PERFORMANCE EXAMINATION

Patients Waiting:
Access to Elective Surgery in Western Australia

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PERFORMANCE EXAMINATION – Patients Waiting: Access to Elective Surgery in Western Australia

This report has been prepared consequent to an examination conducted under section 80 of the Financial Administration and Audit Act 1985 for submission to Parliament under the provisions of section 95 of the Act.

Performance examinations are an integral part of the overall Performance Auditing program and seek to provide Parliament with assessments of the effectiveness and efficiency of public sector programs and activities thereby identifying opportunities for improved performance.

The information provided through this approach will, I am sure, assist Parliament in better evaluating agency performance and enhance Parliamentary decision-making to the benefit of all Western Australians.

D D R PEARSON
AUDITOR GENERAL
December 9, 2003
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In 1999, the report on elective surgery titled *A Stitch In Time: Surgical Services in Western Australia* made a number of recommendations to improve the delivery of elective surgery in the public health system. The Department of Health has made progress in implementing these recommendations but still has some way to go.

The health system continues to face strong demand pressures for its services as well as ongoing resource constraints. In this context, the Department and the health system have introduced a range of measures to improve access for elective surgery patients. This included the restructure of the health system into Area health services in 2001-02.

Nevertheless, there is still much to be done to reduce both waiting times and the number of patients waiting. Average waiting times for elective surgery have remained steady over the past four years, but many people still wait longer than the clinically desirable waiting times for their procedures.

This report provides an analysis of access to elective surgery and proposes some strategies to help improve access within resource constraints.

It is acknowledged that the elective surgery system is large and complex and operates in a changing environment. Nonetheless, it is important that proposals that will improve access, including those in this report, are implemented properly and fully. Further, to ensure provision of timely and equitable access to elective surgery, an ongoing monitoring and improvement process is critical.
Executive Summary

Key Findings

- Like public health systems the world over, the State’s public health system is subject to increasing demand pressures (with admissions rising by an average of 3.2 per cent over the last ten years compared with population growth of around 1.7 per cent). This has been compounded for elective surgery by a shortage of fully trained surgeons and nurses, as well as higher bed occupancy (102 per cent at teaching hospitals in June 2003).

- For elective surgery, this pressure has been alleviated to some extent by improved efficiencies in same day surgery and bed management as well as by more people having their surgery performed at private hospitals following the introduction of the 30 per cent health insurance rebate in 1999. A concern is that this shift to private hospitals was reversed slightly in 2002-03.

- Despite the pressures, the average waiting time for elective surgery has remained steady over the past four years at around four and a half to five months (excluding the time between visiting the General Practitioner (GP) and being put on the waiting list by the specialist).

- The main concerns with waiting times are that:
  - 42 per cent of teaching hospital patients are waiting longer than the clinically desirable waiting time for their procedure (almost 72 per cent of urgent elective surgery is performed at the general teaching hospitals)
  - 47 per cent of semi-urgent patients are waiting longer than the clinically desirable time.

- Reasonable waitlist and waiting time information is available in this State. However, to effectively manage access to elective surgery, the Department needs to use the full range of data and ensure the waitlist represents a true picture of numbers waiting and waiting times, so that appropriate decisions can be taken and resources allocated to priority areas.

- Elective surgery continues to be less accessible to people in regional areas, though the drift to the city has reduced slightly in recent years.
EXECUTIVE SUMMARY (continued)

Key Recommendations

The Department of Health and Area health services should manage waitlists to focus on priority areas, which presently are the long waiting times at teaching hospitals and the large proportion of semi-urgent patients waiting longer than the clinically desirable waiting time.

The Department of Health should:

- actively manage the scope of elective surgical procedures on the waitlist to be performed in the public sector
- report the total waitlist, and the time between visiting the GP and being placed on the waitlist, to enable better management of the waitlist
- ensure the waitlist represents a true picture of numbers waiting and waiting times by:
  - developing a set of guidelines for specialists, in conjunction with them, to assist in categorising patients more consistently
  - developing guidelines on waitlist management
  - extending clerical audits to the full waitlist
  - instituting regular clinical reviews of long wait patients.
- introduce performance agreements with Area health services to drive and assess their performance with elective surgery
- develop a clear role in central office for transferring public patients between the Area health services, where Central Waitlist Bureau (CWLB) information indicates that this would help to ease pressures on a particular Area health service
- actively promote to GPs and to patients, the availability of information provided by the CWLB (including on its website) to facilitate referrals
- continue to action the Country Health Services Review where this better aligns services with country requirements.

Area health services should continue to:

- introduce measures such as more same day surgery and day of surgery admission to improve access by reducing the average length of stay
- examine opportunities to improve the scheduling of elective surgery to better utilise available bed capacity through the year
- examine and introduce measures to better coordinate elective surgery between teaching and non-teaching hospitals. This should include examining ways of overcoming the various constraints on making more use of non-teaching hospitals without significantly increasing costs to the overall health system.
What this Examination is About

This examination reviewed how effectively elective surgery is being provided to public patients in Western Australia in terms of how readily patients access their required surgery, coordination of access by the public health system, and usefulness of the waitlist information for managing elective surgery.

Why We Did this Examination

Elective surgery is an important part of the State’s health system, with almost 30 per cent of total admissions and 77 per cent of surgical admissions being for elective surgery. Further, for many years now, the success of the health system in dealing with the demand for elective surgery has been considered one of the key indicators of the performance of the system.

Originally, an examination was planned to follow-up on the 1999 performance examination *A Stitch in Time: Surgical Services in Western Australia* (*A Stitch in Time*). However, in view of the increased pressures on the health system, the changing environment affecting it and the changed health system structure, a fuller examination was undertaken.

What We Did

The examination focused on the provision of elective surgery to public inpatients (whether treated in a public hospital or private hospital under contract to the Department of Health). It used data from the CWLB, the Hospital Morbidity Database (HMDB) and the ten hospitals visited during the examination (including the three general teaching hospitals, four non-teaching hospitals and three country hospitals) which were selected to provide a reasonable picture of the health system as a whole. The examination also included interviews at, and information supplied by, the Department of Health, interviews with relevant staff at each of the ten hospitals and the results of a questionnaire to country hospitals.

What is Elective Surgery

Elective surgery is all surgery that can wait beyond 24 hours. It can include quite complex and serious procedures such as coronary artery bypass, more simple procedures such as tonsillectomies or cosmetic procedures such as liposuction.
What We Found

Demand Pressures and the Changing Health System

Like public health systems the world over, the Western Australian system is subject to strong demand pressures resulting from the ageing population and the rising costs of new technologies and pharmaceuticals.

In Western Australia, these pressures have intensified since 1999. This has been moderated to some extent by a significant increase in people having elective surgery at private hospitals (and a corresponding decline in the proportion of patients having their procedure performed publicly) since the introduction of the 30 per cent rebate and the Lifetime Health Cover policy in 1999 and 2000 respectively. However, this shift reversed slightly in 2002-03.

