, you know, that think that they’ve got to ring every three months, or something like that – but yeah, I think usually, once you’ve told them the waiting time, they’re probably happy.”

“Some people get really abusive. ... we phone up the people and say “I’m sorry there’s been a cancer case, so you need to be moved” ...”

Objective 3: Promotion of Healthy Outcomes for the Patient and the Community

Q: And while they're waiting, either for their outpatient appointment or when they're waiting for their surgery, are there any conservative management options available to the patients?

A: No. We just always first refer them back to their GP.

A: Mostly they've tried all the different conservative options when they've seen us. So, we offer them all again, but mostly they've all been tried by the time they've seen us.

Objective 4: Equitable Access to Surgery

Q: Ok. Most of the patients, if we're going back to the federal targets then, most of the (joint replacement) patients would fall into which category?

A: Three.

A: Three, which is non-urgent and surgery within 12 months

A: Oh, it'd be non urgent.

A: Three – they're all in category three.

What are we trying to achieve?

Objective 1: Optimal System Function

Objective 2: Maximal Patient Satisfaction

Objective 3: Promotion of Healthy Outcomes
for the Patient and the Community

Objective 4: Equitable Access to Elective
Surgery

Strategies for System Improvement

Strategy: Experienced Booking Staff

Q: So what would happen if you just had a general reliever come in?

A: "Oh no, it wouldn't work. It would be absolutely chaos".

Strategy: Patient Communication

“I just do a lot of work myself, I sort of ring patients ... It's just a way of, you know, communication, I just like to communicate with the patients”

“... if you look at our DNA rate, the people that don't attend, because we send them out an appointment saying, your times up, and then they don't rock up-”

Strategy: Keep Patients Close to Home

“... they’ve got to go all the way down there for every appointment for the rest of their life, you know, and it’s as ridiculous – so, you need to be putting them in the biggest suitable hospital that’s nearby ...”

Other Strategies

- Better engagement of local general practitioners
- Breakdown of cultural barriers and engagement of hospital staff
- Greater use of allied health staff
- Pre-admission Clinics
- Greater flexibility in resource usage

What won't help?

1. Pooled surgical waiting lists

“No, that wouldn't work because the doctor likes to know the patients' history before the operation...”

“I've experienced patients who've been put on the list by one surgeon from out in the community, and the patient's presented here and because I had a vacancy I've taken them off the list and given them to somebody else, and that surgeon said “they don't need that knee replacement done”, you know really, it's a waste of time.”

What won't help?

2. Increasing funding without system change.

Q: The increase in funding is not going to have a lasting effect?

A: "No. It will certainly support clearing that waiting time but people don't want to engage, people don't want to work here any longer than they have to, and you know for us to do that (meet waiting time targets) something needs to change in the system. As opposed to money being given to us, the system actually needs to change."

Summary

Take Home Messages

Take Home Messages

- Existing elective surgery systems evolved out of necessity
- Existing elective surgery systems rely heavily on having experienced, motivated administrative staff working within them

Take Home Messages

- Waiting time targets are a recent introduction – the systems were never designed with time targets in mind.
- There is no consensus on the patient or disease characteristics that indicates need for elective total hip or total knee joint replacement surgery

Take home messages

- The elective surgery system is complex – past reforms have shown us that focussing on only one aspect of the system will not solve the problem.
- We need reforms that will achieve a balance between clinical need and available resources.

Thank You