For elective surgery, the impact of the greater demand pressures on the public health system has been compounded by the shortage of fully trained surgeons and anaesthetists (which is particularly evident in this State), as well as nurses.

There has also been a significant increase in bed occupancy to around 102 per cent at teaching hospitals in June 2003.

Since the 1999 examination, the structure of the State’s health system has changed with the introduction of a more centrally coordinated system and the establishment of an area system under control of the Department of Health.

In regard to elective surgery, the Department has made significant progress with most of the recommendations of the 1999 report, A Stitch in Time.

Access to Elective Surgery

Despite the increasing pressures on the system, the average waiting time for elective surgery (for the reported waitlist) has remained steady over the past four years at around four and a half to five months.

There are still concerns about waiting times for elective surgery:

- many patients are waiting longer than the clinically desirable waiting time for their procedures. In the two years to August 2003, around 35 per cent of elective surgery patients had waited longer than the maximum recommended times for their procedures. At teaching hospitals, the situation is even worse with 42 per cent of patients waiting longer than clinically desirable (72 per cent of the urgent elective surgery is performed at the general teaching hospitals)
there is a particular problem for semi-urgent patients, with 47 per cent waiting longer than the clinically desirable time of 90 days, compared with 36 per cent for urgent patients and 30 per cent for non-urgent patients.

there were also 1 050 patients who had waited longer than 1 000 days at February 2003, including 280 patients who had been waiting more than five years.

waiting times for particular procedures vary substantially between different hospitals.

With hospitals operating at high occupancy rates, unexpected emergency admissions can mean that patients have their surgery deferred, sometimes very close to the scheduled surgery date. Deferrals of elective surgery rose by eight per cent in 2002-03 (including the impact of patients from the Bali explosion that year), with deferrals because of emergencies taking priority becoming more prevalent.

As major surgery generally needs the special resources of a teaching hospital, elective surgery continues to be less accessible to people in country areas. Some changes have occurred with the restructuring of the State’s country health services into the WA County Health Service and the South West Health Board in 2002. In addition, the Country Health Services Review has been completed and some progress has been made, though it is still too early for it to have been fully implemented.

Improving Access to Metropolitan Hospitals

The health system has introduced a number of measures to improve access to hospitals including increased same day surgery, day of surgery admission, and measures to improve bed management (such as 23 hour wards, transit lounges and improved discharge practices). These measures have reduced the average length of stay in public hospitals to 2.9 days, compared to 4.1 days ten years ago.

Nevertheless, the health system should examine additional measures to further improve access for elective patients. These should include:

- better coordination between teaching and non-teaching hospitals within each of the Area health services (with non-teaching hospitals currently having capacity to be used more to take some of the pressure off teaching hospitals). The establishment of the new Area health structure has facilitated this and some hospitals have begun to trial measures to improve coordination.

- improving scheduling of elective surgery to better utilise bed capacity through the year.
improving central coordination by the Department of Health through:

- the introduction of performance agreements (including elective surgery targets) between the Department of Health and the Area health services to drive and assess the performance of Area health services with elective surgery

- a clear role for central office in transferring patients between teaching and non-teaching hospitals across the various Area health services where CWLB information indicates that this would help to ease pressures on a particular Area health service. The information the CWLB has on waiting times (including its website) should also be actively promoted as a mechanism for GPs to assess waiting times for particular procedures, and for different surgeons, before referring patients for elective surgery.

Improving Waitlist Information

Reasonable waitlist and waiting time information is available in this State as it is collected, reviewed and analysed by the CWLB.

However, the usefulness of the waitlist information for properly managing access should be improved by:

- extending the publicly available information to include data currently collected on the waitlist for medical procedures. At present, the publicly available information (or the ‘reported’ waitlist) includes only surgical procedures and represents approximately 47 per cent of the total waitlist for elective procedures

- reporting the time lag between seeing the GP and being included on the waitlist to provide an indication of a patient’s overall waiting time

- the Department of Health preparing a single set of comprehensive guidelines on waitlist management, which can be used by all hospitals, and providing guidelines to specialists (as is done in other States) to enable a more consistent categorisation (and review) of patients into the various urgency categories. The large number of urgent patients waiting more than six months (the recommended time being 30 days) suggests that categorisation needs to be improved

- extending clerical audits (administrative review of patient details) of the waitlist to the full waitlist and undertaking regular clinical reviews (evaluation of patients’ clinical status) of long wait patients.
The Changing Health System

Findings and Recommendations

Findings

- Like public health systems the world over, the Western Australian public health system is subject to strong demand pressures compounded by a shortage of fully trained surgeons and nurses as well as high bed occupancy, especially at teaching hospitals.

- More people have had their surgery performed at private hospitals since the introduction of the 30 per cent rebate in 1999. This has helped to ease the pressure on elective surgery in the public system to some extent. However, a concern is that this shift was reversed slightly in 2002-03.

- The Department of Health has made significant progress in implementing most of the recommendations from the 1999 performance examination on elective surgical services, A Stitch in Time.

Recommendation

The Department of Health, in conjunction with Area health services, should put in place a clear and measurable action plan to progressively improve access to elective surgery.
Recent Changes

The 1999 review of elective surgical services in the State’s public health system - *A Stitch in Time* – was a broad review covering not only access and equity of access but also efficiency, quality of care and accountability arrangements. It resulted in 13 recommendations. These, together with an assessment of the extent to which they have been implemented, are provided in Appendix 2.

In addition, the structure of the health system changed substantially in 2001-02, arising out of the report by the Health Administrative Review Committee (the HARC report).

These changes focused on developing a more coordinated health system by removing the metropolitan and country health boards and replacing them with four metropolitan areas and seven country health areas (with associated advisory councils) which are responsible to the Department of Health.

The essence of these reforms was the establishment of an Area health service system under the control of the Department of Health. This has allowed for greater coordination of surgical services within each Area health service.

Factors Affecting the Provision of Elective Surgical Services

A wide range of factors can affect access to elective surgical services in the State’s public health system. These are identified in Figure 1. A number of factors are within the direct control of the public health system and changes to these will improve access. However, many cannot be directly influenced by the public health system, though it may be able to have some indirect influence over some of them. Management systems and processes should be in place to allow the system to be responsive to these factors. Some of the key factors are covered in this chapter.
Demand Pressures

Like public health systems the world over, the Western Australian system is subject to strong demand pressures with the ageing of the population, and the rising costs of new technology and pharmaceuticals.

The demand pressures have intensified over the past ten years. The number of people admitted to hospital for surgery as public patients (both elective and emergency) has risen by an average of 3.2 per cent per year over this period, compared with a 1.7 per cent increase in the State’s population each year. These pressures will intensify in future years. The Australian Bureau of Statistics (ABS)\(^1\) has forecast that the number of people in the State aged over 65 will more than double over the next 20 years, compared with a forecast growth in the overall population over that period of 35 per cent.

\(^1\) Australian Bureau of Statistics - Table 1F. Projections of Population By Age - Western Australia.
The pressure on the metropolitan hospitals has been further accentuated by the lack of facilities and doctors for many procedures in country hospitals which has forced country people to have surgery in the city. This drift from the country has reduced in recent years, but is still adding to the pressure on metropolitan hospitals.

The recent reduction in bulk billing by GPs is also adding to the pressure on emergency departments at public hospitals.

Importantly, however, for elective surgery, from 2000 to 2002 more people have sought to have their elective surgery performed as private patients, following the introduction of the 30 per cent rebate in 1999 and the Lifetime Health Cover policy in 2000. Over that period, the proportion of patients having surgery in the private system has risen by seven percentage points (41 per cent to 48 per cent of total surgical admissions), compared with a seven percentage point decline in the public system (51 per cent to 44 per cent). If this swing to the private hospitals had not occurred, the public hospital system would have had to cope with an additional 30,000 procedures over the last three years.

However, over the past year, this move of patients to the private hospitals has decreased by almost one percentage point. If this continues, there could be even more pressure on the public health system in future years.

Resource Constraints

The impact of the increased demand pressures on the public health system has been compounded by resource constraints. The main constraints for elective surgery are:

- A shortage of fully trained surgeons – there is a shortage of surgeons in Australia. While there have been no studies specific to Western Australia, 2001 ABS census data shows that Western Australia has only 76.7 medical specialists (which includes surgeons and anaesthetists) per 100,000 people compared with the Australian average of 80.4. This equates to a deficit of around 72 medical specialists in Western Australia compared to the Australian average.

Added to this is an assessment by the Royal Australasian College of Surgeons, in The Outlook for Surgical Services in Australasia produced in June 2003, which highlighted that 33 per cent of practising surgeons in Australia are over 55. This situation could be accentuated even further if the move to safe working hours for doctors in training (as is now mandated in Europe and the United Kingdom) is extended to Australia.

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2 ABS Austats: 4815 Private Health Insurance.
A shortage of nurses – the 2002 performance examination on nursing shortages (A Critical Resource: Nursing Shortages and the Use of Agency Nurses, August 2002) highlighted the shortage of nurses in this State and some of the implications. The Department of Health has taken some measures to address this shortage since the report, though overcoming it will take time.

Hospital beds – the number of funded and staffed hospital beds in the State’s public health system (including public beds provided at Joondalup hospital and the Peel health service) has increased by three per cent over the past five years while the number of surgical procedures performed has increased by 19 per cent. This, together with the increased demand, has resulted in the average bed occupancy of the teaching hospitals being around 102 per cent (occupancy levels over 100 per cent are possible as patients may have been admitted without a bed being available) since June 2003. This is well above the 85 per cent bed occupancy generally considered acceptable for optimum management of hospitals.

3 National Audit Office Inpatient Admissions and Bed Management in NHS acute hospitals February 2000, p 38.
Access to Elective Surgery

Findings and Recommendations

Findings

- The average waiting time for all procedures has remained steady at around four and a half to five months over the past four years, though waiting times can vary significantly between hospitals and procedures.

- Around 35 per cent of elective patients in the public health system in the last two years waited longer than the recommended time for their surgery. This varied considerably between teaching and non-teaching hospitals, with 42 per cent of patients waiting longer than clinically desirable at teaching hospitals.

- Forty-seven per cent of semi-urgent patients had to wait longer than the recommended time, compared with 36 per cent of urgent and 30 per cent of non-urgent patients.

- At February 2003, 1 050 patients had been waiting more than 1 000 days for their surgery.

- Deferrals of elective surgery rose by eight per cent in 2002-03 (including the impact of patients from the Bali explosion that year), with deferrals because of emergencies taking priority becoming more prevalent.

- Surgical services are still less accessible in regional areas than in Perth, but the actioning of the Country Health Services Review could help improve this.

Recommendations

The Department of Health and Area health services should continue to examine, and implement, measures to address the large number of patients waiting longer than the clinically desirable waiting times for their procedures. A priority should be to address the particular concerns about rising waiting times for semi-urgent patients. To ensure that this happens, the proportion of patients waiting longer than the clinically desirable waiting time should become a key Department of Health performance measure.

The Department of Health should:

- actively manage the scope of elective surgical procedures on the waitlist to be performed in the public sector

- continue to action the Country Health Services Review where this better aligns services with country requirements.
What is Elective Surgery

Elective surgery is all surgery that can wait beyond 24 hours. Surgery that cannot wait 24 hours is defined as ‘emergency surgery’. It can include complex and serious procedures such as coronary artery bypass, simple procedures such as tonsillectomies and cosmetic procedures such as liposuction.

A standard definition for what is a ‘surgical’ (rather than ‘medical’) patient used by the Australian Institute of Health and Welfare (AIHW) is that elective surgical procedures include cardiothoracic (eg heart surgery); ear, nose and throat (ENT); general surgery; gynaecology; neurosurgery; ophthalmology; orthopaedic; plastic surgery; urology; and vascular surgery. Procedures, such as colonoscopy, specific endoscopic procedures and gastroscopies are not included in the AIHW definition.

Process of Obtaining Elective Surgery

The process of obtaining elective surgery is outlined in Figure 2.

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4 For data from the Hospital Morbidity Database, ‘surgical’ episodes were defined on a consistent basis with A Stitch in Time.
Figure 2: The Elective Surgery Process in the Metropolitan Area (public hospitals)

Source: OAG
The waiting time from consulting the GP to being added to the waitlist is not entirely within the control of the hospital and is not included in the published waiting time for a procedure. The waiting time after that point is entirely within the control of the hospital and is the published waiting time.

Some patients may be examined by the specialists at their ‘rooms’ rather than being referred to the outpatients clinic (this visit will be outside the public health system and patients will be charged according to the specialist’s fee schedule with a percentage rebate from Medicare). These patients are then added to the waitlist directly.

Similarly, specialists will examine private patients in their rooms and, if they are to be admitted to the public hospital as a private patient, they will be added to the waitlist along with public patients.

**Waitlist Numbers**

The number of patients on the reported waitlist has fallen from 17,500 in August 1999 to 13,500 in August 2003. Over that period, the number of patients admitted for their procedure also fell from 4,100 to 2,900 per month. The reduction in the waitlist occurred as the number of patients added to the waitlist each month has been less than the total of the patients admitted for their procedure plus those removed from the waitlist for other reasons. This is illustrated in Figure 3.

![Figure 3: Waitlist cases (August 1999 to August 2003)](Source: CWLB)
Waiting Times

A key measure of how effectively access is being managed is the waiting time for elective surgery (and especially the extent to which patients wait beyond the clinically desirable waiting time).

Waiting times (for the reported waitlist) have not increased in recent years. Indeed, the average overall waiting time has remained relatively steady over the last four years at around four and a half to five months and at August 2003 was four and a half months. The waiting time is measured from the date the patients are added to a hospital waiting list to the date of admission to hospital for their surgical procedure.

There are still a number of concerns about waiting times for elective surgery:

- Patients Waiting Longer than Clinically Desirable

Waiting too long for surgery can be stressful for the patient and can increase the chances of other associated problems (known as co-morbidities) arising. These can further complicate the surgery when it is eventually performed.

As shown in Figure 3, around 35 per cent of elective surgery patients in the last two years waited longer than the recommended time for their surgery.

The situation is worse at teaching hospitals, with 42 per cent of patients waiting longer than clinically desirable. In February 2003, 286 urgent patients had not received surgery within the clinically desirable time. Of these, 20 per cent had waited more than six months and some had waited 12 to 18 months. This suggests that some patients may have been classified incorrectly as requiring urgent attention.

The maximum amount of time a patient should wait for surgery is defined in the National Health Data Dictionary (NHDD), and is based on the clinical urgency of the patient. These ‘clinically desirable waiting times’ are defined in the NHDD as:

- Urgent (Category 1) – procedures should be performed within 30 days
- Semi-Urgent (Category 2) – procedures should be performed within 90 days
- Non-Urgent (Category 3) – procedures should be performed in less than one year.
Waiting Times for Semi-Urgent Patients

Since January 2002, patients in this category have waited, on average, 47 per cent longer than the clinically desired time, compared with 36 per cent of urgent patients and 30 per cent of non-urgent patients.
As illustrated in Figure 5, the proportion of semi-urgent patients admitted for their procedure has decreased from around 35 per cent of those waiting for surgery in July 1999 to around 25 per cent in June 2003. Consequently, the proportion of semi-urgent patients on the reported waitlist has increased from 15 per cent in 1999 to 25 per cent in 2003.

**Long Wait Patients (Patients waiting over 1 000 days)**

In February 2003, there were 1 050 patients who have been waiting more than 1 000 days for their surgery, 97 per cent of whom were non-urgent patients. This included 280 patients who had been waiting more than five years. Most of these were for procedures that may be considered cosmetic (and not clinically necessary), but included 770 patients who had been waiting two and a half to five years, many of whom were waiting for procedures such as tonsillectomies and arthroscopies.

Many of the cosmetic procedures (which are not clinically necessary) for which patients have waited more than five years will not be performed in the public health system. Consequently, the Department of Health is currently considering excluding a number of these procedures from the list of those that can be performed in the public system. In addition, Area health services have begun introducing some operational measures to start to address the large number of patients waiting over 1 000 days.
### Variations in Waiting Times between Hospitals

Waiting times for particular procedures can vary substantially between different hospitals. Some examples of this are:

- for a particular knee procedure, the waiting time varied from two and a half months to almost nine months
- keyhole gallbladder removal waiting times varied from one month to over a year for semi-urgent patients
- for non-urgent patients waiting for a release of their carpal tunnel, the wait varied from three months to over 13 months.

### Deferrals

With teaching hospitals operating at such high occupancy rates, unexpected emergency admissions can mean that elective patients have their surgery deferred, often quite close to the scheduled surgery date and sometimes several times before they are operated on. Such deferrals can cause great distress for patients and their families, particularly when this happens late. This can also cause considerable inconvenience, especially for elderly patients where services, such as Silver Chain or Meals on Wheels, may have been cancelled for the expected time in hospital.

Data available from the Department of Health indicates that deferrals of elective surgery at metropolitan hospitals increased by around eight per cent over the last year (this includes the impact on deferrals of patients from the Bali explosion). Apart from patients being unavailable, the main reason for deferrals is because emergencies have taken priority. Deferrals for this reason increased by 11 per cent in the last two years.
This is supported by data from Fremantle Hospital (illustrated in Figure 6).

One strategy used by the teaching hospitals to free beds for emergency admissions and to limit deferrals is to ‘cap’ the number of patients who will be admitted for a stay of more than one day. These ‘caps’ are currently around 25 to 30 for each of the three general teaching hospitals. Although this is an effective strategy for freeing up beds and limiting deferrals, it may cause multi-day patients to wait longer than they should.

Data from teaching hospitals indicated that operating theatre use was more than 90 per cent in 2002-03. Non-teaching hospitals also have made good use of the theatres that are open. Operating theatre staff attempt to fully utilise open theatres. For example, when one specialist is on leave, another specialist may be offered the session.
Regional Surgical Services

Surgical services are less accessible in regional areas. Major surgery generally needs the special resources of a teaching hospital, so many procedures cannot be provided at even the largest country hospitals.

A range of intermediate and minor surgical operations can be safely performed at smaller hospitals. Some are performed by local GPs with training in surgery and anaesthetics. A few surgeons live in regional areas and work at hospitals on sessional or VMP terms. Some hospitals are visited by Perth specialists, either by individual arrangements, links with teaching hospitals or the University Rural Surgical Services unit. The Patient Assisted Travel Scheme (PATS) gives people financial assistance for travelling when specialists are not available locally.

There are no clear statements about the range of surgery that should be offered by different types of country hospitals, or targets for the number of cases to be treated. The management of patients, through booked admission dates or waiting lists, is largely by individual surgeons. Consequently, information on the numbers of patients waiting for elective surgery, and whether they are admitted within the clinically advisable times, is not routinely collected or reported by most country hospitals. This information would assist the Department in understanding how well the provision of elective surgical services is managed in regional areas.

Figure 7: Number of surgical inpatient cases per 1,000 people by health service of residence in 2002-03

Source: HMDB and Department of Health – Epidemiology
The likelihood of having a surgical procedure varies widely according to where a patient lives and the type of procedure required. The total number of public and private surgical inpatient cases per 1,000 population in Western Australia rose from 154 in 1998-99 to 165 in 2002-03, ranging from 121 for Kimberley residents to 194 for Midwest-Murchison residents, as shown in Figure 7.

The likelihood that patients will be treated at a public hospital within their health service of residence, another public hospital, or at a private hospital, also varies widely between health services, as shown in Figure 8. Where a patient is treated is largely dependent on the local public facilities and access to private medical treatment.

Figure 8: Place and type of hospital where surgical inpatients are treated by country health service of residence

Source: HMDB
The only country hospitals reporting more than 2,000 surgical inpatient episodes in 2002-03 were Bunbury (6,681), Peel (5,783), Geraldton (4,577), Albany (4,416), Kalgoorlie (4,388), and Busselton (2,247).

Among the smaller country hospitals, 44 had fewer than 50 surgical episodes in the year. For these hospitals, the operating theatre and associated resources were used for an average of under one case, often an emergency, per week.

In July 2002, Western Australia’s country health services were combined into the WA Country Health Service to be administered through six regions and the South West Health Board. The aim was to strengthen and improve the delivery of health services. Leading hospitals will be designated as regional resource centres. Where practical, these centres will provide general surgery and orthopaedics and offer support to smaller hospitals in the region. Other surgical specialties will continue to be supplied by visiting services from Perth, each country health service being linked with a metropolitan health service.

The Country Health Services Review notes that its proposals “should have a significant impact on the capacity of regions to cater for the health needs of their populations, thereby reducing the need for people to travel to Perth for services”.

An important part of the restructure will be to set targets, including for surgical services, so that performance each year can be assessed and not merely described.

Because of the distances and lack of large towns in regional Western Australia, there will always be challenges in providing surgical services at country hospitals. Balances will have to be found between the preference of most patients to be treated as close to home as possible and the practicalities of providing local services to small, dispersed communities.
Improving Access to Metropolitan Hospitals

Findings and Recommendations

Findings

- Hospitals have introduced a number of measures to improve access, including increased same day surgery, day of surgery admission and improved bed management.

- The rate at which elective surgery is performed varies through the year. For example, monthly admissions are particularly low in the December to February period.

- The new Area health service structure provides the potential for greater coordination between teaching and non-teaching hospitals within areas. Scope for this coordination to occur is evidenced mainly by lower bed occupancy, a smaller ratio of staffed to unstaffed beds and lower proportion of patients waiting longer than the recommended time for their surgery at non-teaching hospitals compared with teaching hospitals.

- Some hospitals have begun to trial greater coordination, though some key constraints are the:
  - availability of staffed beds at non-teaching hospitals
  - difficulty of attracting VMPs to non-teaching hospitals
  - reluctance of doctors to be transferred to non-teaching hospitals
  - industrial agreement between the AMA and the Department of Health.

Recommendations

Area health services should continue to:

- increase the proportion of elective surgery performed through day surgery and day of surgery admission

- examine opportunities for improving the scheduling of elective surgery through the year to better utilise bed capacity through the year

- examine and introduce procedures, including those similar to that of the SMHS trial, to better coordinate elective surgery between teaching and non-teaching hospitals. This should include examining ways of overcoming the various constraints on making more use of non-teaching hospitals without significantly increasing costs to the overall health system.
The Department of Health should:

- introduce performance agreements (which include elective surgery performance measures) with the Area health services

- develop a clear role in central office for moving public patients between hospitals in the various Area health services where CWLB information indicates that this would help to ease pressure on a particular Area health service. This should include implementing consultation mechanisms between the central office and the Area health services and actively promoting to GPs the availability of useful information to facilitate referrals through the CWLB’s website.

### Improving Hospital Efficiency

#### Recent Improvements

Since 1999, hospitals have taken a number of measures to improve the efficiency of their operations and to ease the pressures on them. These have included:

- **Same Day Surgery and Day of Surgery Admission**

  Two measures which have been used to reduce the average length of stay in hospitals and free up more beds are same day surgery and day of surgery admission (DOSA).

  Advances in keyhole technology and anaesthetics together with hospital initiatives, such as 23 hour wards, have helped the hospitals to increase the proportion of same day surgery from 48 per cent in 1999 to 53.3 per cent at present. This is similar to the Australian average.

  Another initiative has been the introduction of DOSA surgery where patients who expect to stay in hospital more than one day attend pre-admission clinics to have tests and anaesthesia arrangements assessed before they are admitted. These patients can then have their surgery on the day they are admitted. Presently, metropolitan hospitals in this State admit 74 per cent of their patients on the day of surgery.

  The effect of these two measures has been to reduce the average length of stay in hospital. Over the past ten years, the average length of stay in public hospitals in Western Australia has been reduced from 4.1 days to 2.9 days. This is in line with the Australian average and better than some other States.
Improved Bed and Emergency Department Management

Hospitals have also implemented a range of initiatives to improve bed management and emergency department practices to help reduce both emergency department admissions and the patient’s length of stay in hospital.

These initiatives have included transit lounges (where patients can be moved on the day of discharge while they are waiting for medication and transport to be arranged so that beds in wards can be freed up earlier in the day). They have also implemented improved assessment procedures in emergency departments and better discharge procedures.

Improved Scheduling of Elective Surgery

One way to further improve access for elective patients would be to schedule elective surgery more evenly through the year.

For example, Figure 9 indicates that emergency procedures remain fairly stable throughout the year, with the peaks in winter becoming less marked in the past two years. Elective procedures on the other hand, are quite variable for most of the year, but are markedly lower in December to February. Over the last three years, the average monthly percentage of elective procedures (both medical and surgical) for summer was 7.7 per cent of annual throughput compared with 8.7 per cent per month during winter.

Scheduling more elective surgery during the lower workload periods, therefore, could help reduce waiting times without creating additional pressures on bed occupancy and operating theatre availability.

![Figure 9: Monthly Admissions (Medical and Surgical)](Source: HMDB)
Coordinating Access Within Area Health Services

The structural changes to the State’s health system in 2001-02, arising primarily from the 2001 HARC report, created four metropolitan, and seven country health areas responsible to the Department of Health.

Of the four metropolitan health areas, three are general Area health services centred on the three teaching hospitals – Royal Perth, Fremantle and Sir Charles Gairdner – and drawing in non-teaching hospitals in the eastern, southern and northern parts of Perth respectively.

<table>
<thead>
<tr>
<th>Teaching Hospital</th>
<th>East Metropolitan Health Service</th>
<th>South Metropolitan Health Service</th>
<th>North Metropolitan Health Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Perth</td>
<td></td>
<td></td>
<td>Sir Charles Gairdner</td>
</tr>
<tr>
<td>Fremantle</td>
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<tr>
<td>Sir Charles Gairdner</td>
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<tr>
<th>Non-teaching Hospitals</th>
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<th>South Metropolitan Health Service</th>
<th>North Metropolitan Health Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swan Districts</td>
<td>Royal Perth</td>
<td>Edmund Bartley Health Service</td>
<td>Osborne Park</td>
</tr>
<tr>
<td>Bentley</td>
<td></td>
<td>Rockingham</td>
<td>Graylands</td>
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<tr>
<td>Kalamunda</td>
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<table>
<thead>
<tr>
<th>Associated Private Hospital</th>
<th>East Metropolitan Health Service</th>
<th>South Metropolitan Health Service</th>
<th>North Metropolitan Health Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nil</td>
<td>Royal Perth</td>
<td>Edmund Bartley Health Service</td>
<td>Osborne Park</td>
</tr>
<tr>
<td>Peel</td>
<td></td>
<td>Rockingham</td>
<td>Graylands</td>
</tr>
<tr>
<td>Joondalup</td>
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</tbody>
</table>

Figure 10: Metropolitan General Health Areas

This new Area health structure potentially could enable greater coordination of services between the teaching, and non-teaching, hospitals within each Area health service.

Differing Pressures on Teaching and Non-teaching Hospitals

Most of the pressures for surgery are in the three general teaching hospitals with admissions to them representing 42 per cent of public surgical admissions to metropolitan hospitals in 2002-03. Non-teaching public hospitals accounted for 28 per cent, and Joondalup and Peel hospitals accounted for 13 per cent, of public surgical admissions in the metropolitan area (the other 17 per cent of admissions were in the Women and Children’s health service).

The teaching hospitals are much larger than the non-teaching hospitals, averaging 468 staffed and funded beds per hospital compared with 107 beds for the non-teaching hospitals. They tend to have the more advanced equipment and services, provide super-speciality surgical services (these include Neuro-Surgery, Cardio-Thoracic Surgery, Endocrinology and Clinical Haematology), have Intensive Care Units, and attract the more highly skilled and specialised surgeons.
For these reasons, the bulk of the emergency patients are admitted to the teaching hospitals. In addition, 78 per cent of the urgent and 55 per cent of semi-urgent elective patients attend these hospitals.

While it is clearly not possible (in terms of available funds) to upgrade all hospitals to a similar status to the teaching hospitals, there is scope for greater coordination between teaching and non-teaching hospitals. This is evidenced by the following:

- the proportion of staffed to unstaffed beds is much lower at non-teaching hospitals – 78 per cent compared with 94 per cent at teaching hospitals in 2001-02
- bed occupancy is only 79 per cent (of staffed beds) at non-teaching hospitals compared with 102 per cent at teaching hospitals
- the median waiting time for elective surgery over the past three years was four months for non-teaching hospitals and 5.6 months for teaching hospitals. Given that 72 per cent of urgent patients (which normally have the shortest waiting time) are treated at the general teaching hospitals, the median waiting times would be expected to be much lower than for non-teaching hospitals. For individual procedures, this difference can be much greater. For example, for a non-urgent cystoscopy, a patient could expect to wait 49 days at Osborne Park Hospital, compared with 860 days at Sir Charles Gairdner Hospital

- for the two years to August 2003, around 20 per cent of patients at non-teaching hospitals were waiting longer than the recommended time for their surgery, compared with 42 per cent at teaching hospitals

- in 2002-03, at the general teaching hospitals, patients were added to the waiting list faster than they were treated for a selection of common procedures. On the other hand, at non-teaching hospitals they were being treated faster than they were being added to the waiting list for the same set of procedures. This is illustrated in Figure 11. For tonsillectomies, Figure 11 shows that only 68 per cent of patients added to general teaching hospital waiting lists in 2002-03 were treated. At this rate the waiting list for tonsillectomies at one teaching hospital will take almost seven years to clear.
Improving Coordination

During the course of the examination, it was evident that since the three general metropolitan Area health services were established in 2001-02, they have begun to plan and move towards greater coordination of the teaching and non-teaching hospitals.

This was clear from planning documents obtained from all three health areas. Furthermore, the South Metropolitan Health Service undertook a trial in the first half of 2003 (for some selected procedures). Under the trial, waitlisted elective patients were prioritised and offered the opportunity of having their surgery performed at any hospital in the area. Alternatively, they could remain on the waitlist for Fremantle Hospital. This initiative is continuing on a periodic basis.

Figure 11: Rate at which specific procedures are performed (2002-03)

Source: HMDB
### Case Study: South Metropolitan Health Service Initiative Trial

**Initiative:**
All patients booked for the selected elective surgical procedures at hospitals in the area were to receive their operations in accordance with the following criteria:
- First – the clinically defined urgency of the patient
- Second – the number of days on the waitlist

Patients (and their GPs) were offered the opportunity to use any hospital within the area, or remain on the Fremantle Waitlist.

**Selected Procedures:**
- Laparoscopic Cholecystectomy (keyhole removal of the gallbladder)
- Repair of hernia
- Varicose veins
- Excision skin lesion
- Colonoscopy

**Procedure:**
1. All patients waiting for the selected procedures at any hospital in the SMHS were identified and prioritised according to the above criteria.
2. The highest priority patients were identified for the earliest operations.
3. The patient’s GP was contacted to determine whether the patient still required the operation and could travel within the SMHS for it.
4. The patients were then contacted to determine their willingness to travel within the SMHS for the operation.
5. The specialist’s rooms were then advised of the waitlist patients allocated for pre-operative review.
6. The original specialist was notified of the transfer of the patient for the operation.
7. The patients were scheduled for review at the specialist’s rooms which liaised with the local hospital to structure operating lists.
8. The patients were then notified by SMHS of their booking date/location.
9. Specialists were paid a facilities fee by SMHS.

**Figure 12: South Metropolitan Health Service Waitlist Initiative Trial**

Source: South Metropolitan Area Health Service
Nevertheless, it is clear that there is still considerable scope to coordinate elective surgery between teaching and non-teaching hospitals. It is recognised, however, that there are a number of constraints that will need to be addressed. Some of the key constraints on greater use of non-teaching hospitals identified in discussions with the hospitals, the Royal Australasian College of Surgeons and the Australian Medical Association (AMA) were:

- the availability of staffed beds and operating theatre time at the non-teaching hospitals. These can be particularly constrained during periods of high demand (and bypass) at the teaching hospitals. To ease the pressure on the teaching hospitals at these times appropriate patients are often transferred to the non-teaching hospitals causing them to defer elective surgery.

- the current shortage of surgeons (with elective surgery at non-teaching hospitals being performed primarily by VMPs) which is being accentuated by an increasing degree of specialisation. Consequently non-teaching hospitals can find it difficult to attract surgeons in a range of specialties because of problems such as:
  - having a sufficient number of patients for each specialty to operate on
  - the availability of support staff for patients having to stay overnight (to manage any post-operative complications that may occur)
  - the availability of anaesthetists
  - the availability of equipment to manage complex surgery and post-operative care

- the industrial agreement between the AMA and the Department of Health which allows existing salaried doctors (at the time of the agreement in April 2002) to be transferred from the health service to which they were appointed only by mutual agreement. However, the agreement does permit greater flexibility for doctors appointed since that time and the Department of Health advises that contracts for some new appointments reflect this

- reluctance of doctors to be transferred to different hospitals. This mainly reflects concerns about remuneration, working conditions, and teaching and training opportunities.
Improving Central Coordination

The new health system structure put in place in 2001-02 also allows greater central coordination of the Area health services by the Department of Health central office.

Some ways in which the central office might improve the coordination of elective surgery for the system as a whole could include:

- **Performance Agreements**
  
  To date, the Department of Health has not introduced performance agreements for the various Area health services as is done in some other States. This issue has been canvassed in discussion papers released in October 2003 by the Health Reform Committee.

  Such agreements would set out how the Area health service fits in with the overall health system needs for elective surgery and establish specific performance measures and targets. They would provide a mechanism to drive and assess performance by the Area health services in providing access to elective surgery.

- **Role of CWLB**

  Health initiatives, like that which was trialled by the SMHS, can help to improve the coordination of teaching and non-teaching hospital facilities within individual Area health services. Nevertheless, some mechanism is still needed to transfer patients between Area health services where this can help ease the pressures on a particular Area health service.

  The CWLB has done this in the past. Between 1998 and 2000, the Department of Health advised that it relocated some 7,000 patients between hospitals, made possible through the injection of $125 million, in the five years to 2003. As of 2003-04, the funding allocation is no longer with the CWLB.

  The effectiveness in transferring patients between the Area health services could be enhanced by:

  - establishing a clear role in central office for moving patients between the Area health services where CWLB information indicates that this would help ease the pressures on a particular Area health service. This would require:

    - establishing a consultative mechanism with the Area health services so that CWLB’s activities are coordinated with, and communicated to, the Area health services

    - actively promoting the CWLB’s website and other publicly available information to GPs as a ‘user friendly’ and ‘immediate’ means of determining the waiting, and clearance, times for particular procedures at different hospitals before referring patients for elective surgery. While, it could be made more ‘user friendly’, the CWLB website currently provides information on waiting times and the number of patients waiting for many procedures and provides a mechanism for GPs to see which doctor at which hospital has the shortest waiting time for a specific procedure. However, GPs could be made more aware of the existence of the website, its usefulness on deciding on who and where to refer patients, and how to use it.
Findings and Recommendations

Findings

- The reported waitlist (which is consistent with the Australian Institute of Health and Welfare (AIHW) definition of surgery) represents less than approximately 47 per cent of the total waitlist (which also contains medical procedures and other surgical procedures).

- The time between seeing the GP and being included on the waitlist is not included in the reported waiting time.

- The Department of Health does not have a single set of comprehensive guidelines on waitlist management that can be used by all hospitals.

- The Department also does not have a set of guidelines for specialists to help ensure a more consistent categorisation of patients into the various urgency categories. Further, it does not monitor the consistency of categorisation (as is the case in some other States).

- Clerical audits (administrative reviews of patient details) of the waitlist are limited to the reported waitlist with no regular clinical reviews (evaluation of the patient’s clinical status) of long wait patients currently being undertaken.

Recommendations

The Department of Health should:

- Report and manage the total waitlist as well as the current ‘reported’ waitlist.

- Report the time between the patient visiting the GP and being included on the waitlist so that patients are aware of the full waiting time for their procedures.

- Develop a single set of comprehensive guidelines on waitlist management that can be used by all hospitals.

- Develop a set of guidelines for specialists in the health system, in conjunction with them, to assist in the categorisation of patients into the various urgency categories and review urgency categorisation for consistency (as is done in some other States).

- Extend clerical audits by the CWLB to the full waitlist.

- Institute regular clinical reviews of patients who have been on the waitlist for an extended period.
Reliable information on waiting times can assist the department and hospitals to:

- develop strategies to manage the demand for elective surgical procedures
- allocate resources effectively
- schedule operating theatre sessions and develop operating theatre lists.

This information could also be useful to patients and GPs when it comes to selecting a specialist.

Reasonable waitlist information is available in this State as it is collected, reviewed, and analysed by the Department of Health’s CWLB – the only central bureau of this type in Australia.

The CWLB provides publicly available information (on both its website and through a monthly news bulletin) for teaching and non-teaching hospitals and each Area health service relating to median waiting times, the number of patients admitted to hospitals for elective surgery, a breakdown by surgical speciality and a range of other useful information. The CWLB also details the proportion of patients seen within the clinically desirable waiting time for each of the urgency categories and by each hospital.

However, a number of limitations to the data are outlined in this chapter.

**The Reported Waitlist**

The publicly available information from the CWLB includes only those procedures in the definition used by the AIHW for its collection of Australia-wide information on elective surgery (as outlined in the section ‘What is Elective Surgery’, page 17).

However, it excludes a wide range of procedures such as colonoscopies, various endoscopic procedures, procedures associated with obstetrics (eg elective caesarean) and gastroscopies.

The reported waitlist also excludes most country hospitals (Bunbury is included). Some country patients are not included in a waitlist, primarily as they are listed by specialists at their rooms, rather than being placed on the hospital computer system. On average, there are 3 700 patients per month on the country waitlist.
A comparison of the total and reported waitlists for the last two years is provided in Figure 13. The figure highlights that the reported waitlist (of around 13,500) is approximately 47 per cent of the total waitlist of patients waiting for elective procedures (which is currently almost 29,000).

**Time Between Visiting a GP and Being Placed on the Waitlist**

Before patients are added to the waitlist, they may have waited considerable time between visiting their GP, seeing a specialist and being added to the waitlist.

While this time period is currently not reported, some data has been collected by the CWLB on the time between visiting the GP and receiving a referral to see the specialist. This information forms the basis of Figure 14.
Ensuring a True Picture of Waiting Numbers and Times

Access to elective surgery is more likely to be improved if decisions are made on the basis of accurate and complete information. This is most likely to be achieved where those responsible for the data have clear guidelines and the data is audited regularly.

Comprehensive Guidelines

At present, the Department of Health does not have a single set of comprehensive guidelines on waitlist management (eg specifying when patients can be added to, or removed from, the list; defining terms such as ‘ready for care’; and specifying when and how audits should be done) that can be used by all hospitals. Some of the hospitals have developed their own sets of procedures, but these were not prepared on a consistent basis and in some cases have not been kept up to date.
A single set of comprehensive guidelines would help to ensure the accuracy and completeness of the data by defining procedures for waitlisting as well as processes that patients should follow when they require surgical or medical intervention.

**Clinical Categorisation of Patients**

An important measure of access to elective surgery and the possible impact of waitlisting on the overall health of the patient is how long they have had to wait beyond the recommended time for their procedure, depending on whether it is classified urgent, semi-urgent or non-urgent.

For this categorisation to be of most use, consistent and accurate classification of patients into each of the three categories is necessary.

The classification is a clinical one decided by the specialists on their assessment of the needs of the patient. Nevertheless, to help improve consistency, some guidance for specialists on how to decide between the categories and reviewing urgency categorisation for consistency (this is currently done in some other States) would be helpful. The South Metropolitan Health Service issued some guidelines for specialists in the area in September 2003, but a consistent set of guidelines for the whole health system is needed.

**The Waitlist**

The CWLB currently does clerical audits of the reported waitlist, but not of the entire waitlist. A comprehensive and regular clerical audit process would help ensure the accuracy of the waitlist information. The audit should include as a minimum, checking that all relevant patient information has been collected, ascertain whether the patient has already had the procedure and check for duplicate recording of patients. In addition, regular clinical reviews of patients who have been waiting long periods should be performed to ensure that the waitlist continues to accurately reflect the number and clinical priority of the patients waiting for admission.
Appendix 1

Examination Approach

The approach taken by the examination included:

- analysis of data from the Hospital Morbidity Data Base (and from the CWLB)
- visiting and interviewing staff at the following hospitals:
  - Royal Perth Hospital
  - Sir Charles Gairdner Hospital
  - Fremantle Hospital
  - Rockingham Hospital
  - Osborne Park Hospital
  - Armadale-Kelmscott Hospital
  - Swan Districts Hospital
  - Bunbury Hospital
  - Northam Hospital
  - Peel Health Campus
- analysis of data and information obtained from these hospitals and the Department of Health
- analysis of the results of a questionnaire to all country hospitals that provide surgical services
- review of annual reports, planning papers and other relevant documents for the health systems of both Western Australia and other States
- discussions with representatives of the New South Wales health system.
## Progress in Implementing A Stitch in Time Recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Progress Towards Implementing Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Maximise the use of same day surgery and minimise the length of stay for other cases.</td>
<td>The use of same day surgery (including day of surgery) has increased significantly. Hospitals now use 23 hour wards and transit lounges to minimise the average length of stay.</td>
</tr>
<tr>
<td>2. Review the medical staffing arrangements at non-teaching hospitals.</td>
<td>Visiting Medical Practitioners (VMP) contracts have been made available to hospitals. The Public Accounts Committee report on VMPs supported the use of VMPs in rural areas, though the use of salaried doctors has increased in the larger regional centres (eg Bunbury and Kalgoorlie) and salaried doctors predominate in the North West and Kimberley. However, little progress has been made in metropolitan non-teaching hospitals in the present climate of shortages of surgeons.</td>
</tr>
<tr>
<td>3. Exercise greater influence over the referral of elective surgery patients.</td>
<td>Referral practices have remained the same overall. The CWLB now publishes information on procedures by hospital and surgeon but it is not actively promoted to GPs and patients. From 2003-04, the CWLB no longer has a funding allocation to move patients between hospitals.</td>
</tr>
<tr>
<td>4. Review the range of surgery that will be offered to public patients.</td>
<td>Consideration is currently being given to a range of ‘cosmetic’ and other procedures (that are not clinically necessary) to be excluded from the waitlist.</td>
</tr>
<tr>
<td>5. Review the surgical facilities and services to be provided at country hospitals.</td>
<td>The Department completed a review of the WA Country Health Service in March 2003.</td>
</tr>
<tr>
<td>6. Include the delay from GP referral to specialist or outpatient consultation in the measurement of waiting lines for elective surgery.</td>
<td>This has not been implemented, though some data has been collected by the CWLB.</td>
</tr>
<tr>
<td>7. Improve and extend the reporting of waiting list numbers and times to all hospitals.</td>
<td>The HCARe waitlist system is being implemented in the country. However, of the country hospitals, only patients from Bunbury are included in the reported waitlist.</td>
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</tbody>
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*continued page 44*
8. Refine the assessments of clinical urgency for elective surgery patients and ensure they are consistently applied. The Clinical Priority Access Criteria project is being re-instituted. This has been trialled previously to selected GPs.

9. Develop visiting services where appropriate and practical. Visiting specialist programs have been funded to cover a broader range of surgical needs in the country. However, the availability of surgery is still an issue at some country hospitals.

10. Conduct research into variations in the delivery of surgical care, overall and by individual procedures. Some research has been done but not on a comprehensive or regular basis.

11. Extend programs of surgical audit and peer review. The Australian Incident Monitoring System has been introduced and a Statewide Clinical Audit project has commenced to develop a framework to guide Area health services in developing policies for clinical audits. In addition, DOH has introduced:
   - clinical governance programs (which include peer reviews)
   - the State Quality Council (which oversees incidents across the system)
   - the West Australian Audit of Surgical Mortality, which audits all deaths from surgery in Western Australia.

12. Enhance the monitoring of operating theatre activity. A comprehensive operating theatre system has been installed in all metropolitan, and some country, hospitals where surgery is performed. Some progress has been made in developing a core set of definitions to facilitate improvements to efficiency.

13. Encourage use of evidence based medicine findings in the development of clinical practice. Teaching hospitals have advised that they are making greater use of evidence based medical findings and the Clinical Access Online has been put in place to support this.
Previous Reports of the Auditor General

1997

The Western Australian Public Health Sector June 11, 1997
Bus Reform – Competition Reform of Transperth Bus Services June 25, 1997
First General Report 1997 – covers financial statements and performance indicators of departments, statutory authorities (excluding hospitals other than Wanneroo Hospital) and subsidiary bodies August 20, 1997
Waiting for Justice – Bail and Prisoners in Remand October 15, 1997
Private Care for Public Patients – The Joondalup Health Campus November 25, 1997

1998

Report on Ministerial Portfolios – Audit Results – Consolidated Financial Statements April 8, 1998
Selecting the Right Gear – The Funding Facility for the Western Australian Government’s Light Vehicle Fleet May 20, 1998
Report on the Western Australian Public Health Sector May 20, 1998
Sale of the Dampier to Bunbury Natural Gas Pipeline (Special Report) May 20, 1998
Weighing up the Marketplace – The Ministry of Fair Trading June 17, 1998
Listen and Learn – Using customer surveys to report performance in the Western Australian public sector June 24, 1998
Report on the Western Australian Public Tertiary Education Sector August 12, 1998
Public Sector Boards – Boards governing statutory authorities in Western Australia November 18, 1998
Send Me No Paper! – Electronic Commerce – purchasing of goods and services by the Western Australian public sector November 18, 1998
Accommodation and Support Services for Young People Unable to Live at Home November 26, 1998

1999

Report on the Western Australian Public Health Sector – Matters of Significance April 21, 1999
Proposed Sale of the Central Park Office Tower – by the Government Employees Superannuation Board April 21, 1999
Lease now – pay later? – The Leasing of Office and Other Equipment June 30, 1999
Getting Better All The Time – Health Sector Performance Indicators June 30, 1999
PREVIOUS REPORTS OF THE AUDITOR GENERAL (continued)

1999 (continued)

Fish for the Future? – Fisheries Management in Western Australia
Public Sector Performance Report 1999 – Controls, Compliance and Accountability Audits – Follow-up Performance Examinations
A Stitch in Time – Surgical Services in Western Australia
Report on Ministerial Portfolios to November 5, 1999 – Issues Arising from Audits
– General Control Issues – Summary of the Results of Agency Audits

2000

Public Sector Performance Report 2000 – Emerging Issues – Management Control Issues
Report on the Western Australian Public Health Sector and of Other Ministerial Portfolio Agencies for 1999
A Means to an End – Contracting Not-For-Profit Organisations for the Delivery of Community Services
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